



## Public Accounts Committee

### Oral evidence: Covid-19: Government procurement and supply of personal protective equipment HC 928

Thursday 10 December 2020

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[Watch the meeting](#)

Members present: Meg Hillier (Chair); Gareth Bacon; Shaun Bailey; Olivia Blake; Sir Geoffrey Clifton-Brown; Shabana Mahmood; Sarah Olney.

Gareth Davies, Comptroller and Auditor General, National Audit Office, David Fairbrother, Treasury Officer of Accounts, HM Treasury, Charles Nancarrow, Director, National Audit Office and Robert White, Director, National Audit Office, were in attendance.

Questions 1-86

#### Witnesses

[I](#): Gavin Edwards, Senior National Officer (Social Care), UNISON, Professor Martin Green OBE, Chief Executive, Care England, Dr Emily McWhirter, Retired Nurse, Royal College of Nursing and Dr Chaand Nagpaul CBE, Council Chair, British Medical Association.



## Examination of witnesses

Witnesses: Gavin Edwards, Professor Martin Green, Dr Emily McWhirter and Dr Chaand Nagpaul.

**Q1 Chair:** Welcome to the Public Accounts Committee on Thursday 10 December 2020. We are here today to discuss the critical issue of the Government's procurement and supply of personal protective equipment at the height of the covid-19 pandemic back in March, April and ongoing through the summer. Today we will hear from frontline medical and care associations, and those representing workers on the frontline, about what it felt like for them at that critical time and what their concerns or issues are now.

Of course, we have been very well supported by the National Audit Office, which has recently published two Reports that examine the supply of personal protective equipment specifically and wider procurement. We will challenge Government witnesses on Monday about how things went.

However, we are really interested in who bought what from whom and at what cost. Of course, this is all taxpayers' money and an eye-watering £12 billion was spent on this equipment, so it is really important that we watch that taxpayers' money.

We are also keen, of course, that lessons are learned. We will have more of covid, even with the vaccine, so we want to ensure that we are learning from this experience, and I hope that our witnesses today will shed some light on that.

I should just say that the National Audit Office's remit is to look at the public sector, so it can go as far as the contracts let but not the private companies themselves; it does not have the powers to investigate those companies. And a number of the private companies that were involved in this area are facing a judicial review, so it is difficult for us to discuss those cases today. But we can and will discuss the general principles, which we will cover in our hearings today and Monday.

I welcome our witnesses. First, we have Dr Chaand Nagpaul, who is the chair of the council of the British Medical Association; welcome to you. We have Professor Martin Green, the chief executive of Care England, who is really here to talk about care homes and the impact on them; and Dr Emily McWhirter, who is formerly the director of nursing at the Royal Hospital for Neuro-disability but is here to represent the Royal College of Nursing. We are pleased also to have Gavin Edwards, who is the senior national officer for social care for Unison, representing thousands and thousands of frontline care workers who were involved in the first wave of the pandemic.



## HOUSE OF COMMONS

All of you are representing really key people who supported us all at that very difficult time and continue to do so. As a Committee, we would like to thank all of them and you.

Before we go into the main session—I apologise that we are audio only; we hope to get the picture back very soon and I am going to carry on nevertheless—I would like to ask, first, Dr Nagpaul about the vaccine rollout. What do your members need to make sure that the vaccine can roll out effectively through GP practices?

**Dr Nagpaul:** With regard to GP practices, the biggest logistic issue at the moment is that the vaccine that has been approved has, as you know, some very stringent storage requirements. That means that we cannot deliver the vaccine as we do a flu vaccination—in our own GP practices. This vaccine has to be delivered in the community at designated sites, which will be served by several GP practices; and of course, as the vaccine is being delivered, we may come across issues like the anaphylactic reactions we heard about yesterday. It also means that the staff who will be delivering the vaccine, the staff who will be manning the sites to register patients and so forth are staff who would otherwise be in our own practices, so it will be an issue that we will mobilise staff who will not be able to do their normal work. I hope that is properly taken into account by the Government in terms of some of the other requirements they place on GP practices.

The most important element of this is to vaccinate those who are in greatest need, and we know that those over 80 and those who are resident in care homes will benefit most from being vaccinated, preventing them from being ill from coronavirus. The difficulty is that because of the restrictions with this virus, the centres may of course not be accessible to many housebound patients—those who cannot actually get to the centres. So I hope that we will in time—very shortly—have arrangements for the vaccine to be taken to at least care homes, because we all know that the most vulnerable are those who will end up in hospital, will occupy NHS facilities and are most likely to not survive.

These are the logistic issues. When we get the next vaccine, the OxfordAstraZeneca vaccine, it will be easier in terms of these logistics. But it is a mammoth task, because we also need to vaccinate as much of the population as possible in the weeks to come. The one thing I want also to emphasise is that no one should let down their guard with regard to the continued need for social distancing, wearing masks and so forth. This programme will take months to deliver. In the meantime, every day there is the risk of people becoming infected and becoming seriously ill, so we must do the two in parallel.

**Q2 Chair:** Do you feel that the BMA is having good and fruitful engagement with the vaccine team to make sure that the roll-out works from your perspective and, as you say, is reaching those vulnerable patients particularly?



**Dr Nagpaul:** Well, we couldn't have input into some of these dialogues; the input is also occurring, of course, at local level. As I said, I think some of the issues really are those of logistics, because of the vaccine's specific requirements, but I also think that the BMA has been very clear about the fact that you cannot have doctors in two places at once. We are asking for some understanding and removal of some of the bureaucratic and other requirements, certainly for GP practices, because it will be very difficult to deliver this programme whilst carrying on doing everything else at the same time, because we just don't have the staff to be doing both priorities.

Q3 **Chair:** Dr Emily McWhirter, a number of members of the Royal College of Nursing will of course also be pretty keen to roll this out. Have you felt that you have had good engagement with Government about these logistical issues and about how you can support the delivery of the vaccine?

**Dr McWhirter:** I have not spoken to them directly about their level of involvement with the distribution, but I know that there are concerns among nurses about how they will be able to deliver the vaccine to smaller care homes because of the logistics of the way it is supplied—the freezing issues and the volume of vaccine they will have. The other issue is about ensuring that families visiting care homes understand the timeframe for it to be working. Obviously, you don't get immunity straightaway, and I think a lot of communication needs to be around ensuring people understand that it doesn't mean that the minute you have the vaccine you are immune to the virus. It's working with the comms around distribution as much as the logistics that we need to make sure we get right.

Q4 **Sir Geoffrey Clifton-Brown:** Good morning, Dr Nagpaul. I have a quick but important question on vaccines. In the rush to get the vaccines administered, are you satisfied that the administrative arrangements for recording who has and who has not had the vaccine are in place? It could be important to trace back any problems later.

**Dr Nagpaul:** I have to be honest and say that, certainly in the community, because we have not yet started the programme until next week, I cannot say that I am confident. We hope that everyone is recorded properly. That is critical because it is not just a single vaccine. You have to recall everyone who has had the first vaccine in order to be fully immunised. I just hope it will all work as it should. It has to be rushed out because of the need to vaccinate, but it is being done at record pace. I have not come across an initiative in the past in my professional life that has been done at such a rapid pace.

The other thing I want to mention is that we really must make sure that members of the public who are most vulnerable, including many in communities that might not be as trusting about the vaccine, have proper public education messaging so that people can trust the reasons why they should be vaccinated, because this is about a public health measure to serve the nation and to improve the health of the nation.



Q5 **Chair:** Those are important points. As care homes have been mentioned a number of times, Professor Green, have you been involved in discussions with the Government about this very big challenge of how the most vulnerable will be able to get the vaccine and when? Can you give us, particularly people who are in care homes and their relatives, any comfort about the likely timeframe from your perspective?

**Professor Green:** The timeframe is unclear. As Dr Nagpaul said, you require two vaccines. Also, the difficulties of transporting this particular vaccine are significant. We should not expect that this vaccine will necessarily do the entire care home sector. There are 11,400 care homes in England, so this is a mammoth task. We have to be realistic, particularly because we need two shots of the vaccine, so the logistics of this are enormous, particularly when the vaccine has to be transported at minus 70° and can only be transported twice.

Q6 **Chair:** It is a salutary reminder that there is still a very big challenge ahead and that in this week of optimism when the vaccine is being rolled out, there are still very many challenges ahead, so thank you all for your candour.

Finally, before we get into the main session, I want to go to Professor Green. We understand that there has been no white smoke from Brussels. We do not yet know if there is going to be a deal when the end of the transition period comes, and we might end up coming to the 31 December with no deal. What are your worries about the impact on the supply chain for care homes? Can you give us any comfort that preparations are in place to mitigate the impact of a no-deal Brexit?

**Professor Green:** We are concerned on two levels. First, as you say, Chair, there is the issue of the supplies to care homes, particularly medical supplies, but a range of other things. We are also particularly concerned about staff. We have relied heavily in our sector on EU staff. If we are not able to bring them in because of the new requirements, that will cause major problems, so I think the Department needs to give some thought to how they are going to make sure that there are enough staff to be able to staff social care effectively.

**Chair:** Does anyone else have any particular issues around the impact of a no-deal Brexit on their sector? I appreciate that is not what you came to talk about today, but it is obviously very pertinent at the moment. We will leave that there for now. Thank you for taking those questions as well. I should say that the hashtag for anyone following this wider issue is #covidspending, which is something the Committee will use to highlight the work we are doing in relation to covid compared with our other workload.

Q7 **Sir Geoffrey Clifton-Brown:** Can I come back to you, Dr Nagpaul? The NHS declared a red alert, the highest that they could possibly issue, on 31 January. When did your members on the ground start to experience problems with their PPE supply?



**Dr Nagpaul:** We started to experience problems in March when the virus took hold within UK shores. Remember, what we were told in February and early March from the Government was that there were adequate plans and there were adequate stockpiles, so the message to us was, “Don’t worry; we have enough.” In fact, there was a coronavirus action plan published by the Government, on 3 March I think, that again reiterated adequate provisions of stockpiles.

As the weeks went by in March, we were increasingly getting reports from doctors that they didn’t have access to the PPE they needed. There were shortages reported in settings such as AGP areas—where there are aerosol-generating procedures—like in intensive care, where you have the highest risk of the virus spreading because of the fine droplets and aerosol-generating procedures. So what we were being told was that even doctors in high-risk areas, about half of them, said there were shortages.

In general practice—I am a GP—when the virus was really spreading within the community, we had received no supplies by the middle of March of any PPE. What was even worse for those of us in general practice was that we tried to then buy our own, and when you looked at all of our normal suppliers, they had run out, because much of those supplies had been directed towards the NHS and they weren’t available. So we felt pretty abandoned in the middle of March.

We then started getting some supplies in general practice during March, but they didn’t include all the equipment we needed. In fact, we didn’t receive eye protection—it wasn’t even in the Government’s specification. We know that coronavirus, like many other viruses, can spread through the eyes—through the mucous membranes. If someone coughs, you can be infected because of the droplets entering your body through the eyes. But there were no goggles in the specification. That was contrary to the World Health Organisation’s recommendations. So we had a pretty difficult March.

