Witness Name: Daniel Mortimer
Statement No: 1
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Daniel Mortimer,

I, **Daniel Mortimer**, of Floor 2, 18 Smith Square, London, SW1P 3HZ, will say as follows:-

1. I am the Deputy CEO of NHS Confederation and I make this statement in response to the Rule 9 request dated 23rd January 2023.

About the NHS Confederation

2. The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. We are a charitable company subject to the regulations of the Charity Commission (charity number: 1090329) and Companies House (companies number: 04358614.) The Confederation is governed by a Board of Trustees.

3. The NHS Confederation is the membership body that represents the whole NHS system. In Wales all NHS bodies are members of the Welsh NHS Confederation and in Northern Ireland all organisations within the integrated health and social care system are members of Northern Ireland Confederation for Health and Social Care (NICON). In England, our networks are:
   a. Acute Network (representing acute NHS trusts and foundation trusts)

b. Community Network (representing community healthcare providers including NHS trusts and social enterprises - a network we run in collaboration with NHS Providers)
c. Integrated Care Systems (ICS) Network (representing all 42 ICS in England)
d. Mental Health Network (representing mental health services provided by the NHS, the private sector and the VCSE sector)
e. Primary Care Network (representing primary care networks and GP federations).

4. We also run NHS Employers, which is the employers' organisation for the NHS in England. NHS Employers is commissioned by the Department of Health and Social Care to support workforce leaders and represents employers to government. NHS Employers also undertakes certain leadership roles on behalf of the NHS and Secretary of State, including management of the national relationships with NHS trade unions. My substantive role since 2014 is as Chief Executive of NHS Employers, and all statutory NHS organisations are members of NHS Employers.

5. The NHS Confederation also provides leadership support to NHS staff via our LGBTQ+ Leaders Network, our Women Leaders Network, our BME Leaders Network and our Non-Executive Leaders Network.

6. The NHS Confederation does not currently have adult social care providers or care homes amongst its membership.

Oversight of the health and social care landscape

7. The NHS Confederation represents healthcare leaders across England, Wales and Northern Ireland. Below I have set out the landscape in each of those 3 countries in turn in January 2020.

England

8. In England in January 2020, the NHS was in a transitional period in terms of structure. Integrated Care Systems (ICS) – 42 constituent areas of the country –

existed in shadow form (following on from Sustainability and Transformation Plans (STPs) established in 2016,). Each ICS has an Integrated Care Board (ICB), which is a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS but they did not become statutory bodies until July 2022. At this stage, ICS were in different stages of development but the important thing to note is that they did not have statutory powers over commissioning services. The NHS Long Term Plan published in 2019 called for the 44 STPs to evolve into ICS by April 2021 (this was delayed to July 2022 owing to the pandemic.) The aim for ICS was to bring commissioners and providers together to take major decisions about planning and delivering services together and drive improvements in population health.

9. Prior to this, health services in England had been governed by 211 Clinical Commissioning Groups (CCGs), which were introduced as part of the Health and Care Act (2012). The establishment of CCGs aimed to engage clinicians in the commissioning process, with all general practices (GP practices) as members and involved in redesigning services on behalf of their patients. The premise for this was GPs being the main initial point of contact for the public with the NHS. Between 2012 and 2022, a number of mergers of different CCGs took place meaning there were 106 CCGs operating by July 2022.

10. Governing bodies of CCGs were elected and included GPs, other clinicians (including a nurse and a secondary care consultant) and lay members. They were responsible for approximately two thirds of the total NHS England budget (equivalent to £79.9 billion in 2019/20). CCGs were responsible for commissioning healthcare including mental health services, urgent and community care, elective hospital services and community care. NHS England had three core roles in relation to CCGs – assurance, development and direct commissioning highly-specialist services (and in a minority of cases, commissioning primary care).

11. As noted above, local authorities are responsible for public health and this was the case in January 2020. CCGs worked closely with them to develop a joint needs assessment and strategy for improving public health through local health and wellbeing boards. The NHS worked in partnership with Local Resilience Forums

on pandemic preparedness and response delivery in healthcare systems in England and Wales. Public Health England provided specialist technical expertise to support both planning and delivery arrangements in England, working closely with public health agencies in Wales, Scotland and Northern Ireland. These organisations developed plans for coordinating the response at a national level and supporting local responders through their regional structures.

