CLOSING SUBMISSIONS, NHS ENGLAND

Module 2 of the Covid-19 Inquiry

Introduction

1. These are the written Closing Submissions of NHS England, in respect of Module 2 of the Covid-19 Inquiry.

2. Module 2 has explored the decision-making of the central Westminster government and its advisors in respect of the Covid-19 pandemic. NHS England, and the NHS more broadly, have played a small part in that exploration. The Inquiry's investigation at this stage is to be followed by further consideration of the response of the healthcare system to the pandemic, which will be examined in Module 3 in particular. These submissions therefore reflect the boundaries of the role of NHS England in Module 2. The topics that we have addressed are not comprehensive but address those issues which touch on the pandemic response of the NHS, or of NHS England, most directly. Our Submissions address, in Part 1, the general topics of:

    a) The role of NHS England in the healthcare system in England;

    b) Central Government decision making, and the role of further groups and organisations including executive agencies such as NHS England;

    c) The early response of NHS England to the emerging threat of the pandemic, to 11 March 2020;

    d) Brief comments on the period which followed, including Wave 2 and the deployment of vaccines;

    e) Maintenance of NHS capacity throughout the pandemic;

    f) NHS Resilience and strengthening the NHS.

3. Part 1 is followed by a second section (Part 2) in which we comment on specific issues raised in the course of Module 2 hearings. We have addressed: (i) government decision-making structures; (ii) Social care and delayed discharges; (iii) NHS information and data flows; (iv) High-Consequence Infectious Diseases ("HCIDs") and the declassification of the virus as an HCID; (v) hospital discharges and care homes; (vi) inequalities, and the role of future modules in considering topics such as PPE and other protective measures for staff.

4. In filing these submissions, we have aimed to highlight the following matters:

    a) The importance of structures outside of central government, as specialist resources that worked co-operatively with central government to respond to the challenges of the pandemic. Such structures, when they existed in a reasonably well-resourced and organised form, played an important part in enabling that response. When, however, they did not exist – as in the case of social care in England, which lacked a central national organisational resource or voice – the gap was significant;

    b) The fact that specialist bodies such as NHS England responded rapidly to the emerging threat, including in the early months of 2020;

    c) That, although the early data on the spread of the virus and its likely impact was imperfect and there were many uncertainties, there was sufficient data for NHS England to realise the likely scale of the challenges ahead and also – by early March 2020 - to appreciate the imminence of the risk to the maintenance of NHS capacity to treat. The data improved over time, becoming more granular, clearer and better tailored to the needs of the pandemic.

(1) Introduction: The role of NHS England

5. NHS England is primarily responsible for the co-ordination of the provision of health care services in England and oversight of local commissioners and providers of those health care services. It also provides leadership and operational

guidance to NHS organisations in England; but it is not, of course, the employer of the vast majority of NHS staff and is not a provider of NHS services. As a body with England-wide responsibilities:

a) NHS England enabled national coordination of the healthcare system's response to the pandemic within England.[1] Together with other key health-related agencies such as Public Health England, it gathered expertise to determine and lead that response.[2] As a body appointed to lead the NHS, it was able to stand up organisational structures to further that end. It declared a Level 4 Emergency, the highest level of response to an emergency, as early as 30 January 2020;

b) Further, although the NHS is made up of many hundreds of individual organisations (including some 215 hospital trusts and 6,366 GP practices), through NHS England it is able to engage with Government generally and the DHSC in particular.

6. Full details of NHS England's remit and functions are set out in its M2 Corporate Witness Statement at [INQ000116811], §37 – §47, including of its regional teams [§60 – §61]. *To note, when paragraph numbers without further reference are given in these Submissions, they are references to that Corporate Witness Statement (or "CWS").*

7. In this Module, NHS England was invited to provide, and has filed: (i) its Corporate Witness Statement, as noted [INQ000116811]; (ii) a Supplementary Statement addressing the issue of Long-Covid [INQ000232195]; and (iii) a Written Statement [INQ000280647] from Lord Simon Stevens, the Chief Executive of NHS England at the time of the events considered by the Inquiry in Module 2. Further, Lord Stevens gave oral evidence to the Inquiry on 2 November 2023 (Day 17). These Submissions are intended to be read with those materials.

[1] For the purpose of these Submissions, when we refer to "national" decisions we mean decisions relating to England, as one of the UK's Four Nations and the area for which NHS England has a remit.
[2] See the evidence of Lord Stevens, Day 17, p3, line 16.

(2) Module 2: Central Government Decision-Making and the NHS.

8. This Module has, to date, been focussed on the central government within Westminster and its actions, although we recognise that the Inquiry's focus will shortly widen to consider decision-making within the nations of Scotland, Northern Ireland and Wales (in Modules 2A, 2b and 2c), and that there are further modules planned, including of course Vaccines and Therapeutics (M4), Healthcare (M3) and Social Care (M6). There has also been some, but limited, consideration of liaison with local government, most frequently in the context of the Tiers system.

9. The reality of government decision-making and action is that there are a great number of interdependencies, with decisions requiring collaboration with, and implementation by, bodies outside Number 10, the Cabinet Office or individual Departments. Government systems include the Arms-Length Bodies established by Parliament. The range of other national health-related bodies alone is wide, including as they do (or did) NHS Digital, NICE, CQC, MHRA, PHE/UKHSA etc. NHS England is one example of such a body; established by Act of Parliament in 2012, it was able to focus on the response of the NHS whilst the DHSC had a wider cross-government and systems role. During the pandemic, it worked closely not only with the Government and NHS bodies, but also other arms-length bodies and local structures, whether within local government or social care.

10. Whilst we recognise that this is also an issue to be considered more fully across other Modules, we note the contrast between the position of healthcare in England, with the NHS organised as a national system headed by NHS England; and the organisation of social care, which lacked an equivalent responsible body. We noted in the course of Module 1 evidence that NHS England had been amongst those calling for further funding and reform of the social care sector, prior to the pandemic (see paragraphs 46 – 47 of the NHS England Closing Submissions in Module 1).

11. Despite its central role in the task of mobilising the NHS response to the virus, it is clear that NHS England was not a government decision-maker on measures to

encourage or require reduced societal transmission of the virus, or Non Pharmaceutical Interventions ("NPIs") including lockdowns, which were a matter for central Government and its Ministers (or the Devolved Nations, outside of England).[3] The role of NHS England in respect of these decisions was to provide information and advice on NHS capacities and capabilities.

(3) The Early Months of 2020

12. NHS England took early steps to respond to the emerging evidence of the 'Wuhan virus'. In summarising these steps below, we have focused on its interaction with central Westminster activities and decision-making, given the focus of Module 2. We acknowledge that the details of most of the "NHS-facing" steps are for Module 3, and the steps are therefore only briefly set out. But we highlight them at this stage partly because of the point we have made about the wider landscape of decision-making and response; and because the Inquiry has been concerned to explore whether sufficient steps were taken to plan for a pandemic in February – early March 2020, in particular. The full pattern of activities includes not only assessment, planning and action by central government, but the wider efforts that were undertaken in co-ordination with those central actions.

13. The healthcare response, across the healthcare system or 'family' was developed in partnership with the DHSC and other organisations, including professional and clinical associations. We note the evidence of Mr Hancock, that he sought to lead "*a positive culture, a can-do culture*" within "*the Health family*", in which "*we essentially had a collaborative system where everybody came together and did their level best in a positive spirit, and when something went wrong we asked how to fix it.*"[4] Discussion and partnership with other stakeholders was also a key part of NHS England's approach. There was collaboration in February 2020 between, for example, DHSC, PHE and NHS England as well as the FCO in organising quarantine facilities for British nationals repatriated from Wuhan. There was

[3] This was confirmed by Lord Stevens in oral evidence: Day 17, page 5, lines 21 – 24; also p15, lines 4 – 7, lies 20 – p15 line 4.
[4] Day 29, 30 November 2023, page 12 lines 19 – 25; page 84 lines 8 – 16.

discussion and agreement with professional associations representing healthcare workers and their regulators upon support for healthcare workers who would be asked to work in unprecedented conditions.[5]

14. The NHS England response drew upon its EPRR Framework, which defined the organisational emergency 'control and command' structures such the Incident Management Team ("IMT").[6] However, despite the activation of EPRR structures in early 2020, it is also crucial to understand that much was still uncertain at that time. It was not certain if or when the pandemic would reach the UK, and what impact it would have, as the Government's scientific advisors have reminded the Inquiry.[7] In addition, groups such as SAGE and SPI-M-O were refining their own analyses of this during these months.