We did a major survey of doctors at the end of March/beginning of April, and only about half of doctors in the most risky areas—as I said, in intensive care, for example—felt they had adequate protection. Only 2% of GPs felt they were properly protected. It was a very difficult month of March.

**Q8 Sir Geoffrey Clifton-Brown:** So when did it start to improve? The Government set up their parallel supply chain in March and Lord Deighton was brought in on 19 April. When, from your surveys, did you detect that things were starting to improve and you were getting the supplies you needed?

**Dr Nagpaul:** I would say in about May. In early April, at the BMA, we had about a hundred contacts of suppliers and people who were saying they could help the NHS with supplies but they said they had hit a brick wall in trying to contact the Government, the Department of Health or NHS England. We ended up forwarding significant numbers of people who were saying they could supply PPE. Some of those were known to doctors



themselves, so I can say that there was veracity in those offers. There was some sort of block.

I wrote to the Government in early April, urging for domestic manufacturing, because in my own practice the only eye protection I had received was from a school that had manufactured eye protection and from a local business that had manufactured it anew. We were very clear at the time of lockdown that there was the possibility of repurposing industry to manufacture PPE, because we were in a desperate situation of just not having the equipment to protect ourselves.

**Q9 Sir Geoffrey Clifton-Brown:** That is pretty shocking.

Can I turn to you, Dr McWhirter? I don't want to go over the same ground that Dr Nagpaul has been over, but do you have anything significant to add?

In framing that question, I should note for the record a fairly shocking statement in your evidence. You say the RCN's UK procurement specialist nurse network was not consulted to help develop the recent PPE strategy, despite the forum offering to assist and provide their expertise. It does not even sound as though you were listened to during this period. Would you like to enlarge on that?

**Dr McWhirter:** That is right. They tried to offer support—they have a team there that would help. But they didn't get in touch; they didn't reply.

I can reiterate Dr Nagpaul's experience on the ground. I was leading the operation in my hospital. We had 250 of possibly the most vulnerable patients in hospital, where I was director of nursing at the time. We have a supply chain—we use the NHS supply chain for our PPE. We continued to order right through March and it just never appeared.

There was nothing that said the order hadn't gone through, but it just never appeared. Very occasionally, we would receive one single item box of something, but there was no confidence at all that any orders that we had put through were arriving. It just fizzled out as the weeks of March went by.

Our absolute pinch point was running out over the Easter weekend. We had enough on Easter Sunday, 12 April, to last until 7pm, and then I had absolutely no gowns to provide protection for my staff. We had a lot of patients with covid, so we were using a fair amount of PPE. I spent the entire bank holiday weekend making phone calls and trying to find private providers, phoning friends in organisations to say, "Can you lend me 20 masks?" The hospice down the road put 10 masks in a taxi. It was at that level that we were trying to get our supplies.

Really, it didn't kick in and start working until the beginning of May. From that point onwards it worked well. We had a really good relationship with a mutual aid team based down at St George's Hospital in central London. I



could phone them up and they would send things. From that moment on, it got a lot better.

**Q10 Sir Geoffrey Clifton-Brown:** Summing up between the two of you, your replies are slightly different. Dr Nagpaul is saying that he thought the supply chain began to get into order in April, and you are saying it didn't really—

**Dr Nagpaul:** Can I correct that? I said May. April was a dreadful month for us. The Easter weekend was dreadful. If you remember, on 17 April we were so short that the Secretary of State admitted that we may run out of supplies on the weekend of 17 and 18 April. There was an order placed with Turkey that weekend that was promised to be delivered after the weekend, but then it was delivered on Tuesday. There was a national emergency in the middle of April of shortages of PPE. It was in May onwards that things improved. April was a very tough month.

**Q11 Sir Geoffrey Clifton-Brown:** I am so sorry, Dr Nagpaul, to transcribe something you didn't actually say.

I see Professor Green desperately waving in the background. We know, because we have done a study into the social care sector, that you had 25,000 patients discharged from hospitals with no testing, so you were in a desperate situation. Do you want to take it from there and describe what situation you faced with PPE procurement?

**Professor Green:** We had the same issues that colleagues have just raised in social care, but we also had the challenge that a lot of our organised supply chains were disrupted. I have never been able to get to the bottom of whether or not it was the suppliers who diverted things to the NHS, or whether the Department of Health or NHS England asked for that. You might like to pose that question to officials in the next session. We certainly had the same problems getting PPE.

One of the challenges for us was that the pandemic planning process seems to have been about pandemic planning only in the NHS, but some of the most vulnerable people were in social care. We have seen the impact that this had—20,000-plus deaths in the first wave of people in care homes.

The PHE report clearly identified the numbers of people with learning disabilities who have died because of this virus. The issue about learning disabilities was that they were not really accounted for as being a priority group until much later in the pandemic. So, all the things that have been said were mirrored in social care.

**Q12 Sir Geoffrey Clifton-Brown:** It looks very much as though you were the second-class citizens. The NAO said that whereas healthcare settings got 80% of their needs, you only got 14%. You were desperately trying to get enough supply—I know that from my own local care homes.



**Professor Green:** Yes, and we should acknowledge that we were in a desperate situation and we were the ones who were managing and supporting the people who were in the most severe need. We were the people who were involved in caring for people who, tragically, were the most susceptible to this pandemic. One of the challenges was that there was no analysis of where those who were most vulnerable were situated. The assumption was that they were in the NHS, but in fact they were in social care.

**Q13 Gareth Bacon:** My questions will be directed initially to Dr Nagpaul, then Dr McWhirter and then Professor Green. On 17 March, the director for acute care in NHS England appeared before the Health and Social Care Committee and expressed great confidence in the stockpiles that the Government had already set aside—the pandemic influenza preparedness stockpiles. The focus was on emptying the stockpiles or distributing from the stockpiles out to wherever it needed to be. A high degree of confidence was expressed that that would be sufficient to meet the needs of the pandemic. Did you share that confidence at the time?

**Dr Nagpaul:** You raise a really important point. I can speak as a doctor. I actually believed—because this is what we were being told, both on 3 March in the coronavirus action plan and, as you say, on 17 March from the chief operating officer of NHS England—that there were sufficient stockpiles and that the issue was one of delivery.

If you remember, a couple of weeks later, we were then given information that the Army would be drafted in, and it was all about the logistics of delivering PPE to so many thousands of sites within the nation. So we took it at face value that they were sitting somewhere, but they were just not here with us on the frontline, and therefore, that it was an issue of delivery.

Of course, later it transpired that the stockpiles were clearly not there at all in sufficient numbers. That is what happened by the middle of April when we had to try to get stocks from Turkey and any other part of the world at very short notice.

We took it at face value. We knew that we did not have the supplies on the ground, but we were at all times told that there were issues of delivery—the message we got was that the logistics of delivering the PPE was the issue. But, as I said, we now know that there were not sufficient supplies, certainly not for the pandemic and the months that were needed.

**Q14 Gareth Bacon:** Same question to you, Dr McWhirter.

**Dr McWhirter:** That was our expectation as well. The other thing is that we did receive some from that stock and the expiry dates were covered over with new dates, because the products were already expired. So they had put a new date on and they said that it was still safe.

As a leader in an organisation where giving expired equipment, using expired equipment or giving an expired drug is tantamount to a significant risk—it is an error for nurses—and all of a sudden, we are saying to them, “It’s okay for you to use expired stock for yourself,” it really undermines the kind of safety that we try to promote, because you are saying that all of a sudden. They did not know whether it was safe or not. What were the tests that said the expiry date had lapsed and it had passed its expiry date, but it is still safe for you to wear and keep you protected? That was a really difficult issue for them—well, for all of us—to work through.

We did receive some stock where the elastic of the masks was rotten and every time you put it on, they just broke. You could not use them; they did not create any sort of seal. So although some stock did come through, some of it was of poor quality and created another layer of complexity for staff to understand why they should be using out-of-date products.

**Q15 Gareth Bacon:** Just to clarify what you have said, some of the PPE that was sent had expired and someone had just put a sticker on it that gave a different expiry date.

**Dr McWhirter:** Yes, that is right. You could see both.

**Q16 Gareth Bacon:** And no guidance was given. Sometimes, obviously, with food and other things, the expiry date is a safety time limit. It says best before whatever date, but actually you could probably have it for another two weeks. Was there any guidance given on that?

**Dr McWhirter:** No, there was nothing that I could ever find that said what they had done to reassure that it was still working and still effective. We did our own tests on many of the products to see whether they were water resistant, because we wanted to check, but that is not a formal process to reassure people. We tried not to use that stock where possible.

**Dr Nagpaul:** On that point, we got a lot of feedback from GP practices and we raised it with NHS England, because of concerns. The answer we got initially was that these supplies had been re-tested and they were safe. What we later discovered, in June, was that many of these expired stocks that had a new label put on them were from a supplier called, I think, Cadronel. Some 67 million units of those had to be withdrawn later because they failed the safety checks that we were assured they had passed. So the issue did not end at that point. It later transpired that many of them—millions of them—were actually faulty. They did not meet the safety standards, even though we were initially told that they had.

**Chair:** I think we are all stunned by that.

**Q17 Gareth Bacon:** Professor Green, I am interested in your perspective from the care sector.

**Professor Green:** We had no confidence on 17 March about the evidence that was given, because it focused on the NHS, not social care. At the time,



we assumed that our supply chains, which were quite established, would not necessarily be changed, but in fact we found that some of the supply chains were drying up because service providers were diverting them into other markets. In terms of where that left us, one of the things that has come out of this pandemic is that the focus was on an organisation—the NHS—and social care did not receive much support, or indeed much thought, at the start of the pandemic.

On another point, I would like to ask a question about the pandemic planning process. If anything has a sell-by date, if somebody is doing effective pandemic planning, they would be making sure that everything that was available would be available and appropriate at the time. There is clearly a systemic issue about the way in which the pandemic planning process went on in relation to some of the equipment.

**Gavin Edwards:** I want to put a bit more flesh on the bones of the situation in social care during that March, April and early-May period. I concur with what has been said so far. We carried out a survey of our members in May and June, and 16% of our members working in social care categorically said that their employer had not supplied them with the PPE to comply with the public health guidance. A further 23% said that they were not sure that they had the right PPE, and overall 45% of members said they had to raise concerns about PPE with their employer. I

think that backs up the points that have been made so far that there were serious and acute problems with the supply and quality of PPE during that period in social care.

**Q18 Gareth Bacon:** Coming back to Dr Nagpaul, you said that you trusted the statements that were coming out of Government and the national health service in mid-March, and you assumed that the stockpile would be sufficient. From that, would I be correct in thinking that you did not order additional supplies or anything over and above the ordinary at that point in time?

**Dr Nagpaul:** I will give you the experience of our own practice. We were getting very worried that patients were coming to our practice and we had no supplies from the NHS. We tried online suppliers—the normal suppliers that supply the practice with medical equipment. They had no supplies. We managed to get some online, and we paid £150 for five FFP2 masks. That was how desperate we had become. There was a real issue wherever you went, even Amazon. We tried some of the building merchants to see whether they had masks. The stocks had dried up.

