People's Covid Inquiry February-June 2021

Professional witness statement
Dr Rachel Clarke

Session 4 7 April 2021

Impact on the population (1 of 2)

Including families, social care, disabled people

STATEMENT

I Dr Rachel Clarke

Job title/ role/ occupation Specialty doctor, Palliative medicine

will say as follows:

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 7 April.

2. I am able to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.

3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement

   I am a speciality doctor in palliative medicine and have occupied this role for over 4 years. I qualified as a doctor in 2009 (ie 12 years ago).

4. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

   Worked as palliative care doctor in acute hospital and hospice settings.
   Wrote a book about the first wave and have written extensively about the pandemic for the national press.

5. How are you able to assist the Inquiry – what is your expertise/ knowledge/ specialism?

   First hand experience of acute hospital and hospice inpatient settings.

6. What in your view were the original vision and principles underpinning the NHS?

To provide health care to all those in need and according to need, rather than on the basis of power, standing, authority, wealth or ability to pay. An egalitarian system, in which the needs of the patient come first.

1. PPE

At the start of the pandemic (Feb 2021) I was working as a palliative care doctor on the inpatient unit of Katharine House Hospice near Banbury. Although in terms of clinical governance, hospices are classified as hospital settings, for the purposes of pandemic PPE procurement, they were classified as care homes. This meant we received the same supply of PPE from NHS England as care homes, namely, one box containing a roll of aprons, a box of gloves and 300 fluid-resistant surgical masks. To put this in perspective, the hospice mask requirements then were around 150 per day – so we were issued with only a two-day supply of PPE to protect staff.

In late March, NHS England and the Dept of Health and Social Care issued guidance that all patient-facing staff (NHS or care home) should wear Level 1 PPE. This caused a crisis in our hospice. With only a two-day supply of masks – and no way of sourcing any more (they were simply unavailable from NHS England) the hospice faced endangering its frontline staff (against government PPE advice) or being forced to close its inpatient unit and send our terminally ill inpatients away to the local hospital's A&E.

The full detail of what happened next is described in the accompanying extract (1. PPE) from my book about the first wave of the pandemic. In essence though, the hospice called the allegedly "24/7" PPE hotline set up by the government to address PPE concerns. Widespread press coverage at the time claimed this hotline would fix any issues care homes faced with sourcing PPE. However, on multiple occasions no-one answered the hotline. Nor were emails answered. Eventually, when my medical director managed to speak to someone, and said that the hospice would have to close in 24 hours and send all our vulnerable patients away if they could not send us more masks, he was told they could not help.

This is exactly the predicament care homes across the country faced too. In NHS supply chain terms, hospices and care homes alike were the lowest priority for PPE, despite the fact that our patient populations were most vulnerable and most at risk of dying from Covid.

With no help forthcoming from the NHS supply chain, we were forced to beg charities for help (as described in the extract). We narrowly avoided closing the hospice when a charity sent us an emergency supply of masks.

There was clearly a two-tier system in operation, with hospitals in tier one, receiving PPE first, and care homes and hospices in tier two, left essentially to fend for themselves.

I split my working time between the hospice and local acute hospital settings, and should note I never had any problems receiving the right PPE when working with Covid patients in the hospital setting.

2. Testing

In the acute hospital setting (a district general hospital) during the first wave, the turnaround times for testing ranged from around 2-4 days. There simply wasn't capacity to receive results sooner. This meant that vulnerable patients were, on occasion, discharged from hospital back to their care home

without a test result having been obtained. Although this was consistent with official NHS England / DHSC advice at the time (ie no negative result was required prior to discharge) as a member of the medical team, I was profoundly uneasy at the time (as were other doctors) about the risks of patients seeding their care homes with undiagnosed Covid on discharge to hospital. We felt hamstrung by the lack of testing capacity. Without prompt and efficient testing, vulnerable patients were at risk both inside the hospital and inside care homes (and indeed my hospice). We couldn't understand why capacity had not been expanded earlier and more swiftly.

3. Impact on palliative care patients

The extreme focus on Covid patients during the first wave, plus the government message of "protect the NHS" meant patients with other illnesses/needs (eg terminal illnesses requiring palliative care, or symptoms of cancer requiring urgent diagnosis and initiation of treatment) did not always have those needs addressed adequately.

Patients with metastatic cancer or other terminal diagnoses felt as though they were "second class" patients, causing great distress (see attached extract from my book, 2. Cancer patients' testimony).

In my opinion – and I saw a great many of these patients both in hospital and hospice settings – they were right to feel distressed. The public narrative and reconfiguration of hospitals focused almost entirely on patients with Covid in the early days. Other patients felt scared and abandoned and left to fend for themselves. We started seeing very 'late' diagnoses of cancer appearing in the summer of 2020 onwards – patients whose scans had been cancelled or who were too scared to present to a hospital, and who, hence, received their diagnosis when it was too late to attempt curative treatment.

I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Rachel Clarke	**4/4/21**
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SIGNED	**DATE**

Please return to Inquiry@keepournhspublic.com

Thank you

Olivia O'Sullivan
Secretary to the panel
The People's Covid Inquiry

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