15. Details of NHS England's actions are set out in the CWS, from §74. Early steps were taken to understand the potential impact of the virus, to consider the readiness and capacity of the NHS, and to assess its potential for surge. Yet it is important to remember that, at that time, the actions were taken alongside managing other NHS pressures and priorities, including those of the winter of 19/20. In addition, immediate measures to support those affected by Covid-19 in those early months (e.g., through the activation of the HCID network or involvement in the establishment of isolation facilities for those returning to the UK from affected areas) took place in parallel with longer-term planning.

16. The Statement notes, for example:-

January 2020

a) The period of 'vigilance and concern' of January 2020, with NHS England joining a PHE communications cell from 9 January 2020, to spread information and guidance on the new disease (§83); the first guidance on IPC from PHE

[5] See for example the statements of early March 2020, noted at §16(o) below.
[6] Annex 5 of the CWS (p171) contains a brief outline of NHS England's EPRR function.
[7] Evidence of Professor Sir Chris Whitty: Day 23, 21 November 2023, pages 139 (lie 22) – page 140 (line 19); Evidence of Sir Patrick Vallance: Day 22, 22 November 2023, pages 26 (line 23) – page 28 (line 1). Evidence of Professor Van-Tam: Day 24, 22 November 2023, page 177 – 186, including early lack of knowledge of factors such as the doubling time (page 185, lines 8 – 11).

on 15 January 2020 (§89) and the classification of the virus as a High Consequence Infectious Disease ("HCID") on 16 January 2020 (§90), leading to the activation of network of the highly specialised HCID treatment centres for the care of those infected.

b) Daily National Sector calls were established by DHSC from 21 January 2020, in which NHS England participated.[8] On 23 January, the first "tripartite letter" relating to the virus was sent by the CMO, Professor Sharon Peacock as Director of the National Infection Service at PHE, and the National Medical Director on behalf of NHS England, to medical directors, CCG clinical leads, NHS 111 and 999; a CMO alert was also sent via the NHS Central Alerting System (§98 - §100). On 29 January, NHS England's EPRR and Specialised Commissioning teams wrote to Chief Executives of providers that hosted a HCID facility, asking them to prepare to treat patients and to act as an advice resource to other providers. The following day, the first two positive case of C-19 were identified in the UK and transferred to a HCID unit in Newcastle (§106).

c) On 30 January 2020, as the UK CMOs raised the risk from "low" to "moderate" and the WHO declared the spread of Covid-19 to be a public health emergency of international concern, NHS England declared an NHS Level 4 Major Incident, the highest category of emergency under the NHS England EPRR Framework (§11 – 13, §110). This was followed by instructions to Trusts to organise "Coronavirus Priority Assessment Pods" to enable those patients with symptoms indicative of the infection to get quick assessment (§115, see also §144 on enabling community testing). Weekly webinars commenced from 6 February 2020 with leaders from NHS organisations, hosted by NHS England's Strategic Incident Director (§131).

[8] Third Statement of Sir Chris Wormald [INQ000144792] at §87, p36.

February 2020:

d) NHS England supported the establishment of isolation facilities at Arrowe Park for UK nationals repatriated from Wuhan, as well as directing the use of HCID facilities for Covid-19 patients (CWS §315 – 319).[9]

e) On 7 February 2020, NHS England's IMT produced analysis of the ability of the NHS in England to free up beds if elective treatment was stopped, except for urgent and emergency care and cancer services. There was initially said to be scope to free up between 12,000 and 13,000 beds; of that number, 50% could be freed in 5 days, with 90% being freed in 28 days (§133). On 12 February 2020, NHSE modelling on the impact of the SPI-M RWCS was shared with NHSE's Incident Director (§220). At this point, there were 3 confirmed cases in the UK (§135). On 14 February 2020, NHS England, via the IMT, agreed to share modelling data with SAGE and NHS England's "Two Steps Ahead Group" meetings commenced (twice weekly until 24 April 2020) to support strategic planning. NHS thinking from this group was shared with key officials including the CMO and GCSA.[10]

f) On 12 February 2020, NHS England participated in the Nimbus Exercise. This was a table-top Cabinet-Office led exercise (CWS, Annex 7). The evidence of Lord Stevens was that "*My sense at the time was that it helpfully sensitised a wider range of government departments (beyond the health sector) to the type of pressures the UK might experience.*"[11]

g) During the course of February 2020, NHS England was also making extensive plans as to how it would provide capacity beyond HCID settings, including needs for O, O+ and V beds.[12] In addition, it expanded capacity within the

[9] See also the Third Statement of Sir Chris Wormald [INQ000144792] at §103, p40.
[10] [INQ000228664], [INQ000229869] (the '2 Steps Ahead' exhibit to the first email) – see further para 15(e) below.
[11] §21, [INQ000280647]; see also his oral evidence at Day 17, p29 line 25 – p30 line 15.
[12] V-beds are beds in which patients with lung failure can be treated using ventilators; O-beds are beds with standard oxygen flow; O+ beds are beds with the capacity to support high oxygen flow (such as the ability to support CPAP). See CWS §248.

NHS-111 service, which began to see considerably increased demand.[13] Provisional assessments were received on 1 February 2020[14] and 1 March 2020 of critical care capacity and mechanical ventilators. On 27 February 2020, NHS England launched a further assessment of the preparedness of the NHS to provide critical care capacity for people suffering from Covid-19, including ventilator availability. This reported back in the first week of March 2020.

h) NHS England officials liaised with key government officials on preparation plans, attending (for example) the COBR meeting on 18 February 2020 chaired by Mr Hancock.[15]

i) On 21 February 2020, NHS England's 'Two Steps Ahead' Group noted that the initial modelling suggested that, even with continued mitigation work, the NHS would be overwhelmed well before the peak without significant interventions to flatten the curve; this intelligence was shared with DHSC/Government (§152, and see [INQ000228664], [INQ000229869]).

j) From c20 February 2020, NHS England worked with PHE to establish new surveillance systems to detect cases of Covid-19. Details of the PHE CHESS system are set out at §155, §221; the statement of Dame Jenny Harries [INQ000251906] provides further details of community and hospital-based PHE-led surveillance (see §722 – §726 for details of S-COVER, the initial system for hospital-based surveillance and §727 - §730 for its replacement, CHESS, from early March 2020). Lord Stevens notes that: "*PHE's CHESS process for tracking inpatient numbers [SLS12 - INQ000283160] was supplemented initially by manual daily data submissions, which were then upgraded and automated*

[13] CWS §139, §167 (demand); NHS-111 was one of the early 'cells' established by NHS England: §12, p186.
[14] They indicated that there were some 3,500 critical care beds and the ability to double this to 7,000 by using anaesthetic recovery rooms and other areas, and approximately 7400 available mechanical ventilators. See CWS §439 - §478, which gives details of the steps taken to increase the numbers of ventilators available from Feb – April 2020. NHS England was responsible for the allocation of ventilators, DHSC for their supply (except for the ventilator challenge which was overseen by the Cabinet Office). There was close working between DHSC and NHS England (CWS §459).
[15] Minutes at INQ000056227.

in the second half of March once the number of COVID-19 patients began to increase." (§27, INQ000280647).

k) The National Medical Director first attended SAGE from 25 February 2020 (§32, §66), to improve information flows and co-ordination. Before that, from the third SAGE meeting onwards, the EPRR team was routinely sent copies of the SAGE minutes.

l) Before NHS England's National Medical Director joined its meeting, SAGE had discussed whether the NHS had capacity to cope with a pandemic, based on the SPI-M-O modelling. The NHS England view, based on the NHS modelling, was that the NHS would not have sufficient capacity if the modelling proved correct, as set out above. To test whether this emerging view was justified and to ensure coordination of approach to modelling, the NHS England National Medical Director and Sir Patrick Vallance agreed that SPI-M-O modellers should meet with NHS England's own analysts, and this was agreed (§161 – 163, §222).