We eventually got some stocks in our practice in the middle of March, and other practices were getting them from about the second week of March, but they were tiny supplies—300 masks for a very large practice would not stretch very far. Thereafter we had an NHS supplies helpline number given to us, but when we phoned the helpline sometimes what we got was a



response saying, "You can buy them from x and y supplier." Then, when we tried those suppliers, the stocks were not there, so it was a really difficult time for us. We were just worried about not having the equipment. The first eye protection we got, as I said, was donated to us by a local school, and that was at the end of March.

**Dr McWhirter:** I have been a nurse for 30 years, and I have led a lot of incidents and major incidents, but I can honestly say that the weekend over Easter, without having the correct equipment to protect my staff, was the most stressful weekend in my entire nursing career. I have a workforce who are 61% from BAME communities, and it was just at the time when people were saying that this is a disease that has the worst effect on people from a black and minority ethnic background. Trying to find equipment to keep my staff safe, so that they could look after the patients that we needed to deliver care to, was absolutely the most frightening thing that I have had to do as a nurse.

**Q19 Gareth Bacon:** So it is fair to say, then, that the confidence expressed in the middle of March by NHS England that the stockpile would be sufficient turned out to be misplaced. At what point did you draw the conclusion that there was a major problem in terms of getting things through the supply chain?

**Dr McWhirter:** I think we found that out very early on. I think the media really whipped that up to a frenzy. You only needed to turn on the TV or radio to know that there was a massive shortage everywhere.

That reinforced to our own staff that—even if we did have enough equipment and we managed to survive without ever running out, although we got very low—we were running out completely and they would be asked to work without any protective equipment. I maintained right from the beginning that I would never ask a nurse or a carer to go into a room and care for someone without the correct equipment.

That message was undermined by being told every day on TV and radio that there was not enough, that boats had never appeared and that Turkish products were insufficient or unsafe to use. When we said to our own workforce, "We are okay," they did not believe that. That was a really difficult message. When you started to get to a point where you could reduce the use of PPE, because some of our patients were getting better, staff felt that we were reducing the PPE that they needed to wear because we didn't have enough and not because there was a clinical reason to do so. That really undermined leading an organisation through that.

**Q20 Gareth Bacon:** Dr Nagpaul, what is your view on that?

**Dr Nagpaul:** The other thing I wanted to say about March was that the PPE guidance employed in the UK was not the same as the World Health Organisation's guidance. The biggest concern we had was that we were not



protected in accordance with international standards. In particular, the guidance at the time did not recommend eye protection in GP practices. I said earlier that we know that if a patient with coronavirus coughs, the infection could be spread through the eyes. That is standard WHO guidance. We had to fight hard. I wrote a letter in the third week of March saying that this was not acceptable. I raised it at the Health Select Committee on 28 March. The guidance finally changed in the UK with Public Health England on 2 April, so that we were in line with the sort of protection that any health care worker should deserve in terms of being protected from this virus. There was that added problem and lack of confidence that even the PPE being offered was less than that which we should have been receiving.

I entirely concur with what Emily just said. We found that in the beginning of April it was transparent that the issue was not about being unable to deliver the PPE, but about not having enough. At the BMA, we had to put in place a 24-hour helpline, because we knew that doctors were panicking about sometimes being asked to go into wards that had coronavirus patients where they did not feel that they had adequate protection. They needed advice and we had to provide advice as to what to do in those circumstances. They needed advocacy.

As you also heard, we then started to find that health care workers were dying from the disease. That came to a head in the first week of April, when the first 10 doctors who died all came from a BAME background. I do not know whether we will talk about that later, but that had another major impact on the profession at large, in terms of their sense of being protected and the risks of working in an environment of lack of protection.

**Q21 Gareth Bacon:** Mr Edwards, I saw your hand raised again.

**Gavin Edwards:** I just wanted to pick up on that point about the interplay between PPE supply issues and public health guidance in social care. One thing that came up on a regular basis during the period of March, April and May was the length of use of PPE, particularly masks. Changing guidance from Public Health England in April sent a signal to social care employers. We were regularly being told by frontline care workers that they were being forced to wear the same mask for the entirety of a 12-hour shift. They felt that was fundamentally unsafe, given the number of people they were providing care to.

**Q22 Gareth Bacon:** So when you have provider organisations saying that they were running out of PPE, were the Government able to arrange emergency supplies of PPE, and if so, how long did it take to get through?

**Dr McWhirter:** I spent a long time speaking to senior people about the fact that we were running out. One person said to me, "I am really sorry, but I cannot help you anymore." I had to source it myself.

The helplines that you could call all ended up sending you back to the same organisation that was helping you in the first place. When the mutual aid



supply chain that we were getting things from started to run low, in every call I made I ended up being redirected back to that first base, so I was just going in circles. They actually just said no, they had nothing else.

**Professor Green:** Yes, it is absolutely the same as Dr McWhirter just outlined in social care. In fact, it is even worse, because in social care we had the added problem of a lot of this being done at local level, so you were in situations where you were trying to engage with lots of different local authorities. I really understand what Emily said about the endless going round and round the houses. You would ring somebody who would then refer you back to where you started, and at the end of it there was no appropriate response in terms of getting the equipment to you. In social care, we suffered tremendously because of that at the start of the pandemic. If it is a national pandemic, we might also need to think about having a national and centralised approach to it, which we did not get in social care.

**Q23 Gareth Bacon:** That is a nice segue, because I was going to ask what lessons the Government could learn from the way this pandemic has played out. If we were to have a future pandemic, how do you think they should change things, to make it plain? I will start with you, Professor Green, because you have opened the door to that.

**Professor Green:** The first thing they need to do is identify who is at most risk, not thinking about organisations and processes but about people and outcomes. At the pandemic's start, it was quite clear that the most vulnerable were older people and those in social care, so there should have been some acknowledgement of that. The planning process around the pandemic quite clearly failed, partly because it was a planning process for the NHS—it obviously failed there—and did not really take account of social care. That is another lesson that needs to be learned.

The other lesson is about this issue of localism versus the national approach. Yes, I am all for localism in times that are good, but there are times when we need central national positions on things. We also need some clarity about who is going to make decisions on what. At the moment, we hear endless problems about the Department of Health and Social Care issuing guidance on the testing process and then local public health directors issuing completely contrary guidance. Nobody seems to know where the demarcation is around that, so getting the local/national power differential sorted would be a really good place to start.

I also think that we need a recognition of the enormous contribution of staff right across the system and to ensure that they are protected, because that is a mechanism whereby we protect citizens. There was an issue about the differentiation in how staff were treated. I have to say that I am particularly irritated by the fact that NHS workers have received extra money but there seems to be no plans to give social care workers extra money because of what they did in the pandemic. Some of those issues need to be on the table when we are discussing how we make things better in the future.



Q24 **Gareth Bacon:** The same question to Dr Nagpaul really—the lessons learned question. If we were in this place again, what should we do differently, from the BMA’s perspective?

**Dr Nagpaul:** The first thing is that we should always assume that we may well be in this position again, because pandemics occur completely without warning. Another pandemic could occur next year. The most important thing is what you do before the pandemic, and whether you, as a nation, have done the proper pandemic preparedness. I think the lesson we can learn is that there was not sufficient preparedness in advance. We should have planned to have a pandemic that required the sort of PPE that should have been in place. It should not have taken the coronavirus to hit our shores for us to realise that we did not have enough masks and gowns and so forth. That should have been prepared for well in advance—we know about Operation Cygnus.

The second is that when we, as a nation, discovered the new coronavirus, we actually had a head start in planning, because the scenes in Italy and Spain told us where this pandemic was heading. We were weeks behind, and I believe that, at that moment in time—in January and February in particular—all the efforts to produce, manufacture, acquire and procure the equipment we needed should have been done, and efforts made to make sure we were properly served.

I think the third is communication—that it wasn’t fair to us as healthcare professionals to be told that everything would be okay and that we had enough stockpiled. I have now just remembered that I wrote a letter to the Prime Minister as early as 21 March to say that the pronouncement that we had adequate stockpiles was just not being matched on the ground. So, it was quite early on we realised that there was a mismatch between the rhetoric and the reality. I do think that we deserved to be told properly the situation in terms of stock, and the situation in terms of delivery. The profession did not feel connected and involved, and we did not feel we were being told what was happening.

The other important point is inequalities. I think what we have learned from this, and must learn for the future, is that viruses like this—pandemics—do affect some populations more than others. I have never, as an NHS worker, seen a distinction between myself and a care worker. I would never have wanted the NHS to have priority over the social care sector. We should have had enough PPE for both; and I would also extend that to essential key workers. They haven’t been talked about enough. When we were in lockdown the taxi drivers, the bus drivers, those in supermarkets, security guards, cleaners—all of those people who had to go out to work—were not protected at home. The BMA called for protection for them in April, because, as an association, we could see people becoming unwell and hospitalised, and we wanted to protect the nation.



I think there is a lot to be learned in terms of broader issues of inequalities and how you protect those most vulnerable, as well as protecting those who deliver care. The most important thing, as I said, is planning well in advance. We should be planning now for something like this that could happen in the future.

**Q25 Gareth Bacon:** I am going to ask the same question, and ask for slightly briefer answers, if I may, because we need to move on to other colleagues—moving to Dr McWhirter, first, from the RCN.

**Dr McWhirter:** I will reiterate, obviously, what Dr Nagpaul has said. Firstly, the RCN were very disappointed that they weren't engaged—and I think lessons learned are to engage with the people who understand what their workforce needs and that is a way of communicating that they didn't have. So that would be a lesson. I also think that it is about an investment in the workforce. Most hospitals were running on enormous levels of staff sickness and there were no replacements; I think there has been a longterm lack of investment, particularly in the nursing workforce, and so when you suddenly need a lot more people you do not have them. We were hearing that there were numbers of nurses signing up to join the register, but on the ground you didn't see anybody. You didn't see that in reality. I think you get a mismatch of what you are hearing and what you see day to day. I think we must not forget that the people working in our hospitals are not people who signed up to work in infectious diseases units, and they are not paid an enormous amount of money—particularly our healthcare assistants. They are getting £10.50 an hour in some areas, and you have to demonstrate that they are really valuable, and you have to invest in those people in order to ask them to do something that has been really, really difficult and very frightening. Just going in to wash somebody who has an infectious disease that could then kill your family is a very big ask and we need to invest in the workforce so that they would be happy to do that.

**Q26 Gareth Bacon:** Final word on this section to you, Mr Edwards.

**Gavin Edwards:** I will be brief. I would say that it is about the centrality and importance of working in partnership with the workforce in social care. Although there were massive problems in the NHS, there was partnership working in place in the NHS that was able to deal with some of the issues that came up during the pandemic, and that simply was not in place in social care. That would be the first lesson. The second would be to get the Department of Health and Social Care focused on social care. Throughout the pandemic there were issues around the lateness of guidance, the kind of language that was being used—social care was being missed off—and a lack of understanding of the sector, frankly, from the Department of Health and Social Care. It needs to get focused on what is an essential public service that they are responsible for. Finally, social care was acutely underfunded before the pandemic. With PPE, you throw in the expense of the PPE and all of the issues around fragmentation and the involvement of private providers in PPE, and you have a perfect storm. I think making sure



that we have a properly funded social care system in this country is absolutely crucial.

