OPENING STATEMENT ON BEHALF OF NHS ENGLAND
MODULE 3 OF THE UK COVID-19 INQUIRY

Introduction

1. These are the Opening Submissions for the Covid Inquiry's Module 3 from NHS England. In it we address: (i) the suffering caused by the COVID-19 pandemic; (ii) the response of the NHS and the role of NHS England; (iii) challenges for the NHS, as the pandemic struck; (iv) learning from what worked; and (v) the challenges of recovery.

2. NHS England[1] has existed since 2013. It is the body that co-ordinates the provision of health care services in England and had the responsibility of leading the emergency response of the NHS to the pandemic within England. It is separate from government but answerable to the Department of Health and Social Care, Parliament and the public in many ways. Whilst NHS England is not "the NHS", we have tried to reflect on aspects of the unprecedented and sustained NHS response to the pandemic in these opening comments.

3. NHS England believes that being a learning organisation is a vital part of its character and make up. Improving the provision and experience of care, as well as the experience of working in the NHS, is central to its mission. Over the course of the pandemic, teams have periodically taken stock, seeking to identify and learn lessons from their response, so that they can adapt and improve their approach. NHS England sees this Inquiry as critical to not just being prepared for future pandemics, but also to improving patient care now. We share the Inquiry's desire to learn from past mistakes but also to learn, we hope, from what went well, so that the NHS can continue its mission to improve and innovate. We trust this is demonstrated in the thorough approach we have taken to our statements and other evidence. We reaffirm our commitment to place the public interest over organisational reputation and will continue to support the Inquiry openly and candidly.

4. When SARS-CoV-2 was identified in early 2020 it was clear that its spread would require a rapid response. By 30 January 2020 NHS England had declared a Level 4 Emergency, the highest level of response of the service to an emergency. All NHS England, Regional and National teams stood up response arrangements: over 30 dedicated national expert cells were set up with staff from across the organisation redeployed to support them; and a new decision-making and management architecture was introduced, informed by

[1] During the period of the pandemic, NHS England and NHS Improvement became known as NHS England and this Statement uses that term to refer to the joint organisation.

new data flows. On 11 March 2020, the World Health Organization formally declared the current COVID-19 outbreak as a pandemic. By mid-April 2020, the NHS in England was treating nearly 19,000 COVID-19 positive patients in hospital, with almost 3,000 on mechanical ventilation, and the country was in lockdown. By the end of September 2022, there had been nearly 20 million cases in England.

5. The NHS remained at or near the highest level of alert until 18 May 2023 (after the Relevant Period of this Inquiry), when the COVID-19 "incident" was finally stood down. Such a sustained incident – or more accurately, a continuing series of incidents – inevitably stretched the service and the people that provide it to their limits. The NHS, like the country and in common with other countries across the world, is still recovering from the pandemic.

6. The NHS responded to the pandemic whilst facing several challenges which predated the emergency and impacted the resources it had. Coming into 2020 there was little flexibility in the existing capacity to respond to a rapid and significant surge in demand. This affected not only the NHS' ability to respond to the pandemic, but also its ability to recover. It has been thanks to the skills, compassion and dedication of staff that the NHS continued to provide routine care as well as caring for Covid patients.

7. NHS England always works with its partner organisations, including the Department of Health and Social Care, national organisations such as NHS Digital, NHSX and Health Education England (who are now part of NHS England), the UK Health Security Agency (formerly Public Health England), the devolved administrations of the nations of Scotland, Wales and Northern Ireland, local authorities, and other government departments, public bodies and stakeholders.

8. Collectively, these organisations weighed, made and supported countless choices to try and mitigate the most harm. At least with hindsight, some decisions may have been taken differently. Others could have been made more quickly or more effectively. But for many decisions that presented, there were no good outcomes. There were a number of possible options, but none without costs and harms associated. Throughout this Module in particular, we would ask the Inquiry to consider not only what information and resources were available at the time but also the potential impact of different choices or counterfactual scenarios – not just on those immediately affected, but on the wider population, services and staff.

