IN THE MATTER OF THE INQUIRIES ACT 2005

AND IN THE MATTER OF THE INQUIRY RULES 2006

The UK Covid-19 Inquiry

NHS England's Note re: First Preliminary Hearing in Module 3 of the Inquiry

A. Introduction

1. NHS England welcomes this Inquiry. It will allow the facts to be set out and the truth to be told and, through that process, learning and understanding to be identified for the benefit of the future. Consistently with the NHS Values, and in particular to work together for patients, NHS England looks forward to participating in the Inquiry to help it in its important work. NHS England is grateful for being designated a Core Participant ("*CP*") in Module 3 of the Inquiry.

2. Given the subject matter of Module 3 of the Inquiry, and the provisional scope of the Module - as identified in the Inquiry's "Module 3: Provisional Scope" document of 8 November 2022 and in paragraph 33 of Counsel to the Inquiry's ("*CTI*'s") note of 14 February 2023 – NHS England expects to be an active CP in Module 3 of the Inquiry and to play a significant role in it, not least because the scope of the Module includes "the impact of the COVID-19 pandemic on healthcare systems", including "the capacity of health systems to respond to a pandemic".

3. NHS England has not made oral submissions in the Inquiry to date; indeed, it has not commented publicly on the Inquiry – this Preliminary Hearing will be the first occasion on which it has done so.

B. The importance of the Inquiry to NHS England and its commitment to the Inquiry

4. Responding to the pandemic has been the single biggest challenge the NHS has faced in its history. This challenge has become increasingly complex over time as the NHS has had to manage the pandemic alongside a rebound in demand, elective recovery and vaccine deployment.

5. When SARS-COV2 was identified in early 2020, little was known about the novel coronavirus; how it would affect the human body; what might be effective in treating it; whether, how quickly or in what ways it could be transmitted; and to what extent it would impact on individuals and countries around the world. Globally, healthcare providers and the systems supporting them had to adapt and expand their care offering to look after people with Covid-19, while never ceasing to care for people with other conditions including emerging ones such as post Covid disease/long Covid.

6. By mid-April 2020, the NHS in England was treating nearly 19,000 Covid-19 positive patients in hospital, with almost 3,000 on mechanical ventilation and the country was in lockdown. By end September 2022, there had been nearly 20 million cases in England.

7. The 'second wave' was, in many respects, worse than the first. At the peak of the pandemic in January 2021, over 34,000 NHS hospital beds were occupied with patients with a Covid-19 diagnosis, with almost 4,000 new Covid-19 positive admissions every day. More lives were lost in the second wave than the first.

8. The country benefitted from the NHS as a national service in so many ways – it was able to transfer admissions regionally between hospitals as needed, helping to manage pressures on different parts of the service, and its ability to rapidly stand up large scale clinical trials has been one of the great success stories of the pandemic. Then later, in the Omicron wave these kinds of figures were reduced, helped by the routine use of these trialled therapeutics, the national vaccination roll-out and the maturity of community testing and self-testing.

9. Throughout these periods the NHS also continued to treat non-covid patients. At no stage were NHS hospitals "covid only". Even at the peak of the first wave, there were significantly more non-covid inpatients than covid inpatients. By the peak of the third wave, the proportion of non-Covid inpatients was considerably higher still.

10. As a 'representative' of the wider NHS in England (more of which, below), the Inquiry will acknowledge the successes and contributions of NHS staff across England, not least because the Inquiry is potentially an opportunity to recognise, learn from, and capitalise on some of the innovative beneficial changes to healthcare service delivery that arose in response to the pandemic

11. NHS England is prepared fully to account for its responsibilities and actions during the pandemic and passionately wishes to learn and implement lessons from the Inquiry: it is a learning organisation, which aspires to the highest standards of excellence and professionalism, with the patient at the heart of everything the NHS does. It would like to implement lessons identified, to support the wider NHS to prepare as effectively as possible for future pandemics, and to promote delivery of high-quality health care across England.

12. NHS England is accordingly committed to the provision of every assistance and facility to the Inquiry.

C. The NHS; NHS England; and participation by other parts of the NHS in the Inquiry

13. The healthcare landscape in England is very complex and has evolved over recent years. The summary which follows is accordingly very significantly truncated and set out at a high level only.