March 2020

m) An all-day workshop accordingly took place on Sunday 1 March 2020 at Imperial College: see §168, and §223 – 225). It was co-chaired by NHS England's National Medical Director and Professor Sir Jonathan Van Tam and aimed to reach a consensus between SPI- M-O and the NHS on the underlying model parameters on which to base the RWCS such as hospitalisation rates and length of stay. A "*key omission in the initial SPI-M-O work that was resolved in this workshop, was that it did not include accurate model parameters about the length of stay; the correction of which rapidly increased some of the concerns about lack of capacity*." (§168).

n) The outputs of this summit were presented at (i) the COBR meeting of 2 March 2020 and (ii) the SAGE meeting of 3 March 2020 (see §169 and §351(h), together with [INQ000087263], [INQ000087264]). The RWCS presented at this point suggested that the unmitigated epidemic was expected to result in

demand for 990,000 non-ICU beds and 130,000 ICU beds at its peak, with 570,000 deaths.[16] [17]

o) On 2 March 2020, NHS England sent an NHS Preparedness and Response letter to the NHS system, instructing acute providers to step up preparations, including how they should segregate clinical areas in the event of escalation (§171, §324). In early March 2020, work was under way on both facilities and workforce expansion, including use of clinically-qualified returners, health professions students and volunteers. On 3 March 2020, the Chief Executives of the statutory regulators of health and care professionals issued a Statement on the regulatory approach to support changes in practice required by the pandemic,[18] and this was subsequently built upon by the Chief Nursing Officers and other Nursing and Midwifery colleagues.[19]

p) On 6 March 2020, a ventilator survey was sent out to trusts seeking information about available ventilators across the NHS, with advice being given that all trusts needed to mobilise maximum capacity and prepare space (§181).

q) Discussion took place with DHSC regarding the development of the Shielding Programme (see CWS at §418 – §432 for a high-level account of involvement in the Shielding Programme, including NHS England's specific role).

r) Measures to free up hospital capacity were discussed and agreed with the Government in the week beginning 9 March 2020, ahead of issuing NHS operational guidance setting these measures on 17 March 2020 (§184 - §186, with substantive decision making by Ministers on 11 March and in Cabinet on 17 March 2020).

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[16] For context, the average total number of beds across the whole of the NHS between January 2020 – March 2020 was around 129,000 in total, including maternity and mental health. Of those, around 100,000 were 'General and Acute' ("G&A") beds, of which c.90,000 were occupied (§172).

[17] "*SPI-M-O continued to develop the models over the following fortnight; all illustrated that the NHS would be under severe pressure, without mitigation to reduce numbers. NHS England's modelling team liaised with SPI-M-O and Imperial to ensure a consistent approach was adopted in respect of the input model parameters used, and population base*." (CWS, §226).

[18] [INQ000047927].

[19] Statement of 12 March 2020 [INQ000283205].

17. We stop this summary chronology at or around 11 March 2020, when the WHO declared a pandemic; please see the CWS for a much fuller account covering the whole of the Relevant Period for this Module.

18. There has been some suggestion that no early steps were taken to consider the capacity of the NHS and its potential for surge. However, the chronology set out above shows how, for example, NHS modelling on this issue began as early as 7 February 2020, 'pre-pandemic'. The NHS also has experience in surging capacity in response to winter pressures, and indeed was operating on that basis at the time (see for example the Spreadsheet for 17 February 2020, which gives details of the General & Acute 'escalation beds' that had been opened at that point).[20] Ultimately, measures to free up hospital capacity were discussed and agreed with the Government in the week beginning 9 March 2020, ahead of confirmation at the full Cabinet meeting of 17 March 2020 and the issue NHS operational guidance setting out these measures on the same date.

19. However, as Lord Stevens stated, "*Given the inevitable disruption to wider health services and non-COVID patients from redeploying staff, equipment and facilities to be ready to care for COVID-19 patients, it was important not to activate this switchover too far in advance.*" (§30, [INQ000280647,] as well as the Corporate Witness Statement at §246 - §253).

(3) Emerging from Lockdown, Waves 2 and 3 and the deployment of Vaccines

20. These topics are addressed in the NHS England CWS, or will be scrutinised further in forthcoming Modules. However, it is important to note that:

    a) Whilst the details of actions taken during this period appeared to receive, on the whole, less attention during the oral M2 hearings, this is not indicative of the importance of events during that period, or of the pressures upon the NHS. "*By mid-January 2021 hospitals were under extreme pressure, with a 15,000 increase in COVID-19 inpatients just since Christmas Day. For comparison, around 34,000 inpatient beds were being occupied by COVID-19 patients that January,*

[20] [INQ000283193].

compared with around 19,000 in the first wave in mid-April 2020. While medical advances meant clinical outcomes had continued to improve, population infection levels meant more people died after the first pandemic wave of Spring 2020 than during it." (Lord Stevens, §44, and see the table of inpatient numbers which follows, or CWS §3).

b) The NHS learnt from the experience of the first lockdown, and knowledge of how to manage the demands of the pandemic improved. Through the growth of scientific knowledge, including NHS clinical trials of potential treatment options, knowledge of effective treatment and management options increased, and patient outcomes improved. Thus, speaking of the second lockdown, Sir Chris Whitty wrote that: "*The NHS had learned how to balance better the need to maintain non-COVID services with the need to expand intensive care and wider COVID capacity in hospitals. Clinical care of moderate and severe COVID-19 cases had improved, through trials such as RECOVERY and clinicians getting experienced in management and so the mortality from those who were admitted to hospital was reduced, albeit not to the point where lockdown was unnecessary.*"[21]

c) Throughout the course of the pandemic, the NHS also continued to treat non-Covid patients. "*At no stage were NHS hospitals "Covid only", although hospitals had to adapt their spaces into Covid and non-Covid areas. Even at the peak of the first wave, there were significantly more non-Covid inpatients than Covid inpatients. By the peak of the third wave, the proportion of non-Covid inpatients was considerably higher still*." (§5).

d) The general pattern of government decision-making during the pandemic was supportive of the NHS. Specifically, the DHSC/HMT met the costs of the additional needs that arose as a result of its response to the pandemic. That said, NHS England has noted that its request to expand overall bed capacity by up to 10,000 further beds, made in June 2020 was rejected (CWS §270 – 285). Thus, "*One caveat to this would be the decision in summer/Autumn*

[21] [INQ000251645] para 8.80.

2020 not to fund our proposed extra 'buffer' inpatient capacity in hospitals going in to winter 2020/21. The funding the NHS sought at this time to limit further impact on non-COVID health services was relatively modest compared with the sums the Government was spending overall on the pandemic response. When COVID-19 again took hold in October 2020 - March 2021, more patients had their non-COVID care disrupted than would otherwise have been the case." (SLS §61). NHS England recognises, however, that as the CWS noted that "*At that time, tackling community prevalence was a key Government priority and investment was needed elsewhere, for example, to establish Test and Trace*." (§276).

e) The UK's response to the pandemic was transformed by the development and deployment of vaccines. "*UK research and procurement decisions taken early in the pandemic meant that on 8 December 2020 the NHS become the world's first health service offering COVID-19 vaccination, and by mid-January we were able to vaccinate four times faster than people were catching SARS-CoV-2 [SLS22 - INQ000283162]. Further increases in vaccine supply meant NHS England was subsequently able to deliver the Government's target of offering vaccination to all adults a month early.*" (Lord Stevens, §45). The vaccine deployment programme was an ambitious programme, with obvious importance. It was also another form or example of the NHS 'surging' to meet further pressing needs, and it was not accomplished without some displacement of care, mostly in the primary care setting. Further, without undermining its success, timing of availability of the first vaccine meant the impact of the vaccination programme had a time lag such that it could not stop the high point of Covid-19 admissions in January 2021. Thus at that time, the NHS had to deal with both the peak of admissions and the roll out of vaccinations.

(4) The Maintenance of NHS Capacity to Treat

21. The Inquiry has been exploring what led to the decisions to lockdown and the importance of the Government's policy objective of maintaining the NHS's capacity to treat patients. It has also explored the practicability of knowing when such a point might occur.

