Written Closing Submissions on behalf of NHS England for the UK Covid-19 Inquiry, Module 1

2 August 2023

Introduction

1. These submissions are filed on behalf of NHS England, a statutory non-departmental arm's length body responsible for the co-ordination of the provision of healthcare services in England and the administrative (as opposed to clinical) oversight of local commissioners and providers of those healthcare services. Our comments build on the NHS England Corporate Witness Statement[1] and the High Consequence Infectious Diseases (HCID) Programme Statement[2] which were filed with the Inquiry for Module 1; there has been no oral evidence heard from NHS England staff but we have been active participants. We are engaged with the Inquiry and seeking to assist it to the best of our ability.

2. We would like to start by again recording our sincere sympathies for all those who have been so terribly affected by the Covid-19 pandemic. The suffering of so many was vividly encapsulated by the opening video played to this hearing on 13 June. No-one who saw it, including of course the representatives of NHS England, can have failed to be affected: both directly by its contents, but also by the memories which it touched off, relating to the experiences of so many during the pandemic.

3. Those experiences include the experiences of NHS staff, who – along with others – gave so much in responding to this national emergency. All worked with exceptional dedication, and some gave their lives. Healthcare providers and the systems supporting them had to adapt and expand the services provided to look after people with Covid-19, as well as continuing to care for people with other conditions. Staff and teams were put under incredible pressure and responded with

[1] INQ000177805, referred to in the footnotes below as the "CWS".
[2] INQ000184893.

dedication and compassion as they cared for patients with Covid-19. Staff now continue to battle not only the personal physical or psychological effects of their experiences, but also to re-establish services fully in this prolonged period of recovery. During this Module, as the Inquiry has looked backwards to events prior to January 2020, it has sometimes touched on a part of those experiences, and we know that the Inquiry will soon be looking at those events in more detail. We look forward to assisting it.

4. In that spirit, we would draw attention to NHS England's "Learning Lessons from Covid-19" document. This was sent to the Inquiry on 14 July 2023. It reviews activity both before the start of the pandemic and throughout it. It is less detailed, of course, than will be the evidence to this Inquiry. But we hope that it will help to provide at least key points from the perspective of NHS England. It may also reflect some aspects of the experience of the wider NHS – that, the bodies which make up the publicly-funded health service in England, such hospitals, primary care and community services, as well as their commissioning bodies – but it is, of course, a document produced by NHS England.

5. Turning back more directly to the evidence the Inquiry has heard in Module 1, we would like to make a few short points, relating to:

    a. A summary of the Emergency Preparedness, Resilience and Response ("EPRR") role of NHS England;
    b. The topics under investigation in this module and the modular structure;
    c. Preparedness and the structures in place before 2020, and pandemic planning;
    d. Resilience and health inequalities.

6. As part of these comments, we have provided some comments on the submissions made orally by Core Participants on 18 and 19 July 2023.

7. We hope that the Inquiry will find these submissions helpful.

(1) National Emergency Preparedness and the role of NHS England

8. As NHS England has not given oral evidence in this module, we very briefly mention its role in pandemic planning and preparedness. This is both to set the scene for future modules, which will look at the NHS and NHS England and their roles in the pandemic in more depth, but also to put NHS England's interest in Module 1 issues and these submissions in context.

9. Details of NHS England EPRR functions are set out in more detail in its Module 1 Corporate Witness Statement.[3] In brief, NHS England has a duty to plan and prepare for risks identified on the National Risk Assessment (NRA) and National Risk Register (NRR), including pandemic flu risks and also the risk of emerging infectious diseases, as defined in the national risk assessments. It is responsible for setting a risk-based EPRR strategy for the NHS and leading the mobilisation of the NHS in event of an emergency. NHS England had (and has) in place an EPRR Framework (2015 and revised in 2022), ensuring that there are structures in place to respond to emergencies. In addition, the NHS England Incident Response plan is a generic policy for responding to any health-related incident or emergency at national level (including pandemics). Under the Civil Contingencies Act 2004, NHS England is a Category 1 responder.

10. In terms of pandemic planning, before the Covid-19 pandemic, NHS England had in place an Operating Framework for Managing the Response to Pandemic Influenza (revised in December 2017 following Exercise Cygnus[4]). It also had HCID service specifications and protocols (2018), responding to known infectious diseases of high consequence but also for use in the case of emerging infectious diseases as outlined in the NRA and NRR. The HCID Protocols were activated in the early stages of the Covid-19 pandemic when little was known about the disease and it was designated as an HCID on a precautionary basis.[5] These plans were designed to be adaptable, and were adapted, to respond to the particular circumstances of the pandemic as it unfolded.

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[3] CWS, paras 62 – 66 and 107 – 112.

[4] CWS, para 203(h).

[5] Covid-19 was declassified as an HCID on 19 March 2020 (CWS paras 187 – 189). Decisions on classification were a matter for the Four Nations Public Health HCID Group.

11. In addition to its own plans and structures, NHS England had representation on the PFRB, the PIPP Board, attended SAGE as required and was a guest at NERVTAG meetings. It participated in a number of national emergency preparedness exercises,[6] some of which the Inquiry has examined.