Suffering Caused by the COVID-19 Pandemic

9. At the start of this Module, NHS England wishes to acknowledge the pain and suffering experienced by so many in this country – and worldwide – because of the pandemic. Many suffered death, or bereavement, pain and loss: official UK

figures put the number of deaths involving COVID-19 in the four nations of the UK at over 225,000 by June 2023.[2]

10. Suffering and pain were caused both by the direct experience of infection with COVID-19 and its long-term after-effects, and by the secondary effects of the pandemic. These indirect effects were multiple. They include the impact on the mental health of the population caused by lockdowns and isolation; the pain suffered by NHS patients and their families when, for example, they were not able to visit family members in hospital; and the acute stresses experienced by NHS staff: for example, those who were redeployed to overstretched ICU wards with inevitably limited training in Covid care. The effects further include damage caused by ill-health that was undiagnosed or untreated during the pandemic as services were reprioritised to provide emergency care, and as members of the public became understandably reluctant to come forward for treatment. As the Inquiry noted in its Module 1 Report, the backlog for treatment has now reached historically high levels. [3] We fully recognise that the response to COVID-19, placing as it did extraordinary pressures on the NHS and its staff, has also impacted significantly on the experience that patients, their families and loved ones have had of NHS treatment and care.

11. These brief, opening remarks cannot summarise all the many and varied impacts, which is why we supported the Inquiry in its early work to launch Every Story Matters. We recognise also that everyone reading or listening will have their own experiences and memories. But, as an organisation at the centre of the healthcare system's response in England, we know that, despite the concerted efforts made to mitigate the pandemic's effects, many – both patients and staff – suffered greatly.

The Response of the NHS

12. The scale of the NHS response to the pandemic was huge. By February 2021, as Wave 2 was subsiding, an NHS England Board paper noted that: "*...the NHS in England has cared for over 380,000 Covid-positive patients with around one person with the virus admitted to critical care every 30 minutes, inevitably impacting on other areas of patient care. At the peak of the pandemic in January 2021, around 4,000 Covid patients were being looked after in critical care every day. In order to ensure that all those who needed critical care received it, hospitals expanded critical care capacity by around 50% above their usual ITU capacity, with some areas surging to over 80% above their usual capacity. The NHS has provided 26,476 Covid-19 patients with the most intensive level of care since the first case was diagnosed.*" [4]

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[2] UK Covid-19 Inquiry Module 1 Report page 7.
[3] UK Covid-19 Inquiry Module 1 Report page ix: "*The impact on the NHS, its operations, its waiting lists and on elective care has been similarly immense. Millions of patients either did not seek or did not receive treatment and the backlog for treatment has reached historically high levels.*"
[4] [INQ000087492].

13. It is right that the Inquiry hears from those who suffered from the pandemic, both patients and NHS staff. It is also important to learn from the efforts made across the whole of the NHS to maintain services, secure vital medicines, and create bed capacity to ensure people continued to receive care and therapeutics during a global pandemic, as well as to protect the many millions by the vaccination campaigns which will be considered in Module 4.

14. Alongside the care of Covid patients in hospital settings, vital efforts were also made across NHS services to protect communities from the virus and attempt to sustain routine non-Covid care. The NHS was never a Covid-only service:

    a. In hospitals across the NHS in England as a whole, even at the peak of Wave 1 and Wave 2, there were significantly more non-COVID-19 in-patients than COVID-19 in-patients. By the peak of Wave 3, the proportion of non-COVID-19 in-patients was considerably higher still. Nearly 20 million people continued to receive emergency care in England's A&Es in 2020.

    b. Primary care services, including GPs and community pharmacists, made rapid and life-saving adaptations to the way they worked during the pandemic, to enable continued access to care. This included pooling resources to establish Covid-specific environments to care for patients face-to-face, helping to deliver the COVID-19 vaccine to millions of people, and continuing to dispense vital medicines safely to those isolating at home.

    c. NHS community services that support people with rehabilitation and management of long-term conditions also played a key role in the pandemic response. They supported many people to stay well and remain at home or be cared for in the community, enabling hospitals to focus on acute Covid care and expand intensive care capacity.

NHS Staff

15. No patient care would have been possible without the sustained and dedicated efforts of NHS staff, who worked under extraordinary pressures for very lengthy periods. We endorse the words of the CMO, who recognised in his fifth Inquiry Statement: *"Watching the suffering of so many people with severe COVID-19 early in the pandemic when we had no vaccine and limited medical countermeasures was painful for all healthcare workers, and deeply traumatising for many … Despite this, doctors, nurses and many other professionals in the NHS provided what I consider heroic levels of care, often whilst deeply concerned about the possibility that as a result of their profession they were putting themselves, or vulnerable family members they went home to, at increased risk."*[5] We acknowledge that for NHS staff, the pandemic has

[5] [INQ000410237_0005] para 1.9.

almost certainly been the most challenging period of their working lives, with many courageous personal sacrifices made.