12. Commissioning of social care in England was also the responsibility of local authorities but it was and remains commonplace for individual health and social care providers to work closely together directly to arrange for discharge of patients and care packages.

Northern Ireland

13. The health and social care system in Northern Ireland is an integrated system. It provides health and social care services for a population of 1.9M people. In January 2020, policy functions were led by the Department of Health, commissioning was delivered by the Health and Social Care Board, and services were delivered by five delivery Trusts. Further regional functions were delivered by the NI Ambulance Service, the Public Health Agency and the Business Services Organisation.

14. As a devolved administration, Northern Ireland receives a grant from the UK central government which is then distributed between the different departments, The policy function is led by the Department of Health within the Northern Ireland Executive and allocated by the Health and Social Care Board.

Wales

15. In January 2020 the NHS in Wales delivered services through seven Local Health Boards, three NHS Trusts and one Special Health Authority. The seven Local Health Boards are responsible for planning and securing the delivery of primary, community and secondary care services alongside specialist services and public health for their areas.

16. There are three NHS Trusts with an all-Wales focus. Public Health Wales NHS Trust is the national public health agency that works to protect and improve health and wellbeing and reduce health inequalities for the people of Wales, they work closely with Directors of Public Health and public health professionals within each Health Board. Velindre University NHS Trust provides specialist cancer service and a national service through the Welsh Blood Service. The Welsh Ambulance Services NHS Trust provides a range of out-of-hospital, emergency and non-emergency services. There was one Special Health Authority prior to the pandemic, Health Education and Improvement Wales, which has a leading role in the education, training, development and shaping of the healthcare workforce across Wales. In April 2021 Digital Health and Care Wales was established and became the second Special Health Authority.

17. NHS organisations work closely with their Local Authority partners, and wider public sector and third sector partners, through Regional Partnership Boards (RPBs) and Public Service Boards. RPBs bring together health boards, local authorities and the third sector to meet the care and support needs of people in their area. Public Services Boards improve joint working across all public services in each local authority area in Wales.

18. As a devolved administration, Wales receives a grant from the UK central government which is then distributed between the different departments, including NHS Wales. The policy function is led by the Department of Health and Social Services within the Welsh Government. Funding is agreed by the Department and allocated to NHS bodies.

NHS preparedness for a pandemic as of January 2020

19. It is the view of the NHS Confederation and our members that long-term issues, driven by underinvestment in the 2010s, severely weakened the foundations of health and care, which meant the NHS was not optimally prepared to deal with the pandemic and its fallout when it came in January 2020.

20. Throughout this period we are not aware of any express commissions to the NHS Confederation to develop guidance or convene members with regards to pandemic preparedness. Any role that NHS Employers may have previously undertaken in working with DHSC on such commissions was increasingly assumed by NHS England following its formation in October 2012.

Investment in the NHS

21. NHS leaders have told us that the decade of austerity leading up to the Covid-19 pandemic reduced the NHS's ability to respond optimally. The NHS received close to flat funding for most of the decade, which in part led to more than 100,000 vacancies across the NHS in England alone. The NHS went into the pandemic under significant pressure, with a range of performance targets not being met. Since its creation, NHS spending has increased by an average of 3.7 per cent per year in real terms. But from 2010/11 to 2018/19, NHS funding growth slowed to 1.4 per cent per year.

22. In particular, members of the NHS Confederation told us that low investment in NHS capital since 2010 had a negative impact on infrastructure and estates, including infection control measures. The 2018 NHS funding settlement had only covered frontline NHS services – so-called 'revenue' spending – but it did not cover a number of other key areas, including investment in new buildings and technology, known as capital spending. By January 2020 England was spending just over half the OECD average for capital spending on health with a consequent impact on clinical infrastructure and facilities. For example, as widely reported, the UK entered the pandemic with five times fewer ICU beds than Germany.