12. The EPRR team, together with NHS England more broadly, also had the experience of planning to surge NHS capacity every winter, dealing with winter flu and other pressures, and of responding to incidents such as terrorist attacks, critical supply and service disruptions, often concurrently.[7]

(2) The Topics under Investigation in Module 1 and the Modular Structure.

Language and Responsibilities

13. The Inquiry has set out to consider pandemic preparedness, looking at structures and specialist bodies within central government concerned with risk management and civil emergency planning. It has looked at planning, readiness and capacity within the public health system. In doing so, it has distinguished between "the healthcare system" and "public health", with the latter being the focus of scrutiny in this module – although the overall resilience of the NHS has been touched upon. It has also sought to avoid the topic of 'operational readiness', intending that this will be the subject of later modules, including those looking at the provision of healthcare in more detail.

14. We appreciate that any Inquiry will need to carve up issues in this way. The fact that there will be areas of overlap or grey areas is simply part of the inevitable complexities that have to be negotiated. However, we would wish to touch briefly on the question of language, definitions and responsibilities.

15. The terms "health system", "healthcare", "public health" and "the NHS" have, at times, been used without clear definitions or boundaries. By now, the Inquiry will be very familiar with the fact that not everything concerned with "health" falls under

[6] CWS, paras 158-164; 198-206 and Annex 4.
[7] CWS, para 31, paras 207 – 228 and Annex 5.

the NHS (as well as the fact that NHS England is not the same as the NHS in England). At a local level in England, since 2012 local authorities, supported by Public Health England (PHE),[8] have had primary responsibility for public health matters.[9] The Inquiry has heard evidence about funding and structure of these public health bodies in the years before the pandemic, and also upon the role of PHE in pandemic preparedness and planning. By contrast, although the NHS within England does seek to assist in keeping the nation healthy,[10] rather than merely treating illness and disease, it has very limited public health functions.[11] We have commented further below on the interface between the NHS and the public health system, and also the issue of fragmentation, including on the initiatives fostered by NHS England seeking to overcome such problems.

16. Consistently with its duties, in preparing for a pandemic the overall focus of NHS England was on the actions needed to secure treatment for those affected, and to maintain access to healthcare services for those who needed treatment. To put the NHS and NHS England's roles in context, in any response to an incident there are a number of stages: Detect; Assess; Treat; Escalate and Recover (DATER). In the pandemic, PHE was responsible for leadership of the 'detect and assess' phases, where the NHS took the lead in the treatment and escalation phases.[12] Whilst one of the themes explored in this module has been the preparations that might have assisted in helping to slow the spread of the Covid-19 virus, including systems of surveillance (national and international) and testing capacity, these were not directly a matter for NHS England, but for public health systems and their central government sponsors.

17. In relation to the interface between the NHS and the public health system, we have noted the evidence heard by the Inquiry about the limits of PHE's capacity,

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[8] Until replaced by its successor organisation, the UK Health Security Agency (UKHSA).

[9] There is an account of the responsibilities, as allocated by the Health and Social Care Act 2012 at CWS, paras 67 – 76.

[10] By way of background, the NHS Act 2006 includes a number of relevant duties. The overarching duty, shared with the Secretary of State (s1(1)), is to "continue the promotion in England of a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness"; however, there is a "carve-out" excluding public health services provided pursuant to the public health functions of the Secretary of State or local authorities; see s1H(2).

[11] CWS paras 73 – 76, s1H(2) NHS Act 2006.

[12] CWS, para 76.

including its budgetary constraints,[13] and a linked suggestion that the plan was for NHS England to be responsible for mass testing in the event of an influenza pandemic.[14] We anticipate that the issue of how testing capacity for Covid-19 was developed in the early stages of the pandemic will be the subject of close attention in Module 2. However, we would respectfully note that testing for communicable diseases in the community is and has traditionally been a public health function. For example, if there is an outbreak of (say) diarrhoea in schools, it will be the local Health Protection Team which goes into schools and tests for this; or see the PPE "First Few 100 Days (FF100)" Protocol, with its description of the role of Health Protection Teams and PHE Colindale.[15] The Inquiry has, in effect, been hearing evidence upon the development of capacity for screening and surveillance which in general (subject to some exceptions, such as cancer screening most obviously) NHS England is not commissioned to undertake. We anticipate that there will further evidence about the use of the NHS laboratories and the work done in scaling up their use for "Pillar 1" testing in Module 2 and/or Module 3.

18. We mention this point at this stage, not to side-step responsibilities, but to highlight the importance of being clear as to who is responsible for what – including in relation to consideration and implementation of any recommendations which the Inquiry may be minded to make in an interim report.

The Modular Structure of the Inquiry

19. In relation to areas of overlap between Modules or grey areas, we highlight two areas, by way of example only:

    a. "Planning" vs "Operational" matters. We know that the operational readiness of the NHS is a matter to be explored in more detail, and in particular in Module 3. We look forward to assisting the Inquiry in these later modules. But some evidence in this Module has touched on "operational" matters, and the limits of the investigation at this stage means that such evidence has not

[13] On public health budgets generally see Dr Claas Kirchelle at INQ000205178 p.130 para 108. Or more generally, see the evidence of Dr Richard Horton, editor of the Lancet (Day 20, 13 July 2022, p75-p76) who referred to the "disabling" of the public health system and spoke of the lack of investment in public health funding and the lack of a local testing capacity.