16. Staff working in critical care wards faced unprecedented pressures.[6] Redeployment, whilst essential and effective in reacting to the pandemic, put transferred staff at the front of the storm, with inevitably limited training and experience in Covid care. The toll has been severe, both on staff during the pandemic but also those who continue to live with lasting trauma. In May 2021, the ONS estimated that approximately 122,000 healthcare workers and 31,000 social care workers were self-reporting symptoms of Long COVID. There are many further stark illustrations of the toll taken in the evidence received by the Inquiry, including that of the Intensive Care Society which has highlighted how the pressures of patient mortality in ICU, working long hours, and the discomfort of PPE caused intense psychological stress.[7]

17. In addition to the pressures of work and enhanced infection risk on the frontline, NHS staff experienced the societal and related restrictions that affected contact with and support to, loved ones during the pandemic. Equally we recognise the pain or suffering of staff who were required to isolate or shield at home, and then felt that they were not supporting their colleagues.

18. NHS England wishes to take the opportunity to again recognise and thank the extraordinary efforts that NHS staff went to in the pandemic. Their commitment and sacrifice has been valued and remembered in a variety of ways, including the award of the George Cross on 12 July 2022 by the late Queen.[8]

The role of NHS England

19. The Inquiry is UK wide and inevitably comparisons will be drawn across the four nations. We note that each of the four nations possessed (then and now) devolved powers to run their health systems autonomously. We therefore set out here some key factors about the specific set up of the NHS in England. The Inquiry may find that overall, each country's responses to the pandemic were remarkably similar – with many more points of convergence than divergence. This consistency may offer insight into how policy challenges and appropriate responses were viewed at the time.

20. The NHS in England serves a population size of some 57 million people.[9] It currently employs around 1.5 million people (on a headcount basis, counting each individual member of staff) and 1.3 million people on a full-time equivalent (FTE) basis. That includes, for example, some 386,000 nurses and midwives.[10]

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[6] [INQ000226890_0027] para 27.
[7] [INQ000226890].
[8] [INQ000412890_0006] para 13.
[9] www.ons.gov.uk. The comparable figures for the country's four nations are: Scotland – 5.6m; Wales – 3.1m; N. Ireland – 1.9m.
[10] [INQ000479043_0007] para 15.

It is the largest employer in England[11] and the largest single health system in the world.[12] It is described in our statements as "*an ecosystem of commissioners, regulators and service providers, each with their own distinct role.*"[13] The many thousands of individual organisations within the NHS in England include 223 Trusts, 6,366 independent GP practices and some 11,800 community pharmacies.[14] The providers of NHS funded care (whether they are public or independent sector providers) employ and manage their own staff; there is no centrally employed NHS workforce. Leadership within the NHS draws upon both managerial and clinical expertise; Trusts are required to appoint a Medical Director and Chief Nurse to their Boards.[15] There are also many nurses, allied health professionals, consultants and GPs in managerial roles throughout the NHS.

21. NHS England operates through its national and regional teams.[16] Its purpose is to lead the NHS in England to deliver high quality healthcare for all. As a national, statutory body, separate from but accountable to government, NHS England works to give the NHS a voice in Government, articulating the healthcare sector's needs to the centre (usually its sponsor department, the DHSC) and its agencies such as PHE, later UKHSA. This happened both formally and informally during the pandemic through many routes, such as participation in the Senior Clinicians' Group, convened by the CMO.

22. As a Category 1 Responder, and in the context of the Level 4 and Level 3 Emergencies that had been declared, NHS England provided direction and operational guidance to the NHS through the pandemic. To ensure the widest range of views are taken into account, its work has always been founded upon extensive discussion and diverse engagement with the NHS, its experts and leaders, both clinical and managerial, as well as representative bodies such as the Royal Colleges, professional regulators, bodies representing staff including the RCN, the BMA and staff unions, or external stakeholders such the UK's Intensive Care National Audit and Research Centre ("ICNARC"), Trust Chief Executives and primary care representatives. In addition, many key posts in NHS England are held by practising clinicians, including roles held by National Clinical Directors or National Specialty Advisors; many of whom continued to work shifts in various healthcare settings during the pandemic. NHS England also receives advice from Clinical Reference Groups, whose members are independent experts, working across the NHS.

