Witness Name: Amanda Pritchard

Statement No: 1

Exhibits: AP001 – AP264

Dated: 16 January 2024

UK COVID-19 INQUIRY

FIRST WITNESS STATEMENT OF AMANDA PRITCHARD

CONTENTS

I, Amanda Pritchard, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

Introduction

1. Responding to the pandemic has been the single biggest challenge that the NHS has faced in its history.

2. On 30 January 2020, before the World Health Organization ("**WHO**") declared a global pandemic, NHS England declared its first ever 'Level 4' incident, enabling it to direct the use of resources across the NHS in England. In the period between 30 January 2020 and 28 June 2022 (the end of the date range for this Inquiry) the NHS in England spent 421 days in Level 4 and 459 days at Level 3. It was not until 18 May 2023 that NHS England stood down the Covid-19 incident. The pandemic was the single biggest event – in scale, duration and impact – that NHS emergency preparedness, resilience and response ("**EPRR**") teams had ever responded to and therefore it drew upon NHS resources far and wide.

3. The novel Severe Acute Respiratory Syndrome Coronavirus 2 ("**SARS-CoV-2**", "**Covid-19**" or the "**pandemic**") was a new virus, meaning no specific plan was available but, as anticipated, other plans were adapted to the emerging incident and knowledge of previous incidents utilised. NHS England was able to respond effectively to Covid-19 due to the totality of its EPRR programme of work - planning, exercising, responding to incidents - and pre-existing relationships, including those developed from preparations relating to the UK's departure from the European Union ("**EU Exit**") (ongoing until July 2021) and links with partners such as the UK Health Security Agency ("**UKHSA**"), the Department of Health and Social Care ("**DHSC**") and the devolved administrations.

4. NHS England has a statutory responsibility to plan, exercise for, and respond to a range of incidents and emergencies. Relevant NHS providers of NHS funded care follow the NHS England EPRR Framework, the objective of which is to prepare for the common consequences of emergencies rather than for every possible scenario. This involves having flexible arrangements (plans) for responding to a range of emergencies which are both scalable and adaptable to work for a wide range of scenarios. In the three years prior to January 2020, NHS England had responded to a range of incidents on an almost continuous basis (see Annex 5).

5. The pandemic was not a single 'incident'. The virus was new and evolved rapidly, and it prompted multiple and varied challenges across the whole NHS, for the duration of the pandemic.

6. Adapting to an emerging situation invariably means evolving the response to deal with the information available, relying on pre-existing plans where available and relevant, adapting those plans, working collaboratively, and feeding back as the situation develops.

7. NHS EPRR contributes (often jointly with many partners) to an effective response, but also relies on an underlying resilience or capacity in the health system, and in co-dependent systems. Resilience can be a combination of what there is (including any preserved headroom) as well as the ability to create more. In the short term this means redeploying existing resources across different priorities. With a growing and ageing population, the NHS in England operates at high levels of usage and occupancy – having little headroom in comparison to similar health systems. While this has delivered significant productivity improvements, it is recognised that this has impacted the ability of NHS services to surge capacity.

8. Underlying resilience challenges across the NHS, which pre-existed the pandemic, were one factor determining how easy it was to implement the necessary response measures. Whilst it was possible to source more beds, they could not be used unless clinically staffed. It was not possible to train new clinical staff at speed, so the NHS faced difficult decisions about how to deploy the clinical staff who were available. Some of the necessary measures depended on the cooperation of non-NHS agencies and partners, such as social care (which had its own underlying resilience challenges).

9. The NHS itself is an ecosystem of thousands of organisations, including NHS bodies (such as hospital trusts) and independent providers (such as GP practices and pharmacies, who hold NHS contracts). These organisations work collaboratively but have some legal autonomy and operational independence (for example, they usually employ their own staff and buy their own supplies).

10. During the pandemic, the NHS was not a Covid-19 service only, but had to deal with the unprecedented challenge in addition to continuing to deliver other healthcare services, to the greatest extent possible. Even at the height of the pandemic, there were significantly more non-Covid-19 patients in hospital than Covid-19 inpatients.

Additional incidents also occurred in England in this period and needed to be managed (see Annex 5).

11. Throughout the response, lessons were being identified and implemented across different time zones, in different forums, and across different levels of organisations. Governments, public bodies, the NHS, researchers, and others, were all adapting to new evidence as it emerged, so the response to the pandemic necessarily changed frequently.

12. Some lessons have been more fundamental and have implications beyond the immediate demands of the pandemic. Acting on these lessons might require significant and costly changes, or they may require the agreement of multiple stakeholders.

13. One lesson we did not need to learn, and which is now truer than ever, is how much the NHS depends on its staff. NHS staff at all stages of their careers (including students and the retired) were under sustained and considerable pressure during the pandemic, but they maintained their dedication and compassion as they cared for patients. Many NHS staff were redeployed to work in difficult conditions and were required to support people and families through the most emotionally-challenging situations. The George Cross was awarded to the NHS on 12 July 2022, in recognition of over 74 years of service, and in particular for the exceptional efforts of NHS staff across the country during the pandemic.

14. I joined the NHS Management Training Scheme in 1997 and have held a range of operational and strategic roles within the NHS and briefly within the civil service since then. I have been the Chief Executive Officer of NHS England since 1 August 2021. Prior to this role I held the position of NHS England and NHS Improvement's Chief Operating Officer and NHS Improvement's Chief Executive Officer from August 2019 until 31 July 2021. Prior to joining NHS England and Improvement in 2019, I was the Chief Executive Officer of Guy's and St Thomas' NHS Foundation Trust from January 2016 to July 2019, having been Acting Chief Executive since October 2015.

15. The Inquiry has provided its Rule 9 request pursuant to the Inquiry Rules in respect of Module 3 to NHS England by way of three 'tranches'. NHS England is responding to these tranches by way of several corporate witness statements.

16. This is the first statement made by NHS England in respect of Module 3. It is a foundational statement with important information on the organisation of the NHS and how NHS England worked before the pandemic ("**NHS England's First Module 3 Statement**").

17. The others, or tranches, can be broadly characterised as follows:

    a. Tranche one (statement two), covers NHS England's response during the Relevant Period and in particular 'surge', and has been drafted concurrently with this statement ("**NHS England's Second Module 3 Statement**").

    b. Tranche two (statement three) covers a range of issues relating to the protection of patients, visitors and staff including healthcare provision and treatment for patients with Covid-19 and conditions other than Covid-19, Do Not Attempt Cardio-Pulmonary Resuscitation notices, an overview of critical care transfers, infection prevention and control, personal protective equipment, palliative care, recording of deaths, shielding and impact on NHS workers ("**NHS England's Third Module 3 Statement**").

    c. Tranche three (statement four) covers primary care, ambulances, 999 and 111 services, at home care, ante-natal care, maternity services, postpartum and neonatal care, Screening, care and treatment for lower gastrointestinal cancer, elective orthopaedic surgery, heart disease and heart attacks, Child and Adolescent Mental Health Services, Long Covid and future risks, reviews,

reports and lessons learned exercises ("**NHS England's Fourth Module 3 Statement**").

18. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The draft tranche 1 request received on 31 March 2023 (the "**Tranche 1 Module 3 Rule 9 Request**") to NHS England is broad in scope and time period and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (both current and former NHS England employees) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement and have not been able to personally review each document exhibited. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

19. Following the period under investigation in Module 3, 1 March 2020 to 28 June 2022 ("**the Relevant Period**"), NHS England merged with:

    a. NHS Improvement on 1 July 2022;[1]

    b. NHS Digital on 1 February 2023;[2] and

    c. Health Education England ("**HEE**") on 1 April 2023.[3]

    This statement refers to the legacy organisations above as is necessary to respond to the Module 3 Rule 9 Request.

20. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England, references throughout to 'NHS England' and 'we' represent the voice of the organisation. I have referred to all individuals (including myself) in the third person and by job title where possible.

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[1] On 1 April 2016, the Trust Development Authority and Monitor were brought together to create "NHS Improvement".
[2] The statutory functions of NHS Digital were transferred to NHS England on 1 February 2023 pursuant to the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.
[3] The statutory functions of HEE were transferred to NHS England on 1 April 2023 pursuant to the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.

21. This corporate statement has been produced with input from a number of colleagues across NHS England, and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.

22. Within this witness statement, we refer to documents which are exhibited to support a particular point being made. These documents are exhibited as **[**APXXX**]**, followed by their INQ document number. In addition, we refer to documents which have been disclosed previously by NHS England or by other Core Participants in this Inquiry within Modules 1 or 2. These are referred to by their INQ number only.

Approach to the Tranche 1 Module 3 Rule 9 Request

23. NHS England welcomes the chance to assist the Inquiry to understand and examine the key issues it has identified as in scope for Module 3 (and in subsequent engagements with the Inquiry team).

24. We understand that the purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in exploring a range of matters as set out in the Tranche 1 Module 3 Rule 9 Request.

25. We understand that the scope of Module 3 is focused on the impact of the pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland, specifically during the Relevant Period.

26. This Statement contains responses to topics and questions set out in the Module 3 Rule 9 Request. As suggested by the Inquiry, the statement adopts its own structure whilst aiming to answer the Inquiry's requests for information in detail. It is important to note that the issues raised by the Inquiry at this stage, and the answers provided in this Statement and also in NHS England's Second Module 3 Statement, have focussed on the response of NHS England to the pandemic and on the actions taken by NHS England. This statement and NHS England's Second Module 3 Statement do not purport to describe the impact of these actions on the many and varied organisations which make up the NHS, or upon its staff and the many patients who received care and treatment during the pandemic. Whilst at times reference to issues of impact or effectiveness or to challenges is made, a comprehensive account of these matters is outside their scope. Furthermore, it would not be possible to do justice to the many ways in which the pandemic was experienced by NHS staff and patients. We anticipate that these matters will be explored in depth by the Inquiry during the course of Module 3, and NHS England will of course seek to assist the Inquiry further.

27. This statement primarily addresses the role of NHS England immediately prior to the Relevant Period. Where we encompass or address the functions or response of any of the now merged legacy bodies referred to in paragraph 19 above, we highlight this.

Outline of this corporate witness statement

28. To understand how the health service in England was impacted by the pandemic and the role of NHS England, it is helpful to understand organisational roles pre-pandemic and how these transformed to confront the pandemic.

29. Like other parts of the public sector, the NHS is not one body, but made up of many parts. By its nature, to understand how it cares for people, it is often necessary to consider and explain medical criteria, roles, responsibilities and so on. Where relevant, this Statement tries to provide that.

30. This Statement, comprises two sections:

31. **Section 1** provides detail on:

    a. the structure of the NHS in England;

    b. how services are organised in 'normal times';

    c. the roles and responsibilities of NHS England including NHS England's role in relation to emergencies; and

    d. an overview of High Consequence Infectious Disease ("**HCID**") services.

32. **Section 2** describes the resilience of the NHS in England prior to the pandemic, including:

    a. resilience and headroom, which includes information regarding discharge and outflow;

    b. the funding of the NHS prior to the pandemic;

    c. pre-pandemic workforce; and

    d. NHS re-organisation to improve local system working and the Health and Care Act 2022.

33. In this statement I have referred to NHS England, the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

34. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this Statement unless otherwise stated.

35. In this Statement, references to workforce or healthcare staff within the NHS should be interpreted as broadly as possible. However, where issues pertain to a particular profession or job role, or to a function of the NHS such as primary care, we have included more specific detail.

SECTION 1: THE NHS IN ENGLAND

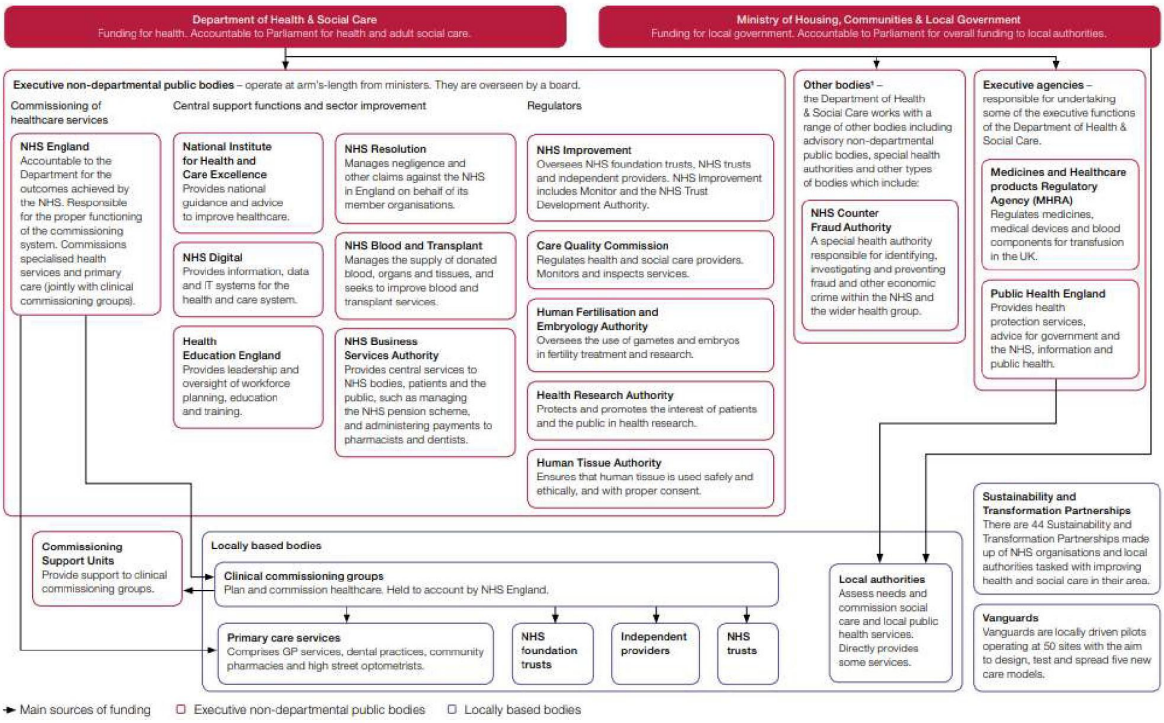
Overview of the NHS in England

36. In accordance with the framework established by Parliament, the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly-funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care and community health as more particularly described in paragraph 51 below. Public health is discussed in paragraphs 47 to 49 and Annex 1 and Adult Social Care in paragraphs 173 to 176 below.