Investment in adjacent sectors

23. NHS preparedness is dependent on preparedness in other sectors, particularly public health and social care.

24. It is not within the remit of the NHS Confederation to assess public health capacity; this would be best addressed by those bodies responsible for public health and its

analysis. However, I am aware that the previous decade of austerity impacted the public health budget –the public health budget in England saw cuts of £1 billion in real terms between 2015/6 and 2022/23 (a circa 25 per cent cut). Public health in January 2020 was at a crossroads with funding cuts especially at the local level; the absence of a joined-up strategy for tackling public health challenges; an overstretched public health workforce; and over-emphasis on treatment rather than prevention. In our view, this arrangement was not best able to deliver protection from high-consequence infections, achieve improvements in population health outcomes or reduce systemic inequitable health outcomes.

25. In England the landscape of public health and its relationship with the NHS had been set by the public health and NHS reforms implemented in 2013, which had transferred directors of public health from the NHS into local government. Seen as a means of being able to influence the wider determinants of health, such as housing, an unintended separation often ensued and was codified by the 2019 NHS Long Term Plan, establishing that the NHS focused mainly on secondary prevention and Public Health England (PHE) (regionally and nationally) led on health protection, prevention, evidence development and supporting local government public health.

26. The NHS England planning guidance of December 2015 established STPs, which were primarily led by the NHS and focused on treatment pathways and as such did not have a significant prevention role. However, their evolution to ICSs led them towards a collaborative approach to improving population health outcomes. The links between the NHS and public health have been strongest at the "place" local government footprint due to the proximity of the communities they serve. The pandemic affirmed how fundamentaly important the local public health system alongside the NHS is and was crucial to control infection, reassure and support communities and maximise vaccination.

27. The Covid-19 pandemic also exposed both the reliance of the NHS on the social care sector, and the long-term policy neglect of that sector. Failure to invest in and reform this area put significant pressure on the NHS during the pandemic and contributed to capacity pressures within the NHS. More importantly it meant that

social care providers lacked resilience and infrastructure to be able to always respond to the unique pressures of the pandemic. I believe therefore that the continued political failure to bring long-promised long-term reform to social care, compounded by long-term underfunding meant the sector was not optimally equipped to support the response to the pandemic.

28. Further, I understand that wider reductions in local authority budgets since 2010/11 had negative impact on services that support the health and wellbeing of the whole community such as housing, transport, leisure centres and green spaces. This disinvestment had the impact of the UK entering the Covid-19 pandemic in January 2020 with a population with less-than-optimal health resilience, a public health system that had reduced its spending on preparedness, and a social care and health system that struggled to keep up with demand.

NHS ability to significantly increase capacity during a public health emergency as of January 2020

29. NHS organisations typically run at almost full capacity and the response to any emergency (such as a major incident) is managed by repurposing capacity from existing resource (e.g. staff, space, equipment) that had been committed to less urgent work. A major incident would typically require time-limited repurposing of capacity for a number of days, depending on the severity of the incident, and might also involve significant numbers of staff working additional hours and/or being deployed to clinical areas where there might not normally work. Such repurposing is also usually concentrated in certain departments of one or a small number of organisations and/or are time limited.

30. For example, in March 2018, former Russian military officer Sergei Skripal and his daughter Yulia were poisoned with a nerve agent called Novichok. The Skripals were rushed to the nearest hospital, Salisbury NHS Foundation Trust, where staff provided life-saving care. Three months later, two Salisbury residents were also poisoned after finding a discarded Novichok container. The incident lasted for five months. Just a small group of staff were involved, and the executive team was split so that some were dealing with the incident, while maintaining capacity for other

operations. Some of these staff had to work additional hours in the first few days, but after that, capacity normalized.

31. Another example is NHS winter pressures. Due to viruses that tend to spread rapidly during winter such as influenza, it is often the case that demand for NHS services increases between October and February, creating additional capacity demands on the system. Due to political decisions about NHS funding and efficiency over more than a decade, the NHS operates with a small staff and bed capacity margin. This means that when there is a demand surge, the NHS often has to redeploy capacity from planned care to meet more urgent needs (including physical space and workforce). That can result in suspension of non-urgent activity, expediting safe discharge of patients to increase the number of beds available, and diverting some demand to providers with more current capacity. Pre-Covid-19, by around February the high level of pressure that usually occurs in the winter months would be expected to subside, enabling NHS recovery.