23. As well as clinical, academic and healthcare stakeholders, NHS England also worked with patient groups and the voluntary sector. Age UK, British Red

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[11] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell
[12] Acknowledged by WHO: https://www.england.nhs.uk/2020/10/nhs-becomes-the-worlds-national-health-system-to-commit-to-become-carbon-net-zero-backed-by-clear-deliverables-and-milestones/
[13] [INQ000409250_0012] para 36.
[14] Figures as at 31 March 2020 or 2019/20 (pharmacies): [INQ000409250_0018].
[15] [INQ000409250_0024-0025] paras 98, 99.
[16] [INQ000409250_0023] para 90.

Cross, St John's Ambulance and the Royal Voluntary Services all played vital roles in our pandemic response. They aided work in hospital admissions avoidance, discharge support and provided vital ambulance support services to NHS Trusts as part of surge planning.

24. In England, NHS hospital care is delivered by legal bodies known as trusts and foundation trusts. Each is subject to numerous legal duties and accountability or engagement obligations and NHS England in turn was subject to a legal duty to promote autonomy. In this context, the Level 4 command and control at this scale and duration was a sea change in how the many elements of the NHS had previously worked together. NHS England was helped in no small part by its EPPR teams, standards, and habits of planning and exercising. Yet the balance between central direction and local flexibility and initiative continued as a live issue.

Capacity, Knowledge and Dilemmas

25. As a system leader for the NHS in England we draw attention to key features of the situation that the NHS, and NHS England, faced at the outset of the Covid emergency. In particular, we would wish to highlight:

    a. The limits of NHS capacity, and its implications for the pandemic response;
    b. The impact of evolving, and initially limited, knowledge of the virus; and
    c. The dilemmas and choices faced by policymakers.

NHS capacity constraints

26. The NHS entered the pandemic facing several challenges which predated the pandemic and impacted the resources it had. The 'table was set' for the health service – whether in terms of its workforce or physical infrastructure.

27. The Inquiry has received evidence outlining how the NHS entered the pandemic after a long period of substantial financial constraint, with limited operational resilience, an ageing NHS estate with few single-bed rooms, limited ventilation or air cleaning systems, and pre-existing pressures on ICUs which were not optimised for creating segregated pathways. All of these factors exacerbated the difficulties of managing infection control in hospitals and ensuring oxygen supplies to beds.

28. Coming into 2020 there was little flexibility in the existing capacity to respond to a rapid and significant surge in demand.[17] The NHS has historically had low bed numbers, including acute beds, and high bed occupancy levels compared with other G7 and European countries. The NHS workforce too was under significant pressure in the run up to the pandemic, with (for example) over

[17] [INQ000403250_0053-0054] paras 202-207.

88,000 substantive posts unfilled in NHS organisations in March 2020. Such vacancy rates contributed to stress and burnout for existing staff. Digital infrastructures were also frequently in their infancy in some areas. For example, general practice had a decentralised system of provision of IT led by Clinical Commissioning Groups.

29. Such long-standing challenges not only constrained NHS capacity going into the pandemic, but also its ability to recover, even when the service strived hard to mitigate their effects.

30. NHS England recognises that the parameters it operates under are part of tough economic choices which have to be made at government level, and that these challenges were recognised by the NHS and Government long before the pandemic began. Multiple national strategies and policies were launched in 2019 which aimed to put the NHS on a more secure and resilient footing – including the NHS Long Term Plan (January 2019), a framework to reform GP services and create Primary Care Networks (February 2019), final proposals for NHS reforms (April 2019), an Interim NHS People Plan (June 2019), and a Health Infrastructure Plan (October 2019). Many of these polices were planned to begin delivery in 2020, but inevitably were impacted by the pandemic.