37. As explained later in this Statement, many bodies hold contracts with the NHS and are part of the publicly funded health service, such as GP practices, dentists, independent hospitals, community rehabilitation providers, but not all will be NHS bodies. For the most part, the term 'NHS' is used as an umbrella term to mean all those performing their services with NHS monies and contracts.

38. The Health and Social Care Act 2012 (the "**2012 Act**") re-organised the NHS, with many of the changes coming into effect on 1 April 2013. The 2012 Act amended the National Health Service Act 2006 (the "**2006 Act**") which remains the main piece of primary legislation governing the NHS. For context, Annex 1 provides an overview of the 2012 changes, also known as the 'Lansley Reforms'.

39. To assist the Inquiry, a diagram outlining the structure of the NHS in England as at 2018 is provided below:[4]



Department of Health and Social Care

40. In general, it is the responsibility of Government Departments to direct national strategy and set funding levels.

41. DHSC is responsible for setting policies that deliver the Government's strategic health objectives; and in turn for making sure the legislative, financial, and administrative frameworks are in place to deliver those policies (including the NHS Mandate as described in paragraphs 223 to 233 below). DHSC oversees the health and social care system through its agencies and public bodies, holding them to account for the implementation of agreed plans and commitments.

42. NHS bodies are those defined as such in the 2006 Act. The SSHSC can, exceptionally, describe an organisation as 'NHS' that is not an NHS body. For example, the 'NHS Test and Trace' programme that was created during the pandemic was not an NHS body or implemented by an NHS body; it was funded and supported by DHSC.

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[4] *Departmental Overview, October 2018, published by the NAO (Ref: 005661-001)*

NHS England

43. NHS England is an Executive Non-Departmental Public Body ("**NDPB**") sponsored by the DHSC. It is referred to as an Arm's Length Body ("**ALB**") as it is a public body established with a degree of autonomy from the SSHSC. It was established on 1 October 2012 and is operationally distinct from DHSC.

44. NHS England is not:

    a. a core political or governmental decision-making body;

    b. responsible for setting national health or public health policy; or

    c. a provider of patient services.

45. Up until 1 July 2022, when changed by the Health and Care Act 2022 (the "**2022 Act**"), NHS England's legal name was the National Health Service Commissioning Board'.

46. The roles and responsibilities of NHS England are set out in this Section and Annex 1.

Public Health England

47. Public Health England ("**PHE**") was established as an Executive agency to DHSC. Its core role was to fulfil the SSHSC's statutory functions (primarily set out in sections 2A and 2B of the 2006 Act) to protect the nation's health, address health inequalities and promote the health and wellbeing of the people of England.

48. Prior to its dissolution on 1 October 2021, and the replacement of its functions primarily by the UK Health Security Agency ("**UKHSA**") and the Office for Health Improvement and Disparities, PHE was the body responsible for providing specialist health protection, epidemiology and microbiology services across England and collaborating with the health protection agencies (providing similar specialised services) in the devolved administrations.

49. Like PHE, the UKHSA is an Executive Agency with close ministerial oversight while still permitting "*independence in the delivery of policy advice*". As set out in the Framework Document between DHSC and the UKHSA, the UKHSA "*will form an essential part of the UK's national security infrastructure, helping to protect the country from societal and economic shocks arising from pandemics and other external threats to health*", while bearing in mind that health is a devolved matter.

Regulators

50. Providers of healthcare services i.e., those that provide direct care to patients at an organisational and clinician level, are regulated by different regulators depending on their structure and the services being delivered. For the Relevant Period this included:

    a. the Care Quality Commission ("**CQC**"), the independent regulator for the quality and safety of care who oversees and inspects organisations that provide health and social care services **[AP001 INQ000269886]**;

    b. NHS Improvement which oversaw Trusts for other matters as more fully described in Annex 1;

    c. the Health and Safety Executive, the national independent regulator for health and safety in the workplace, including within health and social care settings **[AP002 INQ000270069]**; and

    d. for clinicians themselves, the relevant healthcare professional bodies, such as the General Medical Council and the Nursing and Midwifery Council.

Categories of health services

51. Taxpayer-funded health services are commonly grouped into four broad categories, denoting the typical way in which a patient can experience the health system from first point of contact. These services are intended to act as an integrated system:

    a. Primary care includes: general medical practice (GP), community pharmacy, primary dental care and primary optometry services. Almost all primary care providers are independent businesses operating in accordance with contracts commissioned by NHS commissioners;

    b. Secondary care includes: planned (elective) care that usually takes place in a hospital (including specialised dental and ophthalmology), urgent and emergency care ("**UEC**") including 999, ambulance services, hospital emergency departments, and some mental health services. Secondary care is predominantly provided by public sector organisations such as Trusts but can also be provided by independent sector organisations under contract to the NHS;

    c. Tertiary care includes: highly specialist care provided to patients who are

referred from primary or secondary care services. Tertiary care includes neurosurgery, transplants, specialist stroke units and secure forensic mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations also provide this under contract to the NHS. Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

d. Community care includes: community nursing, community mental health services, health visiting, child health services and sexual health services. Community care is provided by a range of independent and public sector organisations. Commissioning of community care is a mixture of local authority and NHS commissioning.

Ambulance services

52. Ambulance Services were commissioned from 'ambulance trusts' by Clinical Commissioning Groups ("**CCGs**")[5] prior to the pandemic.[6] Each of the ten ambulance trusts[7] covers a wide geographical footprint and supports the ambulance needs of individuals present in their region. In addition, they provide support and assistance to neighbouring regions and cross border assistance with the devolved nations by way of mutual aid in accordance with agreed protocols.

53. Ambulance trusts are required to meet the ambulance standards published by NHS England in July 2017 **[AP003 INQ000270128]**. These categorised ambulance calls into different levels of call, those categories enabled ambulance services to prioritise patients according to the urgency of their care needs.

54. The standards assist with the relative prioritisation of calls and the dispatch of ambulances to patients. Those patients would then be assessed by ambulance service paramedics who would, supported by other clinicians if necessary, following appropriate assessments deliver emergency or urgent treatment if required and exercise judgement as to whether or not the patient required transportation (conveyance) to hospital and/or referral to other services.

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[5] CCGs were membership bodies with specific membership requirements pursuant to the National Health Service (Clinical Commissioning Groups) Regulations 2012. Each CCG had a 'governing body' made up of GPs, clinicians and lay members. They were clinically led, including all GPs within their defined geographical footprint as more particularly described in Annex 1.
[6] They are now commissioned by Integrated Care Boards.
[7] Isle of Wight is a combined Trust and so acute and ambulance are all part of single trust.

55. Ambulance service staff did not, either before or during the pandemic, have the authority to make any decision as to whether a patient is admitted to hospital. That decision is made by hospital clinical teams after the patient has been conveyed to hospital by an ambulance or other means.

Patient interactions with the NHS

56. The vast majority of interactions with the NHS occur outside of acute hospitals, in primary care, community services and mental health services. These services support people with complex health and care needs to live independently in their own home for as long as possible without the need for hospital admission.

57. Different patients will have a different journey depending on their clinical requirements and where their journey begins. Depending on a patient's health condition, there are advisory guidelines, provided by the National Institute for Health and Care Excellence ("**NICE**"), for the diagnostic and treatment 'pathway' that providers and clinicians follow which can determine that journey.[8] Professional guidance may also supplement this.

58. For example, when feeling unwell a patient will probably first see a GP (primary care) or contact NHS 111[9] unless they present through UEC routes (e.g., by calling 999). Following first presentation, they then may be given advice, or referred to an urgent community service, a hospital A&E department or more specialist care, perhaps for investigations and diagnosis. In very specialist (tertiary care) or end of life situations (e.g., hospices), the patient will be referred to an appropriate provider.

59. Decisions about hospital admissions are exclusively made by the relevant hospital's clinical team. To avoid doubt, GPs do not make decisions regarding admission to hospitals, rather they make referrals.

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[8] NICE is a national advisory body established by the 2012 Act as an executive NDPB sponsored by DHSC. NICE's role is to provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services. NICE supports the health and care system by describing what good quality care looks like in the NHS, public health and social care sectors and helps promote the integration of health and social care.

[9] NHS111 services provide prepared advice, referral to community pharmacy, GPs, urgent care facilities including A&E and 999 response as appropriate. This was supplemented by a front end 119 Covid-19 helpline.

60. Patients may be discharged into the social care system and may still receive NHS care following discharge such as through NHS Funded Nursing Care ("**FNC**")[10] or NHS Continuing Health Care ("**CHC**").[11]

Delivery of health services

61. As noted above, providers of the different groups of care range from public sector organisations e.g., NHS Trusts (established by orders of the SSHSC) and NHS Foundation Trusts (public benefit corporations),[12] to independent providers including charitable and other not-for-profit providers, and independent contractors (e.g., GP practices) including some for-profit organisations.

62. Trusts can operate multiple hospital and community sites.

63. On 31 March 2020 there were: 74 NHS Trusts,149 Foundation Trusts, 6,771 GP practices in England. In 2019/20 there were approximately 11,800 community pharmacies in England.

64. As of 31 March 2022 there were 69 NHS Trusts, 144 NHS Foundation Trusts,[13] 6,499 GP practices, and approximately 11,500 community pharmacies in England.

65. Independent sector providers provide services to the NHS under contract. Since 2014 they have been required to hold an NHS provider licence unless they are exempt. The NHS provider licence is used to regulate providers of NHS services and was regulated by NHS Improvement during the Relevant Period. It sets out the conditions that providers of healthcare services, for the purposes of the NHS in England, must meet to help ensure that the health sector works for the benefit of patients.

66. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS workforce'.

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[10] FNC is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.
[11] Some people with long-term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as CHC. CHC is for adults. Children and young people may receive a "continuing care package" if they have needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. CHC can be provided in a variety of settings outside hospital, a patient's home or in a care home.
[12] The governance structure of Trusts is determined by statute.
[13] The number of Trusts varies due to NHS merger and acquisition activity.

67. To avoid doubt, the workforce of Trusts are not employed, or managed, by NHS England.

68. "Commissioning" is the continual process of planning, agreeing and monitoring that services are delivered. For example, where NHS England commissions a service, it develops and issues a service specification, which forms part of a contract between NHS England and the relevant provider. Under this contract, the provider agrees to deliver the service in accordance with the service specification, in return for payment by NHS England.

69. During the Relevant Period, CCGs commissioned the majority of NHS services, including most hospital and ambulance services and NHS 111, whilst NHS England directly commissioned:

    a. primary care services; however, during the Relevant Period NHS England had principally delegated this role to CCGs for GP services. NHS England, particularly through its regional teams, retained responsibility for commissioning dental, optometry and community pharmacy services;

    b. specialised services (often provided as part of tertiary care), which includes highly specialised services. These services, which are defined in statute, support patients with rare and complex conditions, and include services for HCIDs;

    c. military and veteran health services;

    d. health services that support children and adults throughout the youth justice and criminal justice systems in England; and

    e. a limited number of public health services (working closely with PHE / UKHSA and DHSC) **[AP004 INQ000270071]**.

70. Further details of commissioning in the context of the requirements of the 2006 Act, are set out in Annex 1.

71. Specific service contracts are mandated for use by commissioners including:

    a. the NHS Standard Contract (**[INQ000113318] [INQ000113214], [INQ000113215], [INQ000113216]**), which:

        i. exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving

a level playing field for all types of providers and allowing economies in the drafting and production of contracts;

ii. is mandated by NHS England for use by commissioners (NHS England and CCGs) for all contracts for NHS funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services); and

iii. has been the responsibility of NHS England since 2013 when the responsibility for the preparation and publication of the NHS Standard Contract passed from DHSC to NHS England. On 4 February 2013, the 2013/14 NHS Standard Contract was published by NHS England. Since the first version published by NHS England, Service Condition 30 (SC30) relating to Emergency Preparedness and Resilience including Major Incidents ("Emergency Preparedness, Resilience and Response" from 2015/16) has been included to require providers commissioned under NHS Standard Contracts to comply with certain EPRR Core Standards and requirements, whether or not they are a Category 1 Responder under the CCA 2004.

b. specific contracts for different primary care services e.g., GP, and optometry.

72. Providers are accountable to commissioners through their contracts for the services commissioned. To maintain services, the health service provider makes its own decisions on staffing, purchasing and stock levels, maintenance etc. Whilst the topic of data collection is dealt with in greater detail from paragraph 211, the general position is that it would not have been proportionate for NHS England to have developed datasets on these matters given the purposes for which they were needed pre-pandemic. During the Relevant Period, NHS England was under legal duties to promote the autonomy of NHS organisations and reduce regulatory burdens.[14]

73. It is the responsibility of the provider to ensure that services are carried out in accordance with specifications, allocated budgets and taking into account appropriate clinical guidance.