**Gareth Bacon:** Thank you very much.

**Chair:** Thank you very much, Mr Bacon. Now to Shaun Bailey MP.

**Q27 Shaun Bailey:** I want to touch more on the lessons learned in respect of the contracting needs and distribution to people on the frontline. Dr McWhirter, you touched on the quality issues around some of the PPE that was received. Given that the Government's focus on its contracting strategy became about need for speed to get these things concluded, do you think that was a factor on the impact on the quality of PPE received? You said there were masks with rotting strings attached, for example. How do you think that interplayed with the issues you have identified?

**Dr McWhirter:** It goes back to the planning and stockpiling, to where you get your PPE and how it is checked for safety. None of those things were really clear. When you are on the receiving end of PPE, you need to have good communication that says, "This is what has happened in the process by which this mask has come to you, and this is why it is safe." In terms of contracting, it was helpful that we had the NHS supply chain eventually as the single point to get equipment, rather than trying to negotiate with 20 different suppliers for 20 different products, which all look different. There was no consistency for staff.

There was a particular issue with FFP3 masks. Those are masks for which you need to be test-fitted properly, they need to have a correct seal and you need to go through a process to ensure that the seal fits the shape of your face. In order for that to work properly, you have to go through a process of testing. Every time you get a different make of FFP3 mask, you need to do the test again, because it is a slightly different shape. So, every time you go to a different supplier, you may well get a different type of mask. Therefore, your testing process did not work. Having consistent suppliers who give you the same product each time is really important.

I would also raise the fact that lots of charities went around and collected PPE from different services. We were sent gowns from nail bars and masks from beauty salons and things, and there was no way we could ever say whether these things were tested properly. Some clarity around the products that you get, whether they have been tested, and what that testing process involves is really important, so that when you are leading a team you can be really honest in reassuring them that it is safe.

**Q28 Shaun Bailey:** Dr Nagpaul, have you got any comments to add to what Dr McWhirter said there?

**Dr Nagpaul:** The first idea is that what we must do in the future, having learnt from this, is to make sure that we have the right stockpile from the outset. What we ended up doing was trying to get hold of PPE in a panic and



in the midst of the pandemic. Take the Turkey example, where we tried to get stock from Turkey at short notice, only about 4,500 of the 67,000 stock that were delivered were considered safe to give to the NHS.

That is what happens when you try to procure without the proper mechanisms and in a panic in the midst of a pandemic. The lesson here is that we must make sure we have the stockpiles in advance. The second thing we have learnt, which I hope will be the case in the future, is not to have so much reliance on overseas supplies and to have much more domestic manufacturing of protective equipment, so that in a pandemic we can ramp up production and provide the supplies to our own citizens. That has now been achieved to a large extent, but that certainly was not the case at the beginning, when about 98% of our PPE, if I am not mistaken, was reliant on other countries.

**Q29 Shaun Bailey:** That is really helpful. In terms of the competition element when contracting, I am very conscious that there was something like £10 billion worth of contracts awarded without competition. Now, surely there has got to be an impact on the quality of the content you are receiving. As we've talked about and Dr McWhirter mentioned, there is a lack of consistency in the quality of the goods and there isn't really competition between suppliers there, because it seems as though, if we can get it, we should grab it, get it in and get it on. What do you think that impact has been on the frontline? It sounds as if, ultimately, that is putting people at risk.

**Dr McWhirter:** It is really difficult when you get a box of something from somewhere to be able to know what the quality checks have been. In the past, you have always relied on the fact it has gone through some sort of health and safety check, and this time, you had no idea where it had come from. It all looked different. Every time you got a box, it looked different. I think, if you are working on the frontline and you are going, "Okay, what kind of gown have I got today? Why is this one different? This feels really flimsy. The elastic isn't strong enough to cover my arms properly," they start questioning whether you are providing them with safe equipment or not. At that level, the effects of that are really frightening for frontline staff.

You cannot say, "Hang on, your equipment is safe," because you don't know where it has come from. I had a box of gowns that I opened and a load of insects crept out of them. God knows where they came from. I spoke to a forklift truck driver on Easter Sunday. He was unloading a boat on Folkestone dock, and he sent me a load of gowns because he put them in a truck with my address on. It was at that level, and at that point, you just don't know the quality of the products that you're getting, let alone what you're paying for.

The money side of it ceased to be a problem. Dr Nagpaul said he spent a fortune on very few masks. With the money, at the end of the day, we didn't



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even ask how much things were costing because it was just that we had to have them. So in every regard, you feel like you're being betrayed, actually.

**Q30 Shaun Bailey:** In that situation, where you're getting goods through like that which have insects coming out of the box, what do you do? How do you respond to that?

**Dr McWhirter:** Throw them away.

**Q31 Shaun Bailey:** Is that what you would do? There would be no process to, say, as in the usual sort of commercial transaction, return those, or refuse to accept them? You just have to accept them, and then throw them away if you could not use them, basically?

**Dr McWhirter:** Yes, you cannot have your staff wearing things like that.

**Q32 Shaun Bailey:** Have you got a rough guesstimate as to how much you had to throw away as a result of that?

**Dr McWhirter:** Oh, a lot. A lot of stuff we never used, because you could just look at it. There were some things called Tiger goggles. I don't know whether you have heard of those, Dr Nagpaul. These are goggles that arrived flat-packed. We were given about 10,000 of them, thinking, "Great, our goggle situation will be resolved now." You had to make them yourself. They had little studs that you had to put into the glasses to create an actual pair of glasses. They took absolutely ages. You could make about three pairs in an hour. We made loads, then they were recalled because they weren't safe, and two weeks later, there was a national recall. They were called Tiger goggles, and they asked us to send them back. We threw most of them in a skip because we didn't have the time to start packing things up and sending them back to various places. It was products like that where you end up thinking, "If that stuff isn't safe, how safe are all the other things that look okay, but there is no confirmation that they will be?"

**Q33 Shaun Bailey:** So effectively, you almost have to pull together these products and build your own PPE?

**Dr McWhirter:** The charities were really trying to be helpful. You would phone them and they would say, "We are going around and collecting up gowns and masks and things. Would you like 100 masks?" and you would say, "Yes, of course, lovely, thank you." They would deliver them, and you would look at them and think, "Well, these don't look right," and yet they might have been fine but you didn't have a clue whether they were safe or not. You get to the point when you're really desperate and you think, "Are we going to have to start using that supply, because we have got no other option?" Is that a better option than saying to staff they can't care for that person because they haven't got the protective equipment that they need?

**Q34 Shaun Bailey:** How close were you to that point?



**Dr McWhirter:** I was three hours away. On Easter Sunday, I had three hours' worth of supplies. Seven o'clock in the night I would have run out. If it hadn't been for a forklift truck driver on Folkestone dock, I would have had to stop people going in to care for patients.

Q35 **Shaun Bailey:** If I could just bring in Dr Nagpaul and maybe Professor Green, as well. Going back to the substantive question: in terms of the impact on the ground, from what you have seen in terms of these competitive contracting practices, what has been the impact?

**Dr Nagpaul:** You are absolutely right. Because the Government were in a desperate situation of not having the stocks, they were contracting with suppliers who were not known to the NHS. These were not suppliers who had a track record, from what I can understand, of even delivering PPE, necessarily. We were finding that these stocks were not arriving through normal processes. It was not normal for us to receive stocks with stickers saying that the expiry date has now been replaced with a new date. We were worried about the quality of these stocks. They were not delivered in the normal way. But remember, we were also desperate. It was a choice between having protection or no protection at all.

I think the lesson learned, as we mentioned earlier, is that we should not have been put in this position. We should have had the stockpile in the first place. We should not have been trying to get stocks from Turkey—out of 67,000 pieces of PPE, only 4,500 were deemed safe. That was a desperate state that we were in, and I absolutely would want to say that the BMA has expressed very serious concerns about the way in which the Government chose to contract without tendering and give significant sums of public money to suppliers, and then allowed those supplies to be delivered without the proper checks that would have given us assurance of safety. As I said, 67 million masks were recalled in June from one supplier, and 50 million from another. Huge sums of money were spent and wasted, because the stocks were not of sufficient quality.

Q36 **Shaun Bailey:** You said you had raised this issue with the Government. What was the response that you received?

**Dr Nagpaul:** The only response we received is that the Government acted in this way because it needed the supplies quickly, and that is why it did not follow the normal tendering process. That is the only response we received, and I can circulate to you, after the meeting, our own analysis of the use of the private sector during the pandemic. We have had significant concerns around the way in which public money has been used during the pandemic, both for this and for Test and Trace.

Q37 **Shaun Bailey:** It sounds as though the Government basically said, "Don't you know there's a pandemic on?" That was their response. It would be really helpful to see that, just to see how they have engaged with you on that.



Professor Green, what is your take on the competitive nature of some of these tendering processes and the impact on the frontline?

**Professor Green:** There was an enormous impact on the frontline. In social care, we had similar problems. One of the reasons we had problems was that we had established supply chains that were then disrupted by the fact that the pandemic was on and things were being redirected. One of the challenges was that social care was not really integral to the planning process. There is a pandemic planning process—it clearly failed, and it certainly failed social care. We were in a space, exactly as Dr McWhirter and Dr Nagpaul have said, where we were desperately trying to get supplies at enormously inflated prices. There is also no way that you can assure the quality. There is no properly agreed quality process for social care. I presume there is one in the NHS, but we need to have similar quality marking so that, as Dr McWhirter said, when you open a box, it might be a different apron but you have a surety that that apron meets the required standard. That is another lesson that needs to be learned from this pandemic. First of all, we need to engage social care in the planning process, because that is where a lot of the most vulnerable are. Secondly, we need to have some quality assurance process that gives us a surety that even if the product is different, it is fit for purpose.

**Q38 Shaun Bailey:** Absolutely. Given the specific challenges within social care—I do not know what feedback you may have had—what was the risk element, in terms of the tough decisions that would have to be made on the frontline, such as: who do we look after, and how do we go about that? How close to the wire was this at times? Obviously, we have heard from Dr McWhirter about there being three hours' worth of PPE remaining. Was it similar for you?

**Professor Green:** Definitely. In social care in some cases, we ran out. The other problem that we had was that, at the start of the pandemic, we were not able to get access to people from the NHS to understand whether or not we needed to transfer somebody to a hospital. All the transfers from hospital were going one way: they were going from hospital to care home. There were some people in care homes who could have benefited from being taken to hospital, but that was not happening. We were left with people who were extremely ill and, in many cases, we didn't have the supply of PPE. As Dr McWhirter graphically illustrated, that was a tremendous risk for our staff, and they stepped up amazingly. I cannot say how fantastic the social care staff were; they were absolutely brilliant, but we were in situations where we didn't have the right equipment, particularly at the start of the pandemic.