31. As a national body and healthcare system leader, NHS England has provided the Inquiry with a high-level perspective on policy and directions, the systems in place, national guidance, as well as high-level data or statistics. This perspective will often, but may not always, reflect the variety of local experiences witnessed in other parts of the NHS. For example, in relation to the capacity of the system it is the case that in many incidents and emergencies such as large-scale transport crashes, local response and care systems can reach their limits and the ability to manage pressures by transferring out becomes critical. Thus, examination of a crisis requires recognition of both the experience of those under pressure, and the system's overall response. One example of such varied perspectives is the evidence relating to the issue of ICU capacity. The Inquiry will hear the voices of those describing intense local pressures on beds availability, as well as evidence of the system response. Fong, Summers and Cook state that "*Although the UK's entire expanded ICU capacity was not exceeded during the first surge, the usual and expanded capacity of many units was exhausted at different times...*"[18] Although concerted steps to expand capacity were taken, including by the opening of specialist beds outside of ICU, we acknowledge the heightened pressures on clinicians and their decision-making.

32. We know we cannot keep in mothball the kind of ICU capacity that we may need for another and similar pandemic when those resources may be better used for

[18] *NHS hospital capacity during covid-19: overstretched staff, space, systems, and stuff*. Fong, Summers, Cook – BMJ – 3 April 2024 https://www.bmj.com/bmj/section-pdf/1095937?path=/bmj/385/8425/Comment.full.pdf

routine care. Rather, active measures will always need to be taken rapidly to expand existing supply. In England, these measures included not only the 'surge' measures that expanded existing hospital capacity, but the swift creation of temporary field hospitals, the Nightingales, and the contract agreed with the independent sector to provide beds, clinical staff and ventilators. The Nightingales provided additional capacity in line with projected need. Initially introduced in London in a matter of weeks at the Excel Exhibition Centre, they were then set up in a range of facilities in other regions of the country. The contract with the independent sector provided for 100% utilisation of this sector and later evolved to enable focus on elective recovery and surge planning. From March 2020 to February 2021 almost 3 million NHS patients were seen in independent sector facilities.

33. **Capacity: External Factors.** The NHS operates as a part of a complex ecosystem of interdependent organisations and services, responsible for public health and prevention through to social care. The Inquiry itself noted the importance of the social determinants of health and the lack of resilience in the population in its Module 1 Report: "*Going into the pandemic, there had been a slowdown in health improvement, and health inequalities had widened. High pre-existing levels of heart disease, diabetes, respiratory illness and obesity, and general levels of ill-health and health inequalities, meant that the UK was more vulnerable.*"[19]

34. Of critical importance to the NHS during the pandemic were, first, the absence of an adequate infrastructure to enable testing for the virus (whether in the community, for patients or for staff), or the inability to create one at pace. This was a major constraint in the first few months of the pandemic, limiting knowledge of the spread of the virus in the community and driving policy choices with regards to the use of scarce testing resource. Absence of testing meant that admission with symptoms was often the first indication of infection - too late as an indicator for planning/response. Second, the pre-existing model for the procurement and stockpile of PPE relied on the decentralised procurement of stocks by numerous NHS organisations, independent contractors, local health and social care organisations, plus a small influenza stockpile managed by PHE on behalf of DHSC. Combined with global supply shortages, both systems of procurement proved inadequate for a major pandemic; problems of supply were compounded by logistics systems based on the 'just in time' principle. We have described, in our Statements, the efforts made by NHS England to direct supplies of PPE to where they were most needed, but we understand that this will be the subject of detailed consideration in Module 5. However, we acknowledge the stress and anxiety, laid out in the evidence from healthcare workers before the Inquiry in this Module, caused by PPE shortages or the threat of such shortages, and the need to learn lessons upon the security of supply in conditions of unprecedented demand. Third, social care capacity is another example of a major system which impacts on

[19] UK Covid-19 Inquiry Module 1 Report p.2.

NHS efficiency, not least as with around 460,000 care home beds, the ratio to hospital beds is around 5:1. Expansion or loss of care home beds has a major impact on hospital discharge capacity but lies outside of NHS control.

Evolving Knowledge

35. From the outset on the pandemic, there were high levels of uncertainty about the nature of COVID-19: its transmissibility, symptoms, mortality and the appropriate methods of containment and treatment. This was a new virus with unknown effects and limited evidence on specific clinical management or therapeutics. What was known evolved rapidly, in real time, assisted by discussions within clinical networks.[20] For example, as Wave 1 progressed, it became clear that patients who were seriously ill with COVID-19 required more than just ventilation, also needing renal replacement therapy and cardiovascular support.