32. In January 2020 the NHS saw an unprecedented urgent and sustained rise in demand. The need for increased capacity affected all NHS organisations and while it was not fully apparent at the time, would persist for years. Whilst some planning and guidance was offered to our members in response to the avian flu concerns, I understand that the scale of the demand (in severity of illness, the nationwide nature of the demand, and the time period involved) associated with Covid-19 had not been anticipated to the degree that it would have been factored into plans in terms of capacity.

33. The NHS did not have sufficient diagnostic capacity to mobilise for large-scale population testing for Covid-19, leading to difficulties implementing a testing programme.

34. In England, healthcare leaders have the ability to influence and direct workforce capacity and resources within their organisations, in partnership with their teams. We saw through the early stage of the pandemic in March and April of 2020 significant alterations in capacity to respond to the developing impact of Covid-19. We saw this again in the wave that hit the country (and the NHS) in late 2020 and

into early 2021. Indeed, it arguably proved easier and safer to create extra capacity within existing institutions (particularly through redeploying staff and spreading them over greater numbers of patients) than to staff the new Nightingale facilities created in many parts of the country. There was an element of national direction in the creation of this 'surge' capacity but the decisions about individual institutions and teams were taken by local executive teams and clinical leaders. These decisions needed constant follow up and review especially in light of the longer period staff went on working in settings and ways they had no or limited prior experience of. It is worth emphasising that the decision to expand and repurpose existing capacity, whether it was taken nationally or locally, relied on the participation and support of the workforce.

35. In Wales, the system is relatively small and there are strong communication and co-ordination mechanisms in place at a national and local level. For example: from the beginning of the pandemic all Welsh NHS CEOs met at least twice per week, Welsh Medical and Assistant Medical Directors met daily and other Executive Directors met weekly to respond to the fast-moving circumstances around the pandemic. In addition, communication professionals worked closely with Welsh Government teams to ensure key messages were shared and coordinated across all NHS organisations in Wales.

36. In Northern Ireland the system is relatively small and there are good communication mechanisms. Specifically, the Regional Management Board (involving all the departments) meets several times per month. There are also sub groupings across the system that mean co-ordination, and the capacity to repurpose was well co-ordinated. During the pandemic the scale and frequency of co-ordination arrangements was able to be scaled up quickly.

Adequacy of training of NHS health and social care staff on emergency plans for pandemics and high-consequence infectious disease outbreaks

37. Our NHS members continued to undertake routine major incident training, and I understand there were nationally and regionally organised briefings and exercises which considered various types of major incident, including pandemics response.

These briefings and exercises were targeted with the incident planning leads within Trust and localities, and there was, I perceive, variation in how far the details of 'unusual' major incidents were shared or rehearsed with specific trusts and localities.

38. There was also a particular focus on:-
    a) The ambulance service: HART teams being developed and trained to deal with incidents involving airborne material (particularly following the domestic terrorist experience after 7/7).
    b) Designated specialist centres (Royal Free and Newcastle) for high-risk contact infections, for example Ebola.
    c) Designated specialist centres (GSTT, Liverpool and Sheffield in addition to Royal Free and Newcastle).

39. The focus on training in these more specialist centres (for example on safe donning & doffing of hoods) did mean that training materials and expertise were available to support the approach of the wider NHS once the response to Covid-19 escalated.

Adequacy of information and guidance disseminated from the UK and devolved governments to those in the NHS frontline prior to and during the early response to the pandemic

40. In England, there were many occasions when information was given to the public by Government prior to the NHS frontline being informed. This created logistical challenges, including around the delivery of the vaccine programme.

41. In addition, the communication line of NHSE national to regional to ICB to front-line teams led, on occasion, to delays and misinterpretation or different interpretations of national policy. The quality and management of communications was an ongoing issue for our members given the amount of information that was being published.

42. To our knowledge, none of the documents/guidance issued by NHS England/Public Health England were date or time stamped and there was no single point of contact resulting in conflicting and out of date information being implemented.

43. The NHS England communications team established WhatsApp groups as a means to disseminate information rapidly, an innovative approach but one that was not an official channel of communication.