22. The importance of ensuring that the NHS retained the capacity to treat patients who were in immediate need of healthcare (both for Covid-19 and for other conditions) was set out to the Inquiry by, for example, Sir Chris Whitty, who outlined both the direct and indirect consequences of the NHS being overwhelmed, noting that if this occurred it would have impacted on treatment for non-Covid-19 healthcare treatment needs as well as impacting on those who sought treatment for Covid-19. [22]

23. The perspective of NHS England is that the pressures on the NHS and its staff during Waves 1, 2 and 3 (including in April 2020 and in January 2021) were extreme, and the maintenance of capacity to treat presenting Covid patients was ensured only with the greatest of difficulties. It was achieved only through the remarkable dedication of NHS staff, as well as through the organisational steps taken to reconfigure and supplement hospital capacity. This includes the steps taken to relieve local pressures on healthcare services (hospitals, wards) that had or were reaching capacity, by diverting or transferring patients to centres where treatment could be offered. This required a detailed understanding of the pressures on each part of the NHS, and the organisational capacity to co-ordinate an NHS-wide response. It further implies that the ability of the NHS to maintain capacity to treat has to be assessed by looking at the service as a whole, given that the aim was to ensure that if even individual hospitals or wards had reached their limits, patient needs could still be met. NHS England understands that such transfers, or 'out of area' treatment, impacted on patients, staff and families and that this will be examined further in M3; but they were an essential means of maintaining the capacity to treat.

24. The Inquiry has sought to explore the robustness of the data presented on the imminence of the risk to NHS capacity, before the first lockdown in particular. Predicting the exact point at which the NHS could no longer treat all patients was

[22] Fourth Statement of Sir Chris Whitty [INQ000251645] at p115, §8.5, §8.6; see also his remarks in the press conference quoted at the bottom of p138 – 139. See also his oral evidence, Day 24 (22 November 2023), p60 lines 23 – p61, line 7.

complex, and understandably some witnesses have struggled to articulate what terms such as "overwhelmed" meant.

25. It is apparent that providing a precise date would have been very difficult, depending as it did not only on ongoing surge arrangements and accurate numbers relating to the number, geographies and demographics of community infections, but also the geographical spread of the latter (with London, for example, being amongst the cities hardest hit at an early point[23]). Ultimately, given also the limits of the infection data available and the speed of exponential growth,[24] forecasting a fixed date accurately would not have been possible. Sir Chris Whitty provided evidence on this, describing the effect of '*overtopping ICUs*', then continuing "*…the reason I would be very cautious about exact numbers is the reason that you have from Sir Patrick and others about doubling times. Because if your doubling time is, for the sake of argument a week, a week, therefore, is the difference between the ICU just coping -- define that as you will -- and having twice as many people as it can possibly absorb. Two weeks at the same rate and it is four times. So you've got a situation where you move -- you really have almost no margin for error*".[25]

26. He continued:

> *"… But once you're on an exponential growth rate, until you stop that exponential growth rate, you are going to be overtopped sooner or later. And our view was, at the rate we were going, it was going to be sooner. I think putting exact numbers on that is a slightly spurious exercise for a variety of reasons, but that principle that you move from -- you are just below your absolute upper end of your margins to well above it in a very short time, I think is the key to understand here."*[26]

[23] See for example the Minutes of the Covid-19 Ministerial Group Meeting of 21 March 2020, with its discussion of the state of ICU capacity in London [INQ000056263].
[24] See the evidence of Professor Chris Whitty at [TRANSCRIPT]
[25] Oral evidence, Day 24 (22 November 2023), p57 lines 20 – p58, line 7.
[26] Page 59, lines 7 – 17.

27. Professor Van-Tam explained how NHS capacity "*is a little bit fluid in terms of regions*", making a "*hard stop*" a "*bad expression*", but "*the NHS is nevertheless finite in the number of staff and the number of beds*". [27]

28. See, equally, the evidence of Mr Michael Gove.[28]

29. This does not mean that it was not obvious that any sustained epidemic was going to breach the limits; see, for example, the NHS England graphs of 1.3.20, the output of the 'data summit' of that date [INQ000087264]. This was appreciated from an early stage in February; see the evidence of Sir Patrick Vallance.[29] Or as Mr Gove put it "*Firstly, one did not need to know the precise nature of capacity within the NHS to be influenced by the broad argument that continued exponential growth would overwhelm it … There would be a level of growth that almost no health system could have coped with if the virus was left unchecked or if inadequate measures had been put in place.*" He also acknowledged the supply of information on this topic: "*Both before and after* [the COBR meeting of Monday 23 March] *I and other ministers sought information and were informed about the precise nature of the capacity constraints within the NHS.*"[30]

30. In relation to the issue of 'elastic' capacity and the difficulties of 'pinning this down', we further draw the Inquiry's attention to the evidence of Lord Stevens, in relation to the second and third waves, at §38- §42 of his witness statement. He pointed out:

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[27] Oral evidence, Day 24 (22 November 2023), pages 192 – 193.

[28] 28 Nov page 89-90: "*A. Several things. Firstly, one did not need to know the precise nature of capacity within the NHS to be influenced by the broad argument that continued exponential growth would overwhelm it. Q. Right. A. By definition. There would be a level of growth that almost no health system could have coped with if the virus was left unchecked or if inadequate measures had been put in place. Both before and after I and other ministers sought information and were informed about the precise nature of the capacity constraints within the NHS. And, again, when we talk about beds we have to recognise that for intensive care beds you need not just equipment but trained individuals: doctors, nurses, others. So NHS capacity constraints are driven by the number of specialists and by the equipment as well as by physical capacity as well. We may go on to talk about the Nightingale hospitals that were built. ….."*

[29] "*Oh, I don't think there's any doubt, if you look at the CRIPS in February, that the people understood the NHS could be overwhelmed. So I don't think that's a new understanding. I think the new understanding on the weekend of 14 and 15 March was that we were much further ahead in the pandemic than we realised, and the numbers that came in that week showed that there were many more cases, it was far more widespread, and was accelerating faster than anyone had expected.*" (20 November 2023 page 36, lines 7 – 22).

[30] 28 November, pages 89 – 91.

a) Although the two are linked, "the NHS not being overwhelmed" is not an accurate proxy for "minimising the number of lives lost". See further his oral evidence, in which he added: "*I personally do not think solely viewing the amount of Covid through the lens of whether or not there are NHS beds to cope for severely ill patients is by itself the right lens because, even with unlimited hospital capacity, if you have large amounts of coronavirus for vulnerable people, lots of people will still die*" (or would contract Long Covid, it may be added).[31]

b) In early Autumn 2020, "*we were not - at least initially - facing a binary switch from 'not overwhelmed' to 'overwhelmed'. Instead we had to consider a more graduated set of impacts, by care type and by geography.*" (See further his oral evidence at Day 17, p42 lines 6 – 17 which expanded this point).

c) There was a pyramid of escalation for care, and the ability to move patients from hospitals where capacity was stretched to other hospitals.

d) Neither of these matters were without consequences or costs, for patients or for staff. Lord Stevens also details further uncertainties at §42. But the evidence explains why capacity was not a fixed concept – although this is clearly not to say that it was infinite.

31. Throughout the course of the pandemic, the NHS also worked hard to retain capacity to treat non-Covid patients (see para 20 (c) above). Professor Sir Chris Whitty noted in his statement that both he and Professor Sir Stephen Powis emphasised that NHS remained open for emergency care in press conferences.[32]

32. That is not to say that the reconfiguration of NHS services was without consequences, or that individual Trusts or services did not, at times, reach the limits of their capacity and had to rely on 'decompression' measures to spread the demand for beds and healthcare services. Furthermore, as noted above, Lord Stevens has acknowledged that reducing deaths from Covid-19 is not the only measure of harm or success, and wider, indirect harms need to be considered. We

[31] Day 17, p42 lines 19 – 42.
[32] [INQ000251645] at para 8.29

expect that the collateral impacts and harms of the pandemic to be an important area of scrutiny and learning in the course Module 3, and look forward to any lessons that the Inquiry can offer on how such indirect impacts can be most effectively managed in any future crisis.

(5) NHS Resilience and Strengthening the NHS

33. NHS England gave extensive evidence about the state of the NHS at the start of 2020 in Module 1. Much of that evidence was repeated in the Corporate Witness Statement in M2.[33] The statement of Lord Stevens reflects on the overall picture and the impact of this issue at §60 - §68 of his Statement. We will not repeat its contents here, but the overall summary was as follows:-

> *"68. In summary, therefore, on the resourcing questions posed by the Inquiry I would suggest a balanced assessment might conclude:*
>
> *a) the Government did generally provide the NHS with the emergency funds needed at the start of the pandemic;*
>
> *b) the main NHS impacts of constrained funding in the prior decade were on its lower capacity and the extra pressure it created for NHS staff when covid hit, and on the operational constraints in running COVID-19 and non-COVID services in parallel. This is one reason why the backlog in delayed patient care is greater than it might have been, and why recovery is taking longer; however*
>
> *c) when COVID-19 struck, the health service - like those in a number of other countries - would probably still have been faced with difficult choices. The 'bottom line' is that sadly no country's health care system, however sophisticated, can ultimately withstand an out-of-control pandemic."* [INQ000280647 at p23].