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[14] See for example, section 13F of the 2006 Act

74. The day-to-day management of patients is the responsibility of the relevant provider. For example, in hospitals clinicians use their professional judgement and appropriate clinical guidelines to determine the treatment that a patient should be offered and receive. This judgement includes the patient's suitability for treatment options (assuming those are NHS-funded and commissioned services/treatments) as well as whether or not a patient should be admitted.

75. Patients, provided they have legal capacity, may refuse treatment, or have a preference for one treatment option over another that is presented to them.

76. The discharge of patients, as well as their admission and treatment, is a matter of clinical judgment. However, for some categories of patients with complex care needs (e.g., the elderly with dementia), declaring that a patient is 'medically fit' for discharge from an acute bed, does not necessarily lead to swift discharge. 'Delayed Transfers of Care' (**"DTOC"**) are caused by a range of factors, but a common problem is ensuring the necessary assessments of the patient are made so that their ongoing needs are met, are safe, and that the patient can receive continuing care if needed. These assessments (where required) are the responsibility of the local authorities and have been under strain in recent years due to limited funding and resources, including care home places and staff.

77. Both admission and discharge decisions are ultimately the decisions of individual clinicians who are best placed to assess all relevant factors.

Roles and responsibilities of NHS England

NHS England

78. NHS England's primary responsibility is the co-ordination of the provision of health care services in England, certain commissioning and oversight of local commissioners and providers of those health care services.

79. As an ALB sponsored by the DHSC, NHS England is party to a Framework Agreement with the DHSC (**[INQ000113155]**, **[INQ000113154]**), and the objectives and requirements of NHS England for each financial year are set out in the Mandate (as discussed in paragraphs 223 to 233 below).

80. Statutory ALBs (such as NHS England) do not set strategic national health and/or public health policy but have a key role in implementing and advising on it. The Government, via DHSC, will seek input from NHS England on how to improve existing policies or address new challenges. NHS England may engage other people

and organisations across the healthcare sector, including service users before providing its advice. The Government is then responsible for selecting from the policy options and ensuring any policy selected is appropriately financed.

81. NHS England is responsible for determining how to operationalise those policies to ensure effective delivery and evaluating their impact. This is reported to Government, via DHSC, through the usual arrangements.[15]

82. One method NHS England uses to communicate priorities out to the sector is through publication of the NHS Priorities and Operational Planning Guidance which sets out the NHS' priorities, typically for the year ahead.[16]

83. Whilst many things changed operationally during the pandemic and NHS England took on many roles beyond its usual remit, the overall parameters of its role in central Government decision making and policy development remained broadly the same as before the pandemic.

84. NHS England did not take on exclusive responsibility for any Government policy and retained its role of providing expert and advisory input (which included providing skilled individuals in areas such as medicines and supply chain), information and modelling, all of which the Government used to inform its decision-making.

85. Both prior to and during the pandemic, NHS England officials at all levels of the organisation regularly met with policy-makers in Government, as part of NHS England's role, contributing to the development of Government policy. There were many channels, including bilateral and ad-hoc meetings, which complemented more formal structures.

86. NHS England officials attended Government meetings such as COBR when requested by Government to do so, and advisory groups such as Scientific Advisory Group for Emergencies ("**SAGE**").

87. In reaching its decisions, the Government had to consider not just NHS England's input, but also that of many others, in and outside of the health sector.

NHS England's operating structure and governance

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[15] See for example the NHS England 2020/21 End-of-year Mandate Assurance Report.
[16] See for example NHS England 2022/23 priorities and operational planning guidance.

88. NHS England is governed by its Board which provides strategic leadership and accountability to Government, Parliament and the public. Further detail regarding NHS England's governance during the Relevant Period is set out in Annex 3.

89. NHS England operates by way of a national team and a number of regional teams. From 2019 there have been seven regional teams: East of England, London, Midlands, North East and Yorkshire, North West, South East and South West.

90. Regional teams are managed by regional directors who report to the NHS England Chief Operating Officer. Regional teams are responsible for overseeing the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

Working with others

91. In discharging its statutory functions, NHS England works closely with a number of other partners at national and regional level, including HEE and NHS Digital (during the Relevant Period and pre-merger), UKHSA, CQC, NHS Blood and Transplant and NICE, to ensure services are safe, effective and clinically and financially sustainable.

92. NHS England oversees the five NHS Commissioning Support Units ("**CSU**"). CSUs operate across the whole country, providing support to several types of organisations including NHS commissioners, local authorities and non-NHS bodies. CSUs deliver a range of support services that aim to ensure that the NHS receives the benefits of scale, including clinical procurement services, business intelligence services and human resources. CSU staff are employed by the NHS Business Services Authority. Although operationally distinct (referred to in NHS England's governance framework as 'hosted bodies'), CSUs do not have separate legal personality, and are legally part of NHS England. CSU activities are included in NHS England's Annual Report and Accounts except where otherwise indicated.

93. NHS England's work is also supported by a number of external organisations such as Primary Care Support England (provided by Capita plc), as well as those directly accountable to DHSC via SSHSC, such as NHS Business Services Authority, NHS

Shared Business Services, NHS Property Services Ltd, Supply Chain Coordination Limited ("**SCCL**").[17]

Chief Medical Officer and Chief Nursing Officer roles

94. The establishment of NHS England posed the question as to which former DHSC roles could or should be moved or replicated in NHS England to ensure that the identified functions of NHS England could be carried out efficiently.

95. Two critical roles, which were reviewed and recreated in NHS England, were the senior clinical leadership roles of the National Medical Director and the Chief Nursing Officer ("**CNO**").

96. Senior medical leadership is required throughout the English health system:

    a. within DHSC, the Office of the Chief Medical Officer ("**CMO**") exists to provide the Government with advice on medical and public health matters; and

    b. every Trust is legally required to appoint a medical director as part of its governance structure.[18]

    As a tried and tested mode, this was one which NHS England adopted.

97. Consequently, the role of a National Medical Director was created; in effect the 'Chief' NHS Medical Director who was to be operationally facing, not primarily an adviser to the Government.

98. The National Medical Director works solely for NHS England. England is unique among the Four Nations in having both a CMO and a National Medical Director; in the devolved administrations the roles are essentially combined.

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[17] SCCL is the management function of the new NHS Supply Chain operating model (previously known as the "Future Operating Model" following the Lord Carter Review. SCCL was incorporated with the SSHSC as the sole shareholder on 25 July 2017 and became operational on 1 April 2018. On 1 October 2021 ownership transferred from SSHSC to NHS England

[18] Foundation Trusts are required to appoint specific executive directors pursuant to Schedule 7 to the 2006 Act, including one who must be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984). NHS Trusts are required (pursuant to Regulation 4 National Health Service Trusts (Membership and Procedure) Regulations 1990) to an executive directors who is a medical or dental practitioner except where an NHS Trust does not provide services directly to patients or whose principal function is to provide ambulance or patient transport services.

99. In the case of the CNO role, likewise Trusts are required to appoint a chief nurse to their boards[19] and NHS England followed that model.

100. It was considered that DHSC, which already had a CNO, would also require ongoing advice but that it would be duplicative and inefficient to have two separate posts. On balance, it was considered more important that the role sat within NHS England, and therefore, the CNO is employed by NHS England but the appointment makes clear it is also a DHSC facing role.

101. Each of the Four Nations has a CNO.

102. Pre-pandemic, the CNO attended regular meetings with the CNOs of devolved administrations, and the National Medical Director of NHS England from time to time would meet with CMOs from devolved administrations individually or collectively.

Other Chief Officers, National Clinical Directors and speciality advisors

103. Additional roles at NHS England which have a DHSC facing role include the Chief Dental Officer for England and Chief Pharmaceutical Officer for England, with each of these roles also existing in each of the Four Nations. This is in addition to the National Clinical Directors and National Specialty Advisers who are practicing clinicians from across England who work part-time at NHS England, providing clinical leadership, advice, input and support across distinct areas of NHS conditions and services.

NHS England's role in relation to pandemics

104. The roles of NHS England, DHSC, UKHSA, Ministry of Housing, Communities & Local Government ("**MHCLG**")[20] and Cabinet Office and COBR are related but distinct in respect of EPRR. It is the EPRR role of DHSC to work with the devolved administrations and internationally for both planning and responding to emergencies. Health is a devolved issue, so understandably NHS England was not always invited to meetings with the devolved administrations and did not have extensive input.

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[19] Foundation Trusts are required to appoint specific executive directors pursuant to Schedule 7 to the 2006 Act, including one who must be a registered nurse or a registered midwife. NHS Trusts are required (pursuant to Regulation 4 National Health Service Trusts (Membership and Procedure) Regulations 1990) to have an executive director who is a nurse or midwife registered on the register maintained by the Nursing and Midwifery Council; except where an NHS Trust does not provide services directly to patients or whose principal function is to provide ambulance or patient transport services.

[20] Since September 2021 this department has been known as Department for Levelling Up, Housing and Communities ("**DLUHC**")

105. The Government assesses the most serious risks facing the UK or its interests overseas through the National Risk Assessment ("**NRA**").[21] This is a classified assessment of the most significant threats and hazards that the UK could face over the following 5 years and is led by the Civil Contingencies Secretariat ("**CCS**") within the Cabinet Office.

106. Individual Government departments lead on key risks relevant to their portfolio - DHSC is identified as the Government lead department for pandemic preparedness.

107. NHS England contributed annually to the NRA, as subject matter experts, in areas such as major incidents and terrorist attacks where the health service has delivered a response. NHS England did not contribute in areas of wider biosecurity, such as pandemic risk, where the expertise lay with PHE. NHS England receives a copy of the NRA.

108. The National Risk Register ("**NRR**") is the public-facing output of the NRA. It outlines the threats and hazards which organisations like NHS England must prepare for based on a 'Reasonable Worst-Case Scenario' ("**RWCS**") basis. RWCS planning allows plans to cover a wide range of potential scenarios within the scope of the incident that is being planned for.

109. The significance of the NRA and the NRR is that they required NHS England to prepare for the worst that could reasonably be expected in relation to a pandemic caused by a non-specified variant of the influenza virus. Emerging infectious diseases were also listed in the NRR and mapped to HCID planning.

110. The management of these risks can be summarised by the following diagram:[22]

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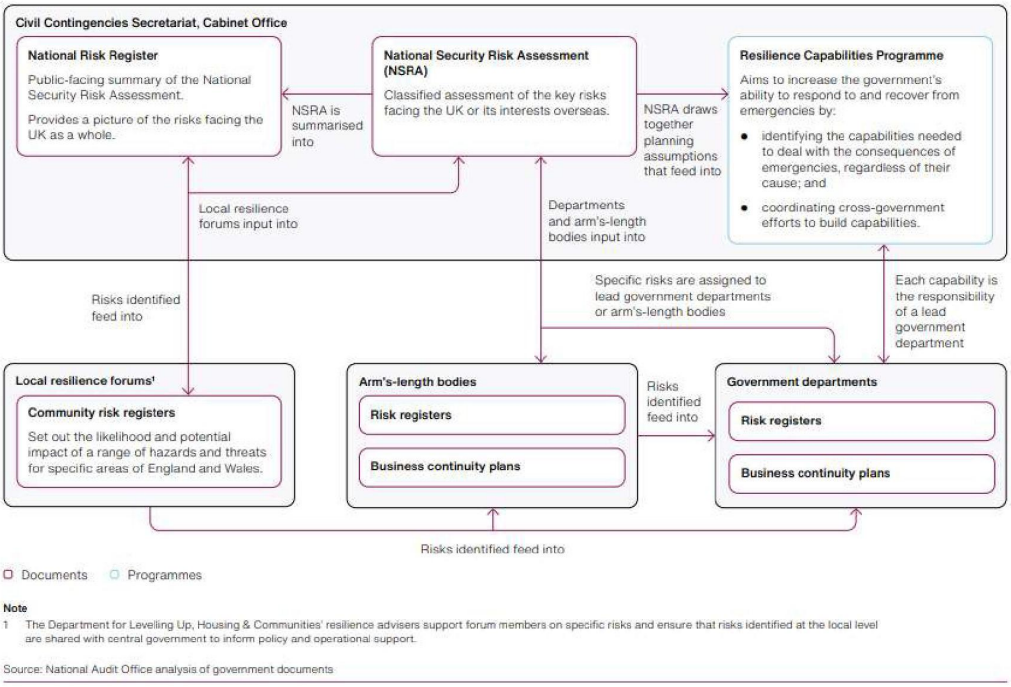
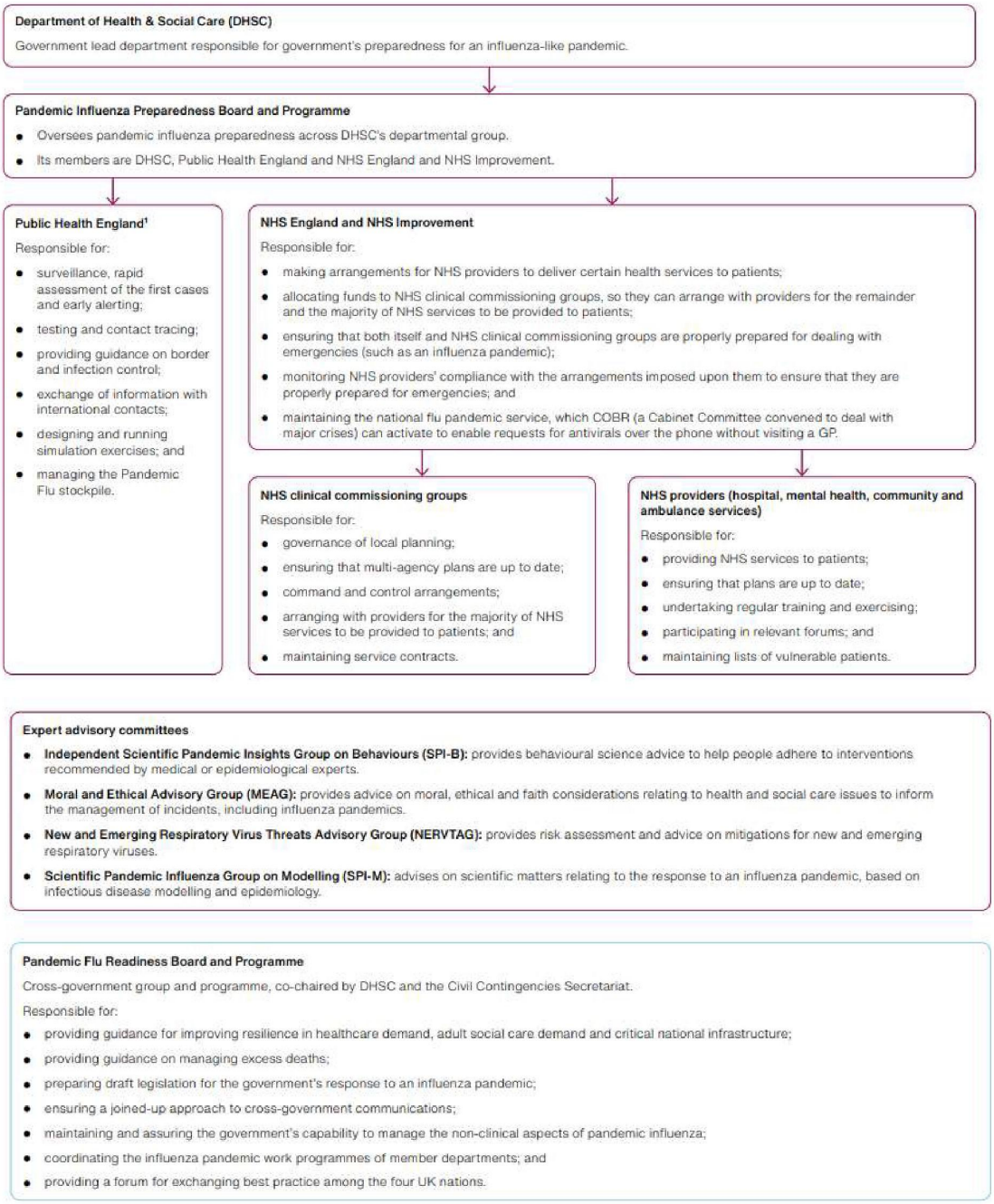
[21] The National Risk Assessment and National Security Risk Assessment merged to be one document in 2019.
[22] The Government's preparedness for the Covid-19 pandemic: lessons for government on risk management, Session 2021-22 19 November 2021 HC 735 (published by the NAO) **[INQ000113283]**.



