Interview between Dr Michael Ward and Dr Alan McGlennan

P: So my name is Alan McGlennan and I am still a practicing anaesthetist, my principal consultant post is at the Royal Free Hospital. So my anaesthetic background is that I started in 1999, so I am [a] pre-millennial anaesthetist I suppose. My medical school training and my post graduate training were all within the M25 despite being from Scotland, and I got my Fellowship in 2001 and became a consultant at the Royal Free [in] 2006.

I suppose the highlights from around that time is that I was the elected council member for the Royal College of Anaesthetists for the trainee role, so I did that for four years, three of which I was a trainee for, one I was a consultant. So I was somewhat College apparatchik, so I understood the College well and the Association well, so I became a consultant at the Royal Free and I did two things of note, three I suppose. First would be that I was the Training Programme Director for North Central London for six and a half years. So I calculated it once, I put it on my CV, I think through my hands there were around about 560 trainees, at some point of their training, some of whom I can remember [laughs], and actually in all of my jobs that I've done that was the best job, that was really good.

Around that time I was a Royal College of Anaesthetist examiner, I did three years as a primary examiner and only two years as a final examiner, reason being was I got sucked up into the medical management machine and my time was no longer my own, so I only did 5 years not 10 years. I also ran the anaesthetic department at the Royal Free Hospital for a number of years and my sub-specialty interests were obstetric anaesthesia so I did quite a lot with the OAA [Obstetric Anaesthetists' Association], I found that really enjoyable. I got involved with ultrasound regional anaesthetists relatively early, when the good ultrasounds came in and people started doing inter-scaling blocks and stuff like that and the guidance, so I got into that quite early.

Anyway, so then I got sucked up into medical management, which is where I am now, I'm one of the Medical Directors in the Royal Free London Trust and there are four of us. I am the Medical Director for Chase Farm Hospital which is an elective surgical unit, which has been rebuilt. I'm also the Medical Director for group clinical services, which is a unified pathology imaging pharmacy for across the [batch], and I'm also the Chief Clinical Information Officer, so you can imagine, I am a full on going over to the dark side there is no hope for me now Michael [laughs].

I: How do you find time to do all these things?

P: Sadly I only give anaesthetics every fortnight now and I'm due for my appraisal, and each time I ask the question of myself which is, 'what are you going to do, you can't carry on like this'. So then that is actually how I got involved in the Nightingale because...

I: That was going to be my next question, how did you get involved in Covid?

P: Right, so, I remember reading about it and thought, 'that's going to cause us problems', and when there was a requirement from our section of London...so London is split into five sectors, and ours in North Central London with a population of 1.8 million. So our sector got together and was talking to all the acute [IW: 00:04:35] and actually, primary care as well, but the point was, what is your plan for dealing with Covid because it looks like it's this prevalent and it looks like you're getting this amount of admissions and this amount of critical care.

So, within our Trust I was given the task of making a report to go to the office in Central London to say how much we could expand our unit. And because I never did consultant intensive care, it wasn't really my thing, I mean I dealt with it and it was under my remit at the Royal Free and I've closely worked with them....I got to the report, I produced the report very quickly. I happen to think one of my attributes is being able to occasionally knock down a few walls, so I understood that we were going to pass 150% of ventilated patients and we were going to have to ventilate outside of the intensive care walls and to get past 200% well, we'd have to do that on the ward. And so, long story short, I was plugged in to the North Central London sector conversation for critical care, and I happened to dial into the first Zoom meeting I ever went on, and I remember being a little perplexed because I seemed to have done more work than anybody else within the set, that's not casting dispersions on their ability or effort, it just appeared quite quickly that I had the information to hand because I'm the Chief Clinical Information Officer.