[14] Evidence of Mr Duncan Selbie, Day 10, p137 – 140.

[15] INQ000148391 (1/12/2015); updated in January by reference to the "Wuhan Coronavirus" at INQ000178244.

been tested. For example, the Inquiry has heard reference to lack of planning for oxygen supplies in hospital building programmes[16] and repeated reference to the issue of not only the adequacy of the Pandemic Flu PPE stockpile,[17] but also issues about training in the use of items of PPE,[18] and its distribution in the pandemic.[19]

b. Events during the Pandemic. Equally, on Tuesday 18 July 2023 the Inquiry heard not only dignified and affecting evidence from members of the Covid-19 Justice Groups that touched on events during the pandemic, but also suggestions as to recommendations that began to look forward to those events, such as the suggestion that there needed to be greater regulation of end of life care.[20]

20. We would suggest that the Inquiry will wish to ensure that both any factual findings it makes and any recommendations, reflect the limited evidence that it has heard to date about events during the pandemic itself, and the fact that they are to be examined in greater detail in later modules. We recognise, however, that in practice, the Inquiry's thinking may in time take account of the evidence heard in Module 2.

21. Data availability. We note further that there has been some commentary on the lack of availability of important information relating to the healthcare, as well as the social care, sector when the pandemic struck.[21] The Inquiry has heard that mapping potential information flow requirements before a pandemic would have been desirable. We support the submission, made on behalf of GO-Science that it would now be useful to carry out further analysis, mapping what data would be required in a future pandemic, who holds it and how would it be analysed. As part of this, it would also be useful to ensure that appropriate data sharing agreements

[16] Day 20 p.42 (evidence of Mr Nigel Edwards).
[17] Day 5 p.133-134 (evidence of Sir Chris Wormald); Day 10 p.21-29 (Mr Matt Hancock).
[18] Day 1, p61 (Submissions on behalf of the Covid-19 Bereaved Families for Justice).
[19] Day 5 p.133 (evidence of Sir Chris Wormald); Day 11 p.149-153 (Ms Jeane Freeman, re Scotland); Day 14 p.55-56 (Dr Andrew Goodall, re Wales).
[20] Day 22, p108 (submissions by Mr Lavery KC).
[21] See the Witness Statement of Sir Patrick Vallance [INQ000147810] at paragraphs 87-94; Professor Sir Chris Whitty, Day 8, p. 112-114; Sir Patrick Vallance, Day 8 p.168.

were also mapped out, enabling openness and transparency so that there was public acceptance of the arrangements envisaged.

22. But it does not necessarily follow that there could or should have been earlier commitment to building systems that would have enabled such data collection to be 'switched on', in the event of a pandemic, at least within the NHS. In practice, we note that systems were built, at speed, in early 2020, to meet new reporting tasks both within health and across government. No doubt this will be addressed in further detail in Modules 2 and 3. For the moment we would simply observe that: first, data collection in the health system represents an ongoing challenge and requires commitment, in terms of time and other resources, including the costs of information technology and systems. It cannot be divorced from the wider issues of system capacity, resilience and prioritisation. Second, and significantly, NHS England does not routinely collect live operational data from NHS Trusts for its oversight, policy, financial planning and assurance purposes. Central data collection on matters such as hospital bed occupancy (e.g. of intensive care beds) is generally driven by current operational needs and has to be justified. The view of the Nuffield Trust was, in fact, that the availability of data for the hospital sector was "pretty good".[22] Finally, the extent to which issues arose from the regulatory/legislative framework on data sharing, as opposed to the physical flow of information, needs further exploration (and see the comments above, at paragraph 20, on the need for data-sharing agreements to be explored).

23. We are sure that the Inquiry will be alert to the issue of the challenges of the modular structure in any interim findings and recommendations delivered by it. There are areas where the evidence, in looking forward to issues which occurred during the pandemic, touched on matters which have not yet been the subject of detailed scrutiny. We are confident that the Inquiry will carefully identify such matters.

[22] Evidence of Mr Nigel Edwards of the Nuffield Trust, Day 20, p55.

(3) Preparedness.

NHS/NHS England EPRR Structures.

24. The Inquiry has examined the EPRR structures and systems in place prior to the pandemic to deliver preparedness. We look forward to its observations on improvements that can be made. But a few points on issues on which the Inquiry has heard evidence.

25. Complexity and the spaghetti diagram. The organogram dubbed by CTI "the spaghetti diagram" made an early appearance in the Inquiry and has been used as an emblem of complexity. We would observe, however, that it is a diagram of the whole national system.[23] It may be that some complexity is inevitable, given the scale of such an operation. Effective simplification may be a challenge – although one of course that the Inquiry may rise to.

26. However, from our perspective perhaps as significant a question is whether organisations, such as those within the NHS, NHS England or any other partners such as Local Resilience Fora (LRFs), 'knew their place' in any structure: knew their partners, their roles, and the systems of accountability. From this perspective, diagrams can be recentred – rather like the Mappa Mundi – and what is most important is how the system is understood and framed by each organisation, and the coherence of those systems.[24]

27. We know that there will be a variety of experiences in answer to that question. Further, NHS-centred structures may be examined in more detail later. However, we would provisionally suggest that the NHS structures were reasonably clearly defined and had a number of features that reflected good practice:

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[23] It was also not complete and therefore not always factually accurate. For example, the NHS Clinical Commissioning Groups (CCGs) were shown as isolated islands, unlinked to any other organisations. Even focusing on the EPRR links only (rather than more general commissioning functions), the fact that the NHS Resilience Standards are contractual standards – see paragraph 25(a) below – means that commissioning bodies have a role in assurance.