**Q39 Shaun Bailey:** Mr Edwards, do you have any comments on this?

**Gavin Edwards:** On that point around the level of distress and anxiety that was being experienced by social care workers, I would like to share with you just one or two short quotes directly from those frontline workers on the issue of quality. The first care worker said, "At the time, explained that the



aprons I was receiving were not good enough: just cheap material that is full of static and rips very easily." Another said, "Only got dust protection masks once the ones that we had had ran out. The majority were out of date, too." Then, finally, "Have been given eye protection glasses that are very flimsy and not suitable to wear over spectacles. Have been told full-face protection may not be available until a later date." That gives you an idea of the kind of quality and supply issues that were being faced on the frontline, which we can feed back to those high-level issues that we mentioned already.

**Q40 Shaun Bailey:** That is great. Dr McWhirter, I know you wanted to come in.

**Dr McWhirter:** I want to pick up on Professor Green's point about the redirection of PPE. In some of the conversations I was having while trying to source it, I was told that a lot had been redirected to ensure that the Nightingale hospitals were set up. Working in south-west London when the Nightingale wasn't being used to the volumes that were expected initially, I phoned there and said, "Look, if you've got cupboards and cupboards of it, can we have some to last us for a couple of days until you need it back, and the supplies have kicked in?" I think we were waiting on that boat from Turkey at the time. I was told that that would not be possible, but the image the staff were getting was that there was an empty hospital full of gowns and gloves and the things we needed, and our hospital was running out of everything. I think that created a really difficult situation.

**Q41 Shaun Bailey:** Were you given any explanation as to why they could not give you any gowns or share PPE with you at all?

**Dr McWhirter:** No. They said they couldn't do that.

**Q42 Shaun Bailey:** Just "no." That has been really helpful. More broadly, the Cabinet Office has obviously announced that it is altering its approach to procurement post-pandemic, and trying to take on the lessons learned. Going in the order I went in previously, Chair, if I may, we have obviously touched on it already, but what would you be wanting to see from that in terms of long-term changes from this pandemic?

**Chair:** Because we have covered quite a lot of that, if you have anything to add to what you said before on that particular review, please say so, but if you don't have anything to add, we can move on.

**Dr McWhirter:** The first thing would be to listen to the staff on the ground as to what they need. We were being told an awful lot about what was available, but very few people asked, "What do you actually need?" I made mask-wearing compulsory in my hospital on 29 March, and 14 days after that was our last infected case of covid. I said several times very loudly, "I think we need to be making sure that every hospital and care home in the country is making mask use compulsory," and that did not happen until a lot later on. I think talking to the people who are living and breathing what is going on would be a really valuable lesson, and they didn't do that.



**Q43 Chair:** Certainly, when the National Audit Office looked at this before, we had information from them indicating that there was a mismatch between what was needed and what was there. That has already begun to be documented. Any other very quick points before we move on?

**Dr Nagpaul:** If we plan for a pandemic in the future, we should think about protecting not just healthcare staff and care staff, but all the key essential workers who had to go to work.

**Q44 Chair:** You made that point very clearly, and it has very much hit home. Professor Green?

**Professor Green:** They should plan for the health and social care sector. The name is in the title: it is the Department of Health and Social Care.

**Q45 Chair:** That is something this Committee has highlighted many times when we have looked at the social care sector. Mr Edwards?

**Gavin Edwards:** I agree with that last statement.

**Q46 Gareth Bacon:** I want to pick up on a point that Dr Nagpaul raised earlier about tendering. This might be an unfair characterisation, but it seems to me that there was a certain amount of complacency within the Department at the beginning of the pandemic, which was then followed by a sudden realisation that there was not enough PPE, and that was followed by panic. Obviously, it is no good spending lots of money on equipment that you then put straight in the bin because it is not suitable. But the question is around the tendering process. In normal times, the reason you have a tendering process is because you want to make sure you get good quality at a value-for-money price. This was not a normal time. Dr Nagpaul, in terms of your understanding of how long a Government tendering process would take, how much do you know about that?

**Dr Nagpaul:** I will be frank: as a doctor, I do not know much about the way in which the Government tenders, or the tendering process. So, I'll be honest—I don't know.

**Gareth Bacon:** That is fine. Do any of the other witnesses have any knowledge of that? That is fair enough—these are specialist witnesses, rather than—

**Chair:** And we know as well from the work of the National Audit Office that although section 32(2)(c)—I think that is right—could be suspended in an emergency as a result of the 2015 Act, there is still opportunity to tender contracts in as short as 10 days. While, at the height of the pandemic, that might have been challenging, certainly by the summer it is something that we need to consider with witnesses on Monday. So, I recognise that these witnesses today may not have that information.

**Sarah Olney:** This question is quite a quick one, but it probably follows on quite nicely from Mr Bacon's question. In the Report, the NAO has highlighted that there was a priority lane—that certain people could get a



kind of fast track to the procurement process. I am interested to know whether that was made available to any of you, to give you the opportunity to connect your suppliers to the centralised procurement facility.

**Dr Nagpaul:** We at the BMA were getting contacts from various suppliers, both those who said they were able to supply PPE from other parts of the world, like China, and also some domestic manufacturers, who felt they could assist.

Now, you could argue that we cannot judge the veracity of these individuals or companies that contacted us, but they all said that they had tried the normal channels of reaching out to the Government but had hit a brick wall; they were not getting responded to.

In two cases, these were suppliers known to doctors themselves—doctors who we knew through the BMA. So, there was an element of trust that these were genuine people here to help, but they also described a very similar experience—that they could not get through to the right person, or they were not getting responses.

We then sent about 100 different contacts to the Government, urging them to follow them up, because this was during the month of April, when we were desperately short, as you heard—almost running out of some supplies in the middle of the Easter weekend. So, that was our experience—that there were suppliers. We had sent about 100 contacts to the Government.

**Q47 Sarah Olney:** I just wanted to ask quickly about the high-priority lane. As far as you know, you did not have access to that; you did not have a quick way of connecting these trusted suppliers. Obviously, we have heard about the issues you experienced in having to deal with PPE from suppliers that you did not know, but you have got these trusted suppliers and they are trying to connect with the Government. You did not have access to this high-priority lane that is described in the NAO Report?

**Dr Nagpaul:** No, we didn't.

**Sarah Olney:** May I put that question to Dr McWhirter?

**Dr McWhirter:** No, we didn't either. Our own suppliers essentially ran out very quickly, so potentially would not have been in a position to be offering anything more.

**Q48 Sarah Olney:** Professor Green—you had your hand up?

**Professor Green:** Yes, because we had exactly the same issue—that we put forward lots of people who we knew were supplying to the sector and we tried to get them into the supply chain, but there was no followthrough.

We also suffered lots of general issues around the supply of things like commodities—soap and those sorts of things. I did contact Lord Agnew and I must say that he and his team were fantastic. They sorted it out within the space of about 24 hours, which was really interesting; it was in marked



contrast to some of the stuff that we were getting from the Department of Health and Social Care.

**Sarah Olney:** That is really interesting.

**Q49 Olivia Blake:** Some of the areas that I want to probe have been covered, but I just want to get a little bit more detail out. To be quite frank, I am horrified by what we are hearing today, but I am not surprised because of what was coming through, as an MP who represents a lot of health workers. Do you think it is systemic and that everywhere was feeling that level of pressure, or were some areas better able to cope than others in regional terms? Have any of your national organisations picked up on that?

**Dr Nagpaul:** I can certainly say that in early April, especially the Easter weekend, as we have heard, this was a national issue. At the BMA, we were getting feedback from across the country, particularly on shortages of gowns at that time. In fact, the Secretary of State for Health and Social Care made a statement that he was worried about the gown issue. When we looked into that further and had some emergency calls with PHE and NHS officials, it was a national problem. They were even trying to get stocks from Northern Ireland, because there just were not enough to go around. There was an absolute national shortage on that Easter weekend. It was not that there were plentiful supplies in one part and not in the other; no one had the supplies. That is why there was a consignment from Turkey: we were desperately short.

**Gavin Edwards:** I agree with that. In the ongoing surveys that we had with social care workers during that period, there were not huge or significant differences between the different regions. We were able to analyse that at the time. It did seem to be a genuinely national problem.

**Dr McWhirter:** The RCN conducted a national survey about what was going on in April—you may have seen a copy of it already—and 51% of the respondents, nationally, said that they were asked to reuse single items of PPE.

**Q50 Olivia Blake:** That seems in direct conflict with evidence that the Committee has heard previously. We should definitely focus on that on Monday. How much of an effect has the mismanagement of conflicts of interest during the procurement process had on supply and quality?

**Dr Nagpaul:** I cannot give you an objective answer to that. I think I speak for most healthcare workers when I say that it was very upsetting for us all to see that during the pandemic, huge sums of money were being spent and given to suppliers—for both PPE and the testing system—that were not known to the NHS or accredited in the way that we have been used to. That was at a time when we have huge resource constraints in the NHS. I cannot give you an objective answer—I am not an expert to be able to answer it—but it just felt very unsettling from the point of view of a healthcare worker. That is not the way in which we have been supplied stocks on a normal



basis. We have been supplied stocks from accredited suppliers that know the NHS, that manufacture equipment for the NHS, and that pass safety checks. Not only were we being handed equipment that had not gone through those processes, as you know, but much of it was then faulty.

**Q51 Olivia Blake:** I recognise that it is hard to comment on that process, and that we have covered a lot of lessons learned, but given the need to be fleet of foot for the procurement and manufacturing of ventilators, do you think the focus of the Department was wrong? Could it have been more focused on manufacturing PPE? Do you think that the Department's approach to ventilators could have been married with the approach it took with PPE?

**Dr Nagpaul:** I cannot agree with you more. In fact, as I said, when our practice received stocks from a local business and from a school, I actually wrote to Alok Sharma at the beginning of March—this is well before Lord Deighton was appointed—and I also wrote to the Secretary of State saying, "Look, we must do something about it." If you can build a hospital in two weeks, this in comparison was a far lesser task to domestically manufacture and repurpose industry to produce PPE, so it was something we called for in early April, well before Lord Deighton was appointed. We saw this as being the obvious thing to do.

**Q52 Shabana Mahmood:** Thank you to the witnesses. We have heard some very stark evidence from you about the availability of PPE and about the quality and usability of the PPE that you then had.

Following on from that, are the Government doing enough, in your view and in what you are picking up on the ground and on the frontline, to investigate whether frontline workers might have contracted or even died from covid-19 as a result of the PPE failures that you have been highlighting with us today?

**Dr McWhirter:** I think that is really difficult to be able to say. People contract covid in all sorts of areas. I think we couldn't really say that a member of staff contracted it because of inadequate PPE. I made sure our staff did not have inadequate PPE. The whole PPE story was a massive distraction. At a point when you should be looking after the welfare of staff and patients, the distraction of trying to get equipment took you down a route that you didn't want to go down. So, did staff contract it? I think it would be very difficult to be able to say that for sure.

**Professor Green:** I would agree with Dr McWhirter. It is very difficult to establish that, certainly in social care. We should also acknowledge that we are still in the midst of this pandemic, so some of these questions might need to be addressed later on, when we can take a long, hard look at this from the perspective of having been through it rather than from the perspective of going through it.



**Q53 Shabana Mahmood:** Do either of the other two witnesses have anything to add?

**Gavin Edwards:** In social care, my understanding of the process at the moment is that the medical examiner will refer the circumstances of a death where they believe that coronavirus and employment have led to the death. They will then inform the employer, and the employer has responsibilities to inform the Health and Safety Executive, under its normal responsibilities for when there has been an incident of that type at work.