14. NHS England is a non-departmental arm's length body ("ALB") sponsored by the DHSC and is the name now used to describe the National Health Service Commissioning Board, a corporate body established by s1H of the National Health Service Act 2006 ("the 2006 Act"), as inserted by s9 of the Health and Social Care Act 2012 ("the 2012 Act"). It is primarily responsible for the co-ordination of the provision of health care services in England and oversight of local commissioners and providers of those health care services. NHS England's core legal function and purpose is to arrange for the provision of services for the purpose of the health service in England, a duty owed concurrently with the Secretary of State for Health and Social Care ("*SSHSC*"). In 2021, the SSHSC announced plans to merge NHS England with NHS Digital ("*NHSD*") and Health Education England ("*HEE*"). NHSD was a non-departmental public body of DHSC, responsible for information, data and IT systems for commissioners, analysts and clinicians in health and social care in England. HEE is responsible for co-ordination of education and training within the health workforce within England, including the training of doctors and nurses. With effect from 1 February 2023, NHSD was abolished and NHS England assumed responsibility for all activity undertaken previously by NHSD. It is planned that NHS England will merge with HEE in April 2023. NHS England's response to Module 3 will then account for the actions and decisions of both NHSD and HEE.

15. It is important to note that NHS England is not the same as 'the NHS in England', the latter being the phrase often used to collectively refer to all bodies which make up the publicly-funded health service (excluding public health) in England.

16. By way of illustration NHS England employees account for only around 1% of the total NHS headcount of the 1.25 million NHS hospital and community health service staff.

17. NHS England is subject to the duty to promote a comprehensive health service under s1(1) of the 2006 Act concurrently with the SSHSC (except in relation to the part of the health service provided pursuant to the public health functions of the Secretary of State and local authorities[1]).

18. NHS England does not have significant public health functions (but the SSHSC routinely delegates some specific functions to NHS England on an annual basis).

19. Its main functions are described in s1H(3) of the 2006 Act which are to:
    a. arrange the provision of services for the purpose of the health service in accordance with the Act; and
    b. (in the relevant period) exercise functions conferred on it by the 2006 Act in relation to clinical commissioning groups (CCGs) so as to secure that services are provided for the purposes of the 2006 Act.

20. CCGs no longer exist and there is more on this below.

21. Under s2 of the 2006 Act, NHS England may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on it by the Act. NHS England is therefore principally a commissioning organisation. More specifically, NHS England is the responsible commissioner for:
    a. Certain community and hospital dental, armed forces and justice estate services (s3B of the 2006 Act);
    b. Certain specified treatments or services, often referred to as Specialised Services, as set out in the Standing Rules regulations[2] made under ss3B and 6E of the 2006 Act;

[1] See ss2A and 2B of the 2006 Act in particular.
[2] The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

c. Highly secure psychiatric services (s4 of the 2006 Act);
d. Some public health functions as requested by and agreed each year with the Secretary of State (s7A of the 2006 Act);
e. Primary care services (GPs, dental, optometry and community pharmacy) (Parts 4 to 7 of the 2006 Act).

22. In the relevant period, CCGs were required to commission all other services for the health service not specifically reserved to NHS England (ss3 and 3A) CCGs commissioned most of the hospital and community NHS services in the local areas for which they were responsible (all areas of England being covered by a CCG). Services that CCGs commissioned include: most planned hospital care, urgent and emergency care; most community health services and mental health and learning disability services. Almost every CCG also commissioned primary medical care services on behalf of NHS England who had delegated this function to them under s13Z of the 2006 Act.

23. It follows that, although NHS England has specific statutory functions which are important to the issues being examined within Module 3 of the Inquiry – and, to some extent at least, or informally, "represents" the wider NHS, NHS England cannot directly speak on behalf of individual healthcare providers, nor on behalf of their employees. As a national body, NHS England cannot account fully for the diversity of actions and initiatives taken at provider level, in response to the pandemic – nor indeed comprehensively account for the actions, decisions, and experiences of their staff.

24. This landscape is made more complicated in that CCGs have now been abolished pursuant to the Health and Care Act 2022, and their functions transferred to new bodies known as Integrated Care Boards who are now responsible for arranging for the provision of services for the purposes of the health service in England. 106 CCGs are now 42 ICBs.

25. NHS England does not know which (if any) local NHS providers and commissioners, or representative bodies of such providers and commissioners, have applied for or been granted CP status - it is possible, on the basis of the information presently known to NHS England, that it is the only 'NHS' organisation representing the health service in England in Module 3 of the Inquiry.

26. NHS England understands that the Inquiry intends to reveal the identities of those who have been granted CP status 48 hours before the Preliminary Hearing. NHS England is

likely to have further oral submissions to make at the Preliminary Hearing once this information has been revealed by the Inquiry and it has been digested.