I found it very easy, and I was the first person on the call to say, 'we have a problem, we have a problem', and the problem isn't necessarily the one that you think it is, it won't be, you know beds aren't the problem, but it will be the equipment and it might be the oxygen, and it won't be the doctors until you've sorted out the nurses. So right from well into March, I had, I was right, don't get me wrong, I'm not Nostradamus or anything, if you knew the business you could figure out where your problems were. I was a bit concerned about oxygen really early on and then I was dissuaded of that, and funnily enough, the place that did have an oxygen problem was the Royal Free well after I was at the Nightingale, which they have to build another [IW: 00:07:21] so I was right [laughs]. So I wrote my plan, and I was dialling in to the calls, and over about two weeks it became apparent that I was correct, that we were, given the model that was provided to us, we were going to have difficulties with equipment, in the form of ventilators. Even if you used the anaesthetic machines, we were going to have a problem with nursing, if you're were going to keep the nursing ratio 1-2-1. Already I'd worked out we were never going to be 1-2-1 and I was already seeing foolish numbers like one to eight and getting the opprobrium that you'd expect from the senior nurses on that.

It came to a head one day and I think it was the 31st March [2020], whereby no central London had fed into a critical care call within the whole of London and some people from St Barts [St Bartholomew's] in London, some people from [St Guy's and] St Thomas' had said relatively similar stuff and said we're going to have to have a London plan and the reason why....it was all particularly London centric was, as you know, it seemed to be two or three weeks ahead of the wave. And so we thought urmm that we were going to have to act first and it was also, terrible thing to say, there's first movers and [IW: 00:08:50] as well that if there's national equipment, we might be able to get it first, you know I'm nothing if not Machiavellian. So in this meeting, and the reason I'm labouring this is because it shows you [hesitates]...

We called a meeting that happened on a Saturday and a Sunday, which given we'd been working weekends for the last three weekends anyway because it was all getting out of hand, so it was quite...everybody that was invited knew they [weren't'] invited casually, it was really important. It was held in Great Ormond Street [Hospital] for a variety of reasons, which I won't bore you with. But anyway, I remember going there on Saturday and it was the day after a version of lockdown was being talked about, and it was when the first time you saw shops being boarded up, it was that time. I remember walking along the street, really early, it started at 7.30 in the morning and I'm there thinking, I remember feeling like I was in the middle of a movie, I remember thinking that. Anyway, I went into the room and a third of the people were doctors, and a third of the people were military and a third of the people were business sort of KPMG Management Consultants. And I remember sitting down thinking either this is a different scale of problem than anyone thought, or this meeting has been incorrectly called and because it's always a bit off putting when you're sat next to military, I mean, they were in fatigues. So anyway, that whole weekend was about a suggestion that I had made in our section that was we were going to consider providing off site ventilation. The reason we could do it off site was one, it would address what I thought was an oxygen issue, and the second thing which it's addressing is line of site issue. You can't do 1 to 8 if you've got a lot of side rooms. You can only nurse 1 to 8 if you've got a clear line of sight, if you've got a Nightingale Ward.

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The reason that I was brought in was we had already scouted a site, near, in Enfield, which isn't Chase Farm, but it's near it, which the Royal Free owned which had a lot of industrial power and industrial water because it was a re-processing plant. I'd sent one of our estates guys over there and said, just out of interest, could we put in a VIE and could I put 100 ventilated patients in there?

I: VIE is?

P: BOC Vivid Oxygen Cylinder (Vacuum Insulated Evaporator). So long story short, the estates guy went out there and said, we could do it, he said I'll need to do more work, we could do it. That happened on the Friday and so on this Saturday and I Sunday I was in this meeting saying what numbers are we expected to ventilate in excess of the normal amount and the number talked about was about 1000 throughout the whole of London. Now, that was on the modelling, that wasn't the actuality, that was on the modelling.

The conversation the next day was very detailed about what the model should be, whether or not you should have one central place where they should do it, not completely off-site but in a car park, or whether you should actually export non-Covid patients but other patients there, so those were the sort of conversations we were having. And they were quite technical and a little bit techhy [sic] and like I say, only a third were clinical, not everyone was intensive care and not everyone was anaesthetists, there was a lot of Chief Medical Officers in the room who were nutritionists and A&E doctors so it wasn't fully nuanced. Anyway, on the Sunday, at some point somebody came in, one of the senior clinicians and they looked, again it felt like a movie, they looked ashen faced and everyone noticed it, and they said I've just taken the new model that's come through NHS London, and I know that the gap from the cabinet table to NHS London was only 1 or 2 hours, so this was the red hot information and the concern was we might, given the doubling rate that was in London at the time, the expectation was we needed to do 6000 ventilated patients off-site.