111. The roles and responsibilities for preparing for pandemic influenza can be illustrated through the diagram set out below:[23]

[23] The Government's preparedness for the Covid-19 pandemic: lessons for government on risk management, Session 2021-22 19 November 2021 HC 735 (published by the NAO)



Notes

1 In October 2021, Public Health England's health protection duties were transferred to the UK Health Security Agency, a newly established executive agency of the Department of Health & Social Care.

2 This figure only includes bodies and groups that have specific responsibilities for preparing for an influenza pandemic. Other bodies, set out in Figure 3, have responsibilities for preparing for an influenza pandemic as part of their wider responsibilities for risk management and emergency planning.

Source: National Audit Office review of government documents and interviews with government officials

112. This distribution reflects the response to pandemic influenza based on a "DATER" approach (**D**etection, **A**ssessment, **T**reatment, **E**scalation and **R**ecovery), with

different organisations being responsible for each phase consistent with their legal and statutory framework:

a. **D**etect and **A**ssess phases: Led by PHE. This is when there are initial cases and small clusters in the country and the focus is on understanding the epidemiology of the virus.[24]

b. **T**reat and **E**scalate phases: The NHS takes the lead for pandemic influenza response during the Treat and Escalate phases, when there is an increasing demand on services, as the number of patients with influenza increases.

c. **R**ecovery phase: Alongside planning for and delivering a pandemic response, it is essential that the recovery phase is also planned and managed. It is essential that plans are maintained after it appears the pandemic has abated in the event that there is a further wave of disease.

Civil Contingencies Act 2004

113. NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 ("**CCA 2004**") and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the "**2005 Regulations**").

114. Other Category 1 Responders include:

a. UKHSA (previously PHE) under delegation from SSHSC;

b. DHSC on behalf of SSHSC;

c. NHS foundation trusts if, and in so far as, they have the function of providing ambulance services, or hospital accommodation and services in relation to accidents and emergencies; and

d. local authorities.

115. The CCA 2004 requires Category 1 Responders to assess, plan and advise, which includes a requirement to undertake a number of tasks, specified in section 2(1) of that Act.

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[24] Testing for communicable diseases in the community is and has traditionally been a public health function.

116. NHS England, as a Category 1 Responder, has certain duties of co-operation under the 2005 Regulations. This includes co-operation with other general Category 1 Responders in connection with the performance of their duties and co-operation with relevant general Category 2 Responders (listed in part 3 of schedule 1 to CCA 2004, and which included CCGs until July 2022)[25] in so far as such co-operation relates to or facilitates the performance of the relevant general Category 1 Responder's duties.

117. There is a reciprocal duty on relevant Category 2 Responders to co-operate with relevant Category 1 Responders, as well as a duty for Category 2 Responders to co-operate with each other. Under the CCA 2004 and 2005 Regulations, responders have a duty to share information with partner organisations.

118. NHS Improvement, NHS Digital and HEE were not Category 1 or 2 Responders under the CCA 2004.

119. Primary care (including out of hours providers), community providers, mental health service providers, specialist providers, NHS Property Services and other NHS organisations are not listed in the CCA 2004 and may not be contracted via an NHS Standard Contract (which sets out certain requirements within the Service Conditions regarding EPRR). However, NHS England's EPRR Framework expects them (as NHS funded organisations) to plan for and respond to emergencies and incidents in a manner which is relevant, necessary and proportionate to the scale and services provided. Guidance for primary care, for example, has been updated due to lessons identified from the pandemic to a include provision confirming that practice business continuity plans should also consider practice resilience arrangements including the capability for home and remote working, alternate consultation channels (e.g., online, video) and exceptional demand management (**[INQ000113337]**).

NHS England's Emergency Preparedness, Resilience and Response Function

120. NHS England recognises that the scope of Module 1 deals with preparedness; however, in order to contextualise NHS England's response within the Relevant Period, and support Module 3, it is helpful to set out, at a high level, details regarding NHS England's EPRR Function.[26]

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[25] Since July 2022, ICBs established under section 14Z25 of the 2006 Act have also been Category 1 Responders.

[26] The Witness Statement of Dr. Michael Charles Prentice in relation to Module 1 (and published on the Inquiry's website) sets out detail NHS England's EPRR role since establishment **[INQ000177805]**.

121. In England,[27] NHS England is responsible for setting a risk-based EPRR strategy for the NHS, ensuring there is a comprehensive NHS EPRR system, and leading the mobilisation of the NHS in the event of an emergency, working with partners where a joint response is needed.

122. In relation to EPRR, NHS England works with a range of national partners, including the devolved administrations and other Government departments and public bodies, as well as regional and local partners.

123. NHS England has had an EPRR team in place since 1 October 2012. The EPRR function is organised on a national and regional basis, to reflect the fact that planning, preparation and response can need different levels of co-ordination. The national EPRR team sits within the NHS England Chief Operating Officer's directorate.

124. NHS England maintains an EPRR Framework, together with a number of specific incident plans as well as a generic overarching 'Incident Response Plan', not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

125. The Incident Response Plan confirms, amongst other things, who in NHS England has the authority to activate a national response as well as the activation of relevant response structures.

126. Annex 2 provides details of the Key EPRR documents in place during the Relevant Period for information.

127. In the years prior to the pandemic, working with partners, NHS England maintained standing plans for HCID incidents and for pandemic influenza **[INQ000113189]** as directed by DHSC and the NRA. Both plans were maintained and updated in discussion with national and regional stakeholders and in response to learning from incidents and exercises. The plans supplemented NHS England's overarching national EPRR Framework, and the NHS Core Standards for EPRR ("**EPRR Core Standards**") (the minimum requirements for NHS funded organisations) which every Trust and CCG (as they then were) were required to fulfil (**[INQ000113145]**).

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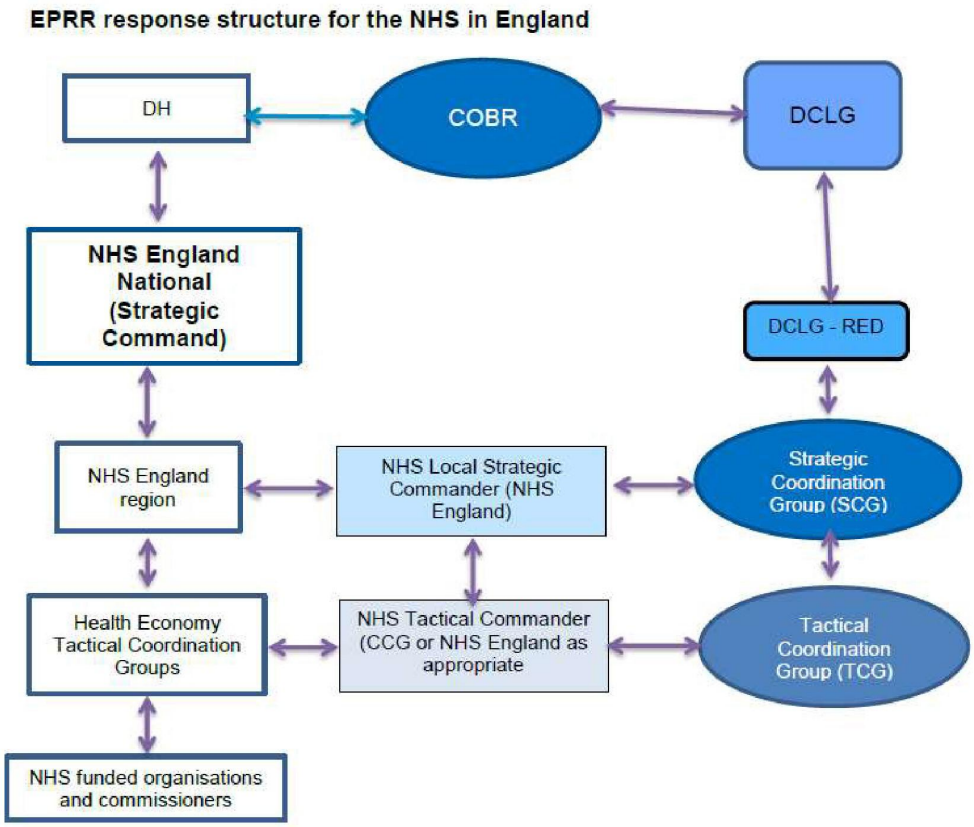
[27] As health is a devolved matter, there are four distinct health systems within the UK.

128. For the purposes of the Relevant Period, NHS England's EPRR Framework 2015 applied **[INQ000113172]**. [28]

129. The EPRR response structure for the NHS in England, as set out in the Incident Response Plan and the 2015 Framework, during the Relevant Period can be illustrated as follows:



130. In relation to the NHS in England, all NHS-funded organisations are required by the EPRR Core Standards to have an Accountable Emergency Officer ("**AEO**") for EPRR. NHS England also has an AEO.[29]

131. NHS England's regional teams represent NHS England on Local Resilience Forums ("**LRF**") and Local Health Resilience Partnerships ("**LHRP**") (including sub-groups) and various regional groups (e.g., steering groups and health protection groups) as well as directly working with, for example, NHS funded organisations, NHS

[28] To take into account changes made by the 2022 Act, an updated version was published in July 2022
[29] NHS England AEOs since establishment: Dame Barbara Hakin, Ian Dalton, Matthew Swindells, Amanda Pritchard and David Sloman.

commissioners, safety advisory groups, Ministry of Defence (Joint Regional Liaison Officers), Directors of Public Health and PHE (now UKHSA).

132. LRFs are multi-agency forums made up of representatives from Category 1 Responders and are supported by Category 2 Responders. The geographical area of forums is based on police areas (apart from London, where one area covers London boroughs and the city of London).

133. LHRPs provide a strategic forum for joint EPRR planning across a geographical area; they are not statutory organisations. LHRPs coordinate strategic planning for incidents impacting on health or continuity of patient services and effective engagement across LHRP and local health economies. LHRPs feed into the activity of LRFs in relation to health planning but are not formally part of any LRF (**[INQ000226884]**). [30]

134. In 2019, the National Director for Emergency Planning and Incident Response identified a need for an additional resource to provide specific focus on risks which had not yet materialised. This need was based on learning from the increasing frequency of incidents, 'market' conditions and potential incidents (such as potential failures of providers on which the NHS was dependent).

135. To meet this need, a national Potential Incident Investigation, Preparation and Recovery ("**PIIPR**") team was piloted from late 2019. The role of the PIIPR team was to work in support of the EPRR team, undertaking rapid background investigation and analysis in relation to providers. This was so that when a risk materialised the EPRR team would have all of the necessary information on which the Incident Management Team ("**IMT**") could make decisions in relation to its coordination role; the IMT would know that those decisions would be based upon accurate data and information. Once the acute phase of the incident was resolved it was anticipated that the PIIPR team would support the return to business as usual or new business arrangements (as appropriate).