D. Scope of Module 3 of the Inquiry

27. There are three particular issues which NHS England respectfully suggests require attention by and clarification from the Inquiry:
    a. First, the need by the Inquiry to explain to CPs (and to the public) its plans for later Modules in the Inquiry (and to set out with greater precision the issues to be addressed in Module 1 and 2 of the Inquiry).
    b. Second, whether to provide CPs with a list of issues that the Inquiry proposes to examine.
    c. Third, the approach to be taken in Module 3 to the obtaining and presentation of evidence from the devolved administrations.

The Modules:

28. The Inquiry has divided its work into modules. This enables the exceptionally broad canvas painted by the Inquiry's Terms of Reference to be addressed in a manageable and controlled manner; assists with the effective and efficient working of the Inquiry, not least because it allows workstreams to progress concurrently; and admits of the possibility of the delivery of interim reports pursuant to s24(3) of the Inquiries Act 2005.

29. But there is a disadvantage. The issues in this Inquiry cannot be hermetically sealed *within* modules. Many of the issues have relevance *across* modules: they are cross-cutting issues. It follows that, in order for the Inquiry to function efficiently and effectively (and for CPs to understand how the Inquiry proposes, or has determined, that cross-cutting issues are to be addressed across the Modules), it is necessary for the Inquiry to (i) identify the later modules in the Inquiry, (ii) set out the issues that will be addressed in later modules (i.e. disclose the provisional scope for each module), and (iii) explain how, in the light of this picture, cross-cutting issues will be addressed across the modules.

30. For an Inquiry that was established in December 2021, and whose Terms of Reference were set in June 2022, it is reasonable to expect that the Inquiry should be in a position to identify (at the least) the later modules in the Inquiry and the issues that will be addressed in later modules (i.e. disclose the provisional scope for each such module).

31. As matters stand, save for Modules 1 – 3, the Inquiry has provided limited information about these issues. Thus, in paragraph 21 of CTI's Note it is said:[3]

> "Later modules, details of which will be published in the coming months, will address, very broadly, 'system' and 'impact' issues across the UK. The system modules will include vaccines, therapeutics and antiviral treatment; the care sector; government procurement and PPE; testing and tracing; government business and financial responses across the UK. The impact modules will look at health inequalities and the impact of Covid-19 on the education and business sectors; on children and young persons; and on public services and on other public sectors. In due course the Inquiry will provide further detail about the order and provisional scope of those modules."

32. The present description of the provisional scope of Module 3, and the absence of information about the identity and provisional scope of later Modules is problematic. By way of example only, the Inquiry's Terms of Reference include issues which appear relevant to Module 3, but which are not included within the current draft of Module 3's scope, including:
    a. Mental healthcare provision;
    b. Ante-natal and post-natal care;
    c. NHS care in care homes;
    d. Elective waits/recovery;
    e. The role of volunteers in the NHS response;
    f. Primary care settings outside of general practice (e.g. dental care, community pharmacy, or optometry); and
    g. Community health settings.

33. The Inquiry is respectfully invited to identify the later modules in the Inquiry and the issues that will be addressed in later modules i.e. disclose the provisional scope for each such module (and, therefore, when and where the issues identified above – grounded in the Terms of Reference – are to be addressed).

[3] See also the Inquiry's *Newsletter* of 20 January 2023, which stated that "future modules will consider issues including vaccines, therapeutics and antiviral treatments; the care sector; government procurement and PPE; testing; tracing; government business and financial responses; health inequalities; education, children and young persons; public services, and frontline key workers."

Specific issues:

34. It is now common for an Inquiry Legal Team to set out how it proposes to carry its Terms of Reference into effect by way of the provision of a List of Issues – certainly most significant public inquiries over the past 15 years have promulgated such Lists (e.g. the Baha Mousa Inquiry (Sir William Gage); the Al Sweady Inquiry (Sir Thayne Forbes); the Infected Blood Inquiry (Sir Brian Langstaff); the Undercover Policing Inquiry (the late Sir Christopher Pitchford and then Sir John Mitting); the Grenfell Tower Inquiry (Sir Martin Moore-Bick); the Post Office Horizon IT Inquiry (Sir Wyn Williams)).

35. A range of CPs in Module 1 of the Inquiry suggested in their written and oral submissions, made on 31 October 2022, that this Inquiry ought to adopt the practice of settling a List of Issues. CTI suggested that the Inquiry Legal Team would consider this suggestion, and the Chair's Ruling of 17 February 2023 confirmed that a List would be provided for Module 1. CTI's Submissions for the second preliminary hearing in Module 2, also dated 17 February 2023, confirm that a List of Issues will be provided in relation to that Module as well. NHS England respectfully suggests that the practice has been adopted for good reason[4] and now ought to be embraced by this Inquiry in relation to Module 3.