Now, let the record show, I think at our peak we were at 2500 in total and that was only 1500 in excess of what London normally did, but if you went on the model that came direct from the scientists that we've all heard of, then you could see why everybody was looking a little bit concerned. Because it was at that time, the week before we were starting to see the pictures coming out of Lombardy Northern Italy, and they looked grim and anybody that knows anything about intensive care knows that Northern Italy has got a very strong history of intensive care, they're not amateurs at all, they're got respect and they were overwhelmed as we saw and we were anticipating that. And so the model was written, so then it was very clear that decisions had to be made there and then. Now I wasn't privy to the central decisions that were clearly OK'd by Cabinet and NHS London, but it was, by the time we left that meeting, somebody said, we were sat down and the NHS London Medical Director was saying, tell me more about this model, and I said my model is this, I mean I wasn't the only person saying it, there were other people saying similar things, you know.

It's really about understanding what your resource issues are, and the issues are there's not enough equipment, not enough oxygen, not enough nurses and a very homogenous, what we thought, it didn't prove to be quite true, a very homogenous population we thought. Normally about 60 single organ failure, put them on a ventilator six days, extubate them, turns out it's not as simple as that, but that was the science at the time. So, we wrote a medical model that would support multiple thousands, well, I wrote it down, can you write a model for industrialised intensive care respiratory support? That

was the exam question. I wrote the question, and I wrote the first answer and we had clinicians from Kings and [St] Barts London, [St] Barts cardiac and we provided, well the question that was asked, 'How do you deliver that?' And I said well, we already understand hospital structures so you have to have a hospital infrastructure, medical, nursing, ops OK. And I know how a medical executive works, I'm a medical executive so I'll be the Medical Director, you be the Divisional Director, you be the Clinical Director, you be the Audit Lead, you be the Equipment Lead, ding, ding, ding, ding, ding. And a bit like playground football teams, you know, you're lined up against a wall and we're all assigned tasks, and I remember thinking, this is just to get a staff base, other people will come along who are [laughs] better at it and I will move aside, and I'm completely fine by that. But I got the sense that given the numbers we couldn't waste 24 hours, or have another meeting, so the next day I was stood inside the Excel [Excel London].

We considered two venues, one which was the Excel and the other one which was Olympia in Earls Court, and so the next day we had a medical executive, a nursing executive, an ops team, and the same amount of military people. I cannot emphasis [enough] the military, I have no experience in military, it's not my background at all and I'd never really worked with them. It was a pleasure doing business with them because, it wasn't what I expected, but they had logistical expertise, that's all they do, they do big change projects involving extremes. And very quickly they encapsulated what we were trying to do, they said, in fact one of them said to me, you know, you're providing a proportionate response to a disproportionate problem. Keep asking yourself that. Is this proportionate to the problem as you see it, it may well be wrong, but as you see it, is this a proportionate response? Those were the thoughts that kept me, each time I was involved in convening the place to make a decision, I made very few decisions myself, from then on it was collaboration all the way. But I was in the room when decisions were made, I was frequently at the table asking the questions, but I very rarely made the answers.

The amazing thing that happened from then on in, good people phoned their friends, or their friends phoned up, you couldn't, you know the expertise was incredible. It was fireman running into the fire, that was the experience. People going, this is the sort of thing I know all about, 'I know all about the psychological trauma of this, let me go there', 'I know all about repatriations of respiratory diseases, let me go there', 'I've got experience of the operational management of field hospitals, let me go there'. And basically, I used to walk along, it was a very long corridor in the Excel, I'd walk up and down it all day long talking to people. By the length of each walk, they would tell me their problem, tell me what they needed, ask for the authorisation, get the authorisation and by the [IS 00:19:54-56] the next day they had a team of three of four people enacting it and it was incredible you know. So that's how I got involved.

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I stayed involved because these things have a momentum and we knew that, it went in three periods. Until we opened we had in our mind a model with multiple thousands in the whole, and we were to produce a model that was, the aim was, we were going to save as many lives as possible. I understood very early that if those numbers were correct, the standard of healthcare that we provide ordinarily in ITU could not be delivered. Ok, you cannot get a Savile Row suit for Woolworths prices, so you had to understand that the quality was going to be different, but there would be a metric where you felt that was the best you could do. Because I was anticipating civil unrest, I was anticipating an overwhelmed country, I was anticipating the rest of healthcare collapsing under the weight of the ask, so that we were the only functional area for Covid ventilation.