136. The newly formed PIIPR team almost immediately became responsible for leading the NHS England programme to plan for and prepare the NHS for the UK's departure from the European Union ("**EU Exit**"), and for then maintaining an EU Exit response

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

capability throughout the transition period. NHS England's role in EU Exit, including impact and lessons, is set out in Annex 4.

Exercising

137. The range of potential threats and hazards that NHS England must prepare for requires periodic exercising to test plans and roles, without creating a constant exercise mode scenario. The NHS operates 24/7, so time taken to exercise needs careful resource planning.

138. An emergency preparedness exercise helps to increase and improve health emergency preparedness, by running through the circumstances and sequences that would occur within an emergency and how the NHS would recover from a set of circumstances.

139. Nationally, DHSC funded and commissioned PHE to co-ordinate a programme of training and exercises, some of which the NHS and NHS England took part in, e.g., Exercise Cygnus (pandemic influenza).[31] When involved in such exercises, NHS England would work closely with PHE to help plan for and design these. The theme would change each year depending on what was in the NRA (e.g., terrorism, pandemic influenza etc.). NHS England would also itself commission exercises e.g., Exercise Northern Light (for Ebola) to test the operational response to specific scenarios. NHS England did not take part in all preparedness exercises that are organised by PHE.

140. Regional exercises would similarly be co-ordinated by PHE and aligned to the theme set by the national EPRR team. NHS England's regional teams would work with PHE to tailor the exercise to local services (e.g., police, social care, air ambulance, coastguard, local authorities etc.). LRFs may also run local exercises to test local plans.

141. The main types of exercises used in the NHS are:

    a. Discussion-based (DBX)/ Table-Top (TTX): this type of exercise brings together relevant staff, and partners as required, to discuss the response, or specific element of a response, to an incident. A particular scenario is worked through and this can provide validation to a new or revised plan. Participants

[31] NHS provider organisations were able to commission training and exercising directly from PHE.

interact and gain knowledge of their own, and partner organisations' roles and responsibilities.

b. Command post (CPX): this tests the operational element of 'command and control' and requires the setting up of the Incident Coordination Centre ("**ICC**"). It provides a practical test of equipment, facilities and processes and provides familiarity to those undertaking roles within the ICC. It can be incorporated into other types of exercise.

c. Field (also called live): this is a live test of arrangements and includes the operational and practical elements of an incident response. For example, simulated casualties being brought to an emergency department or the setting up of a mass countermeasure centre, hostage situation or mass evacuation.

d. Communications: this exercise ensures that organisations are able to make contact with key staff, providers and organisations in the event of a major incident.

e. Off the shelf exercises are also available for independent self-delivery and (emanating from observing Covid-19 restrictions at the time) virtual exercises have been developed.

142. During each exercise it is intended that all participants and key stakeholders can identify key lessons and make recommendations to further enhance and improve their operational response to each scenario. These would be documented in a final report for each exercise.

143. Since establishment, NHS England has participated in a range of exercises dealing with matters from international sporting events such as the Commonwealth Games, terrorist incidents, nerve agents, the death of a senior member of the Royal Family, and cyber-attacks, to human diseases such as pandemic influenza and HCIDs.

144. Relevant NHS funded organisations are required to undertake defined exercises, at defined intervals, to test plans to ensure they are fit for purpose in accordance with the EPRR Framework.

Learning from exercises

145. Although the scope of Module 1 deals with exercising prior to the pandemic, this section has been included to highlight some of the key exercises that NHS England

participated in leading up to the Relevant Period, and which directly, or indirectly, assisted with preparedness for the pandemic.

146. NHS England has a regular programme of training and exercising delivered by PHE across the NHS at regional and local level - this programme reflects the NRR. This is audited through the EPRR assurance process to ensure training and exercising are consistent with best practice.

147. Surge Capacity Exercise for Ebola (March 2015) (**[INQ000113299]**):

    a. The exercise was designed to consider the current arrangements and capabilities of the four HCID surge centres (at that time) in England and their options for surge capacity in response to multiple positive cases of Ebola. Representatives from DHSC, PHE, NHS England, the National Ambulance Resilience Unit, appropriate Ambulance Services, Local Authority, the Health & Safety Executive, Public Health Wales and the Ministry of Defence took part.

    b. Recommendations were focused on improving the management of HCIDs, and led to the development of an HCID plan.

148. Exercise Alice (for MERS) (February 2016) (**[INQ000113294] [INQ000113173]**):

    a. Exercise Alice was a tabletop exercise to explore the challenges that a large scale outbreak of MERS could present nationally to health partners very early on in England. The exercise was prompted by a request from the CMO and was focused on two stages of response; initial actions and public health response and the health care aspects of a wider spread of cases. Participants in the exercise included representatives from NHS England, PHE and DHSC. Additionally, observers from the Cabinet Office, the Devolved Administrations and GO-Science attended.

    b. Recommendations from Exercise Alice were incorporated into the remit of the HCID Programme and were operationalised ahead of the HCID Programme closure or considered as part of the pandemic flu programme (**[INQ000113259]**).

149. Exercise Northern Light (for Ebola) (May 2016) (**[INQ000113279]**):

    a. Exercise Northern Light was commissioned by NHS England to explore the challenges that were likely to arise for the Newcastle upon Tyne Hospitals

NHS Foundation Trust when the Royal Victoria Infirmary (RVI) became the UK's main High-Level Isolation Units ("**HLIU**")[32] facility during the period July to August 2016. The Royal Free Hospital's HLIU was due to be offline for planned refurbishment and upgrade during this period and the intention was that on completion, The Royal Free Hospital was to revert to being the UK's main HLIU facility.

b. The exercise explored the roles and responsibilities of the RVI and key partner organisations in supporting the hospital and the wider health community during the receipt of patients in to the HLIU.

c. The exercise also tested the arrangements for the transfer of patients from an Air Transportable Isolator at the airport into a stretcher isolator unit.

d. The exercise did not identify any immediate risks to staff or patient safety but highlighted areas where resilience could be improved in relation to communications, staffing levels and arrangements for supporting NHS HLIU surge centres. Much of the learning was specific to the physical layout, facilities and staffing of the unit at the RVI.

150. Exercise Cygnet and Cygnus (for Pandemic Influenza) (2016) (**[INQ000113297] [INQ000113185]**):

a. Exercise Cygnus was a command post exercise delivered by PHE on behalf of DHSC. Planning for Exercise Cygnus started in 2014 and was postponed due to the Ebola response (WHO declared Ebola an international health emergency on 8 August 2014). Planning was resumed in December 2015.

b. The exercise was designed to assess the UK's preparedness and response to a pandemic influenza outbreak. The virus that was exercised in Cygnus demonstrates the considerable value of an exercise and the degree of translation that may be useful even if not the exact plan required for a pathogen which later presents.

c. As part of the build up to Exercise Cygnus a national-level table-top exercise called Exercise Cygnet was run to help DHSC, NHS England and PHE prepare for the exercise. Those activities informed the development of

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[32] As further described in the HCID section of this Statement.

Exercise Cygnus, as well as the learning identified from Exercise Cygnus. Internal briefings were also provided within NHS England to provide background on the Pandemic Influenza response (**[INQ000113307]**).

d. Exercise Cygnus focused on the Treatment and Escalation phases (of DATER) of the pandemic response. During these stages the emphasis is on considering the enhancement of public health measures to disrupt transmission, and the escalation of surge management and triage of service delivery, in order to maintain essential services.

e. NHS England contributed to cross government, multi-agency work on pandemic flu planning through the Pandemic Flu Readiness Board ("**PFRB**") (a cross government group chaired by CCS and DHSC) and the DHSC Pandemic Influenza Preparedness Board (health specific, chaired by DHSC).[33]

f. A number of pandemic influenza preparedness workstreams within NHS England, DHSC and other government departments slowed due to EU Exit in addition to other incident responses and winter demands prior to the pandemic. Certain workstreams were paused due to resources being re-directed, whilst others were paused due to interdependencies with other paused workstreams. Workstream progress is set out in the minutes and associated documents of the PFRB (**[INQ000023091] [INQ000105584]**).

g. Cygnus focussed on a fictional airborne influenza virus ('Swan Flu') evolving pandemic which had similarities with Covid-19 (see **[INQ000136256]** for an example of the commonly recognised information (CRIP) picture from the exercise):

    i. The Exercise virus in Cygnus was novel with little pre-existing immunity producing a typical influenza illness of moderate severity lasting 1-2 weeks but with some individuals experiencing an early severe illness including viral pneumonia.

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[33] NHS England's Pandemic Influenza lead became a lead for two workstreams under the remit of the PFRB (healthcare and community services (jointly with DHSC)). NHS England's Pandemic Influenza lead also had an invitation to NERVTAG.

ii. The clinical attack rate is of between 25-50% and Case Fatality Ratio of 2-3%; UK CFR estimate is lower at 1.5% due to expected antiviral drug impact.

iii. No vaccine available or the seasonal flu vaccine offers protection.

iv. The risk of severity and relative mortality was equally distributed across age groups with a slight increase in young adults and those with underlying chronic conditions including the elderly.

v. In the UK 3% of the symptomatic patients would require hospitalisation and up to 291,000 excess deaths could occur.

vi. Clinical diagnosis is used to confirm cases rather than lab testing.

vii. 20% or more of the workforce could be absent during the peak.

viii. Antivirals were only expected to reduce the severity of symptoms and stocks expected to be exhausted 1-3 weeks after the wave peak in 4 weeks.

ix. PPE (respirators and facemasks) orders were in place to enable NHS to draw on stocks to support BAU, if required.

x. The virus was not designated as an HCID at any stage.

h. A number of the lessons from Exercise Cygnus were relevant to NHS England's Covid-19 response, including:

i. The Operating Framework for Managing the Response to Pandemic Influenza was updated following Exercise Cygnus. This document sets out roles and responsibilities within NHS England at a national, regional and local level in relation to the response to a future influenza pandemic. This document, recognising the scale of any pandemic response, also sets out the planning responsibilities of NHS organisations at all levels. This plan formed part of the foundation of NHS England's response to Covid-19 as set out in NHS England's Second Module 3 Statement.

ii. NHS England contributed to the Draft Pandemic Flu Bill (**[INQ000113194]**). This was held ready and rolled into the Coronavirus Bill 2020.

iii. Meetings of the Four Nations Health Ministers and CMOs formed part of NHS England's 'battle rhythm' for the Covid-19 response.

i. Other points raised as part of Exercise Cygnus, such as plans to deploy clinical countermeasures (for example pharmaceuticals and vaccines) in response to a future influenza pandemic are kept under review. Similarly, matters such as Military Aid to the Civil Authorities would need to be considered at the time on a case-by-case basis in line with normal procedures.

j. NHS England commissioned Exercise Pica to examine the impact of a pandemic influenza on the primary care system following the Exercise Cygnus recommendations (see paragraph 152 below).

k. Exercise Cygnus assisted regional teams working during the early stages of Covid-19, specifically in relation to communications and management of individuals repatriated from Wuhan and the cruise liner 'Diamond Princess'.

l. Exercise Cygnus did present a challenge in the way in which it was designed. It did not allow the participants to fulfil the roles, due to the then SSHSC calling an early closure of the exercise. NHS England gave an assessment, based upon the data provided by PHE, that this did not allow surge arrangements to be explored because the data suggested that critical care was already overwhelmed.

151. Exercise Broad St (for Lassa and H7N9 Influenza) (January 2018) (**[INQ000113195]**):

a. PHE and NHS England had developed protocols and plans as part of the joint HCID programme to describe clinical and public health operations for the definitive HCID service for England.

b. The Ebola outbreak in West Africa in 2014 to 2015 challenged the ability of the NHS in England to provide appropriate, scalable care for HCIDs. The learning from Ebola needed to be consolidated and incorporated into a long-term resilience plan to enable the NHS in England to deliver care safely and effectively for a wider range of known and unknown HCIDs.

c. Exercise Broad Street was designed to test HCID pathways and algorithms for the HCID service in England. Both contact (Lassa Fever) and airborne (H7N9 influenza) HCIDs were used in the scenario.

d. Findings from this exercise were incorporated into ongoing development of the HCID approach.

152. Exercise Pica (for Pandemic Influenza) (September 2018) (**[INQ000113205]**):

a. Exercise Pica was sponsored by NHS England.

b. Pandemic influenza remained at the top of the NRR. One of the lessons identified as part of Exercise Cygnus concerned the NHS's ability to scale-up its services during a pandemic, including primary care which would play a key role in providing health care and reassuring the public.

c. Exercise Pica reviewed and assessed pandemic influenza preparedness and response within primary care by providing an opportunity to review and explore the existing processes and arrangements.

d. Following Exercise Pica an action plan was developed to track recommendations (**[INQ000113308]**).[34]

EPRR Assurance

153. Formal assurance of local, regional and national emergency preparedness takes place annually.[35] The assurance process helps to identify areas requiring further attention (via action plans) as well as building upon good practice that can be shared.

154. NHS-funded organisations run an assurance check every year against the EPRR Core Standards and undertake an annual self-assessment subject to a peer review from other NHS organisations.

155. NHS-funded organisations are required to provide evidence of their compliance to their board, at a public board meeting, and for their board to issue a Statement of EPRR Conformity to their commissioners.

156. For NHS England, those reports inform the assurance report that has been presented to the NHS England Board (in public) annually (see: **[INQ000113156], [INQ000113162], [INQ000113175], [INQ000113183], [INQ000113193], [INQ000113217]**). That report identifies where there are gaps and informs the work plan for the following year. This process in turn informs the NHS England annual

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[34] Primary care will be discussed in further detail in NHS England's Fourth Module 3 Statement.
[35] On 6 March 2020 NHS England's Strategic Incident Director wrote to organisations to ensure NHS preparedness **[AP016 INQ000269899]**

statement of assurance provided to DHSC in relation to EPRR. At each meeting of the EPRR Partnership Group (a tripartite group between DHSC, PHE and NHS England) one of the agenda items was EPRR Assurance and both NHS England and PHE reported on EPRR assurance at these meetings.