[24] The Inquiry heard similar submissions from the Northern Ireland Department of Health on Day 23: (transcript at p78) and from the Cabinet Office (p89 – 91).

Standards

a. NHS Resilience Standards: in the years before the pandemic, NHS England had in place Core Standards for EPRR required to be met by providers of NHS funded care: Acute Trusts, Ambulance Trusts, Mental Health Trusts, and Community Providers.[25] We note that NHS England's creation of a single accessible document containing key guidance (the "Summary of Published Key Strategic Guidance for Health Emergency Preparedness, Resilience and Response (EPRR)") was regarded as a helpful step by Professor Alexander and Mr Mann.[26]
b. A healthcare EPRR qualification, the Diploma in Health Emergency Preparedness, Resilience and Response, which has been available since 2005 and is awarded by the Royal Society of Public Health. It was previously known as the Diploma in Health Emergency Planning and is now recognised as the leading qualification for Health EPRR professionals; the NHS is the only sector to have a services specific emergency preparedness qualification.

Assurance

c. Within the hospital setting, a system of annual Trust board assurance on organisational EPPR preparedness, planning and capacities, with assurance considered in public board meetings;
d. Also at a local level, links between the NHS and local LRFs, and, most pertinently, the Local Health Resilience Partnership (LHRPs), which exist to enable joint planning. These latter were established in 2013 as forums for joint planning for emergencies for the new health system, supporting the health sector's contribution to multi-agency planning through LRFs. Members of the LHRP were expected to be executive representatives, able to authorise plans and commit resources on behalf of their organisations.[27]

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[25] CWS para 30; the Standards are a contractual requirement contained in the NHS Standard Contract SC30. The NHS Core Standards were referred to in the Independent Review of the Civil Contingencies Act 2004 and its Supporting Arrangements [INQ000187729] as an example of good practice, see p.25: "Although there is good practice in some sectors, especially the police and fire rescue services and the NHS". See also pp.206 - 207, 213 and 253 for further evidence of NHS practice.

[26] INQ000203349 (Report of Professor Alexander and Mr Mann) at p124 – 125.

[27] LHRPs are briefly described at paragraph 119 of the NHS England Corporate Statement. LHRPs were devised during the establishment of NHS England and their purpose was to ensure, at a local level, that all NHS organisations were engaged in planning for emergencies and secondly, and where appropriate, to undertake health-related activity on behalf of the LRF (with the consent and permission of members).

e. An upwards assurance process from Trust Boards, via NHS England regional teams;

f. Regular audit of NHS England's own EPRR functions, both internal and external;[28]

g. At a central level, the Inquiry will have seen that NHS England was represented within key EPRR committees at the national level, including DHSC committees (as set out at para 11 above). Further, NHS England EPRR committees were – amongst other things – means for ensuing the engagement and involvement of key stakeholders. For example, there was an elected representative of the BMA on NHS England's EPPR Clinical Reference Group.[29] Further, Ms Gallagher of the RCN was a member of NHS England's Clinical Response Group, with effect from November 2018.[30]

Powers of Response

h. An EPPR framework and broader legislative framework[31] which enabled central co-ordination and direction for the NHS in the event of an emergency, if justified by events. Whilst this is a topic for Module 2, it is our view that, judged overall, the national direction for the NHS that was envisaged by the most serious Incident Level within the EPRR Framework[32] was a source of strength in responding to the pandemic.

28. We acknowledge that there will always be more that can be done to spread knowledge, increase training and awareness, make guidance accessible and – dare we say – minimise jargon. We are sure that the detailed scrutiny of Module 3

[28] CWS, para 228.

[29] See the statement of Dr Banfield (INQ000205177) at paragraph 50. The BMA also provided ethical advice to NHS England on a number of occasions in 2016 (Banfield, para 58 – 60).

[30] Statement of R Gallagher, (INQ000177809) at para 8(f)). Other advisory committees within NHS England also provided channels for engagement and advice, see for example CWS p.153, Annex 8: the 2017 National Escalation Pressures Panel (NEPP) was established in 2017 to advise the National Director for Urgent and Emergency Care on pressure and clinical risk. The NEPP brought together clinical experts from, among others, the Royal College of Physicians and the Royal College of Nursing.

[31] See s253 of the NHS Act 2006 (emergency powers of the Secretary of State for Health).