And each time we were dialled into the NHS London meetings, several times a day, we went with the information that we had, and the model they had which they took from the central scientific mode, which was the correct thing to do, it turned out the numbers were incorrect, but that's okay, I would rather I [had] too much insurance than too little insurance. But even on the day we opened to patients, their modelling had only shifted in timeline, not in the peak, so by then...when we were on the front of the papers you saw a hospital being built in the middle of London with a military cordon around it. Funnily enough, people started washing their hands and socially distancing and so on. I think that was a very strong message, along with Boris Johnson getting ill, and along with, actually we did a really good public health message, once we got going, we did a good job for the UK, the public as well as the NHS. We could start to see that effect just on the day that we opened, when we first started taking patients.

I remember thinking, I said, we'll take one patient on the first day, ten on the second day and then we'll just open the floodgates. And I got a lot of grief for doing that, a lot of people said, 'what the hell do you think you're doing?' But I said, 'guess what, we're not having a hundred pour through on the first day', because I didn't want to end up like the face of a poorly executed public crisis, I didn't want to end up like the Grenfell Fire Officer or the Hillsborough Police Officer in charge. Now you may well, I don't know the cases well enough, but they're castigated in the public eye. They may have made bad decisions based on what they thought was the correct decision at the time, but I felt that I had one modicum of control, which was, I could stand on the hosepipe whenever I wanted to stop the flow and I would do, that was the only thing I was going to do, you know, take a unilateral decision if I didn't feel comfortable with the flow, I would stop it.

So we took one, we took 10. It was only when we took 10 the next day, that I was expecting people to be screaming at me [makes noise] and they weren't, that was the first time central numbers for the peak, the modelling changed, it changed into, 'Alan, expect 2000 not 6000', it was still a stupid number [laughs]. So, from them on we were taking our information from Central Government, but also we were very well connected people, everybody there were working in [The Royal] Brompton, working in [St Guy's and St Thomas'] Tommys', working in UCL, and I'm a well connected guy, so I was

phoning people up and getting messages saying, ‘what’s it actually like?’. And the message we were getting was, ‘it’s hell on earth’, ‘we don’t think we can cope any longer’, build your place very big, build it as good as you can and very soon the dam is going to break. We’re building our ITU, but it’s not going to be enough. You know and I know, that NHS London ITU's did it, they built an ITU and they tripled it, that with the social distancing measures, with a few overspill that came to us, that was enough.

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And it was only about 10 days in to us taking patients, I think we had 38 at one point, that I thought, do you know what, I think we might be over the peak. And if we’re over the peak, our model is for industrialised intensive care with an expectation that the standards are not the same as in peacetime. Well, things are not going to get that bad, in fact they’re going to get better. So our standard of care needs to be exactly, exactly the same as you would get at [St Guy’s and St Thomas’] Tommys’, Queen Marys, UCL, because, because that’s what’s going to be expected of us. So we changed our ratios, all the stuff you’d expect. Now the paper’s going to be out in the BMJ [British Medical Journal] in a couple of weeks time, but our figures are [IS 00:26:08-10] to NHS London’s averages okay, and we did that with a lot, a very different estate, clearly, we did that with a different nursing model because very few of our nurses were..... There was one central ITU nurse and our auxiliary team were quite dislocated, they weren’t critical care nurses, or theatres nurses, or anaesthetic nurses, they were district nurses, ophthalmic nurses, we were a very disparate team.

I: Were they are all volunteers, the nurses and the medical staff, or had they been dispatched from their other jobs?

P: 90% of them were from NHS, there were some from the private sector, which had closed down, and there were some returnees as well. The ones who were from NHS London, they were asked, ‘Who’d like to volunteer?’ and they put their hands up. Nobody was there under a management instruction. So when we realised that we had to increase our standard, and at some point I thought, we’re over the hump.