157. The assurance papers provided to the NHS England Board annually seek to:

a. update the Board on NHS EPRR statutory requirements placed upon NHS England by the CCA 2004 and the 2006 Act, as required by the NHS England EPRR Framework; and

b. provide the Board with assurance that NHS England and the related NHS bodies in England are prepared to respond to an emergency.

158. To meet the objectives in paragraph 157 above, the assurance papers update the Board on actions since the previous year's report and the outcome of the annual EPRR assurance process and resulting actions. This includes an update on incidents, lessons learned, training and development, audit and review and other key activities undertaken by EPRR. DHSC are recipients of NHS England board papers.

159. The NHS England Annual Report contains a section on EPRR, which details the range of potential threats to patient and public safety during the relevant year. For example, the 2019/20 Annual Report detailed information regarding the pandemic response to date, EU Exit and the London Bridge terrorist attack. It set out how, before the pandemic, the NHS responded to the threat of HCIDs both in England and overseas, including the threat to the UK from the Ebola outbreak in the Democratic Republic of Congo, repatriation of workers suspected of being exposed to Lassa Fever, and one case of Monkeypox. This was in addition to several other incidents including Listeria contamination and the home parenteral intravenous nutrition shortage (**[INQ000113272]**).

160. NHS England is not aware of any organisations having not participated in the annual assurance process. It was each regional team's (and more recently ICB's) responsibility to support all organisations to ensure they participate in the process recognising local challenges.

161. For the 2018/19 assurance process, 13 NHS funded organisations returned an overall organisational assurance rating of non-compliance that year, this included one CCG and six Trusts.

162. All organisation's EPRR assurance ratings are based on the percentage of Core Standards that the organisation asses itself as being fully compliant with. Organisations that report non-compliant organisational assurance ratings are fully compliant with up to 76% of the relevant Core Standards. Where an organisation has not assessed itself as fully compliant against a specific Core Standard, the expectation is that these will be included in an action plan to achieve full compliance within the following 12 months.

163. It would not be considered unusual for organisational assurance ratings to change following an initial self-assessment and on the outcome of local assurance processes and peer review with health partners - as this provides the opportunity for scrutiny and benchmarking of returns. During 2018/19, the process of local assurance was led by the LHRPs on behalf of NHS England who would facilitate 'confirm and challenge' sessions. Once the self-assessment has been agreed, the organisation's final overall assurance rating is the then formally reported to and signed off by the organisation's board/ governing body/ senior management team; presented to a public board meeting (where one exists); and published in the organisation's annual report.

164. Of the 13 organisations that reported organisational assurance ratings of non-compliance in 2018/19, 10 reported an improved position as part of the 2019/20 annual assurance process. The three organisations which remained as non-compliant were the focus of intensive support work by the relevant regional team and locality team to address gaps.

165. With specific regard to pandemic preparedness, the 2018/19 assurance process required organisations to assess their compliance against the following Core Standard which referred specifically to "Pandemic influenza":[36]

[36] Local organisational level detail of self-assessments and compliance against specific standards not held nationally.

Domain	Standard name	Standard Detail	Supporting information
Duty to maintain plans	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

166. As part of a triannual review of Core Standards which was undertaken in 2021/22, the standard was renamed "new and emerging pandemic" and reworded to reflect generic (disease agnostic) pandemic arrangements rather than disease specific planning, and differentiate separately from arrangements that were likely still in place at the time to respond to the pandemic.

NHS England's EPRR Incident Levels

167. The EPRR Framework separately sets out three types of incident:

a. business continuity: an incident where an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. This could be a surge in demand requiring resources to be temporarily redeployed.

b. critical: a localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services. Patients may have been harmed or the environment is not safe, requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/ disruption to services that are or will have a detrimental impact on the organisation's ability to deliver safe patient

care.

c. major: any occurrence that presents a serious threat to the health of the community, or causes such numbers or types of casualties, as to require special arrangements to be implemented (as was the case with Covid-19).

168. Within the NHS, EPRR incidents are also described in terms of the level of response and coordination required, which may change as the incident evolves. They must be used by all organisations across the NHS when referring to EPRR incidents. Appendix 1 to the EPRR Framework describes how escalation and de-escalation decisions are made, and the box below details, at a high level, each incident level:

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

169. The incident level informs how the EPRR Framework will respond. When NHS England moves to a Level 3 or 4 Incident, the Framework allows for both the architecture of NHS England and the NHS to pivot to support incident response, significantly increasing capacity to respond to that incident, and potentially displacing other activity that the NHS or NHS England would usually carry out.

170. Throughout the Relevant Period, the NHS in England was at either a Level 3 Incident (**[INQ000113315], [INQ000113274], [INQ000113284]**) or a Level 4 Incident (**[AP005 INQ000087445], [INQ000113316], [INQ000113280]**):

a. A Level 4 Incident response allows for the co-ordination of NHS resources across England. This would only be required in certain situations such as pandemic influenza. In such incidents NHS England (national) gives direction on how NHS resources should be used, and this is co-ordinated and actioned through the NHS England regional teams. Powers could have been exercised by NHS England under section 252A (Role of the Board and clinical commissioning groups in respect of emergencies) or if directed to do so by the SSHSC exercising his powers under section 253 (Emergency powers) of the 2006 Act to deal with the emergency.

b. A Level 3 Incident requires the response of a number of health organisations across geographical areas within an NHS England region. The relevant NHS England regional team takes command, control and coordination of the NHS across their region with national oversight. Tactical command will remain with local responding organisations, as appropriate. Practically, meetings between regional and national teams are based on an agreed rhythm (series of meetings) with mechanisms for briefing on issues and requesting support.

171. The inquiry should note that the NHS EPRR levels are specific to the NHS in England and are not the same as, nor are they interchangeable with, the UK Covid-19 Alert Levels (**[AP006 INQ000270105]**), or any other organisation's alert levels.[37]

172. For reference it is highlighted that issues occurring within the Covid-19 Incident (i.e., EPRR incidents that might normally have been raised as an EPRR 'incident') would not generally have been separately notified to NHS England.

Adult Social Care

173. NHS England has no statutory functions in relation to care homes and social care beyond a general duty to promote integration between health and social care services (Section 13N(2) of the 2006 Act). Responsibility for adult social care and care home provision is primarily shared between the DHSC, local authorities, the CQC and care home providers.

174. The NHS (usually CCGs within the Relevant Period) does, of course, commission healthcare for patients in care homes who need it.

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[37] The EPRR incident levels are also not interchangeable with other incident frameworks within the NHS e.g. the Operational Pressures Escalation Levels Framework or the NHS England Serious Incident Framework.

175. To assist the Inquiry:

a. DHSC has overall responsibility for adult social care policy and funding;

b. pursuant to Part 1 of the Care Act 2014 ("**Care Act**"), local authorities are responsible for meeting individuals' social care needs, including through the commissioning of accommodation in care homes. Sections 14 to 17 and Schedule 12 of the Coronavirus Act 2020 (which came into force on 31 March 2020) relieved Local Authorities of various assessment and other related social care functions;

c. care home providers owe a range of duties to their residents, including a duty to act compatibly with their European Convention on Human Rights, including Article 2 rights (right to life);

d. care home providers are also regulated providers for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**CQC Regulations**"), which set out, among other things:

i. a general duty to provide care in a safe way for service users, which includes, among other things, a specific duty to "assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated";

ii. a duty to employ sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the standards set out in Part 3 of the CQC Regulations;

e. the CQC is responsible, among other things, for monitoring and regulating care home providers' compliance with the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

176. Under section 63 of the Health and Social Care Act 2012, the SSHSC has a power to make regulations enabling or requiring Monitor (part of NHS Improvement during the Relevant Period) to exercise certain specified functions in relation to adult social care in England. As of the date of this Statement no regulations have ever been issued under that section.

Highly specialised services: High Consequence Infectious Diseases

177. This section sets out an overview of how highly specialised HCID Services operate, including:

a. NHS England's role in relation to HCIDs;[38]

b. the criteria to be designated as an HCID;

c. the type of HCIDs; and

d. a high-level overview of the process for admitting patients and capacity.

178. HCIDs are a different threat in comparison to an influenza pandemic. They are rare in the UK, and typically associated with recent travel from countries where the infection is endemic or there is a current outbreak. For example, with Ebola there was typically only one case every few years.

179. The precautionary classification of Covid-19 as an airborne HCID, before it was declassified on 19 March 2020 following a review by the Four Nations Public Health Group (**[AP007 INQ000119498]**), is covered in NHS England's Second Module 3 Statement.

180. As set out previously, NHS England commissions 'specialised services', including a subset of services classified as 'highly specialised'. Each highly specialised service is provided to a smaller number of patients compared to specialised services; usually no more than 500 patients per year. HCID services are part of a wider range of highly specialised services. Services are commissioned for readiness/reaction and resulting activity is very small. They are typically delivered nationally through a small number of specialist centres (**[INQ000113285]**).

181. Only diseases which are designated as an HCID (by the Four Nations Public Health HCID Group) are managed through HCID protocols. These protocols do not apply to other types of incidents that require staff to be appropriately protected, in particular CBRN (chemical, biological, radiological and nuclear incidents), or other infectious diseases.

182. There are many diseases (including influenza) which can cause serious illness which are not classified as an HCID; infectious diseases are dealt with by the NHS as part of business as usual.

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[38] Further detail regarding the HCID Programme is set out in the Second Witness Statement of Dr Michael Charles Prentice submitted as part of Module 1 and published on the Inquiry's website.

183. The decision to designate a particular disease as an HCID is made by public health agencies based on the criteria set out below. In a new and emerging infection, this assessment is likely to change over time as more becomes known about the characteristics and impact of the disease. NHS England does not have a role in this process, although NHS England will work closely with these agencies in the case of an emerging infection where a designation may be made on a precautionary basis and is kept under review.

184. An HCID is defined according to the following criteria:

a. acute infectious disease;

b. typically has a high case-fatality rate;

c. may not have effective prophylaxis or treatment;

d. often difficult to recognise and detect rapidly;

e. ability to spread in the community and within healthcare settings; and

f. requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely.

185. HCIDs are then further classified based on their mode of transmission, contact and airborne:

a. contact HCIDs ("**HCID-C**") are usually spread by direct contact with an infected patient or infected fluids, tissues and other materials, or by indirect contact with contaminated materials and fomites e.g., Lassa fever, Crimean Congo haemorrhagic fever, Ebola and Marburg virus disease; and

b. airborne HCIDs ("**HCID-A**") are spread by respiratory droplets or aerosol transmission, in addition to contact routes of transmission e.g., Andes virus infection (hantavirus), Middle East respiratory syndrome ("**MERS**"), Monkeypox (Clade (variant) I only), Pneumonic plague and Severe acute respiratory syndrome ("**SARS**").[39]

186. If an HCID is identified, an IMT would be established to ensure that the patient is admitted to the most appropriate clinical facility in England (devolved administrations

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[39] SARS is still designated as an HCID in the UK as it remains a notifiable disease under the International Health Regulations (2005) but there have been no reported cases since 2004.

are dependent on HCID facilities in England). The local clinician and the IMT would agree admission and would coordinate transport from the location where the initial diagnosis has been made. Transport may involve the use of national assets such as the RAF Tactical Medical Wing (if overseas) and the Air Transit Isolator or specialist paramedic Hazardous Area Response Teams ("**HART**") in the UK (see paragraphs 194 - 195).

187. Patients require careful management to prevent the staff caring for them from becoming infected. This service is required to be in a heightened state of preparedness and there are specific PPE requirements which apply to diseases with that designation.

188. NHS England's HCID plan consists of HCID Standing Operating Procedures for both modes of transmission (see Annex 2), which is about internal process/ actions for the National EPRR Duty Officer to follow when on-call and notified of a confirmed case.

189. There are two NHS HCID networks governing the provision of care, grouped under two main headings relating to their mode of transmission: contact and airborne.

190. HCID beds and HLIU require a number of features for that designation. HLIUs are specialist facilities to manage patients with HCIDs that are spread by contact and not the airborne route.

191. HCID-C units are located at the Royal Victoria Infirmary (Newcastle) and the Royal Free Hospital (London), with secondary units at the Royal Liverpool Hospital and the Royal Hallamshire Hospital, Sheffield. Both the Royal Victoria Infirmary and the Royal Free Hospital are HLIUs.

192. HCID-A units are located at Guy's and St Thomas' NHS Foundation Trust (adult and paediatric services), Royal Free London NHS Foundation Trust, with a paediatric service provided by Imperial College Healthcare NHS Foundation Trust (St Mary's), Liverpool University Hospitals NHS Foundation Trust, with a paediatric service provided by Alder Hey Children's NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust (adult and paediatric services). Each centre routinely provides 2 beds (8 in total for HCID-A). Specific service specifications outline the care pathway and unit requirements (**[INQ000184161] [INQ000184160]**).

193. In 2019/20 NHS England's total spend on all specialised services was £18.5 billion. NHS England's expenditure on airborne HCID was <£1 million and on contact HCID was >£1 million but <£8 million in 2019/20 (**[INQ000113285]**).[40]

Specialist response services: Hazardous Area Response Team (HART)

194. HART is a nationally commissioned and available resource that is hosted across the 10 ambulance trusts in England.[41] HART personnel are paramedics with additional specialist training. There are 15 HART vehicles, which are not patient carrying vehicles. If a patient needs transport then a standard NHS emergency ambulance is deployed. HART personnel may or may not accompany a patient.