44. In Wales, the Welsh Government had an established weekly meeting with communication representatives from all NHS bodies and these meetings were increased in frequency during the pandemic. In addition to meetings, there are MS Teams groups and email distribution lists to enable key information to be shared from Government, to the NHS to then share with the public. As part of the Covid-19 response the Welsh Government developed a range of communication assets and tools that all NHS bodies in Wales could use, ensuring consistent and up to date information was being shared quickly with the public during a fast-moving time. Furthermore, the NHS Chief Executives met a couple of times a week with the Director General,/NHS Chief Executive to share information and a number of Executive Director Peer Groups met weekly to share guidance and insight.

45. Relatedly, the Covid-19 pandemic was often described as an infodemic, meaning an overabundance of information both online and offline. Technology and social media was used to enable people to stay safe, informed and protected; however, the dissemination of inaccurate information undermined the public health response and led to poor observance of public health measures and caused significant problems for the NHS frontline.

46. During the early phase of the pandemic our members told us that information and advice directed at the public was not specific enough and not always disseminated in formats and languages that were accessible to all groups e.g. ethnic minorities and disabled people.

47. Also, information was regularly conveyed to the public (via the media or the government's daily televised briefings, for example) about new NHS services they should access or other NHS-related actions they should take. On many occasions this information was given to the public prior to informing the NHS frontline, or given to the public a matter of hours later. Our members found this disrespectful, chaotic, but also logistically impossible. On several occasions they described to us the public descending upon NHS providers to access services that they had understood were immediately available, before NHS staff had been given information about what services were required and how to implement them, creating further capacity problems and frustration for both NHS staff and the public.

Adequacy of stockpiling provisions for Personal Protective Equipment (PPE) on 21st January 2020

48. It is my understanding that several pandemic-modelling exercises led by the UK government between 2015 and 2018 (including Exercise Alice for Middle East Respiratory Syndrome (MERS) and Exercise Cygnus for influenza) identified the need for government to hold stockpiles of personal protective equipment (PPE) as an important aspect of pandemic preparedness, which I understand they did; however, I heard that use-by dates were not monitored adequately so some of the stock was out of date when it was needed. It is not the remit of the NHS Confederation to monitor or manage PPE supply and distribution so I did not have insight into the specifics of these stockpiles at that time.

49. However, with the surge in demand for PPE, NHS Confederation members in England and Northern Ireland found access to PPE from those stockpiles to be insufficient in terms of (1) overall quantity, (2) availability of certain key items (particularly gowns and visors), (3) certain sizes (with women and smaller people having less available stock), (4) reliable distribution of stockpile products across the NHS and other care providers, and (5) expiry date issues with some products. As a result, the early days of the pandemic were characterised in the NHS (as well as in social care and other healthcare providers) by inadequate and/or inconsistent PPE supply, which put both staff and patients at risk.

50. In Wales, the preparations that NHS organisations had put in place ahead of the UK leaving the EU, such as facilities to store consumables, enabled the Welsh NHS to be more responsive during the beginning of the pandemic. This included being able to buy and store a significant amount of PPE in facilities that had been purchased in preparation for the UK leaving the EU. NHS Wales Shared Services Partnership (NWSSP), working with Life Science Hub Wales (an arm's length body of Welsh government) and industry in Wales, were able to maintain an adequate stock of PPE to meet demand from both health and social care sectors in Wales.

Ways in which the early NHS response to the pandemic was effective

51. The NHS was able to rapidly respond to the pandemic, creating capacity through clear, focused leadership at the national and local level, flexing both staff and estates to meet the need.

52. The NHS was also able to transcend previous barriers to support an innovation landscape where regulatory and other practical obstacles blocking the implementation of innovative practices were addressed, creating a lean, light and agile environment in which to innovate. NHS Confederation members remarked that innovation they might have expected to take years pre-pandemic was able to be implemented in a matter of weeks.

Ways in which the early response to the pandemic revealed any deficiencies in the state of the NHS's readiness in practice.

53. The NHS preparations for a future pandemic had focused on an influenza-type pandemic. This meant initial underinvestment from the government in preventing the spread of Covid-19 led to high numbers of people seeking NHS care.

54. Neither preparedness for managing asymptomatic disease, nor the process for decision-making about when and how to lock down including the practical implications seemed to have formed a significant part of pre-Covid-19 pandemic planning. These plans, along with the necessary infrastructure to deliver, had to

be developed and retrofitted during the pandemic which led to delays and uncertainties in implementation, during which more people required NHS care.