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Now, guess what, politicians building something then closing it down, also people like insurance policies, it’s like security blankets to be next to them, and so there was a desire to keep it open, keep it open, keep it open. To which I said, if you’re coping, if you’re sending us patients, if you need to send us patients, we’ll stay open. We had three days in a row where patients were not sent to us, and I said, ‘I’m a medical director, but I’m an anaesthetist clearly, but I’m a medical director as well and I understand risk and I understand strategy’, if we don’t start the conversation to say, what

do you want us to do, you built us, you know, 6000, but you don't need 6000, in fact you don't need us at the moment but you want us to be ready. I think we should go to a state of hibernation, mothballing, zero occupancy, whatever you'd like to call it. I think we should get to that point quickly, so that we can free up equipment, free up resource, free up learning, and not create too much of a hoopla. Because in the middle of it I was in the media circus as well which we had to deal with. Because it's interesting, it looks fantastic and Matt Hancock was there, and the military, and there's a helicopter out the front, and there were all these, so... So you can see from the medical director point of view there was the frenzy of, one, getting it open, and being the first to grasp that the numbers were going to be big, and the models had to be different, I'll tell you about the model in a sec. And then there was getting it open and making sure it's safe and it works, the machine works and then realising you don't need us to the same extent as you wanted us, so we are going to safely.... So we got a car, we built a car, we took it to the garage, we put it on the road, we got it to first gear, second gear, and you realise you don't wanna go anywhere, so you put it back in the garage. And I'm happy with that, because I think it was a proportionate response to what we were told was a disproportionate problem.

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Let me tell you a little about the clinical model, my medical executive, or medical executive training would say, you describe the issue, the population you're dealing, you need a business model, and you need a medical model and from that you get an operations model, a staffing model and a finance model. But the medical model was very important and so we think it's up to number 37, while hospitals operating were up to 24, we wrote the model every single day, and added to it and subtracted and changed it. I wrote the first one and it was only three pages long...this is what we are, this is what's the problem, this is what we're going to provide, this is how we're going to do it, and these are the central things that are different to normal. So industrial healthcare, some guidelines and ways of working that we've done in the past do no longer, we need to save the greatest number of lives for the least amount of resource, and we're going to do that by spreading very thin, but as safely as possible. Our resource which is, number one, nursing resource is more at risk than medical resource, and the rest of it was about describing the way that you would harmonise and standardise all the things you'd expect, intubation, ventilation, all the nursing tasks of critical care patients, the feeding. And then over days and days and days all the complications, the GI [gastrointestinal] complications, the stroke complications, the real complications, so we had to have medical models for that. By the end we'd brought in an RO [reverse osmosis] so that we could do hemer-dialysis. We had a hemer-dialysis centre in the middle of it with purified water, we brought a purified water plant in, so each day we would consider in depth, what else had to be added to the medical model, if more detail, down to the line. And what we built clearly is, take recent evidence that was published, and it was published in the BJA [British Journal of Anaesthesia], it was published online, or on a Twitter page, or in a conference call. For example, not using peak [flow] at such a very high level, not

over flooding them with fluid, about the thresholds for renal replacement, about the aggressive [IW:00:32:21] embolism guidance.

All of these things were taken really quickly because we were right in the middle of the web of people who were having all the fancy discussions; we got all that news first. Now, the next thing you have to know that's a little bit different from normal is we had the business model and we had the medical model. Central to the medical model was the learning model, whereby we were lucky we were in a conference centre because although we had all the halls downstairs, upstairs was a whole lot of admin rooms. So I basically sat in a massively big chief executive lounge [laughs], it was brilliant, and we had these massive breakout rooms, so each day we would have 30 or so of the senior doctors, 30 or so of the senior nurses and the operations team, plus the military, plus the press, all this literally in one room, and we would come together each day and say, this is what we've done, this is the problems that we've had, these are some of the issues that we need to solve now, this is some of the functional problems that we've had, we've had a disconnection [IS:00:33:34-37], late or early, we've had a line infection [IS:00:33:39-41], and this is what we had to do.