195. HART was not originally established to undertake HCID transfers/swabbing of infectious patients. This is a role that has developed since the inception of HART. HART was originally established to deal with incidents such as CBRN and MTA (marauding terrorist attacks), Safe Working at Heights and Swift Water Rescue. HART was not designed as a capability for pandemic preparedness or HCID, these capabilities have been developed because of changes in the threat assessment.

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[40] The devolved administrations do have infectious disease units where HCID patients might be initially taken, for example, Gartnavel in Glasgow and a case of Crimean Congo haemorrhagic fever.
[41] Isle of Wight service does not have HART, Isle of Wight is a combined Trust and so Acute and Ambulance are all part of single trust.

SECTION 2: THE RESILIENCE OF THE NHS PRIOR TO THE PANDEMIC

Overview: Resilience

197. The 2015 EPRR Framework defined resilience as the "*ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges*".

198. To "withstand, handle and recover", a system requires a stable platform, and ideally, 'headroom' or the means to create headroom. Headroom which creates resilience can be made as a result any of the following:

    a. the ability to deploy reserve or acquire new resources at speed (e.g., surge beds, additional or redeployable staff, stockpiles of equipment, medicines and consumables and laundry);

    b. the ability to change the designated function of a particular resource (e.g., use capacity for pre-planned care for emergency care when required); and/or

    c. the reduction or cessation of other less time critical activity (with decisions taken as close to the patient and/or incident as possible).

199. Key features of capacity to ensure a stable platform include:

    a. *funding*: to procure resources for all services;

    b. *workforce*: people to provide the range of clinical and non-clinical skills, expertise and services required in and out of hospital (e.g., to support and deliver assessment, triage, investigations, treatments, record keeping, dispensing, after care and recovery, and wider management);

    c. *bedded areas of different types*: in which to treat patients' specific needs (inpatient and day cases for clinical specialities, including critical care and paediatric);

    d. *estate*: for face-to-face patient care, to shelter the physical resources, and facilitate the different types of healthcare environment and technology (e.g., provide medical gases (including oxygen), diagnostic equipment (including scanners) and data access);

e. *access to supplies used in treatment*: such as medicines,[42] non-pharmaceutical products, consumables and laundry; and

f. *access to information systems and data*: to assess capacity issues and understand where best to deploy resources.

200. NHS England does not have the principal responsibility for all of these key features. For example:

a. most centrally procured physical supplies are procured by or on behalf of DHSC; and

b. estates and fabric and fittings of hospitals are the responsibilities of the health care provider, with overall capital budgets and capital expenditure approvals set by DHSC.

201. The NHS and its staff are experienced at managing surges in activity through flexing existing capacity. Flexing capacity is required to prioritise resources for both unpredictable incidents (such as terrorist attacks) and predictable events (such as winter when pressure on UEC services are at their highest).

202. The NHS has historically had low bed numbers and high bed occupancy levels compared with other G7 and European countries, which meant that coming into 2020 there was little flexibility in the existing capacity to respond to a rapid and significant surge in demand.

203. NHS England (and its predecessors) has collected and published data on a range of matters for a long time. This is covered in more detail below. The data collection for bed occupancy has been in its current form since 2010.[43] The data is segmented as follows:

a. Day only inpatient beds, which includes general and acute ("**G&A**"),[44]

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[42] NHS England's Third Module 3 Statement deals with medicines supply.
[43] See NHS England's published 'Bed Availability and Occupancy Data' – Overnight Statistics
[44] As described further in NHS England's Second Module 3 Statement (i) critical care encompasses 'intensive care' and 'high dependency' units. Critical care is needed if a patient needs specialised monitoring, treatment and attention, for example, after routine complex surgery, a life-threatening illness or an injury; (ii) G&A beds are intended for those patients who require short-term medical care and treatment in hospital, for acute illnesses or injuries. They are typically located in medical, surgical, or speciality wards in hospitals. For the purpose of this Statement, G&A beds are distinct from critical care,

Learning Disabilities, Maternity and Mental Illness admissions;

b. Overnight inpatient beds, again which includes G&A, Learning Disabilities, Maternity and Mental Illness admissions; and

c. Critical care beds.

204. In 2018, England also had one of the lowest numbers of acute hospital beds per head of population across OECD countries. NHS England had acknowledged this publicly.

205. Around one in five mental health and learning disability beds were closed between 2013 and 2019, as the NHS responded to concerns following the Winterbourne View scandal and the Building the Right Support agenda. This agenda focused on providing care to support people living independently in the community, improving quality of care and productivity. Following the publication of the Five Year Forward View for Mental Health, there was an increase in access to talking therapies, provision of community perinatal mental health services in all parts of England, improved access to children and young people's mental health services and eating disorder services, and adult liaison psychiatry teams in all acute hospitals.

206. Within acute services, significant focus was also placed on reducing length of stay, increasing the amount of inpatient care that was delivered via day-cases, outpatients and same-day emergency care; avoiding overnight admissions to hospital; and improving quality and efficiency. In 2018 the NHS in England had one of the shortest inpatient lengths of stay among OECD countries, having achieved one of the largest reductions internationally.

207. Even with significant reductions in length of stay, challenges across the wider health and care system, including social care capacity, means that timely discharge from hospital for many older patients is difficult due to, for example, DTOC. The combination of these challenges resulted in NHS hospitals in England operating at one of the highest occupancy rates internationally (**[INQ000113287]**).

208. NHS resilience is also affected by the resilience of systems on which it depends, but which are outside of the control of the NHS (such as social care).

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mental health and learning disability, or maternity beds; and (iii) a 'hospital bed' includes any device that may be used to permit a patient to lie down when the need to do so is as a consequence of the patient's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment, or transport.

Planning for winter

209. Planning for winter is an annual example of how the NHS actively ensures that the capacity available is used most effectively. Resilience issues are anticipated every year and significant preparation takes place months in advance.

210. The NHS England Board maintains an overview of planning: see for example (**[INQ000113201]**). Then in the intense periods, daily updates on the pressures on UEC services are available to NHS England's executive directors every weekday, and at weekends during the winter period. During the winter these situation reports ("**SitReps**") are published; for example, in the winter of 2019/20 SitReps were published from 13 December, covering the position from 2 December. These include key measures around acute care - bed occupancy, critical care capacity, ambulance arrivals/delays, and the responsiveness of the NHS 111 service (**[INQ000113323]**, **[INQ000113326]**, **[INQ000113324]**, **[INQ000113325]**, **[INQ000113327]**, **[INQ000113329]**, **[INQ000113328]**).

Measuring and Monitoring Capacity

211. NHS England's approach to measuring capacity and identifying system pressures is similar to that of other developed countries. NHS England publishes regular data across a range of services.

212. As an official statistics service, NHS England, through its Analytical Services function, routinely publishes and disseminates a large number of National Statistics products "*to inform debate, decision-making and research both within Government and by the wider community*". These cover the capacity and use of a wide range of healthcare services (**[INQ000113218]**). NHS England's National Statistics are required to comply with the Code of Practice for Official Statistics, while NHS England's official statistics follow the Code as best practice (**[INQ000113203]**).

213. Those existing data collections included the Hospital Episode Statistics database, or **"HES Data"**, which is collected by NHS Digital and shared with NHS England as well as NHS providers. HES Data is collected from NHS hospitals and independent providers where the care is NHS-funded, and details admissions, A&E attendances and outpatient appointments to include the following:

    a. clinical information about diagnoses and surgical interventions;

    b. patient information such as age group, gender and ethnicity;

c. administrative information such as dates and methods of admission and discharge; and

d. geographical information such as where patients are treated and the area in which they live.

214. HES Data is subject to strict statistical disclosure rules, in order to suppress small numbers so as to avoid individuals being identifiable when shared with NHS England and providers. HES Data is used by NHS England and others to, amongst other things, monitor trends and patterns in NHS hospital activity but also to form the basis of monthly publications. It therefore became another broad source of intelligence as to what was happening on the ground during the pandemic. HES Data is used by NHS Digital to produce a number of published datasets, to include:[45]

a. monthly publication of:

i. a high-level breakdown of hospital episodes, both inpatient and outpatient (since 2009); and

ii. a monthly breakdown, both nationally and at individual provider level, of care quality indicators for Emergency Departments, to include total time spent in A&E, time to assessment, time to treatment, attendances that left A&E before treatment and unplanned reattendances within 7 days (since 2011);

b. annual publication of reports detailing the following areas of activity in English NHS hospitals and English NHS-commissioned activity in the independent sector:

i. A&E (since 2009);

ii. admitted patient care (since 2000);

iii. outpatient care (since 2006); and

iv. maternity (since 2006).

215. Pre-pandemic NHS England also collected (either itself or via NHS Digital) a broad range of SitReps in connection with its health system oversight role, and in many

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[45] These data sets commenced prior NHS England's establishment in October 2012.

cases published data related to those areas. There were, and indeed remain, at least 100 such data collections and a significant number of associated data publications so it is not proportionate to summarise all of them. A full list, including those publications which have been discontinued, can be found on NHS England's website.

216. One such existing SitRep collection, and a particularly important one, is the Urgent and Emergency Care Daily Situation Reports, or "**UEC SitReps**", which continued during the pandemic. These took the form of an annual daily return from acute trusts instigated each Winter to measure performance against metrics including bed occupancy by long stay, G&A, adult critical care as well as paediatric and neonatal intensive care patients. It also collects data on A&E closures, numbers of diverted patients and ambulance handover delays. This has been collected and published down to an individual provider-level since 2010, and although its rapid turnaround from providers meant that minimal data validation was undertaken the data is nonetheless considered fit-for-purpose. The UEC SitReps were used during the pandemic to supplement more Covid-19 focussed data collections and to inform strategic briefing documents, as detailed further below.

217. In addition to the UEC SitRep, we set out below by way of overview, a non-exhaustive list of long-running SitRep collections and associated publications (a number of which pre-date NHS England's establishment in 2012).

Name of data collection	**Details of data collection**	**Publication start date**
Cancelled Elective Operations Data	Number of cancelled elective operations and breaches of the standard. Data is also available on the total number of operating theatres and those which are dedicated day case theatres.	1996 (although paused between April 2020 and February 2022)
Bed Availability and Occupancy	Quarterly collection from all NHS organisations that operate beds, open overnight or day only. It	2000

	collects the total number of available bed days and the total number of occupied bed days by consultant main specialty.	
Monthly Diagnostics Waiting Times and Activity	Primary source for diagnostics waiting times and activity for 15 key diagnostics tests. It is used to measure performance against the operational standard, that less than 1% of patients should wait 6 weeks or more for a diagnostics test.	1 April 2006
Referral to Treatment: 18 Weeks Waiting Times	Data collection to measure performance against the operational standard, that more than 92% of patients on incomplete RTT pathways should not have been waiting more than 18 weeks from referral.	2007
Cancer Waiting Times system	Data to monitor NHS providers' compliance with the government's operational standards for ensuring that cancer services (diagnosis and treatment) are delivered to patients in a timely manner.	2009

Critical Care Bed Capacity and Urgent Operations Cancelled	The monthly situation report collects data on: • The number of urgent operations cancelled, including those cancelled for the 2nd or more time throughout the month. • Critical care capacity, including adult, paediatric and neonatal available and occupied critical care beds, as a snapshot at midnight on the last Thursday of the month.	2010, although this publication was paused in March 2020 in light of the switch to more focussed Covid-19 SitReps related to critical care (as described elsewhere) and critical care bed information also continued to be published through the UEC SitRep (as described above).
Urgent and Emergency Care Daily Situation Reports	Summarised above, but included in this table for completeness.	2010
Weekly, Monthly and Quarterly A&E Attendances and Emergency Admissions	Total number of attendances in the specified period for all A&E types, including Minor Injury Units and Walk-in Centres, and of these, the number discharged, admitted or transferred within four hours of arrival.	2011

Ambulance Systems Indicators and Ambulance Clinical Outcomes	Data to help identify pressures in the urgent and emergency care system and provide early warning of areas where patient care may not meet requirements. Also provides long term measures of Ambulance Service work based upon patient outcomes.	2014
Maternity Services Data Set	All activity relating to the mother and baby or babies, from the point of the first booking appointment until mother and baby or babies are discharged.	2016

218. In addition to the above, each delivery team within NHS England has its own governance and reporting structures, as well as its own key performance indicators. Given the volume and breadth of these we have not attempted to list or source them all here. However, in addition to papers and reports to its Board and sub-committees of the Board, other examples of how the senior leadership of NHS England maintains oversight of capacity and resilience factors include:

a. The publication, as set out above, of national performance statistics covering UEC, planned care, cancer and mental health are exhibited (**[INQ000148444]**). Reports covering the period June 2019 – February 2020 are exhibited at **[INQ000113223], [INQ000113229, [INQ000113232], [INQ000113235], [INQ000113240], [INQ000113243], [INQ000113245], [INQ000113247], [INQ000113253]**. A monthly Combined Chief Executive report ,summarising the latest national position using the national performance statistics published monthly, covering UEC, planned care, cancer and mental health and Activity and Planning Summary dashboards

([**INQ000113242**], [**INQ000113244**], [**INQ000113322**]). Reports are also provided on a regional basis (see exhibit [**INQ000113220**]).

b. Progress against deliverables set out in the NHS Long Term Plan were tracked across a number of metrics. Headline finance metrics included the percentage of overall NHS revenue spent on primary medical and community health services, and the percentage of overall NHS revenue funding spent on mental health services ([**INQ000113278**]).

c. From April 2019, as part of Board Governance, NHS England and NHS Improvement (who at the time had a provider oversight role) had 'committees in common' which included a 'People Committee' (referred to as the People, Remuneration and Nominations Committee in the 2020/21 and 2021/22 NHS England Annual Reports). The committee typically meets three times per year with its role being (amongst other things as further described in Annex 3) to set an overall people strategy and oversee the delivery of the NHS People Plan, and provide the Board with assurance and oversight of all aspects of strategic people management and organisational development. The responsibilities in relation to the NHS People Plan included oversight implementation to support and advise on workforce initiatives and issues, and to support, challenge and advise on NHS Long Term Plan commitments (including strengthening the workforce in primary and community settings via training, recruitment and retention). The papers for the committee include reports and action plans relating to the NHS People Plan, see for example: **[AP008 INQ000270003] [AP009 INQ000270004]**; **[AP010 INQ000270027]**; **[AP011 INQ000270032]; [AP012 INQ000270022]**; **[AP013 INQ000270051].**

The Funding of the NHS

219. The NHS in England provides care free at the point of use.[46] It is funded by the tax-payer, with its budget set by HM Treasury ("**HMT**") and DHSC.