55. The NHS did not initially have access to the necessary PPE available of the correct quantities, types and sizes to fully meet its needs due to both inadequate supply; and a lack of ordering and distribution system suitable to meet this sudden increased need. New national procurement and distribution arrangements in England were rapidly designed and implemented but frustrated our members by being initially unreliable, leaving some of our members feeling powerless to resolve supply issues at a local level. Our members described being unable to plan for surgical procedures, for example, due to lack of access to the necessary PPE, and unable to assure the safety of their staff.

56. The NHS did not initially have access to testing facilities for large-scale population testing for Covid-19; significantly less than neighbouring countries. Despite mobilizing additional capacity from testing capacity within universities, it took many months before scaling up to the levels needed was achieved. This led to rationing of Covid-19 tests, disruption to other non-Covid-19 testing because the capacity was being used for Covid-19, and policy decisions to cease testing people with Covid-19 symptoms and their close contacts, all of which is likely to have contributed to the spread of Covid-19.

57. The configuration of many NHS estates, particularly older buildings, were not optimised to enable isolation of large numbers of patients; to enable the segregation of Covid-19 negative, Covid-19 positive, and as-yet-undetermined patients entering health facilities and being admitted to hospital; to enable optimal ventilation of rooms, or to support the increase in demand for high flow oxygen delivery. However, the NHS was successfully able to expand its provision of high dependency and intensive care facilities to accommodate the increased need.

58. Digital infrastructure and NHS workforce digital skills were also found to be in their infancy and were not ready for the sudden, vast increase in digital consultation. For example, there was a national directive to move to remote consulting overnight and remote team working, and particularly within general practice, there was

limited support for the digital capabilities required to provide patients with continuity of care. The NHS app had limited functionality, and alternative, innovative solutions had to be deployed.

59. Reporting infrastructure was also found to be suboptimal. During the pandemic our members were asked to report on a range of indicators that explained exactly what the situation was on the ground in hospitals and clinics across the country. This was often essential information to be understood at a national level. However, the scale and frequency of these information requests was unwieldy and members repeatedly shared their concerns that these information requests took significant capacity away from being able to manage patient care. Our members were particularly frustrated that several different national bodies requested the same, or very similar information, but did not have the interoperability capacity to access it from one location, meaning NHS staff were spending significant time everyday compiling, formatting and submitting substantial, largely similar information to a range of portals on a complicated, mandatory schedule. Members felt this could have been streamlined.

60. As noted, the NHS does not operate with significant spare capacity. As it routinely does in responses to other urgent needs, the NHS responded by scaling up capacity to receive and treat patients with Covid-19 by scaling down non-urgent services and increasing the efficiency of discharges to create physical capacity for Covid-19 patients. In retrospect, this approach, while effective for short term urgent needs, was problematic as the pandemic demand extended into the longer term, leading to disruption in non-pandemic services that continues to this day. Reducing non-urgent services has contributed to significant waiting lists and worsening health problems associated with delays in seeking or accessing treatment caused by diverting resources to managing the Covid-19 pandemic.

Extent to which the UK's pandemic planning and emergency preparedness took into account pre-existing inequalities and vulnerabilities

61. Covid-19 was found to have disproportionately affected people from minority backgrounds. Inequalities in access to healthcare persist and were exposed by the pandemic. Differences in disease outcomes occurred by age, sex, ethnicity, geography, deprivation, comorbidities, inclusion health groups and whether the person is resident in a care home. During the first wave of the pandemic, 40% of all UK deaths were among care home residents. Six out of ten people who died with Covid-19 between January and November 2020 were disabled. And people from ethnic minority communities had significantly higher risk of mortality – 3.7 times greater for black African men than their white counterparts during the first wave and Bangladeshi men more than five times more likely to die during the second wave.

62. There was a particular concern about the disproportionately high exposure to Covid-19 for NHS staff, along with individuals working in other people-facing occupations such as the care sector, retail, hospitality, transport and security that had not been fully planned for, particularly in terms of preparedness to protect these people who often did not have access to adequate, well-fitting PPE. And there was further concern that in addition to being disproportionately exposed to the virus, NHS and social care staff were being exposed to psychological distress and extreme, sustained pressure in their working conditions. There was deep concern that BAME people were disproportionately affected and more likely to have adverse outcomes, exacerbating existing inequalities.