[32] Supported, when needed, by Directions from the Secretary of State under s253 of the NHS Act 2006; Directions were issued enabling, for example, the commissioning of the Nightingale Hospitals and contractual arrangements to be made for capacity to be purchased from independent providers in the private health sector. The Incident Levels are set out and explained in CWS p40.

will lead to evidence of variable practice – weaknesses as well as strengths – and lessons for improvement. However:

a. To the extent that the Inquiry develops recommendations about the need for reformed EPRR National Standards, we would observe that there needs to be careful study of how these would affect or interrelate with the NHS standards, as well as how standards should apply to private (independent) providers of medical services, who have not been heard in this Module. The same might be said, we respectfully observe, of the social care sector. Although there has been reference to planning weaknesses in this very disparate sector, the extent of its existing regulation and the role, for example, of the Care Quality Commission (CQC), has not yet been the subject of examination.[33]

b. More generally, there will always be a difficult balance to be struck between planning and exercising for emergencies and dealing with the challenges of the 'here and now.' Particularly when the NHS is stretched (and we make brief comments on resilience below) time spent away from direct patient care inevitably has to be justified. This is linked to the issue of "reflecting on the value of insurance against future risks" that was referred to in the submissions made on behalf of GO-Science on 19 July 2023[34] – a wide-ranging issue which relates also to the judgments that had to be made on the extent to "operationalise" plans in advance of an emergency. Furthermore, pandemic risks are not the only risks that must be planned for, exercised for and responded to.

c. GO-Science's oral submissions made the explicit point that there were judgments to be made on resource allocation. Consistently with this, we would stress the need for financial resources to follow any recommended regulatory changes. So we note, for example, the submission on behalf of the Covid-19 Bereaved Families for Justice that a system of audit, rather

[33] The limits of the Inquiry's ability to make recommendations, at this stage of this work, upon the social care sector was acknowledged, for example, by the TUC in their oral submissions on Day 23, p23.
[34] Transcript, Day 23, p47.

than self-assurance, of emergency preparedness should be put in place.[35] By contrast, Counsel for the Local Government Association and the Welsh Local Government Association suggested that a system of peer review for LRFs would bring both external insight and local assurance.[36] In the case of the NHS, the annual Trust assurance system referred to above was predominantly[37] one of self-assurance, but that self-assurance was subject to peer review from other NHS organisations, with methods such as 'confirm and challenge meetings'.[38] An audited or more directly regulated system will have costs as well as benefits, and needs to be funded, as well as being integrated into other existing regulatory schemes such as those of the CQC (not heard from directly in this Module). There is need for careful consideration as to whether additional regulation would be an effective and proportionate means of increasing resilience or effective response capacities, at least within the NHS.

29. The Inquiry will also have well in mind that there will be fresh insights to be gained into EPRR structures, as it continues its work. For example, we would suggest that a further topic of inquiry will be whether it could be useful to add the MHRA (the Medicines and Healthcare products Regulatory Agency) and NICE (the National Institute for Clinical Excellence) to the list of Category 1 responders, when examining any potential changes to the CCA 2004. The place for exploring why we make that suggestion is later modules, as it arises out of the experience of the pandemic. But the case for such changes relates to thinking about the nimbleness and speed required to produce new clinical guidance for clinicians, or to approve new treatments, new or substitutable drugs or vaccines in an emergency situation.

Wider System Links – Localism and Subsidiarity

30. Returning to the issue of complexity in structures, the Inquiry has heard criticisms of fragmentation within the public health system at the local level, with varying views on the reforms to public health made in 2012, although Directors of Public

[35] Day 22, p82.
[36] Day 23, p41.
[37] For Ambulance Trusts the EPRR assurance is shared with the CQC and forms part of the CQC assessment.
[38] CWS para 127. We would add that a letter detailing the assessment process is sent out May/June each year detailing the process and includes a topic for a 'deep dive'.

Health were clear that the siting of public health functions in local authorities was a source of strength and should not be altered.[39]

31. We have mentioned the role of the LHRPs above (para 25(d)). NHS England recognises the importance of local knowledge and its centrality in both designing and delivery local services. We also acknowledge the need for further strengthening and improvement of the links between the local NHS, public health and local authority bodies, as well as further progress in building effective links with civil society, including the voluntary sector. The central importance of public communication and public engagement has been one of the key lessons from the pandemic.

32. We would, however, wish to highlight that the pre-2020 position described in Module 1 has been changing. There has always been a legal duty to co-operate with local authorities,[40] but in our Module 1 statement we also drew attention to the changes made by the Health and Care 2022 Act, and the creation of 42 Integrated Care Partnerships in England, from 1 July 2022. These were the culmination of a lengthy journey, including NHS legislative proposals in 2019; please see Annex 5 (p143 – 145) of the NHS England CWS, outlining the development of these reforms to the healthcare and public health system.

33. In brief summary, Integrated Care Partnerships (ICPs) are statutory committees jointly formed between the local NHS Integrated Care Boards and all upper-tier local authorities that fall within the ICS area. ICPs bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally.[41] Each ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICP area. Although local authorities remain responsible for social care and public health functions, this represents a clear mechanism for planning for the population's health in partnership with the NHS.

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[39] See the Witness Statement on behalf of the Association of the Directors of Public Health [INQ000183419] at paras 149 – 152. See also Mr Duncan Selbie, Day 10 p.12 and Mr George Osborne Day 6 p.100.

[40] s82, National Health Service Act 2006.

[41] Details are contained in s116 and s116ZA of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Care Act 2022 (s26).

Further, tackling health inequalities is a core duty placed on health services,[42] amongst other partners, and should be at the heart of this work.[43] In addition, a key aim of these changes was to improve data flows, including in health and adult social care[44] – as was noted by Professor Kevin Fenton on 5 July.[45]

34. The change represents the biggest national move to integrated care of any major western country and was the culmination of a lengthy process, starting well before the pandemic, of enabling enhanced co-operation between public health, the NHS England and social care. In addition: (i) Health Education England is now a part of NHS England; and (ii) so too is NHS Digital.