34. His evidence represents, NHS England submits, a balanced assessment of the impact of, on the one hand, a stretched healthcare system and, on the other, the reality that even more resilient systems were challenged by the scale of the pandemic.

[33] To enable it to be accessible to M2 Core Participants.

Part 2 - Specific Issues Raised in Oral or Written Evidence

35. There have been a number of issues touching upon the NHS or NHS England raised in the course of Module 2. We have addressed the following matters of detail in this Part of the Submissions:-

    a) The NHS, and government decision-making structures;

    b) Social Care and Delayed Discharges;

    c) NHS information and data flows;

    d) High Consequence Infectious Diseases ("HCID"), and the declassification of the virus as an HCID;

    e) Hospital discharges and care homes;

    f) Inequalities, and the role of future modules in considering topics such as PPE and other protective measures for staff.

36. We are conscious of the fact that these topics are somewhat disjointed, but this reflects the Module 2 division between policy and the operational response, and the place of the NHS within that landscape. We look forward to providing further clarification of any points of interest within Module 3 or other relevant Modules.

(1) Government Decision-Making Structures

37. The witness statement of Lord Stevens contains reflections on the effectiveness of government structures at §12 to §18. NHS England has already noted that its position as the leader of the NHS response generally gave it access to DHSC and No.10 or CO decision-making structures. This is not to say that issues did not, on

occasion, arise. We have noted that the NHS England National Medical Director began to attend SAGE from 25 February 2020 at his request (although there was earlier receipt of minutes); this chimes with the evidence of Sir Chris Whitty that SAGE membership being arguably too small in the start, but expanded later on.[34]

38. These points were put in context by the observations in the CWS, which stated in the section on 'learning lessons': "*Pandemic response structures, such as SAGE, NHS England EPRR Cells, are 'activated' when needed, resulting in early teething problems. During the initial stages of establishing any new organisations or structures, there is a period of learning and identifying the most effective methods and people to proceed. …*" (§557(g), p140).

39. A further, more forensic observation arises out of the fact that Government administrative procedures were inevitably put under pressure in the pandemic. The great pace of activity in the early days of the pandemic inevitably led to some record keeping that was less well developed and/or circulated for review less frequently than would usually be the case, and so was more prone to error. NHS England has observed during the Module 2 hearings that it is often only through Inquiry disclosure that it has seen for the first-time minutes of meetings that its officials attended, although it would usually have expected such minutes to be circulated for checking. Some of these records therefore appear to be inaccurate or incomplete. Further, it has noted that on many occasions in the absence of formal minutes the Inquiry has had to rely on more informal notes, whether taken during meetings or later, again not necessarily fact-checked by those to whom they refer. The Inquiry may wish bear in mind, it is suggested, that such records are therefore less likely to reflect the perspectives or recollections of all who attended.

[34] Transcript, Day 23, 21 November 2023, page 45 lines 10 – 20.

(2) Social Care and Delayed Discharges

40. The Inquiry heard from Mr Johnson that decisions relating to the NHS and/or to lockdowns in the first wave were affected by the problem of delayed discharges.[35] It has asked whether it could be argued that delayed discharges somehow "forced" the first lockdown. This matter was clearly addressed by Lord Stevens, who wrote:

> *"The facts do not support this contention. The emergency influx of COVID-19 patients in March 2020 was projected to vastly exceed the number of beds blocked by delayed discharge. Furthermore, as a result of Government making legal changes to continuing care assessment processes and HM Treasury allocating earmarked funding for social care support there was a significant reduction in delayed discharges - yet even so, the Government decided subsequently to introduce two further national lockdowns. (It should also be noted that the changes Government introduced were not something either local authorities or local hospitals had the statutory or funding authority to bring about by themselves. The fact that these solutions had not been previously introduced was therefore self-evidently not because local councils, social care providers or hospitals had in some way "failed to grip" them.)"* (Footnote 9, p12, INQ000280 647; see also the transcript of his evidence at Day 17, p46 lines 9 – p47, line 16).

41. See, further, the report from Lord Sedwill dated 10 May 2020 [INQ000136756], in which he commented on the lack of excess capacity in the NHS and continued by identifying the structural weaknesses of the social care sector: "*This [i.e., NHS capacity limitations] was compounded by the inadequacies of a fragmented social care*

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[35] Oral evidence 7 December, page 201, lines 7 – 10: "*I think the fact that we had those delayed discharge patients was very, very difficult in the NHS. I hope that this Inquiry will give a kick to the powers that be to make sure that we really address that*." See also the written statement: para 331 [INQ000255836]: "*It was very frustrating to think that we were being forced to extreme measures to lock down the country and protect the NHS - because the NHS and social services had failed to grip the decades old problem of delayed discharges, commonly known as bed blocking. Before the pandemic began I was doing regular tours of hospitals and finding that about 30 per cent of patients did not strictly need to be in acute sector beds*"

system, which, as we know from Brexit lobbying, is over-reliant on low paid immigrant labour. The most obvious symptom was the thousands of vulnerable elderly (disgracefully labelled 'bed-blockers') who, through no fault of their own, were stuck in hospitals as the pandemic approached." (§4). He argued that reform was needed to both the health and social care sectors. Regarding fragmentation, we have already highlighted in these Submissions the effect of the lack of a central national organisational resource for the social care sector, in contrast to the statutory arrangements establishing NHS England as a central and independent voice for the NHS.

42. NHS England noted in its evidence for both Module 1 and Module 2 that it has long sought reform, including increased funding, of the social care sector, not least because of the interdependencies between health and social care.[36] In this Module, Lord Stevens set out his personal views on the approach needed:

> *"... it needed to be not just about ensuring that people didn't have to sell their homes but also that the availability of social care increased and that the social care workforce was addressed. I was clear that I didn't think this could be done just as a private Whitehall process, a sort of behind the bike sheds agreement between ministers, it had to be a public open process. And ideally, if it was going to create a national consensus, so social care reform actually got done, it needed to be on a cross-party basis. That was the basis on which I suggested action was required." (Oral evidence, Day 17, page 27 lines 1 - 11).*

(3) NHS Information and Data Flows

43. Both during the oral hearings, as well as in written statements, the issue of the quality of data and its availability to decision-makers was often raised. NHS England did, as requested, supply information relating to hospital capacity and usage to inform central Government planning and decision-making. Its ability to do so, and to do so on an 'automated' basis, without the need for manual uploads or refreshes, improved throughout the course of the pandemic as information-sharing systems were built at pace.

[36] See CWS at p140, §557(c) - (d).

44. Generally, NHS England's approach to data and modelling specific to Covid-19 and within the scope of Module 2 is addressed within paragraphs 214 to 244 and Annex 10 of the NHS England Corporate Statement (including the establishment and development of the Daily Covid-19 SitReps; §235 gives a focussed timeline of their development and their sharing with DHSC and others). This included daily collection of data for SitReps through the Strategic Data Collection Service (SDCS) run by NHS Digital from 19 March 2020, which was sent to a wide circulation list including the CMO and the DHSC (§237). A daily 'dashboard' was first commissioned by the Cabinet Office on 14 March 2020; NHS England was responsible for inputting data on the number of Covid-19 cases admitted to hospital and deaths by NHS Region, as well as a high-level summary of the impact on the health system (§238). Cabinet Office and Number 10 had direct access to NHS England's Strategic Decision Makers Dashboard from or around 25 March 2020 (§239).

45. Prior to the pandemic, the data routinely collected by NHS England was focussed upon that which was reasonably necessary to discharge its functions as a commissioner (CWS, §216), Lord Stevens has noted that "*Going into the pandemic, the NHS was therefore already publishing more granular and more timely information on its hospital bed availability and usage than probably any equivalent country in the world. Nevertheless, the unique operational management requirements of the pandemic meant that new data feeds and systems were needed.*" He added: "*The fact that at the time it was not possible automatically to 'pipe' real time information on patient case mix and capacity should not have come as a surprise to ministers because in the years before the pandemic DHSC/NHS proposals to invest in giving all NHS hospitals modern electronic health records and nationally-networked clinical information systems had been repeatedly rejected or scaled back in successive Treasury Spending Reviews.*"

46. Lord Stevens continued: "*PHE's CHESS process for tracking inpatient numbers [SLS12 - INQ000283160] was supplemented initially by manual daily data submissions, which were then upgraded and automated in the second half of March once the number of COVID-19 patients began to increase. This was greatly facilitated by new data capabilities*

and platforms (particularly Faculty and Foundry) [SLS13 - INQ000283202] and by the Secretary of State's removal of legal impediments to data sharing via his "COPI" notices." (§27, [INQ000280647]).