The Government have a responsibility to make sure that the deaths of frontline health and care workers are properly investigated, so that their families and their work colleagues know that everything is being done to find out exactly what has gone on, and what local changes could be made. A lot of the things we are talking about today are about national supply chains, but perhaps there are sometimes local circumstances that need to be investigated as well. We need a robust and reliable process in order to do that.

Timing is important. Yes, it is important that we do this at a time when everybody is able to be involved in a way that they would like to be involved, but it is also important that it is done in a prompt way so that things aren't forgotten and issues aren't lost over a period of time. I would like to see the Government doing more on that issue, to make sure that those deaths are investigated properly.

**Dr Nagpaul:** From our end, we were very alarmed. We spoke out on 10 April, when we heard that the first 10 doctors who had died were all from a BAME background. That is not a statistic that can be explained away in a normal manner. We were concerned.

I wrote to the chief executive of NHS England on 9 April and said what should be done at that moment in time—when we could see that healthcare workers were getting infected and dying—for every single healthcare worker who contracts the virus, who may be hospitalised or who may die, in real time. There should have been an assessment of their job role, their exposure to the virus, whether they expressed any concerns about PPE—remember, this was early April when we had severe shortages of PPE—and whether they were in front-facing roles. We could then understand whether certain types of doctors—in our case doctors, because I represent doctors—were at greater risk because of the BAME disproportionate impact. That data is what we asked for, but it was not collected. Had it been collected, we would now be in a much better position to answer that question.

I have to say also that when we did our surveys during that time, between two to three times as many doctors from a black and minority ethnic background told us that they felt under pressure to see patients without adequate protection. We have examples and we have had feedback. There are anecdotes. A doctor, for example, did die and his son did express his

concerns in the media, so it is not a secret. This was in March when, as I said earlier, the guidance in the UK was not the same as the WHO's.

He was desperate. He was on a ward where there were non-covid patients. He asked for a mask and the management refused because it was not policy. He pleaded, but he still did not get a mask. Four patients on that ward contracted coronavirus. This was a non-covid ward. A week later he was in intensive care and he did not survive. That is an anecdote. I therefore think that we cannot just say we do not know. There is plenty of evidence that doctors did not feel protected. They did not feel that they had the right equipment to protect them in the midst of the early part of the pandemic.

We should, I believe, investigate. We should think of any healthcare worker dying as a never event. It needs to be investigated. For a real investigation, the data should have been collected in real time, going back to April when we called for that.

**Q54 Shabana Mahmood:** I just want to follow up on the point you made about black, Asian and minority ethnic doctors and other healthcare workers and frontline staff. You mentioned access to PPE and feeling the pressure of working without adequate PPE. Perhaps Dr McWhirter, Mr Edwards and Professor Green can add to that. What was your experience? What have you picked up from your members about access to PPE and whether there were any differentials between the experience of BAME staff and their white counterparts?

**Dr McWhirter:** In the Royal College's survey, BAME staff had highlighted in greater numbers that they felt they had not undergone fit testing for the FFP3 masks. Those numbers were less. We have talked about that and we cannot really understand why, but it might be a perception that they do not feel that they were prioritised. It is something that needs further review, for sure. Generally, I think that people from a black and minority ethnic background were really fearful, because the news and the headlines were highlighting enormous risk. I think that that caused an extra layer of lack of confidence in the equipment that they were being given.

**Q55 Shabana Mahmood:** What was your impression of the Government's approach, knowing that there was a lack of confidence around Government communications and knowing that there were lots of stories about the BAME community being over-represented in terms of deaths? Do you feel that the Government had this on their radar and were thinking about BAME healthcare workers?

**Dr McWhirter:** No, not at all. I think perhaps at the beginning nobody really realised that there was a connection. It was news that we were all trying to understand. We undertook risk assessments. All healthcare workers were required to have a risk assessment, and people from a black and minority ethnic background would score higher on a risk assessment if they were working on the frontline. That meant you would modify or increase



protection if you could, but it was not clear as to the Government's view or what they should do differently on the frontline.

**Gavin Edwards:** Anecdotally, this is something that has been raised by our members with us. Unfortunately, for the purposes of today's session, we are in a process at the moment of collecting that data so that we can get a comparative analysis. We will be feeding that into the EHRC investigation that was recently announced. It is incredibly important.

I would pick up on the point that was just made about risk assessments. We know there is a disproportionate impact on black and minority ethnic staff in health and social care. The key question is: were those risk assessments taking place? Was a process in place, among both NHS and social care employers, for those risk assessments to take place, to make sure that that issue was being taken account of? Anecdotally, my impression is that, in social care, on a widespread basis those risk assessments were not taking place in the way that they should have been. We do not have the data on that at the moment, but it is definitely something that needs to be looked at more closely.

**Q56 Shabana Mahmood:** Thank you very much. We will certainly follow up on that with our witnesses on Monday, and with the Government more broadly.

Finally, Dr McWhirter, one of the concerns that has been raised is around differential health risks as a result of covid for black and Asian ethnic minority workers compared with their white counterparts, and what that might mean for career progression and the sorts of duties that one group is able to do as opposed to the other. Are you sighted on that? Is that something that you are in conversation with Government or other officials about, to try to make sure that over the course of a career in nursing, for example, there are no disparities in outcomes because of healthcare risks that have been highlighted particularly by this pandemic?

**Dr McWhirter:** I think that is something that the RCN are beginning to be able to review with the data that we have had as a result of the first wave. I think they are still looking at it. Is there discrimination? Will there be? They are anecdotally aware of it, but going back to what Dr Nagpaul was saying, these are anecdotes and we have to provide facts and data to be able to substantiate that, in order to look at the steps to take to move forward.

**Dr Nagpaul:** When we knew that there was a disproportionate impact on BAME healthcare workers, we called for risk assessments in early April. The first time NHS England instructed a risk assessment was at the end of April, and even then it was not a mandate. In fact, all the data that we got back from doctors—we were carrying out surveys regularly—was that the risk assessment was not being done until the end of May. So, in fact, in the peak time when the infection was so rife, we did not have, in terms of doctors, a proper risk assessment programme. They were not risk assessed and protected in the way that they should have been.



Q57 **Chair:** I think one of the things that Ms Mahmood was trying to highlight was the critical issue of career development opportunities. If people are being taken off the frontline for good health reasons, that could limit their prospects. Is that something that the BMA is looking at for your members? I'll also ask Unison to answer briefly on that point—just a quick yes or no. We are trying to keep an eye on that issue.

**Dr Nagpaul:** Our problem was that in the month of April and into May, doctors were not being taken off the frontline, in the sense that the risk assessments were not being carried out.

Q58 **Chair:** Yes, but after that. Now, to keep people safe, are their career prospects being damaged because they are being protected?

**Dr Nagpaul:** We do not have any data on that.

**Chair:** Okay. It is something that we are keen to keep an eye on. Mr Edwards?

**Gavin Edwards:** It is too early to say.

**Chair:** Okay. We are just flagging an interest. That is very helpful, thank you.

Q59 **Gareth Bacon:** Starting with Dr McWhirter, I am interested in the typical lag that you experienced between requesting PPE and its being delivered to you.

**Dr McWhirter:** There was not so much a lag. Speaking to somebody there yesterday, we ordered some particular bins to dispose of PPE in February and they arrived last week, so there was a significant lag. On some equipment, there was not so much a lag as it just did not come. It was about finding other ways to get the supplies in, actually.

Q60 **Gareth Bacon:** Where are you at now?

**Dr McWhirter:** It is much better. The supply chain that linked through the south-west procurement process was absolutely great once it kicked in. We were well supplied and everything that we asked for was delivered quickly, but that was probably not until May. Then it took about a month or two to really gain any confidence that that was how it was going to be long term, but it has played out that that is the case and it is good now.

Q61 **Gareth Bacon:** So, between mid-March and May it was terrible, but from May onwards it has been okay.

**Dr McWhirter:** Yes.

Q62 **Gareth Bacon:** Professor Green, what is your experience of that?

**Professor Green:** In terms of the lag issue, unfortunately if we had been able to know the timelines of things arriving, we would have known if there had been a lag or not. It was very much a question of things arriving when



they arrived. Similarly to what Dr McWhirter said, the situation now is significantly improved and the supply chains around PPE, and the fact that social care can now access it, is much improved, although we wait to see whether or not that will continue in the long term. We need some surety that it will.

**Dr Nagpaul:** I would agree that clearly, after the first peak in particular, supplies have been more readily available. We carry out surveys, and we have done so even more recently, and it is not 100%. We are still finding that some doctors are telling us that there are still some shortages when they need the equipment. There are still issues around eye protection in GP practices, for example, but, by and large, it is not the same as it was before. I have to accept that we are now in a much better place.

Q63 **Gareth Bacon:** So, a general summary would be that in the early stages it really didn't work, but that has been corrected and now it is functioning in a much better place. That would apply to all three of you. Would that be fair?

**Dr Nagpaul:** Yes, except to say that we needed the PPE most for the months of March and April.

**Gareth Bacon:** Yes, that's accepted, but the point of my question was to find out if we have fixed the issue. We can go back and revise what went wrong at that time, but it is much more important that the issue is fixed now. Chair, I will leave it there, as I know we need to move on.

Q64 **Chair:** Before we move off this, Professor Green, the Government have pledged to provide personal protective equipment to social care through the winter. Is that actually happening? Are you confident that that promise is being met?

**Professor Green:** Yes, at the moment I am confident that that is being met, although there are some issues about it not being a holistic commitment. There are some elements where we still have to procure our own PPE, but by and large I am confident that that is being met.

**Chair:** Okay, that is the first piece of good news we have had so far in this jaw-dropping session.

Q65 **Sir Geoffrey Clifton-Brown:** I would like to come to you, Professor Green, and return to some of the truly shocking figures I mentioned to you in my first questions about how, in terms of PPE supply, the social care sector was treated as secondary care. The NAO Report makes quite clear in paragraph 19 on page 11 that the social care sector received 331 million items of PPE—which was only 10% of what you needed, according to the DHSC model—compared with the health sector, which received 1.9 billion items, at about 80-odd per cent. of its estimated need. Why was it that social care was treated so badly, in your view?



**Professor Green:** I think it stems from the fact that the Department of Health and Social Care do not see these as totally interdependent systems and they all tend to focus on the NHS, rather than on social care. If one lesson has been learned from this pandemic, it is that we need to focus on where the most vulnerable people are and make our response appropriate to where the vulnerability is. That has been a big problem.

It has been a problem throughout the pandemic and we are still seeing it now. For example, there is the issue I mentioned about social care staff not being rewarded in the same way that NHS staff have been. In Scotland and Wales, they have identified £500 for each social care worker; that has not happened in England. We have always been secondary in relation to how we are perceived by the Department.

**Q66 Sir Geoffrey Clifton-Brown:** Dr McWhirter has described fairly graphically the situation in the national health sector and almost running out of PPE. What was it really like at the height of the PPE crisis in the social care sector? How close were you to running out?