35. These are all relatively recent changes, requiring significant attention and resources, and need to 'bed in'. Thus there have been major structural changes, very much in their early stages, but aimed, in part, at addressing some of the issues which the Inquiry has been examining. We would respectfully draw attention to the importance of taking these developments into account when examining the case for further change, both within the NHS sector and in the interface between the NHS and public health structures.

Planning.

36. Moving away from structures to the issue of the planning undertaken before 2020, the Inquiry has heard evidence of the content of the National Risk Register and the National Risk Assessments, and we do not intend to comment on these, as NHS England was not directly involved in their genesis or drafting. NHS England took

[42] The National Health Service Act 2006 places the following duty on the Secretary of State: "In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service." (s1C); there are then similar obligations on NHS England under s13G (with regards to access to health services, and outcomes); and then under s14T with regards to Clinical Commissioning Groups, as they then were. The provisions were amended by the Health and Care Act 2022, in s13SA, by adding further duties with regards to the publication of information on health inequalities.

[43] The obligations placed on CCGs under the 2006 Act are reproduced for ICBs in the provisions of s14Z32 (inserted in the NHS Act 2006).

[44] See Part 2 of the Health and Adult Social Care 2022 which contains a number of provisions relating to information sharing.

[45] Professor Kevin Fenton, Day 15 p.51 and p.100: "with the most recent organisation of the health and care systems, where we now have the creation of integrated care systems, ICBs, and stronger working between local government and the NHS, I believe we have an amazing opportunity to look at data differently, how we share data, to understand and improve population health, and how we use those data to tackle inequalities."

its direction, for EPRR pandemic planning, from the NRR/NRA/NRSA and the requirement from these that there should be a plan, as a result, for flu pandemics and also in respect of Emerging Infectious Diseases; this in turn led to the HCID Programme and planning.[46]

37. The Inquiry has received detailed evidence of the HCID programme.[47] This was a direct response to learning from previous serious diseases including coronaviruses such as SARS. Specific drivers were the were the experience of the Ebola outbreak in West Africa (2014 – 2015), the Ebola Surge Capacity Exercise (2015) and the continuing threat of 'airborne' diseases, such as MERS, SARS and Avian influenza.[48] Four regional HCID regional units were created under the programme; after establishment, HCID capacity and capability has been considered as part of the general processes of specialist commissioning.[49]

38. A number of witnesses have told the Inquiry of their view that there was little or no learning taken or absorbed, in the UK, from the South East Asian experience of coronaviruses. We would suggest that this needs to be qualified or analysed in more detail. There was extensive development of knowledge at a scientific level about the clinical features of these diseases[50] and this informed the NHS England HCID programme. We would respectfully suggest that this response should not be overlooked.

39. Whilst drawing attention to the HCID programme, we would also note that HCIDs are defined as diseases which "typically have a high case-fatality rate" (amongst

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[46] For an explanation of diseases that are classified as HCIDs, see the Second Statement of Dr Michael Prentice INQ000184893 at paragraph 2: "HCIDs are highly transmissible infections that are rare in the UK, and typically associated with recent travel from countries where the infection is endemic or there is a current outbreak. They typically have a high case fatality rate and the ability to spread in the community and within healthcare settings if adequate precautions are not in place. Patients require careful management to prevent staff caring for them from becoming infected and coordination is required at a national level to ensure an effective and consistent response." Covid-19 was initially classified as an HCID on a precautionary basis in January 2020 and downgraded on 19 March 2020.

[47] INQ000184893. Also CWS, paras 169 – 186, paras 197 – 199.

[48] INQ000184893, paras 33 – 37.

[49] INQ000184893, paras 38, 60.

[50] See the evidence of Dr Horton on the explosion of scientific research on coronaviruses and other viruses after the outbreak of SARS in 2002/03; it was a "central debate" (Day 20, p87 – p88).

other characteristics).[51] To date, they have been mercifully rare in the UK. The list of HCIDs is agreed by the Four Nations Public Health Agencies, applying specific criteria. Only a few diseases have met the criteria (e.g. MERS has a case fatality rate of 35%) and they have been typically associated with recent travel from countries where the infection is endemic or there has been an outbreak (e.g. Ebola, MERS, SARS). HCID care is highly specialised and involves isolation of the patient to prevent spread of the disease.[52]

40. Covid-19 was classified as a HCID only in its early stages, by the Four Nations Public Health HCID Group. It was declassified by the same Group on 19 March 2020 five days after WHO declared Covid-19 a pandemic, in part because it was by then apparent that the criteria for "high case-fatality rate" was not met. It would be wrong to think along the lines of "*if Covid-19 was not flu (and was not catered for adequately under pandemic flu plans), it should instead be conceptualised as a HCID*". It was neither one nor the other and the choices are not binary. Many serious diseases are not HCIDs and are not managed through HCID pathways. Hence the observations, made by many in the evidence heard by the Inquiry,[53] on the need to move towards "disease agnostic" EPRR plans, with a greater emphasis on the potential range of characteristics that such diseases may display, and the capabilities to respond.