36. By way of example, Module 3's provisional scope addresses "the capacity of healthcare systems to respond to a pandemic." In order properly to explore that issue it is going to be necessary to investigate the impact of contextual and historical factors which influenced, informed, and constrained NHS England's response to the pandemic. And so, a List of Issues might include the following issues – to ensure that this topic is properly and appropriately investigated:
    a. The pre-pandemic capacity and resources of the NHS;
    b. The impact of public health efforts to manage prevalence of Covid-19 in the community, and the subsequent impact on NHS admissions to hospital;
    c. The availability of social care provision, and
    d. The wider social determinants of health over which the NHS has limited control, i.e., education, housing, and poverty.

Devolved Administrations:

[4] The benefits - to the Inquiry, to CPs, and to the public – are set out in the standard texts on public inquiries (not cited here).

37. The provisional scope of Module 3 of the Inquiry states that it is proposed to address all four nations: "This module will consider the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland."

38. By contrast with Module 2, 2A, 2B and 2C, the Inquiry has not decided to split Module 3 into sub-modules which address the four nations one by one.

39. NHS England commissions healthcare services in England only: since 1999, responsibility for health services has been a devolved matter in the other nations. There are significant differences in how healthcare services are paid for and commissioned across the four nations. In the last twenty years, for example, healthcare commissioning in Scotland and Wales has not been characterised by the same split between healthcare purchasers and providers, as it is in England. Nor in the devolved nations is there the same separation between central government and NHS.

40. The Inquiry might offer a useful opportunity to learn from the difference in responses to the pandemic across the four nations, but these differences should be seen in the context of the different devolved governance and commissioning arrangements.

41. As NHS England sees it, the Inquiry is presented with a choice as to whether it examines the issues presently identified in the provisional scope of Module 3 of the Inquiry by:
    a. Addressing the position of each of the four nations one by one; or
    b. Addressing the issues that are within the scope of Module 3 sequentially, or in groups, and examining the position within each of the four nations as that is done and at the same time.

42. NHS England does not adopt a position in relation to which of these choices should be made. There are advantages and disadvantages of each of them: it is a matter for the Inquiry. But a decision ought to be made, and communicated to the CPs: it will have a substantial impact on the organisation and progress of the Inquiry's work.

E. Instruction of expert witnesses

43. The Inquiry has rightly recognised the need to receive a substantial proportion of the evidence that it receives through the provision of expert evidence: this is the only way in which the Inquiry can proceed at a reasonable pace and complete its important work within a reasonable time.

44. The Inquiry will appreciate, however, that (i) many of the issues which it will investigate sharply divided opinions within relevant disciplines and within communities of experts *at the time* of the events which are being investigated; (ii) one of the very issues which the Inquiry may in due course investigate is which amongst a number of divergent expert views a policy maker or decision maker ought to have followed; (iii) after a number of the key milestones in the pandemic passed, especially after the end of the height of the pandemic, a number of commentators have emerged and have sought to coalesce and express views based on inaccurate or incomplete factual foundations; and (iv) the approach taken in other countries may itself also be a focus of attention in the Inquiry (and so seeking expert opinion from other jurisdictions may not be the simple expedient that is often employed in other contexts).

45. The usual safety net of the duty imposed upon an expert - to summarise the range of opinions on the matters dealt with in his or her report, and to give reasons for his or her own report[5] - may be an insufficient bulwark, especially in the context of healthcare matters (where, in the context of legal proceedings, the court searches for a responsible body of medical opinion, even if others differ in opinion).

46. CTI's Note suggests at paragraph 56 that "The identity of the expert witnesses and the questions and issues that they will be asked to address will be disclosed to the Core Participants before the expert reports are finalised" (emphasis added).

47. NHS England would welcome confirmation that this paragraph is not to be read as meaning that the identity of expert witness for Module 3, and the issues they will be asked to address, will only be disclosed at the very end of the process, perhaps shortly before reports are finalised.

48. NHS England does not believe that to be the case (but would welcome express confirmation), not least because:
    a. It would mean that the points made in paragraphs 57 and 58 of CTI's Note (that additional suggestions as to the identity of expert witnesses from CPs are welcomed and will be considered by the Inquiry) are rather empty.

[5] *Cf* in the context of civil proceedings: PD 36, para 3.2(6); and in the context of criminal proceedings: CrimPR 19.4(f).

b. This appears to a repetition of the formulation used in CTI's Note for the First Preliminary Hearing in Module 1 of the Inquiry, dated 22nd September 2022, and paragraph 22 of the Chair Ruling of 17th October 2022, since which time the Inquiry has in fact disclosed the identity of expert witnesses for Module 1 of the Inquiry and a broad statement of the issues that they have been asked to address well in advance of the finalisation of their reports.

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