**Professor Green:** In some cases we did run out. There were services where there wasn't the PPE required in order to make sure that people were getting what they needed. The bottom line was that we ran out in lots of areas, and it was really annoying to us that in lots of areas our existing established supply chains were being disrupted.

If we had had access to our normal supply chains, that wouldn't have been so difficult, but what happened was that the focus was on the NHS, the supply chain was then disrupted and then very late, partly when the mortality figures around how many people were dying in care homes started to hit people, there was suddenly a wake-up call that identified that people in care homes were at the frontline of the pandemic.

**Q67 Sir Geoffrey Clifton-Brown:** Mr Edwards, a lot of your members must have been working in the social care sector. Professor Green has just given a pretty damning reply that some care homes did run out of PPE. Therefore, your members were being asked to work in situations where they were not adequately protected. Is that the situation?

**Gavin Edwards:** Absolutely. In April and May, and in March as well, on a daily basis, we were getting hundreds of inquiries coming into Unison from members telling us that they did not have the PPE that they needed. There is no doubt whatsoever that that was primarily a supply issue to the sector.

I quoted the figures earlier: in May and June, 16% of our members working in social care were saying that they categorically did not have the PPE that they needed. That equates to hundreds of thousands of people working in social care. That shows the level of crisis. Some 45% of them were having to raise concerns about PPE with their employer. There was a

huge crisis. There was a huge shortage.



The one thing I would add to what has been said already is that when you take a supply crisis of PPE and you apply it in the NHS, it is slightly different from when you apply it in the social care sector. The social care sector is structured very differently with thousands of different employers, many of them private sector organisations.

As well as acknowledging that there was a supply issue, there was at times also an access issue to PPE in the social care sector, which perhaps was not so acute in the NHS. What I mean by that is, we were getting regular reports from our members working in care homes, and in domiciliary care, saying that they knew that the PPE was on site, but they were not being given access to it as well. That is very concerning. That was not coming up once or twice; it was coming up regularly: "We know that the PPE is in the office, but it's locked and we can't get to it."

That is also something that we should bear in mind when we are looking at the detail of the issue. Primarily, it is about supply, which is the trigger for everything, but when that is applied in the social care sector, with all the problems that that sector has, some of those problems were exacerbated and made worse from the point of view of frontline care workers.

**Q68 Sir Geoffrey Clifton-Brown:** So if you, as I am sure you will, contribute evidence to the inquiry that is going to be set up, what do you think are the main lessons that need to be learned from what happened in the social care sector?

**Gavin Edwards:** I will come back to what I said earlier about listening to the voice of social care workers which, although there are problems, is listened to in the NHS. The social care sector is an essential public service. The people who are providing social care are skilled and very hardworking, and they care deeply about the people who they are caring for. At the moment, they are not treated with the respect that they deserve. Their representatives, the trade unions, are not listened to in a structured way by the Government. They should be in the way that the NHS is. That is a key point, and that is something I would like to see change in the future.

**Q69 Sir Geoffrey Clifton-Brown:** That is really helpful. Can I ask you the same question, Professor Green? I can see you are itching to get in.

**Professor Green:** I agree with everything that Mr Edwards has said. I certainly think one of the things we need to do is set up mechanisms where staff and employers are much more engaged with identifying what the issues are. We felt, and I imagine Gavin felt this, that we were airbrushed out of these discussions at the start, and people only came to us, usually, to tell us what they wanted to tell us.

There is also the fact that lots of the system is not very good at understanding social care, as Gavin said. For example, some of the quangos surrounding Government showed that they did not understand the social care system. Some of the guidance that we got out of PHE was changing



constantly. The language used was not social care language; it was all NHS language. What people need to understand is that they are interdependent systems.

I really take the point that Gavin has made about the amazing staff in social care. We have to start recognising and rewarding them for the fantastic work and the complex work that they do, which is, in terms of support to the most vulnerable, absolutely akin to what goes on in the NHS, yet the status levels and reward levels are not the same.

**Q70 Sir Geoffrey Clifton-Brown:** Thank you, Professor Green. Has this crisis altered the way in which PPE and other essential supplies are going to be procured by the social care sector in the future? Hitherto in the crisis, it was largely a matter for each individual care home, because they were private sector organisations. Do you think that that should now change and that the procurement should be on the same basis as for the national health service?

**Professor Green:** I think that is something we should debate, because, for example, there is a huge benefit to being able to procure at the levels at which the national health service could procure, and it does have systems in place, so that is something that we would not be averse to talking about, but of course it would be about the guarantee of supply, the quality of access and all the other points that have been made throughout this hearing.

**Q71 Sir Geoffrey Clifton-Brown:** That is the important point, the guarantee of supply, because you had a huge number of deaths in the social care sector caused by the interruption of supply. Therefore, would you agree that we need to think about this very carefully in the future?

**Professor Green:** I would absolutely agree. Tragically, and similarly to the NHS, we lost some really dedicated staff, as well as losing many, many residents.

Another point I want to make is that one of the things that happened was that people with learning disabilities were very much ignored at the start of this pandemic. The Public Health England report on the mortality rates in learning disability services shows how important it is to be inclusive and to recognise that we should focus on where the most vulnerable are and respond accordingly.

**Chair:** Thank you. That is very concerning to us as a Committee, because we have done reports both on learning disabilities and on social care, raising some of these points a long way ahead of the pandemic. Definitely the time for action is now, and we hope we will make our contribution to that.

**Q72 Olivia Blake:** I want to follow up on that, Professor Green. Obviously, the Government have the learning disabilities mortality review. Do you think that they used evidence to guide what their advice was to different settings, or do you feel that different settings—home care, care homes and learning disability support settings—were treated differently?



**Professor Green:** I do not know whether they used what evidence they had, but I can tell you that, for example, I was very concerned about issues around domiciliary care, where people were having to go in and out of people's homes to provide vital support. My great colleague, Dr Jane Townson from the United Kingdom Homecare Association, has made this point on many, many occasions. There did seem to be hierarchies of areas where the Department was engaging, and certainly social care was at a lower level. I think then we found that learning disabilities were at a lower level. I also think the evidence shows that domiciliary care was at a lower level.

Going back to what Gavin Edwards said earlier, I think it is a complex system—it does rely on lots of different organisations—but the Government need to understand that and need to get their processes in place to deal with it, because that is the system that we have. I think there were some issues, which need to be examined when we come out of this.

**Q73 Olivia Blake:** Moving on to the role of local government in some of this, I know we have had discussions about the informal swap shops and mutual aid that popped up, but do you feel that things could have been better managed at local level—through public health directors, for example? Do you think that the distribution across a city in an area could have been better managed with that local input, rather than it springing up organically?

**Professor Green:** Certainly one of the challenges is that there is no clarity about what is national and what is local. If we were clear about who had responsibility and, indeed, accountability for what, we would be in a much better position. Currently, we have the issue around visiting and testing in care homes where we have seen some public health directors issuing completely contrary advice to the advice coming out of the Department. That is impossible to manage for local care home providers, who get lots of relatives saying, "Well, we were told we could visit our relatives in care homes," when public health directors are now saying they cannot. So it is the clarity issue and the accountability issue that I think we really need to home in on after this pandemic.

**Olivia Blake:** Dr McWhirter, do you have any comments?

**Dr McWhirter:** I do. I think it is quite important to consider the guidance documents that were coming out at the time. I think there were over 30. We had someone in a small hospital whose sole job was to read, interpret and translate the guidance, so that it would be relevant for the guys on the frontline. Our hospital had the resources to do that, but if you are in a small care home or an organisation that did not have that, to be able to understand that, coming out of the volume of information that was coming through, was really difficult, and you could miss something really quickly, if you were not on it every single day.



A lot of it came out late on a Friday. Changes in PPE advice would come out on a Friday afternoon and it would need to be implemented on a Monday. That was really difficult to manage. It is about having guidance that is relevant to the people who are receiving it. I am not sure that that was always the case.

**Gavin Edwards:** I agree with the point about guidance as it applies to social care and the interplay that that had with PPE issues. I would point to the changes made in the PHE guidance around early April. A change was made around length of use of PPE. That caused massive problems in domiciliary care and in care homes. We were suddenly getting care home workers and domiciliary care workers telling us that they were being told to keep the same mask on for 12 hours-plus. The interplay between those two issues cannot be underestimated. Undoubtedly, to my mind, that led to a great level of infections in those care settings.

Q74 **Olivia Blake:** Was that true for carers who were moving around the city?

**Gavin Edwards:** People were expected, on a routine basis, if they had six or seven care home visits in a day, to keep the same mask on and to travel around on public transport or in their own car with the mask on. That is what people were expected to do. We were involved in meetings with Public Health England where we raised this as an issue. We raised it in writing, as well.

Often, the spirit and the letter of the guidance are two different things. I believe that that April change in the public health guidance sent a signal. There is a mixture of employers in the social care sector: there are more responsible employers and there are less responsible employers. I think it sent a signal to the less responsible employers that it was okay to tell their staff to keep the same mask on for 12 hours. That was not okay, and it led to problems.

**Dr Nagpaul:** May I say, as a GP, the distinction between social care and health care is so artificial. I look after care homes as a GP. Those care homes should always have been prioritised, because they had elderly patients with underlying conditions living close together in a single, magnified household, so to speak. At the outset, we should have considered care homes as a risk area, to protect residents. We must learn that there is an artificial distinction. I meet care home workers and community nurses. All those descriptions that I have heard are a reality. There is no distinction between health and social care in that regard.

Q75 **Olivia Blake:** I am concerned about aerosol generating procedures happening in schools. Do you think that enough thought has been given to the fact that some of these very vulnerable people are going into educational settings and have been throughout the pandemic?

**Dr Nagpaul:** This is a subject for a bigger debate. We have concerns around the guidance around aerosol generating procedures. Just for everyone's



benefit, where there is aerosol generation, the infection spread is much higher, because it is aerosol, not droplet, spread. That includes resuscitation, where you want aerosol generation. Yes, we have concerns that the current PHE guidance does not spread far enough in protecting all circumstances of aerosol generation.

**Q76 Olivia Blake:** That is useful. I just want to pin down—if anyone has any views on this—whether you felt that local authorities were stepping up and offering some better support.

**Professor Green:** The issue, Ms Blake, was that some were good and some were not so good. That also goes to the heart of who is managing expectations and who is managing quality control around local authorities. We certainly saw some great examples. Hertfordshire was a really great example of a local authority that worked effectively, but in other areas the response was, on some levels, non-existent.

**Gavin Edwards:** A really key area is the local authority's responsibility as part of its contractual relationships with care providers. You can talk about PPE, which is definitely one area, but there are a whole range of other areas, including sick pay, which I know is not within the remit of this investigation. We wanted local authorities checking in with all the care providers in their area that they have a contractual relationship with and asking if they had the PPE. In some local authority areas, that was definitely happening, but in other areas there was not that proactive approach, which I think comes back to that out of sight, out of mind mentality towards social care. You see that at the DHSC and you can sometimes see it at local authority level as well. It is not treated like the essential public service that it is.

**Q77 Olivia Blake:** Professor Green outlined the perceived hierarchy. Dr McWhirter, do you think that that was true in the NHS as well, with different settings given different priority?