36. Available information about the virus also multiplied rapidly, as evidenced by one study which estimated that in just the first six months of the pandemic, over 23,000 unique published articles related to COVID-19 were indexed on Web of Science and Scopus.[21] A further study found an estimated 1.5 million articles on the topic were added to the global literature in 2020 - the largest annual increase in history.[22] Much of this material consisted of secondary articles, such as reviews, opinions and editorials, with fewer papers offering original findings on COVID-19 from human medical research or in silico and in vitro studies. The role of SAGE and the WHO and other expert groups therefore became of critical importance to identify quality evidence, and understand and distil the vast sea of emerging knowledge to inform decision-making and clinical practice.

37. Adding to the many uncertainties were the complexities of the pandemic as it unfolded, including: the demands and uncertainties of staff absences due to COVID-19; local variations in the spread of the infection and its mutations and in the effectiveness of societal measures to curb them; variation, from hospital to hospital or practice to practice, in the ability to introduce measures to control the spread of the virus and to follow guidance on mitigating it; or the challenge of anticipating and managing unintended consequences, such as the public reaction to the "stay at home" message.

Challenges and Dilemmas

38. Working alongside policymakers, NHS England faced many dilemmas and complex decisions. We anticipate that the Inquiry will examine many instances of issues where there was not a 'wrong' or 'right' answer, but rather *"no good choices available," whether to "clinicians, the NHS or the OCMO"* (in the words

[20] [INQ000412890_0025] paras 81-90.
[21] https://www.nature.com/nature-index/news/how-coronavirus-is-changing-research-practices-and-publishing
[22] [INQ000492331].

of the CMO).[23] The pace of the pandemic meant that decisions had to be made in short timeframes with the-then available information, including expert advice.

39. The Inquiry's EPRR experts in Module 1 made reference to the JESIP framework, which recognises that organisations will be grappling with limited information and a range of potential responses ("*There will almost always be more than one way to achieve the desired outcomes*"[24]); delay too is likely to have costs. Decision-makers had to be alive to the need to modify decisions and guidance as new evidence comes in. As the CMO has stated, they were frequently dealing with sparse information, particularly at the outset, and *"With the benefit of hindsight many decisions look more clearcut than they were at the time, for clinicians, public health experts and scientist from all disciplines."*[25]

40. For example:

    a. **Pausing elective procedures or non-essential appointments** enabled redeployment of resources to provide COVID-19 care, but at the cost of delaying other care. However, attempts to mitigate its effects were made from the outset: for example, in mustering the capacity of the independent sector, use of remote consultations for pre- and post – operative care and division of healthcare sites into red (Covid care) and green (non-Covid care) pathways, and in planning for recovery as soon as possible.[26]

    b. The impact of **visiting policies and restrictions on visitors** was harsh and caused much pain. But such policies represented an attempt to balance the needs of families to maintain contact with loved ones, and the need to maintain infection control measures and to avoid nosocomial spread to protect patients and staff. The Inquiry may hear from those who suffered from visitor restrictions – both families and staff, who had to endure social distancing restrictions and could only provide contact or speak with loved ones through devices such as iPads. But it may also hear from those who suffered due to nosocomial infection, of the difficulties in ensuring adherence to IPC rules by visitors, and of staff concerned to secure greater protection against the risks they faced.

    c. In the face of many uncertainties there were dilemmas about what **guidance** to issue, how much, and how frequently. The pace and rapidly changing nature of the pandemic made the need for guidance greater, but it also meant it had to be constantly reviewed and updated. Some NHS organisations asked for greater national direction, whereas others felt there was too much. For example, although the Inquiry will hear that

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[23] [INQ000410237_0005] para 1.11.
[24] https://www.jesip.org.uk/downloads/joint-doctrine-guide/ accessed 15 August 2024.
[25] [INQ000410237_0005] para 1.11.
[26] [INQ000087412].

many clinicians called for guidance and decision-making tools to manage scenarios where demand for critical care beds outstripped demand, this was set against concerns that tools could be discriminatory and the view that local clinical decision-making remained the best option. On this subject, NHS England notes the evidence of Ms Paget,[27] on behalf of the Welsh NHS, who states that the Welsh Government's Extreme Surge Guidance was never implemented and that the Welsh CMO and DCMO expressed concerns about scoring tools. The Inquiry may note the extent to which this account is consistent with NHS England's evidence.[28] The same dilemma was experienced in different systems, but with the same outcome reached.

d. **Recovery.** In a world of finite resources, it was challenging to balance planning for immediate needs against longer term considerations. The Inquiry will hear concerns that the system was asked to 'recover' too soon,[29] also that not enough was done to secure a sustainable recovery.