47. Addressing the issue of data flows further, first, any suggestion that the NHS '*did not know how many beds it had*' is inaccurate.[37] The 'Sit Rep Spreadsheet' of 17.2.20 exhibited by Lord Stevens ([INQ000283193], and see his statement at §27 [INQ000280647]) provides an illustrative example of the granular detail that was not only available to NHS England but was also published weekly on NHS England's website across (relevantly) the winter of 2019/2020, to 1 March 2020. The detail includes figures on (i) General and Acute Beds, including the "escalation beds" being provided at that date; and (ii) the capacity in ICUs.[38] The figures are broken down to Trust level.

48. Second, some of the difficulties experienced by NHS England were a product of the limitations of the tools available at the time. Thus, Sir Chris Wormald wrote in his Third Witness Statement [INQ000144792] that "*In these early stages, data quality and returns provided to NHSEI were challenging and difficult to use, particularly due to low or non-availability of testing data (for example in respect of regional and national hospital admission rates) which in turn meant that informed policy making was difficult for officials and ministers.*" (§86). It is apparent that the root cause of this difficulty was the limited availability of tests for Covid-19 – prevalence could not be accurately or timeously tracked when tests were in scarce supply.

49. Third, and with regards to data sharing upon NHS capabilities and capacity, NHS England did respond to requests for information from central government, often through GO-Science. For example, following the National Medical Director's first attendance at SAGE on 25 February 2020, there was extensive and immediate work

[37] We note that when Mr Johnson gave oral evidence, the suggestion in his written statement that "*the NHS did not know how many beds it has there were in the whole organisation*" (see INQ000255836 at §239) was transformed into "*we did not know how many beds the NHS had*" (Day 6 December 2023, p158, lines 11 - 15).

[38] The figures are still available at https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/winter-daily-sitrep-2019-20-data/; they show that for example the figures for the week of 17 - 23 Feb were published on the website on 27 February.

to collaborate with CMO, GCSA and SAGE/SPI-M-O on modelling. The 'data summit' of 1 March 2020 has already been described above; it took place as a joint initiative agreed by the GCSA and the NHS England National Medical Director, the latter having equally well identified the need for this action.[39] The outcomes of this meeting were immediately made available, on the same day, to the GCSA, CMO and DCMO (see email at [INQ000087263], exhibited at para 351(h) of the NHSE Corporate Witness Statement [INQ000116811], showing when the data was sent and referring to the need to input into the COBR meeting of 2 March 2020, as well as the modelling output itself at [INQ000087264]). The Inquiry may wish to examine the graphs at [INQ000087264] which show the anticipated scale of the challenge to the NHS, both with and without mitigation.

50. NHS England acknowledged however, in its Corporate Witness Statement, the challenges faced, particularly in the early stages of responding to the pandemic: *"Good quality data is vital to an effective pandemic response. Early in the pandemic, however, there was both a proliferation of separate data summaries from different organisations, shared in different formats and gaps in acquiring the information that mattered. New data acquisition at speed was extremely challenging. Huge progress had to be made rapidly at the start of the pandemic to identify, collect, collate and present the information required. These efforts, particularly those led by the Joint Biosecurity Centre's team for data acquisition, went a long way to facilitating swift data sharing but they had to be done whilst responding to the pandemic." [CWS para 557(e)].*

51. Further, whilst modelling on NHS capacity was important, it did not answer questions about where the UK was along the epidemiological curve. This was a question which depended on information about prevalence (coupled with doubling times, etc). NHS England was not the body responsible for tracking the known prevalence of the virus and its rate of spread. As Lord Stevens stated, "*In terms of the Government's situational awareness, PHE took the lead from January 2020 to*

[39] The email of 27 February 2020 [INQ000195863] explicitly acknowledged that "*.. Steve Powis has now grasped it…*"

mid-March 2020 for daily Sitreps reporting the number of COVID-19 cases in the UK." (§22, [INQ000280647], see also the CWS at §235(a)[40]).

52. The key challenges experienced in determining when to extend NPIs were the product not of limitations in the models developed, but rather of the completeness of the underlying data on the number of infections and thus the immediacy of the threat. As Lord Stevens wrote in his Statement: "*Modelling presented to SAGE suggested that without some combination of countervailing action and behavioural change the number of COVID-19 deaths might over a period of time exceed 500,000, and even with the greatest feasible expansion and repurposing of hospital capacity the number of patients could vastly outstrip its availability. But it was unclear how imminent that threat was. That is because the lack of national public health SARS-CoV-2 prevalence testing and community surveillance during February and much of March 2020 meant that the UK did not know how many people actually had SARS-CoV-2 infection.*" (§22, [INQ000280647]; see too §23 - §25 making the point that this problem was compounded by similar problems in other European countries at the time, and the limits of hospital inpatient figures, as a "lagging indicator").

53. We note that Lord Stevens flags how, subsequently, "*important public health surveillance systems were put in place by DHSC/UKHSA including the ONS COVID-19 Infection Survey [SLS07 - INQ000283166] and the Imperial College REACT study [SLS08 - INQ000283167]. 'Early warning system' capabilities such as these (with associated genomic sequencing) are critical defences in the UK's future pandemic preparedness*" (§26).

54. Dealing further with one issue on data that arose in the course of hearings, that of hospital admissions and infection data in the Summer of 2020: the witness statement of Mr Sunak [INQ000263374] suggested at §95 that there were inaccuracies in NHS hospital admissions data which impacted on policy decisions, as errors inflated the numbers of those thought to be infected. At §96 it was suggested that nosocomial (i.e., hospital acquired infections) may have driven

[40] §235(b) adds that "*Between 10 and 16 March 2020 NHS England's existing Sitrep reporting was expanded to include numbers of patients with Covid-19 and of which how many were in HDU or ITU beds. These were shared with DHSC*".

rates of community infections in the early summer of 2020. These matters were addressed in the statement of Lord Stevens: *"For example, the SAGE meeting of 4 June 2020 suggested "Potentially one third to one half of hospital admissions labelled as Covid-19 admissions are readmissions or not acute Covid-19 disease". On investigation, the NHS National Medical Director showed that was not correct, and readmissions were in fact ≤5%, which was then reflected in SAGE minutes of 23 June 2020.… modelling suggestions around that time that nosocomial infections §were a major driver of overall national infection levels were subsequently assessed as inaccurate by the first comprehensive national records-linked study. It concluded that fewer than 1% of national COVID-19 cases during March to August 2020 could be attributed to nosocomial transmission. Even confining the analysis to the subset of laboratory-confirmed COVID-19 cases, it estimated that in June 2020 the figure was ≤4.8% of overall cases."* (Footnote 2, p4 [INQ000280647]).

55. None of this is to deny the point which was made in Lord Stevens' statement, that the needs for data were unprecedented and systems had to be built at speed (eg Dashboards); there were also information law issues that had to be addressed (through the issue of COPI[41] notices by DHSC); but NHS England worked hard to supply what was needed.

(4) HCID and its declassification.

56. The definition of a HCID is set out at §91, together with an account of the work undertaken,[42] predominantly in February 2020, to stand up English HCID capacity for Covid-19 patients, including the work to "surge" this capacity, and the warnings given at the point at which it became apparent that the HCID capacity would no longer be sufficient (§166, §210). On 19 March 2020, the decision was announced that the virus would no longer be treated as an HCID. The Government took its decision after consideration by PHE and the other public health bodies in the UK and a recommendation from the Advisory Committee on Dangerous Pathogens ("ACDP") on 13 March 2020; see CWS §211.

[41] The Health Service (Control of Patient Information) Regulations 2002, see CWS §216.
[42] CWS §92, §106, §139, §166, §180.

57. Issues raised in the course of M2 have been (i) whether the declassification of Covid-19 was appropriate,[43] given the deadly nature of the pandemic; and (ii) potential links between this decision and revised IPC Guidance of (eg) 13 March 2020, and the adequacy of the same.