NHS Confederation engagement in pandemic planning pre-2020

63. The NHS Confederation did not have a significant role in pandemic planning between 2009 and January 2020. The support the NHS Confederation provides to members centres on spreading best practice, improving services and advocating to national bodies on their behalf. Pandemic preparation is not something for which members in England, Wales or Northern Ireland had routinely looked to us for support prior to January 2020. We did not engage in assessment in the adequacy or quality of structures and processes involved in the co-ordination of response to

pandemics with the exception of the following briefings published by The NHS Confederation between 2009 and January 2020:

a) A NHS Confederation briefing for all members in July 2009 called Pandemic flu: ensuring the NHS is ready (DM/1).
b) A joint briefing with the Department of Health and NHS Employers, which is part of the NHS Confederation, in October 2009 called Pandemic Influenza: additional measures to meet workforce supply (DM/2).
c) A NHS Confederation briefing for ambulance commissioner members in March 2013 called Emergency preparedness, resilience and response: a guide for ambulance commissioners (DM/3).
d) During the time the NHS Confederation convened the Brexit Health Alliance, we published a briefing for policymakers in July 2018 called Protecting the public's health across Europe after Brexit (DM/4)

64. To the best of our knowledge, the NHS Confederation and its staff did not further engage or communicate with the UK government, the devolved governments or local government concerning the UK's pandemic planning, preparedness or resilience prior to January 2020. The NHS Confederation was not invited to participate in nation-wide exercises related to pandemic preparedness between 2009 and January 2020. Nor to our best knowledge did our members share with us information about having been involved.

65. Our records have not identified any communication that was directly brought to the attention of the NHS Confederation regarding preparation for a civil emergency. Communication of this nature would tend to be cascaded via NHS England, NHS Improvement or the Department of Health and Social Care in England and the Welsh Government in Wales and the Northern Ireland Executive in NI. I would not expect local authorities to engage directly with the NHS Confederation but rather directly with members in local partnerships, including Local Resilience Forums and local Health and Wellbeing Boards.

66. Of note, in Wales, Public Health Wales NHS Trust are a member of the Welsh NHS Confederation and have been involved in pandemic planning, preparedness

and resilience for Wales. Specific questions on their role should be directed to Public Health Wales NHS Trust.

Impact of Brexit on pandemic preparedness

67. The NHS Confederation played a key role in analysing the implications of the UK's vote to leave the EU on the NHS, advocating for NHS interests during and after the negotiations and advising NHS organisations how to prepare for the end of the Brexit transition period. We set up the Brexit Health Alliance following the referendum in 2016, composed of organisations from across the UK, with representation from the NHS, the health research community, patient groups, the voluntary and academic sectors, industry and public health. In that capacity we articulated our concerns about the possible consequences for public health and pandemic preparedness of the UK's decision to leave the EU, in our June 2018 briefing "Protecting the public's health across Europe after Brexit" which pre-dated both the UK-EU Withdrawal Agreement and the Covid-19 pandemic. We elaborated further after the pandemic struck in our June 2020 "Pandemic ready?" briefing which recommended actions for the UK-EU Trade and Co-operation Agreement that was being negotiated at the time.

68. Given that cross-border health threats such as infectious diseases spread irrespective of national boundaries, our concerns revolved around ensuring that timely and effective collaboration between the UK and EU to tackle these threats should not be adversely impacted by the UK leaving the EU. It is particularly important that the UK and EU should continue to share intelligence, data and planning so we were especially concerned about UK loss of access to European Centre for Disease Control and Prevention (ECDC) systems and databases. We were therefore pleased that the UK was able to request emergency access to the Early Warning Response system (EWRS), which was readily granted, and to ECDC's Epidemic Intelligence Information System (EPIS) data platform, which is open to non-EU countries.

69. The UK was also invited to the EU's Health Security Council during the pandemic. Council attendance is ad hoc and by invitation only, where the EU deems it appropriate.