41. A possible confusion between HCIDs and Covid-19 may be linked to the suggestion the Inquiry has heard, that there were insufficient numbers of HCID beds. The numbers of beds were set out in our HCID statement.[54] Surge capacity for HCID is very different to surge capacity for non-HCID diseases because the HCID service is highly specialised, and the resource implications of further

[51] INQ000184893, paragraph 4 (referencing the PHE definition): Second Statement of Dr Mike Prentice (the HCID programme). Or see INQ000184147 (NHS England Programme Overview, 16/2/2017).
[52] "Isolation" (the separation of an infected patient) can be distinguished from "quarantining" which is the separation of a person who may be considered to be susceptible to disease but is not demonstrating signs or symptoms, or has not tested positive. The NHS is not responsible for quarantine facilities, although in the early stages of the pandemic it assisted in the establishment of such facilities at Arrowe Park for repatriated nationals, due to its HCID experience.
[53] Sir Chris Whitty Day 8 p, 93-94, Mr Hancock Day 10 p.80, Dr Jeremy Farrar Day 12 p.25
[54] Further "In addition to the HCID Centres, there were also around 20 adult Specialist Regional Infectious Disease Centres ("SRIDCs") that offered more specialist provision and advice than that offered in local infectious disease services" (INQ000022826, para 95).

commissioning would be considerable, not least when on its terms the additional HCID capacity would sit redundant for long periods.

42. The Inquiry has heard much criticism of the national flu pandemic plan. However, it was and remains very important to have plans for a flu pandemic – we should not lose sight of the fact that it remains the pre-eminent risk and needs to be prepared for. NHS England's perception is that, in broad terms, exercises such as Cygnus and Alice were also useful, and were built on within the organisation (for example, in the refresh of the Operating Framework for Managing the Response to Pandemic Influenza, and the delivery of options for NHS surge and triage to the Chief Medical Officers[55]). However, it accepts the submission that there should be greater transparency with regards to the outcomes of such exercises and that this would support liaison with partners who had not been directly involved in the exercise, as well as accountability generally.

43. In relation to completing recommendations from Exercise Cygnus, the Inquiry has heard that some work was paused as a result of the need to plan for a 'no-deal' Brexit and Operation Yellowhammer. However, NHS England would also agree that aspects of this Brexit preparation work assisted with the response to the pandemic. In our corporate witness statement, we explained that from NHS England's perspective, its EU Exit preparations were significant contributors to the Covid-19 incident response arrangements.[56] We draw attention to a range of gains, set out at paragraphs 250 – 263 of our Module 1 CWS on this topic. Whilst it has been suggested that such gains were "fortuitous" and only serve to underline the limits of the pandemic flu planning,[57] the reality is that emergency preparedness planning in one area has crossover benefits for other scenarios. Operation Yellowhammer required EPRR functions to be expanded, and the "standing-up" of all NHS organisations by NHS England EPRR was timely preparation for the pandemic that followed.

[55] The CMO briefing is at INQ000022826, dated 9 October 2017.
[56] CWS INQ000177805 at 258. See also Mr Matt Hancock Day 10 p.64.
[57] See questions from Covid-19 Bereaved Families for Justice to Mr Gove, Day 20 p.149-152.

44. Linked to the point of experience of Brexit planning is a related issue as to operational experience. We would suggest that the focus in these hearings, in which scrutiny of plans and similar documents has played a very large part, has perhaps meant that there was less scrutiny of the experience gained by actually putting EPRR planning into practice. The experience gained from Operation Yellowhammer is an example of this, but the NHS England Corporate Statement refers (Annex 5, pp126 – 142) to the numerous incidents or emergencies to which the NHS responded, to 2022. Equally important was the NHS experience of annual surge planning and preparedness, and putting this work into practice to cope with winter pressures. Perhaps we are straying into 'operational' territory here – but the experience of crisis management which was ultimately drawn upon, when Covid-19 hit, drew upon these reservoirs as well as the planning documents and pandemic exercises.

(4) Resilience and Inequalities.

Resilience

45. In the evidence heard by the Inquiry, there has been widespread acknowledgement of the pressures upon the NHS in England by 2019. Our own Corporate Statement dealt with this issue at Section 6 ("Resilience", paragraphs 294 – 358, especially para. 318 onwards). The fact that the NHS was relatively protected from spending pressures from 2010 onwards, at least when compared to (say) PHE or local authorities[58] does not alter that fact – see the evidence on international comparisons.

46. Equally, NHS England recognised the pressures on social care, prior to the pandemic. It commented publicly on the need for social care funding increases and structural review.[59] There has always been an interdependency, with hospital beds and resources closely affected by the availability of social care in the community, whether at home or in residential care. There is also an NHS contribution to social care budgets.[60] Although the issue of social care during the

[58] See the evidence of Mr Osborne (Day 6, p97 – 98) and Mr Hunt (Day 8, p183).
[59] Corporate Witness Statement, paragraph 302.
[60] Corporate Witness Statement, paragraph 303.

pandemic is a matter for a later module, we would suggest that resilience and capacity issues in social care are national issues which must be addressed from the centre and not left solely to individual local authorities, or indeed individual care providers – despite the importance of both of these sectors.[61] We endorse the calls for action in this area, even if we understand that the Inquiry may not have heard sufficient evidence to call for specific solutions.