58. As to the first issue, the evidence of Sir Peter Horby included a clear explanation of the rationale of declassification:

> *"So the purpose of the classification is to mitigate the risk of transmission, either from patients to other patients, healthcare workers or visitors to hospitals, and to mitigate the risk of infection in a laboratory, of laboratory workers or escape from the laboratory. Now, that only makes sense as a measure if there's not already widespread transmission of the virus. Once you have the virus in the community, then those measures make a lot less sense. In fact, they're counterproductive, because they inhibit your ability to manage patients and to do laboratory diagnostics, for example… it would have been counterproductive .. to have maintained that classification."* [44]

59. Further, plans for the mass infections inherent in a pandemic would inevitably envisage that when infection levels hit a certain point, care would move beyond

[43] See for example the oral Submissions of FEMHO on 4 October or those of the Covid-Bereaved Families for Justice on 13 December 2023.

[44] Day 12 (18 October 2023): see pages 161, line 6 - p163, line 7 for the full evidence. See also the witness statement of Yvonne Doyle [INQ000273878] at §32 for the consequences of designation as an HCID, on diagnostic testing: "*The initial limitation of available laboratories for testing was not as a result of PHE pursuing a centralised testing approach … but as a result of a joint decision taken by senior public health specialists at a time when very little was known about this emerging pathogen*." Sir Chris Whitty also addressed the topic at [INQ000251645], §7.47 - §7.50 (classification) and §7.87 - §7.89 (declassification) and in oral evidence on 22 November 2023, at pages 81 -84.

the HCID centres. It was never intended that the small number of HCID beds would be sufficient for a pandemic.[45]

60. As to the second issue, it is right that the declassification had an immediate impact on the level of PPE required. But NHS England's understanding was that the primary basis of the decision was that the Case Fatality Rate did not support the continuing classification [INQ000087332]. However, it is apparent that the topic of developing knowledge of aerosol transmission and of IPC guidance is a complex one which must be for more detailed exploration during the course of M3.

(5) Hospital Discharges and Care Homes.

61. Mr Hancock's oral evidence discussed decisions Government took on testing and freeing-up hospital capacity in England in March and April 2020, and its engagement with care homes and the wider social care sector; similar decisions were taken in Scotland, Wales and Northern Ireland. The matter was extensively explored by the High Court of England and Wales in the case of *R (Gardner and others) v Secretary of State for Health and Social Care and others* [2022] EWHC 967 (Admin). The Inquiry is not bound by those findings, but it is submitted that they provide a useful reference point. See also:

    a) §36 of the Statement of Lord Stevens, which cites the Court's judgment accepting the reasonable nature of the decisions taken within the NHS;

    b) The fourth witness statement of Professor Sir Chris Whitty [INQ000251645], who at §7.128 - §7.133 explains "*why I thought at the time, and continue to think, that this was a prudent decision in which there were both risks in doing nothing and*

[45] See the Government's 3 March Coronavirus Action Plan [INQ000182380] at §4.11 – 4.12 (p13). The Second NHS England Module Corporate Statement in M1 (on HCIDs) explained that with the number of cases identified in early March 2020, even with urgent HCID bed expansion plus assistance from several specialised Infectious Diseases services providing surge capacity, diagnosed cases had exceeded the available specialist HCID beds. A revised model adopted in early March used HCID/Infectious Diseases units to provide support and advice to other hospitals through a structured geographical approach, with patients treated in their own healthcare systems. (Second Witness Statement of Dr Michael Prentice, §90 - §92 [INQ000184893], M1). Previously, Previously, during the NHSE and PHE HCID Programme (2016-2018), pandemic influenza was explicitly excluded from HCID preparedness efforts, accepting that cases of a novel avian influenza outbreak may be treated as an HCID initially, but then pandemic influenza plans would take over. This is analogous to what happened with COVID-19.

risks in acting, but where doing nothing in my view carried the greater risks". Further, at §10.11 – 17 he discusses the practical realities regarding the (non) availability of tests and their limitations, including both the delay before receiving test results and that a negative test did not guarantee that a patient was not infectious (having been incubating the disease or subsequently acquiring). [46]

62. The Inquiry will be aware that, first, the guidance applied to all patients who were medically fit for discharge - care home residents would have been a small proportion of these only. We note that there was some potential confusion on this issue in questions to Lord Stevens on Day 17, where it was suggested in questions that the policy was intended to "*to free up hospital beds over 30,000 patients were expected to leave hospital into social care imminently*", quoting Cabinet minutes of 17 March 2020 [INQ000056135/8]. Reference to the NHS England "Next Steps" guidance of 17 March 2020 (see [INQ000087418]) reveals that some 15,000 hospital beds were expected to be freed up by reducing delays in patients leaving hospital, with community health providers to make urgent arrangements for social care for those who needed it.[47] Thus, some of these 'long-stay' patients would not need social care; others would receive care in the community; only a proportion would be expected to be discharged to care homes (either because they were formerly resident there, or because – for perhaps 5% of patients - care outside of their homes was commissioned on discharge).[48] The intent was not to increase the overall numbers of patients leaving hospital and entering care homes. Instead it was simply to reduce the delays patients experienced in leaving hospital when they no longer clinically needed to be there.

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[46] This is not an exhaustive list of references. The Inquiry will be aware of other evidence, for example Professor Van-Tam [INQ000269203] at §9.15 "*.. it was always going to be extremely difficult to keep infection out of care homes; and in my view, the only way of doing that was probably to require workers to live in the home in which they worked for an extended period of time*".

[47] A further 12,000 – 15,000 beds were expected to be freed up by postponing elective capacity; and further capacity was to be created by buying up independent sector beds and freeing up community and intermediate care beds. (see p2 – 3 of the Letter).

[48] For the figure of 5% who were expected to be unable to return to their homes and might need a commissioned bed for ongoing care, including in a care home, see para 2.5 (p7) of the Covid-19 Hospital Discharge Service Requirements, 19 March 2020 [INQ000049702].

63. Second, as set out above, medical discharge was to be supported by arrangements made locally for appropriate social care support.

64. Third, PCR testing capacity (as well as PPE) was extremely limited at that time, and testing priorities had been set by PHE on 11 March 2020, approved by the Secretary of State (§187, §329 - §330[49]).

65. Fourth, as Sir Chris Whitty explains, hospitals with large numbers of COVID-19 patients inevitably also posed a risk to those awaiting discharge; and hospital capacity was needed to ensure the continued ability to treat all patients who needed such care.

66. We note that these issues are linked to the emergence of information about the characteristics of the new virus, and to understanding of the risk of asymptomatic transmission. However, given that NHS England derived its understanding of the virus and its characteristics from expert bodies such as PHE (which also led on IPC measures), we have not separately addressed this issue here.

67. Given that these issues are likely to be the subject of further exploration in both M3 and M6 (scrutiny that will no doubt consider the issue of potential isolation facilities outside hospital, see *Gardner*), NHS England does not make further submissions on this at this stage.

(6) Inequalities - Healthcare and Future Modules

68. We recognise that the pandemic laid bare fault-lines based on existing inequalities and, at times, exacerbated them. As the CMOs' Technical Report acknowledged, "*Infectious disease epidemics and pandemics usually expose and exacerbate existing disparities in society, such as those associated with deprivation, ethnicity, sex, age and sexuality*"[50] and this pandemic was no exception. NHS England is keenly aware of those staff who lost their lives on the frontline, including early (and continuing) deaths amongst the ethnic minority community.

[49] "*Given the constrained testing capacity, PHE's testing prioritisation was accepted for the time being by the CMO, DCMO, and senior clinicians in PHE and NHS England and endorsed at a meeting with the SSHSC on 11 March 2020*" (CWS §330).
[50] Chapter 2.

69. The Inquiry has heard evidence on these topics during the course of M2. The evidence of Mr Ade Adeyemi on 6 October 2023 raised the issue of race and ethnic inequalities within the NHS. The Closing Submissions on behalf of FEMHO included the statement that the stark statistics on early deaths, from Covid 19-related causes, of members of ethnic minorities, "*reflect the harsh reality of a healthcare system that perpetuates inequality*.[51] The matters covered by FEMHO's evidence and Submissions are important ones, requiring attention and careful investigation. However, it is the understanding of NHS England that – insofar as they relate to the response of healthcare systems to the challenges of the pandemic - they are matters which the Inquiry intends to explore in Module 3 (and Module 4). NHS England was not asked to address structural health inequalities in its Corporate Module 2 statement (although there is some material on the topic in the Personal Statement of Lord Stevens, please see below). The Corporate Statement further noted that: "*Certain aspects are dealt with at a relatively high level as we understand that many of the issues to be discussed may be addressed in greater detail at a later stage in the Inquiry*." (§23). Findings on issues related to healthcare systems should, therefore, await the fuller consideration of the issues that will take place.