**Dr McWhirter:** Possibly so. The focus was on big London hospitals; those were the ones being talked about in the media. You felt that they were well plugged into lots of resources, and smaller hospitals— The hospital I work in is an independent charity, not an NHS hospital, but all the patients within it are NHS-funded. We felt a bit of a small player in that. Once you accessed the system, it worked eventually, but if you were not in it at the beginning, it was difficult to penetrate. One lesson for my own organisation is that this partnership working is really important and something that we need to really embrace for the future. Everybody working independently had a much harder time. I think it showed the value of being plugged into these bigger systems for sure.

**Q78 Olivia Blake:** If you did not have the informal swapping—the forklift truck—when would you have run out of supplies?

**Dr McWhirter:** Seven o'clock on Easter Sunday, 12 April.



**Chair:** That is ingrained in your mind.

**Dr McWhirter:** It really is, yes. The saddest part is that that became the focus of our work, whereas the focus of our work should have been the care of our patients.

**Chair:** Thank you very much. It has been a very sobering hearing.

Q79 **Sarah Olney:** My mother was a nurse for 30 years, just as you said you have been, Dr McWhirter. Some things you said sent a chill down my spine. I am thinking of all your staff and their families and just imagining the situation they must have found themselves in, actually being fearful to be at work. I just wanted to comment on that.

Dr Nagpaul, when you were reflecting on how we could plan better for a pandemic, you mentioned some groups of people other than health workers who ought to have been given PPE. That is something that I was very aware of back in the summer, because according to a written answer from the Mayor of London, as of 29 June, 44 Transport for London workers lost their lives due to covid. This bothers me greatly. You said that they should have had PPE from the start, and that that should have been planned for. Could you give me a sense, from your own experience, of the extent to which there has been a greater burden on the NHS because of the failure to provide proper PPE from the start to those groups of workers?

**Dr Nagpaul:** We knew in the first week of April that one third of patients in intensive care units came from a black and ethnic minority background, compared to 14% of the general population. That is a pretty stark statistic.

When you start to think “Why is this happening?” it is either because the black and ethnic minority population are more exposed to the virus, or because they are less protected. It is pretty obvious that significant proportions of black and ethnic minority people are over-represented in certain jobs—I think, nearly half of taxi drivers in London come from a Pakistani background—you know that they were working when we were all locked down and people were staying at home protected. In my own area public transport workers were more represented among people from a BAME background—

**Sarah Olney:** Thirty-one of the 44 I quoted were from a BAME background, according to the Mayor of London’s statistics.

**Dr Nagpaul:** So there you go. It is obvious that if the logic is that this virus spreads and you need to be protected by wearing a mask—at least a mask, if not eye protection too—it didn’t make sense that we were going through April and May with essential key workers in close contact with others, with no protection. Now, we were short of PPE, but if you ask the question, looking forward, how we should pandemic-plan, the plans must protect all key workers who keep the nation functioning. During the lockdown all of those transport workers—as well as those who kept the supermarkets open because we couldn’t have got our supplies otherwise, and other essential



provisions—were serving the nation. I am just saying that that has to be factored in for the future.

**Q80 Sarah Olney:** Dr McWhirter, in your experience and your members' experience, were those groups of people that Dr Nagpaul was talking about—the taxi drivers, the supermarket workers, the transport workers—over-represented in the people that you saw, that you were treating, in your hospital? Do you think that getting PPE to those people might have prevented that?

**Dr McWhirter:** I think it absolutely would. Who are the people most exposed to catching it first of all, and then who are the people most at risk of a severe outcome? I absolutely agree with Dr Nagpaul, and I still to this day don't understand why we took so long to tell hospital staff to wear a mask at work when we knew in March that there would be a benefit of doing that. We had several areas within our hospital where we had asymptomatic staff—we did point prevalence surveys towards our staff at periods throughout the first wave—who had covid but had not transmitted it to any patients in the wards they were working in. So the masks and the PPE clearly made a difference. I think that was the frustration—that people didn't really accept that early enough. Had we recognised that, we would have been able to stop the risk.

**Q81 Sarah Olney:** I wonder if Mr Edwards has any comment on that point about non-healthcare workers and their lack of protection.

**Gavin Edwards:** Well, yes. I mean if we accept for a moment the artificial distinction between healthcare and social care, then, absolutely—I think I have said several times that I think social care was hugely over-exposed during this pandemic. It was not given the priority that it needed. It was treated as a secondary consideration when it should have been at the top of the Government's list in terms of PPE. I think that is absolutely crucial. Also, more widely in public services, other council workers who were out and about providing services to people while others were locked down at home, as well, should have been given more consideration.

**Q82 Sir Geoffrey Clifton-Brown:** I have just got two quick topics I want to raise. One is for you, Dr Nagpaul—the role of Public Health England. They are, after all, responsible for public health protection. We have heard in this hearing that they had the wrong stockpiles to start with. They were very slow to build up the PPE. In fact, the job had to be taken away from them, with the parallel supply chain. They gave a lot of changes of advice—30 times up to 31 July—and you yourself said that their guidance was different from the WHO guidance. What should we be doing about Public Health England's role?

**Dr Nagpaul:** I think it is important to say that Public Health England did not operate at any stage in isolation. I know that there has been a lot of comment about Public Health England. I would agree that the guidance in March was not in keeping with that of the WHO. We were very unhappy



about that, and we had to negotiate, and secured, a change to that guidance.

I am not sure that the provision of PPE, procurement of PPE and standards of PPE are Public Health England's responsibility. That is not their role, so I think it is important to disaggregate the role of Public Health England from the role of the Government, of NHS England, and so forth.

**Q83 Sir Geoffrey Clifton-Brown:** The NAO tells us that 32 billion items of PPE were ordered by the end of July, and DHSC expects to have four months' supply by November. However, although much more of the PPE has been used than in normal times, less has been used than the DHSC expected. Critically, they say, the 32 billion items could last around five years. To all of you, perhaps starting with Dr Nagpaul, if those figures that the NAO has stated are correct, and we are going to have a surplus for five years because of the contracts that have already been entered into and not yet delivered, what should we do with that surplus?

**Dr Nagpaul:** The most important thing is to properly pandemic-plan, in the sense that we could have another pandemic at any stage. Instead of just blinding us with numbers, as we saw throughout the pandemic of x millions, or billions, of units of PPE being delivered, we need to be able to show a proper projection of what would be the demand for those who provide care. We have now just explained it should not just be health and social care workers, but essential workers. What is the demand with a projection of infection spreading across the nation with a similar pandemic? We need to make that absolutely transparent, and make sure that those supplies are in place before a pandemic hits the UK in future. That is what we should be doing. I cannot comment about the individual contracts, because I am not party to that information, but I certainly think that that is what needs to be done now.

**Sir Geoffrey Clifton-Brown:** Dr McWhirter, what should we be doing if the NAO are right, and we have got this huge surplus about to hit us?

**Dr McWhirter:** We need to be really clear on how long it lasts. If we don't use a box of it for five years, is it still in date, has it been safety-checked to last that long? What is the mechanism for making sure that the people who are going to be using it will know that when it comes to them? I think the risk is that some of it will last a while and some of it won't; I would never want to be in a situation where you're giving people equipment that looks okay but isn't. So robust health and safety advice is really important.

**Q84 Sir Geoffrey Clifton-Brown:** Given those important comments by Dr McWhirter that some of it is date-limited, Gavin Edwards, shouldn't we make sure that the social care sector gets its fair share if this surplus is around?

**Gavin Edwards:** Absolutely, and I hope that we can build on other initiatives that we hope the Government will come forward to make sure



that the social care sector is better structured and better able to deliver services in a better way. I would agree with what has just been said: have a proper plan that covers all of the areas where we need PPE. Having a stockpile itself is not a bad thing. We need stockpiles in order to pandemic-plan. As Dr Nagpaul says, we could have another pandemic next year, and we need to have that in place. This is what Governments are supposed to be good at: having a proper national plan that is robust, so that we know that at a moment's notice, we can start to deploy that PPE to the areas that need it. That is what we need, and everybody needs to have confidence that that's in place.

**Q85 Sir Geoffrey Clifton-Brown:** That is helpful advice, Mr Edwards. Can I come to you, Professor Green? Given that some of this stuff is datelimited, isn't it really important that we have a proper plan for how we should use it or stockpile it if it's in date?

**Professor Green:** I agree, and I agree with all the comments that have just been made. The other thing I would add is to make sure that we not only have a clear a plan, but to also have a logistics plan on how to do it, so that we know what our supply chains are going to be like and what our — *[Inaudible.]*—networks are going to be like.

**Dr McWhirter:** I just want to make one more point. If you are planning for a further pandemic, we need to be sure that we have considered all options of transmission of a different pandemic. This is a droplet virus, but if it had been an airborne virus, the requirements would have been different. Next time might be different. We need to ensure that, whatever supplies we have and whatever planning happens takes that into consideration, because we may never be in exactly the same position again. It might be different next time.

**Q86 Sir Geoffrey Clifton-Brown:** I understand that it is Public Health England's job to manage the stockpile of PPE. What should it be doing about this wave of surplus that is about to hit us?

**Dr Nagpaul:** I did not realise that Public Health England is responsible. At the moment, Public Health England is being incorporated into, or rather replaced by, a new national institute, so I am not sure about its current role in the NHS because of the new proposals. I think that, at the heart of this, is a process of procuring the right PPE, with a plan for sufficient supplies. You need to project that a pandemic could last a year and make sure you have got the supplies to last.

Public Health England has public health doctors at a senior level. What I look to in Public Health England is proper, impartial advice around how to protect the nation's health in terms of PPE, and what protection will protect healthcare workers and other staff. That's what we look to Public Health England to provide. I did not realise that it was involved in the delivery and logistics of PPE. When I gave evidence alongside Yvonne Doyle at the Health



and Social Care Committee at the end of March, she also made the point that the logistical, practical elements of PPE delivery and provision were not her responsibility. I might be wrong.

**Chair:** The NHS supply chain and Department of Health and Social Care have a role in this. For anyone who is interested in looking into that, all the details are in the National Audit Office's report. There is a summary of how it works—let alone whatever happened.

I thank our witnesses enormously for your candid and, frankly, jawdropping evidence. Although we think we have heard all of this before, we have heard today some shocking things. The situation on the ground was clearly incredibly stressful. As we have discussed, while Government have a role to practically deliver things, the impact on people on the ground has got to be a part of that consideration.

On Monday we will be having evidence from senior officials in Whitehall about this from their perspective. One of the things we have been saying for some time as a Committee is that transparency about how contracts have been let is important, as is honesty about what has gone wrong and information about what is changing. We will be constrained in talking about some of the private companies involved, because of pending legal action, but the Public Accounts Committee never lets anything go. We will worry away at this until we have answers.

I want to warmly thank our witnesses. The transcript of this will be publicly available by Monday or so, uncorrected on the website. We will alert you to that and we hope you will have time to tune in on Monday afternoon when we quiz officials. Just to remind anyone following, we have a hashtag for this strand of work, which is #covidspending. This will help you follow through from today to Monday and beyond.