47. There has been discussion of bed capacity and workforce in the hearing chamber. The NHS needs staff. We now (in 2023) have a long-term workforce plan but there are "no quick fixes". There was also some mention in evidence of the issue of the NHS estate and capital spending. The Corporate Witness Statement drew attention to the "*age and design of the NHS estate [which] means a lack of flexibility into surge response is 'baked in'.*" (para 343). Evidence heard[62] suggested that recent building programmes had not made sufficient provision for modern facilities such as oxygen piping; but 12% of the estate pre-dates the founding of the NHS in 1948, around 17% is over 60 years old and about 44% is between 30 and 60 years. Furthermore, facilities that are needed go beyond infrastructure for oxygen, to flexible theatre/ ICU space, spaces that can be segregated to enable good infection prevention control measures and adequate ventilation systems (as well as enabling digital healthcare). These were issues in the pandemic and can be linked to aging estates.

48. We draw the Inquiry's attention to the NHS England "Learning Lessons from Covid-19" report, which on the topic of NHS preparedness and resilience states:

> "1. **NHS Resilience / Bed capacity** – Sufficient bed capacity is a pre-requisite in being able to effectively respond to surges in demand without having to negatively impact other services and/or stand up more expensive 'just in time' capacity.
>
> 2. **NHS Resilience / Workforce** - Sufficient workforce is a key factor in usable bed capacity - and the shortages/limitations of trained and skilled

[61] They were not ignored in EPRR work; see for example the fact that a number of exercises took place to explore the issues arising from the failure of care home providers.
[62] Day 20, p42 (Mr Nigel Edwards, Nuffield Trust).

workforce faced by the NHS going into the pandemic were a limiting factor in our response.

3. **NHS Resilience / Estates** - The age and configuration of the NHS Estate caused multiple challenges during Covid-19 such as infection prevention and control, patient segregation, and providing oxygen supply. It was a rate limiting factor in the NHS' ability to adapt and increase our capacity. Investment in the NHS estate is needed to improve the quality of care that can be provided to patients and to enable greater resilience and flexibility in times of surges in demand or pandemics." (p18).

49. Data too is a resource, and the capabilities of information systems within the NHS will, no doubt, receive further attention by the Inquiry.

50. We note that discussion of increasing NHS surge capacity can mean different things to different people or take different forms. In particular, there is a difference between redundant capacity in the system, and flexible staff and equipment, etc, which can be pivoted into different roles and uses. It is probably the latter which is key for further pandemic planning - but it is only possible to train staff to work more flexibly into different roles/environments if they can be freed up to attend training and refreshers. This requires 'surplus' staff numbers on rotas, which is not currently possible in relation to many staffing groups across the NHS.

Inequalities and Protected Characteristics

51. The Inquiry has heard evidence from Professor Marmot and Dr Bambra upon rising health inequalities and their social and economic determinants, including housing, education, race and poverty (and that is not an exhaustive list). These factors in turn have been increasing demand for healthcare. Equally, the point has been made repeatedly that, as a matter of history, pandemics have hit the vulnerable and the marginalised the hardest, and that these vulnerabilities are broader than clinical vulnerabilities. We note that, broadly, the UK national healthcare system is not the cause of inequalities in health; Professor Marmot made that point that in the UK, access issues are not the driver of ill-health because the NHS has equality

of access.[63] The NHS has, further, taken a lead on seeking to address health care inequalities issues and sought to focus on the needs of those who are least likely to use health services. Thus, whilst this will be an issue for Modules 3 and 4, one of the major planning efforts during the pandemic was on securing equality of access to vaccination facilities, and seeking to ensure that vaccination take-up rates were even across population groups.

52. In 2022, NHS England updated the EPRR Framework to reflect the experience of the pandemic. It included an updated section on health inequalities; this included explicit reference to consider health inequalities during both the planning phase and during the response to an incident.[64] But we acknowledge that there will be lessons to be learned about how to focus on securing access to health treatments and health care for those most likely to be adversely impacted by pandemics.

Conclusions.

53. We note the Inquiry's intention to produce an interim report by the summer of 2024. We recognise the commitment needed to do this at the same time as continuing with a heavy schedule of hearings, relating to Module 2 and its successor modules. NHS England will seek to provide any further assistance, by way of information and evidence, to the Inquiry in that task. We look forward to further participation in this Inquiry and to the lessons it will enable NHS England to learn.

NHS England

DATED THIS 2ND DAY OF AUGUST 2023

[63] Day 4, p5, p29. Or see the written evidence of Mr Duncan Selbie [INQ000192268, para 22]: "NHS services are of course important but do not have such a significant impact as economic, societal and environmental factors."

[64] CWS para 276 and INQ000113334; see Section 18, 18.1. This includes the following: "Reducing the actual or unintentional impact from health inequalities during a major incident is vital. During the planning phase, AEOs must ensure the diverse range of local health needs is considered when preparing for a range of incidents. Additionally, Incident Commanders, as part of their role leading the response to an incident, should consider the impact of their decisions on health inequalities either within the existing population or on the community as a result of an incident. This, along with other decisions, should be appropriately recorded in incident logs along with the rationale underpinning the decision being made."