We would change and reiterate all things.....any good hospital has a good governance system, and we had it wired in right from the start. We were really lucky because most hospitals' work stopped and a lot of the medical support organisations stopped, so the Kings Fund, or the Health Foundation, the MRC [Medical Research Council], they had loads of staff who were doing nothing and wanted to be part of the story. And guess what, they're really clever kids, so, and they understand the world of medicine, so we got them in and they formed part of the learning model. Whereby they would literally be on the ward watching things, making sure they were enacting the most recent change of our medical model, taking measurements, getting feedback, getting staff feedback, getting patients, relatives feedback so that each day at 4.00 o'clock we could sit in a meeting, massive room, and it would all get fed back so that we would, so each day, we would change, we would make fundamental changes and then communicate them out.

So really, we ended up replicating a very highly functioning hospital, albeit with one patient type, and albeit will all of the tools of the state to my hand. We were bathed in luxury in some things. It's very much worth stating here that you were reading, in social media, that we had lots of equipment and ventilators. We never did. We were always passing PPE and ventilators and Vast caths [Vast Catheters] and [IW 00:35:31] back out, we only ever had 10% more than the patients we were expecting the next day. We had a very clear understanding which was, we cannot hog equipment, but, we did have our hand, because we were expecting to be the overflow, we did have an excess of estates, military, and money was never an issue, obviously it all has to get paid for, but nobody said to me can you do a business case for this.

I: Nobody ever said that to you?

P: No, no, but there were finance people there who were doing it for me. Don't get me wrong, we weren't being reckless with money. There was somebody there doing it. But like I say, it felt like I was at the head of a lot of bright doctors and nurses and we were iterating our medical models, which was the most important thing, by using the learning model, anything else would distract us, estates, press, finances [IS 00:36:39-43]

I: Where do you go to now? What's the future for your hospital?

P: So, currently, I mean we're speaking now in September 2020, it's currently occupied by NHS London. We have, the infrastructure is still there, in the form of the oxygen supply route, the cargo supplies, so basically medical equipment and medical drugs supply route, we have a number of beds, a small number of medical equipment, and the same for consumables as well. We still have half of the hall taken over by us. We left the building a week after the last patient, and in that week we spent writing down what happened, doing the statistics, analysing what it meant and iterating the model. So we said, given certain circumstances that would have to be true for London, we will reopen it, we will reopen it differently because now we have the experience, this is how we'll reopen. And so we put all those things in place. When we left we wanted it to be like that until November, I think the contract is open until March [20]21, and that would take us basically through the most likely time for a second surge and particularly if that was mixed with a flu surge as well. So anybody who worked there is technically on short notice to return, we spoke everyday about that, and when we had our wrap up education event, you know I said that, we have no way of forcing you but given the feeling of the place and the feedback I got, I got the sense people would return in a heartbeat because we had got quite good at doing something quite unusual, and if we were called to do it again, we would do it.

I: The only person I have spoken to who worked there, was actually seconded onto the training department, involved directly with training, found it an immensely positive experience, the whole thing. He was actually not a Consultant, he was SAS grade. You may know John Shubbaker?

P: Oh yes.

I: I've already spoken to him and he was very positive about the experience and found it an immensely valuable experience, and it was pure chance that I was put in contact with him. I've also spoken to Carl Waldmann, but you know, he was Chair of the Intensive Care Society, and he told me about his experience in Berkshire. I asked him, and I'm going to ask you the same. Was there anything particular that you did that you wish you'd done differently or you would change if it happened again?

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P: Yeah, if I had my whole time again, I would insist on....if we were off-site we would have to be co-located to a hospital. So much of it, even though within a couple of days of opening we officially went under the management of St Bart's Hospital, and that was brilliant because they provide a layer of infrastructure and governance, and just people to deal with that we really needed, and it gave us a better sense of importance. You know, it's the oldest hospital in the UK and we were the youngest hospital, it was quite nice in that respect and they treated us very well. I mean I was, I met Alwen Williams who is their CEO three of four times a week, he was extraordinarily supportive, all of their executive team were available to us, Charles Knight who is the Chief Executive of [St] Barts Cardiac was on site every day, he was our Chief Executive, it was excellent. However, we still had to have a supply line that went through [St] Barts and although it's nearby, it's not next door, and every hospital has a big car park, we could have put it [the Nightingale Hospital] on a car park, I would definitely do that.