70. However, it may be helpful if we comment on specific points made about the NHS response by Mr Ade Adeyemi in his evidence, on 6 October 2023, when he referred to:

    a) The letter dated 7 April 2020 that the British Association of Physicians of Indian Origin (BAPIO) sent to Professor Chris Whitty, Professor Steven Powis, Mr Duncan Selbie, Mr Danny Mortimer, Mr Niall Dickson and Sir Simon Stevens [INQ000148476];[52]

    b) The conduct of NHS staff risk assessments (transcript page 99 line 3- page 102 line 12).

    c) The suspension of Workforce Race Equality Standard ('WRES') data collections (transcript page 98, lines 2-21).

[51] Day 35, December 14 2023, page 4 line 4.
[52] 6 October 2023, Page 91, line 24 – page 95 line 3.

71. As to these specific points:-

a) A reply to the letter of 7 April 2020 was sent to BAPIO by Mr Duncan Selbie, dated 20 April 2020 and copied to all the recipients of the 7 April letter, as well as additional recipients. A copy has previously been supplied by NHSE to the Inquiry. The letter sets out some of the steps taken by that stage; see, on this the "Friday Message" from Mr Selbie of PHE dated 24 April 2020 [INQ000320620], although further steps were also taken.

b) Thus, the NHS Corporate Statement explains how on 9 April 2020 the NHS England's National Medical Director led an item at CMO's senior clinicians' meeting on the impact of Covid on ethnic minorities, during which the Chief Nursing Officer raised the issue of ethnic minority staff deaths. The CMO asked PHE to lead on looking into the wider issue of the impact of COVID on the different groups (§417). The statement of Lord Stevens explains how on 15 April 2020 he convened a 'summit' of stakeholder groups and staff representative organisations in the light of emerging concerns.[53] This was followed on 29 April 2020 with a letter from NHS England to all NHS employers setting out further action they should be taking [INQ000087412]. The letter referred to the PHE investigation that had been commissioned and recommended that, in advance of its conclusions, employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly. The 'whole system letter' was in effect the most directive approach that NHS England could take in the 'Level 4' incident with all trusts (not strictly having legal powers of direction). This direct approach was taken only in the most serious circumstances.[54]

c) Lord Stevens further explains how, working with NHS England, NHS Employers published additional guidance for NHS organisations including

[53] See too the further BAPIO letter of 22 April 2020 [INQ000120826] which acknowledged that in response to its letter of 7 April 2020, Sir Simon Stevens launched a review meeting.
[54] For example, in the letter to all NHS trusts issued on 17 March 2020 setting out the Next Steps on NHS Response to Covid 19 [INQ000087418].

on staff risk assessments.[55] This sat alongside guidance PHE had developed on PPE and other protections for NHS staff. This work was reinforced by wider advice from a national expert group on reducing race and ethnicity-based inequalities in health services during the pandemic.

d) Lord Stevens also discusses the decision, announced on 30 May 2020 to establish and fund the NHS Race and Health Observatory, hosted by the NHS Confederation (see para 52 of his Statement). The aim of the Observatory was to identify and tackle the specific health challenges facing people from ethnic minority backgrounds, with the aim of offering analysis and policy recommendations to improve health outcomes for NHS patients, communities, and staff. (See the statement of Lord Stevens at §46 – 53).

e) In relation to WRES data collection, it is correct that WRES data collection was suspended on 1 April 2020 owing to the unprecedented pressure faced by NHS providers at that time. However, collection was restarted on 20 May 2020, given the critical importance of workforce equality issues. WRES is not a 'real time' data collection, and the short suspension did not impact upon the ability to identify and mitigate unequal impacts of Covid-19. WRES reports continued to be published, in each of 2020, 2021 and 2022. The reports are available online.[56]

72. In addition, the Inquiry has received evidence on matters related to at-risk and other vulnerable groups in the NHS Corporate Statement (§414 - §417); there is also an account of NHS England's contribution to the shielding programme. We also note the points made by Professor Sir Chris Whitty [INQ000251645] at Section 11 (p201 onwards), including that: (1) whilst it was predictable that there would be significant structural inequalities in the health outcomes for Covid-19, it was not entirely predictable which groups would be most at risk (§11.8); (2) the principal

[55] Risk Assessment Guidance issued 30 April 2020; and a Risk Reduction Framework published on 12 May 2020 (copies available on request but to be exhibited within the M3 evidence).
[56] Workforce-Race-Equality-Standard-2020-report.pdf (england.nhs.uk); Workforce-Race-Equality-Standard-report-2021-.pdf (england.nhs.uk); NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts.

means of optimising safety for those from minority communities employed in public-facing roles, including healthcare workers, was to optimise safety for all (§11.13); and that (3) the nature of what would have been effective countermeasures relating to many of Covid-19's unequal impact is less clear than the existence of those differential impacts (§11.14).

73. **PPE**. The adequacy of Personal Protective Equipment (PPE) available is, we understand, a matter for M3. However, in the context of inequalities, the question of PPE scarcity was raised with specific regards to availability and fit-testing for (i) those with religious requirements that might mean that they had beards or wore turbans, and (ii) small people, particularly women.

74. As Lord Stevens stated, in response to questions about a stocktake of PPE in January and February 2020, "*Public Health England was responsible for creating and overseeing the PPE stockpile*."[57]

75. The issue of the rules and responsibilities regarding fit-testing prior to the pandemic, and during it, is a complex one. It engages duties under 2008 Health and Social Care Act and the work of agencies such as PHE, the MHRA and the HSE. NHS England is preparing evidence on this issue for Module 3; it would be wrong to rehearse such evidence now.[58]

76. Focusing on the intersection of these issues with central government decision-making and the evidence that the Inquiry has heard to date, the Inquiry heard from Ms Helen MacNamara [INQ000273841] §104. She referenced a specific concern around inadequacies of PPE for women's bodies. Lord Stevens gave oral evidence

[57] Day 17, p54 lines 4 – 9.
[58] We note that Lord Stevens was asked about these issues during Core Participants' questions on Day 17; NHS England is providing answers through its evidence to Module 3.

in response, referring to [INQ000088643] and outlining the steps that had been put in hand by that date.[59]

Future Modules, and Healthcare Topics.

77. We have noted that issues relating to fit-testing, and PPE more generally, will be considered in the course of Module 3. Similar considerations apply to the questions that have been raised on aerosol transmission and IPC guidance, as well as the use of DNACPRs during the pandemic.

78. Further topics that have been touched upon during the course of M2, but will be investigated more fully in future Modules include that of Long-Covid. NHS England submitted a supplementary Statement on this topic from Professor Sir Stephen Powis [INQ000232195] outlining the NHS response. The Inquiry is referred to this statement, which includes evidence on the following matters:

    a) Involvement in decision-making on NPIs: as set out above, NHS England was not a decision maker on NPIs and their impact, either in relation to Covid-19 or in consideration of potential impacts with regards to Long Covid;

    b) A summary of the evolution of NHS England's understanding of the condition (Section 1);

    c) A brief outline of the services commissioned to support and meet the healthcare needs of those with Long-Covid, beginning with the 'Your Covid Recovery' online resource, work on which began in May 2020 and which was launched in July 2020 (§44-45), and developing into the five-part package of measures announced on 7 October 2020, and then the Long Covid Plan, which has continued to evolve (§53 et seq). The account is brief, given the focus of Module 2, but demonstrates that within 10 months of the Covid-19 virus arriving in the UK, NHS England had a nationally commissioned

[59] Day 17, p49 line 12 – p51, line 16. [INQ000088643] is the minutes of the Covid-19 Strategy Ministerial Group dated 30 April 2020, at which Lord Stevens is minuted as saying that "*There was ongoing work to investigate the suitability of PPE for all those using it, and testing to make sure it was suitable for women, those who are Black, Asian and minority ethnic (BAME) and those with different face shapes or facial hair.*" (p7).

service in place for those suffering from Long Covid, which was one of the quickest responses in the world.

Conclusion

79. We look forward to offering further assistance to the Inquiry, most immediately in Module 3 which is scheduled to start oral hearings this autumn.

NHS England

15 January 2024