41. There are many other examples of policies that were regarded as necessary in the face of the pandemic, although they undoubtedly carried risks and downsides. Organisations setting guidance and staff did their best to introduce counter-measures or mitigations, and to engage extensively with partners and stakeholders.[30] Although the Inquiry will hear many instances of differing perspectives on how to balance competing pressures, differences were not generally a product of failing to engage or to listen, but rather the intrinsic difficulties of the judgments in question.

Inequalities

42. An area of particular concern is that of inequalities, in their many and varied forms, including racial and disability disadvantage and discrimination, or the social inequities which impact directly on health inequalities and which the NHS alone cannot address. The pandemic is widely recognised as highlighting and exacerbating entrenched inequalities nationwide, including in the NHS workforce.

43. NHS England acknowledges the legitimate force of the concerns about this area. It shares an ambition to fully minimise health inequalities as far as possible. An Opening Statement cannot address the complexities of the topic, including the issue of the interactions between health and social care during the pandemic (an issue for Module 6). But NHS England has throughout been concerned to ensure equal access to treatment, this being a key means of mitigating health inequalities. So, for example, it responded rapidly to reports of the inappropriate or 'blanket' use of DNACPRs on 7 April 2020.[31] Despite that,

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[27] [INQ000486014_0106] para 291-293. See also [INQ000485721_0062-0065] paras 146-147.
[28] [INQ000412890_0046-0055] paras 163-180, especially para 173.
[29] [INQ000410447].
[30] See e.g. [INQ000410447_0013 – 0020] para 40-41, 49, 50, 57.
[31] [INQ000412890_0055-0058] paras 194-200.

NHS England recognises that the Inquiry will hear that there were times when the specialised needs of vulnerable or disadvantaged groups did not get the attention that they deserved.

44. People from Black, Asian and minority ethnic backgrounds make up over 20% of the NHS workforce.[32] We have provided, in the Corporate Witness Statement and the Chief Nursing Officer's Witness Statement, an account of what was done to respond to the concerns that emerged in April 2020 of the disproportionate impact of COVID-19 on these staff members, such as the guidance issued on matters such as risk assessments, and its follow-up. Actions included matters which should have a lasting impact, such as the creation of the NHS Race Observatory in May 2020 as well as wider health and wellbeing initiatives. This includes continuing to deliver on the Model Employer Strategy and recommendations set out in the Workforce Races Equality Standard 2021 data analysis report for NHS trusts and foundation trusts.[33]

45. We anticipate that these will be further explored by the Inquiry. However, we echo the words of Sir Chris Whitty in his Statement – whilst we did our best to reflect the importance of disparities and inequalities in the advice or guidance we issued, "... *nobody looking back at COVID-19 can claim it was sufficient. The scale of the difference by deprivation and ethnicity is clear; what would have been effective countermeasures is less so*..."[34]

Learning From What Worked

46. There are many aspects of the NHS' and NHS England's response which we hope will be explored and ultimately recognised as positive ones in this Module.

47. New systems to overcome constraints were built at great speed, from the outset, with an 'all hands on deck' approach adopted. Some of these new capacities, including the expansion of central data-gathering, the Inquiry examined in Module 2. Others, such as the rapid expansion of critical care capacity to the highest level in NHS history, will be examined in this Module. Community, primary and secondary care sectors all showed remarkable agility and adaptability in their responses to the need to reshape how care was provided.

48. The pandemic response involved active and sustained collaboration and co-operation across the healthcare system between organisations and individuals. For example, the UK IPC Cell was a four-nations group.[35] Ad-hoc teams were created to manage new needs as they emerged, such as the Renal Incident

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[32] [INQ000412890_0210] para 803.
[33] https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
[34] [INQ000410237] para 4.65.
[35] Membership of the UK IPC Cell included NHS England, PHE/UKHSA, PHW, ARHAI, Scotland, the Scottish Government HAI Policy Unit, PHA NI, the Association of Ambulance Chief Executives and DHSC: [INQ000421939_0035] para 128.