There were some estate things that I would do differently straight away, which is co-locate with the hospital, because even if it's as mundane as computer printers, or electricity, or Venflons [cannulas], you know that it's over there, and we were in, you know, the Isle of Dogs in the middle of Docklands so it's a very difficult place to get to. In regards to the medical model, I wouldn't have changed that because given, I think we, the set of cards we were dealt, I think we played correctly, in that we needed to set this model up at this stage and when we realised that was disproportionate to the problem we were now facing we changed it. So, we did manage to provide a safe and equitable intensive care experience for other people, and then at the very first opportunity we thought that there's a chance we would not provide as good care as you would get at St Thomas's or the Royal Free, then we made plans to close it safely. So I wouldn't change anything about that. The difficulties that we actually had were dealing with so many agencies that it was distracting. You had to deal with your sector, you had to deal with the Trust, you had to deal with NHS London, you had to deal with NHS England, you had to deal with any government people, and there were quite a few of those, you had to deal with the press. The press were not universally positive because there was literally no other story in town, and once you've written the, 'hooray for the Nightingale story' there is only one other story that you can write, which is, 'what the hell's going on in the Nightingale?' So I found that, I didn't think there was anything we could do about it.

The experience was stressful in dealing with so many agencies all at once, everyone wanted a bit of you. I was very visible to pretty much everybody that I could be, I didn't sit in my office, I just walked up and down the corridors so people could feel they could see the person most responsible for the clinical work, so you could have access to them. But of course, then you have to talk to

everybody and that was a little bit wearing, and occasionally you'd say the wrong thing and it would be reported back to you in a garbled way.

The other thing that I would advise against is...., it was easy to work with the military because they understand chains of command, centralised control, they understand hierarchy, they understand stresses and people's behaviour in stressful situations and they're very adept at this, they're also very adept at humanitarian things, you know, don't fire too many bullets [laughs], as it happens our military. So dealing with them was very easy. It was quite difficult to deal with any businesses or third parties and management consultants who were with us because they worked in a different way and they couldn't change gear. It wasn't the companies or individuals who were very nice people doing their damndest, it was just it would have been better to keep that within the NHS. They dealt with on screening the patient, the staff and a lot of the HR things and that was quite difficult at times and it was different way that we'd ordinarily work within the NHS.

So you realise, instruments of the State, like the NHS and the military have a very similar way of working, you get very quickly onto their wavelength and it was more difficult for the other organisations I felt. That plus dealing with...we had some very good Press Officers for ourselves, most of the tears that I saw were down to what a very junior, well-meaning, generally nurse, not doctor, had read on social media from...that had been linked to some degree of a bone-fide press article, so, somebody writes something a bit nippy in the Independent or Daily Mail, even if it's ever so slightly tinged with negativity, it gets replied to and amplified on social media and that's what some nurse, that had been banging out the hours for the last four weeks, miles away from home, reads at the end of her shift, and guess what, he or she is in tears. And that was regrettable, and if I had my time again we would put better....we such a lot of psychological support and processes...

46:40

I: That was certainly the view expressed by John to me about the psychological support you received in addition to...

P: Of course what we were focusing on was, you might see things happen that you really don't want to, like, you might see death, you might see care that wasn't what you'd expect it to be, you might see people stressed. What we didn't always prepare them for was, you might read stuff on your social media that you might not like, your mum might see something in a national newspaper that paints you in a bad light. It was just quite disturbing. It seems very small now given the extent of the

problem that we thought we were dealing with, but that created a lot of fall out for our staff.

I mean, I wanted to have good outcomes and we had good outcomes, just we weren't used as much as we thought we were. But I wanted it to be an experience that people weren't coming up to me in the street five years later saying, 'that was a bloody horrible experience Alan, how could you let me do that?' And I think, it wasn't down to me at all, you get a sense of the collaborative way that we were working, but I think we did our.....we always had our patients and their relatives and the staff experience really at the top of our mind.

I: We must begin to wrap this up, but there were a couple of other questions I want to ask you with your particular position. This was very much a London, South-East England resource, was there ever a plan to extend a similar facility in other parts of the country?