70. We were also pleased that our recommendation for the UK and EU to conclude a wide-ranging Memorandum of Understanding (MoU) on strengthening health security collaboration was realised in December 2021. The MoU creates an overarching framework and principles that govern future co-operation and identifies a number of key topics where technical collaboration is considered important, such as on Covid-19, influenza and vaccination/immunisation. This covers exchange of information, mutual consultation in the event of an emerging health threat, training and education, surveillance and possible exchange of personnel and liaison officers.

71. On a practical level, the UK countries have agreed common frameworks covering (for example) health security and substances of human origin, to mitigate the risks of unhelpful divergence between devolved administrations.

72. Whilst the new relationship falls short of the pre-EU exit situation, we did not observe that the UK's purchase and rollout of Covid-19 vaccines was adversely affected by exclusion from the EMA's rapid authorisation for pandemic vaccines. The UK decided not to participate in the EU's initial joint tender for PPE, ventilators and testing kits but did participate in subsequent in subsequent deliveries of PPE and antivirals. An external assessment of the ECDC's Covid-19 response, commissioned by the ECDC itself, and a subsequent report in February 2021 by the EU Ombudsman, identified potential for considerable improvement in the ECDC's own response to the pandemic.

73. In addition to continuing collaboration with our EU and EEA partners, going forward it will be critical for the UK to develop and cement good relationships with public health colleagues in the rest of the world and, especially from a research perspective, the US. In May 2021, the UK Government announced plans for a new 'Global Pandemic Radar', in partnership with the WHO and the Wellcome Trust. The aim of the Radar is to identify and track new Covid-19 variants and other

emerging diseases globally, and share that information internationally, so new infectious diseases can be addressed quickly before they escalate. The UK has also established a new collaboration with the United States (US). Announced in June 2021, the UKHSA has partnered with the US Centre for Disease Control and Prevention to launch a 'Centre for Pandemic Preparedness' (CPP). With regard to data sharing, the most relevant element of the partnership is the agreement to establish an early warning system that will help to monitor and detect infectious diseases. The intention is for the CPP to become a 'world-leading hub for all aspects of pandemic preparedness', with the capability to share early warning information with other countries.

Planning for future pandemics

74. The NHS Confederation is not an authority on preparedness for future pandemics. However, our experience from having heard the concerns of members throughout the pandemic identifies some key lessons. One is that in order to be able to scale up to meet unexpected demand, the health system has to have more flexible capacity built in, in terms of physical space, equipment and workforce. The decision to operate the NHS at the top of its capacity should be balanced with greater ability to respond to a future pandemic.

75. Another lesson is that provisions for skilled, high-quality, clear, accurate communication with NHS leaders, NHS staff and with the public is essential, especially when new information is emerging.

76. Given the need for good, rapid decisions, lessons should be learnt about how innovation was catalysed and enabled, and lean, light and agile regulatory and governance systems with local leaders empowered to make decisions where appropriate should be the default.

77. And given the predictability that pandemics may disproportionately impact members of the population who are already subject to health inequalities, recognition of this risk and developing bespoke arrangements for these cohorts could be better prepared.

78. And finally, investment in physical and digital infrastructure is an investment in resilience for pandemic response.

Entities and organisations the NHS Confederation believes may hold relevant information or material in relation to these questions

79. It is possible that members discussed issues of preparedness for future pandemic at meetings and events that NHS Confederation convened, but I am not aware of those discussions or that we hold useful records of such discussions. The NHS Confederation was not established to take a lead in pandemic planning nor did it have the authority to do so. As a result we did not as far as I am aware arrange meetings on these issues prior to January 2020.

80. Organisations that may well hold relevant materials are:

a) DHSC (including OHID)
b) UKHSA
c) NHS England
d) LGA
e) The Kings Fund
f) The Health Foundation
g) The Nuffield Trust
h) National Voices
i) Welsh Government
j) Public Health Wales NHS Trust
k) Northern Ireland Executive

Topics not addressed in this statement

81. I have answered all questions that are within the scope of the NHS Confederation to address. Questions about assessment of planning and preparedness of public health bodies, and the adequacy of structures and processes for public health co-ordination, capacity, adequacy and enactment of plans do not fall within our role,

remit or areas of expertise as a membership organisation. Similarly we have no knowledge of the planning and preparedness for social care provision.

Statement of Truth

82. I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 12 April 2023