Team, consisting of clinicians, commissioners, data analysts and supply chain/ logistics experts. Staff, in the community, in hospitals and within NHS England, demonstrated flexibility, adaptability and agility. There was a willingness to be redeployed in areas which were unfamiliar, take on new roles and develop new skills at pace. For NHS England, collaborative working included, at times, taking responsibility for initiatives which, strictly, fell outside its responsibilities (such as the creation of quarantine facilities for returnees from China in early 2020, secondments of its staff, the publication of clinical guidance,[36] creation of the capacity tracker for care homes or the provision of 'mutual aid' such as the IPC training offer to care homes).

49. There was extensive innovation and development, for example in the speeding up of using digital technologies to enable remote access to care. The NHS Long Term Plan had already committed GP practices to offer e-consultations from April 2020 and video from April 2021. The COVID-19 pandemic accelerated the adoption of these channels, from March 2020 onwards. Expansion was rapid and significant, with telephone consultations almost trebling between February 2020 and August 2021. We acknowledge that more could have been done to ensure that there was sufficient awareness amongst communities as to how they could access their GP; but without such remote consultations, the impact of increased person to person contact, for patients and clinicians, would have been serious.

50. NHS staff, working with clinical researchers, NIHR and the MHRA, used the NHS's strengths as a national organisation to recruit patients into clinical trials such as RECOVERY, REMAP-CAP and PRINCIPLE and to rapidly disseminate the results about treatments that worked. Indeed, when results from RECOVERY identifying Dexamethasone as the world's first effective treatment for COVID-19 were published by noon on 16 June 2020, the team was able to deploy a national policy and ensure sufficient supply for the treatment to be used later that same day. It has been estimated that by March 2021, the use of Dexamethasone had saved 22,000 lives in the UK and an estimated 1 million worldwide.[37] We know these issues will be the subject of Module 4.

51. Treatment for Long Covid was mobilised across the summer and autumn of 2020, with online services from July 2020 and clinics opening from October 2020.

52. Prior to the pandemic, NHS England had in place EPRR mechanisms covering a wide range of potential threats and hazards. It benefitted from this experience, as well as from standing plans including plans for HCID and pandemic influenza. However, NHS England acknowledges it would have benefitted further from a disease agnostic pandemic plan, as well as from plans for a protracted incident on the scale of COVID-19. Now, NHS England has

[36] [INQ000412890_0042-0045] paras 146-159.
[37] https://www.england.nhs.uk/2021/03/covid-treatment-developed-in-the-nhs-saves-a-million-lives/

refreshed its EPPR planning to require annual exercise planning, on set themes including infectious diseases and a pandemic.[38]

53. Despite all the obstacles to achieving it, there was an early focus on recovery,[39] and a determination to ensure that long-term goals and plans were not lost. NHS England launched the "Help Us to Help You" campaign in May 2020, to mitigate unintended effects of public messaging and the fears that were influencing public reluctance to use health services. Recovery plans were in place for – for example – cancer by December 2020. NHS England has endeavoured to use the resources built during the pandemic to aid recovery. The Virtual ward programme and oximetry at home programmes continue to expand and provide patients with innovative models of care.

Conclusions and Challenge of Recovery

54. This is not to gloss over the challenges and difficulties. We have set out how there were no perfect options and usually no good ones. What we do know is that the NHS did its best to deliver a shared and coordinated response, rapidly share learning, maintain treatment and avoid harm. NHS England was able to provide national co-ordination and integration with local NHS organisations in a way never done before, alongside but independent of the wider focus of government.

55. The Inquiry's Relevant Period ends in June 2022. Over two years later, the NHS continues to face multiple challenges in recovering from the effects of the pandemic. The impact on its staff has been profound, and the legacy of increased waiting times endures. We would hope to see in this Module an examination of issues which will further help recovery and identify and embed lessons to assist in the management of any future crisis.

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[38] https://www.england.nhs.uk/long-read/nhs-emergency-preparedness-resilience-and-response-exercise-programme-2024-to-2030/
[39] [INQ000087412].