P: There was, in fact they opened up a few of them, so some of our team flew to Harrogate, to Bristol, to Glasgow to advise them. So the one in Harrogate looked very different to ours because of exactly what we had said, you know, we wouldn't do that again, do it this way, so their model was different, it was smaller. At one point there were 20 planned and we were on a network call where we were that bit further ahead so we shared our medical model, our staffing model and our learning model and we offered site visits. Now, luckily enough, well you know what happened with the actual height of it, so they weren't called in to use. We were the only ones who took critical care, critically ill patients, we were the only ones to do that. We were also linked in to Toronto, New York and Berlin, so we were on conference calls. Berlin had a different kind of model, Toronto was taking our model and New York, sorry not New York, Boston, so we were linked in with calls with them to say, what are you doing, what problems have you got, what solutions have you come to, well good, we've done that or you can borrow this, so there was a feeling of internationalism about it.

I: I find it fascinating that you were involved with countries that essentially have no National Health Service or socialised medicine service, and that they were gonna take it. Now how were they going to be funded? You and your hospital were funded by the Treasury basically.

P: The American was all Federal, you just dealt with the State. Toronto I think, the funny thing about Toronto was I had a conference call and I

couldn't get on through the normal telephone call, so I did it, linked on it through my phone on some email link, and I thought it was free, but I got a bill for about £170 a month later [laughs], I wondered what it was.

I: [laughs] I hope you put that down in your expenses

P: I thought, who am I even going to ask to get that money back?

I: Yeah, I don't know. This has been absolutely fascinating because one of the things that I as a member of Joe Public essentially now, very much a retired ex physician, what we've been told is that the great Nightingale Hospital had a total of, I don't know, a trivial number of patients at huge expense and was it worth it. But I think you've persuaded me that it was worth it actually, as a resource, I mean, do you share that view?

54:14

P: Yes, so, we were wired into the intensive care network and there were quite a lot of naysayers saying, what the hell are you doing, we don't need you, we need our intensive care doctors and they think their way is the right way, funnily enough, and they tend to be right. But I remember some of the greatest naysayers, I won't name the hospitals they came from, but one of them came and visited the place and went, 'my god, you built an intensive care unit, unbelievable', and he could not believe it because he'd heard all sorts of stories, but he saw it and said, this is an intensive care unit, happens to be in Docklands, but it's amazing. The second guy, from a very prestigious area had said, we really pushed our envelope, we really really were doing stuff that was really daunting, and we did that because we knew that you could take it, if it all failed we could export 25 patients to you [snaps fingers] like that and so you provided a psychological [IW:00:52:23]. And so, I think it was definitely worth it, when the numbers get crunched, the cost clearly is not economical and there will have to be a reckoning about why did we not have these things ready because there was going to be another pandemic sooner or later. We need to learn the lessons, OK, so we've learnt the lessons this time round, we've gotta make sure we don't have to learn them next time round, and we've been very open with our experience and our data and our thoughts, and we've produced massive documents for whoever wants to have them. So for those reasons, it was very much worthwhile. I'll be honest with you, the greatest thing that we did was when we were trying to, the government were blown away by the amount of social distancing people actually did, hand washing they did, the lockdown that was performed to close the box on the disease. That was the success, part of that was like I said Boris Johnson getting unwell, very good comms, very

good role modelling by people, but you can't beat building a hospital with the military and a helicopter in the middle of London to scare the be-jesus out of people, and it did do that as well. When I was interviewed, it was deadly serious, we thought we might have 1000 people in there next week and you IS:00:53:53-55]

I: Well that's a very interesting and a very good point upon which to close. An expensive stick though to drive the population, nevertheless it worked.

P: Whatever number gets reported about, most of that money we actually get back because a lot of the infrastructure [IS:00:54:16-21]

I: Well presumably that is part of the story which will come out in the wash eventually.

P: Well, if I have to go to an enquiry to talk about the use of money I'd much prefer it than having to go to an enquiry because of a mass oxygen failure in the Docklands. As some point I remember thinking that, that was my number one worry, a big oxygen failure was number one, number two, what if C. Diff [clostridioides difficle] just rips through that building, then what do you do?

I: Thank you so much for your time. I hope you found it useful for you as well, but thank you for your time, I know how busy you are and it's been a pleasure to meet you