220. Established commentators such as the Health Foundation, the Kings Fund and the Institute for Fiscal Studies regularly report on the funding made available and how it compares internationally **[INQ000113320]**. For example, in 2022 the Health Foundation reported that average day-to-day health spending in the UK between

[46] Subject to certain mandated charges such as for prescriptions and dentistry.

2010 and 2019 was £3,005 per person – 18% below the EU14 average of £3,655. If UK spending per person had matched the EU14 average, then the UK would have spent an average of £227 billion a year on health between 2010 and 2019 – £40 billion higher than the actual average annual spending during this period (£187 billion). Matching spending per head to France or Germany would have led to an additional £40 billion and £73 billion (21% to 39% increase respectively) of total health spending each year in the UK **[INQ000113321]**.

221. NHS England reports on the overall position of the NHS, including funding levels, in its Annual Reports. From April 2013, NHS England's Chairs have provided their reflections at the front of each report. In the immediate years leading up to the pandemic, the increased pressure on NHS finances, and the need for wider change and system change, were a common theme:

    a. 2017/18: "*Following nine years of austerity funding, it is clear that significant further investment is required to maintain and improve NHS services. Serious investment will be essential if we are to ensure that the public receive the best health care available"* **[INQ000113196]**.

    b. 2018/19: "*...This has all been achieved within a constrained budget by historic standards and has only been possible because of significant year-on-year improvements in NHS productivity. …. Simply putting more pressure on the existing service risks breaking the system. We have to face the facts: waiting times are going up and pressure on A&E departments is rising. It is too difficult to see a GP and health inequalities are too great… So, we have to change. Not incrementally but fundamentally, though not in a chaotic, adversarial, destructive way. The last thing we want is another ideological, top down, politically inspired reorganisation*" **[INQ000113230]**.

222. Since its establishment, NHS England's budget had risen in real-terms by an average of 2.7% a year above inflation between 2013 and 2019. This exceeded many other areas of public spending, but was below the long-term growth in the health budget of 3.7% since the NHS was founded in 1948. It is also lower than independent estimates of growth in pressures of around 4% a year due to a growing and aging population, with increasing levels of multimorbidity and rising public expectations **[INQ000113277]**.

The Mandate

223. Before the start of each financial year, SSHSC issues an annual 'mandate' for NHS England setting out its objectives which NHS England must seek to achieve and its budget, which sets limits on the use of capital and revenue resources (in effect, this sets NHS England's financial allocation) (section 13A of the 2006 Act) (the "**Mandate**"). Certain resources are ringfenced by the Mandate meaning that those sums cannot be used for any other purpose, even if there is an underspend.

224. NHS England is accountable to the SSHSC for the delivery of the Mandate.

225. The Chair and Chief Executive Officer meet the SSHSC periodically to provide assurance on progress against Mandate objectives. The Mandate is reviewed annually by Government and an assessment is laid before Parliament. Copies of the mandates for 2017/18, 2018/19 and 2019/20 are exhibited **[INQ000113192, INQ000113219 and INQ000113255]**

226. The Mandate funding is sometimes increased; for example, some winter periods saw additional funding being provided.

227. Financial Directions accompany the Mandate which are made by the Government exercising its powers pursuant to 223D and 223E of the 2006 Act.

228. NHS England produces a business plan that sets out how NHS England will deliver the objectives set out in the Mandate. For 2017/18, NHS England's business plan was incorporated into the 'Next Steps on the NHS Five Year Forward View'.

229. NHS England reports on its financial position each year in its Annual Report.

230. Operational responses to civil emergencies, whole system civil emergencies, epidemics and pandemics are generally funded from within the budget allocations or sums for services, subject to any additional funding made available by the Government to deal with a specific contingency or emergency – as happened during the pandemic and covered in NHS England's Second Module 3 Statement.

231. NHS England is responsible for making allocations of this NHS funding to CCGs (now Integrated Care Boards ("**ICBs**")) for the purpose of commissioning local health services from providers. Annual funding allocations to the system by year are available online and a diagram of how healthcare sums are spent is set out below:[47]

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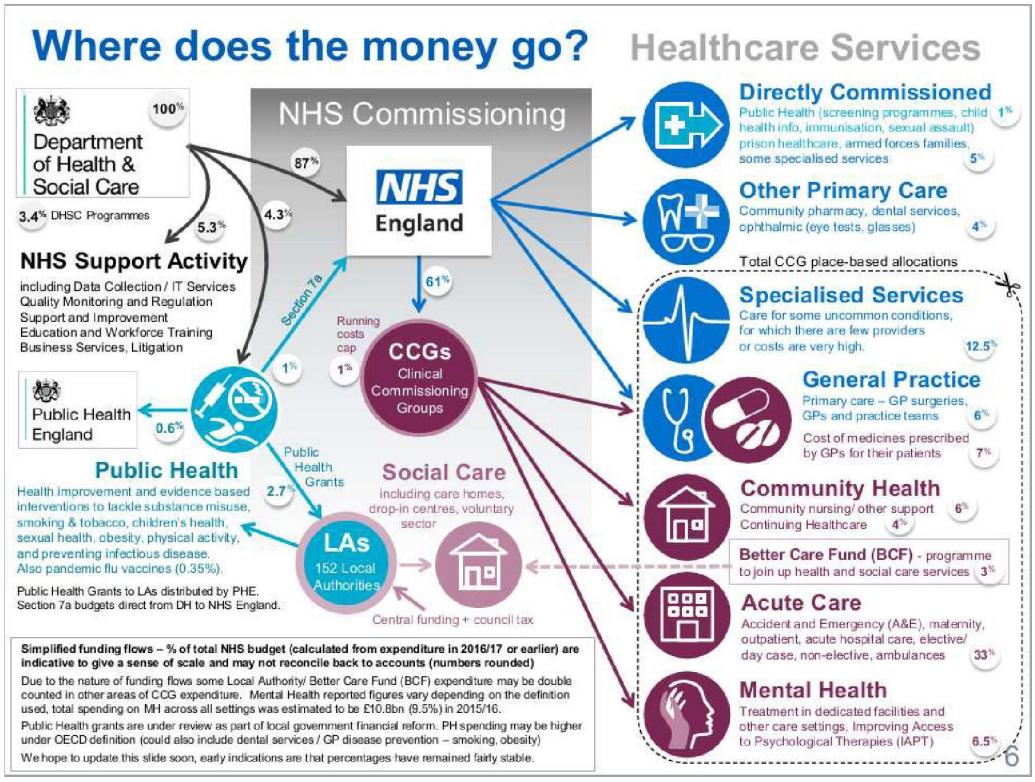
[47] NHS England's publication "Fair Shares – a guide to NHS allocations Infographics (updated and expanded for CCG allocations 2019/20) (**AP014 INQ000269894**)



232. NHS England has an obligation to operate efficiently, effectively and economically, and to manage budgets within the economic envelope afforded it by the Government. The NHS seeks to continuously improve productivity, in line with the requirements set out annually in operational planning guidance to the NHS.

233. In June 2018, the Prime Minister announced a five-year funding settlement which promised a 3.4% average real-terms annual increase in NHS England's budget between 2019/20 – 2023/24, equating to £20.5 billion increase over the period. NHS England subsequently published the NHS Long Term Plan which set out key ambitions for the NHS over a 10-year period including in relation to funding and committed to get all NHS providers back into balance and eliminate deficits. The NHS was one year into the Long Term Plan when the pandemic commenced.

Workforce

234. NHS care is predominantly provided by NHS staff. The NHS workforce is its greatest asset, and also its largest area of spend. In 2021/22, the total cost of NHS staff in England was £66.2 billion which amounted to 45.2 per cent of the NHS budget.

235. By the time of the pandemic, there was a well-established concern around clinical workforce supply and workforce gaps (**[INQ000113222]**). Although workforce

headcount figures were on the whole increasing, the required full time equivalent supply was not meeting a growing demand due to a variety of factors (an ageing population, changes in services and changing work patterns with the desire to work more flexibly). This created gaps in some medical specialties, with some professions (such as nursing) being impacted more than others.

236. The time taken from starting training to achieving registered status is uniformly lengthy, and takes from 3 years for nurses, physiotherapists and paramedics to at least ten years for a GP (and longer for consultants).

237. The NHS workforce is large and incredibly varied. Prior to the pandemic, the NHS England 2018/19 Annual Report (published in July 2019) stated that the NHS employed 1.3 million people. Roles within the NHS include those staff that are most easily associated with healthcare (e.g., doctors, nurses, dentists, and pharmacists); however these form just a part of the NHS workforce which extends to e.g., laboratory scientists, cleaners, porters, administrative staff, and facilities management. All were important in the pandemic.

238. NHS Digital regularly publishes a range of data relating to the NHS workforce. This data categorises staff using the following headings:[48]

    a. NHS Hospital and Community Health Services (HCHS) Doctors (all roles from Hospital Practitioner to Consultant)

    b. Nurses and Health Visitors

    c. Midwives

    d. Ambulance Staff

    e. Scientific, Therapeutic and Technical Staff

    f. Support to Clinical Staff

    g. NHS Infrastructure Staff

    h. Other Staff

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[48] It should be noted that this does not extend to cover all staff groups, those working in primary care for example, are not reported as part of this dataset.

239. Although DHSC is accountable for national NHS workforce strategy, policy, pay and training and education, responsibility is then shared across the various NHS national bodies. Several Select Committees have highlighted concerns around clinical workforce supply and workforce gaps, and around a lack of national long term workforce strategy, planning and aligned policy making structures.

240. National strategic workforce-related responsibilities (notwithstanding provider-level responsibilities to employees) across NHS national bodies pre-2019 (in general terms) were:

a. National workforce planning and workforce development responsibilities held by HEE (and operationally, by providers). The government's mandate to HEE is a requirement of the Care Act 2014 and sets out the strategic objectives of the government in the below areas, for which HEE had responsibility.

i. Workforce planning

ii. Education

iii. Training

b. In respect of NHS workforce responsibilities, NHS England has historically held responsibility for the:

i. NHS staff survey

ii. NHS Workforce equality standards

c. NHS Improvement, before its absorption into NHS England, was historically responsible for:

i. culture and leadership development

ii. new safe staffing guidance

iii. reducing agency spend and workforce improving productivity

d. Other responsibilities can be seen in the table below (with a particular focus on hospitals).

	DHSC / Wider Government	NHS Improvement	NHS England	NHS Employers [49]	Trusts
Overall approach & accountability	X				
National pay awards & contract	X			X	
Relations with Unions				X	X
Employers Association				X	
Workforce Planning	X	X			X
Workforce Development		X			X
Immigration Policy	X				
NHS Survey			X		X
Workforce Equality Standards			X		X
Culture and Leadership Development		X			X
New Safe Staffing Guidance		X			
Reducing agency spend and improving workforce productivity		X			X

241. Responsibility for NHS workforce planning formally sat (until recently) with HEE. However, over a number of years NHS England contributed to, and led on, several initiatives including a primary care workforce expansion strategy and the NHS Five Year Forward View. A national workforce strategy was first drafted and put out to consultation by HEE in 2017 but was not finalised and published, in part because of ongoing dialogue within Government. In 2018 the SSHSC announced that NHS Improvement would be responsible for signing off HEE's draft mandates going forward.

242. As part of the NHS England and NHS Improvement joint working arrangement, from April 2019 a new 'People Directorate' was created and led by a new Chief People Officer (a shared post between NHS England and NHS Improvement), hosted by NHS Improvement. DHSC stated that this Directorate now had responsibility for providing a cohesive strategic national approach to recruiting, retaining, deploying and developing the current NHS workforce (discussed further below), notwithstanding individual responsibilities held by providers to their employees. It was not responsible

[49] NHS Employers is a membership organisation which is part of NHS Confederation.

for deciding how many training places should be made available in England, the responsibility for which remained with the Government.

243. In June 2019, the new People Directorate at NHS England published the Interim People Plan (**[INQ000113222]**), intended at the time to evolve into a full People Plan in early 2020. The Interim People Plan (and intended follow up People Plan) set out the vision for people who work in the NHS, to enable them to deliver the NHS Long Term Plan. The Interim People Plan addressed the key issues faced by the workforce and the need for the workforce to both grow and evolve to address the requirements of a 21st century healthcare system.

244. The former SSHSC and now Chancellor has said on more than one occasion that the publication of the quantified forecasts in the intended People Plan was blocked ahead of the Spending Review, which was to confirm future NHS education and training budgets: "*This Committee has recommended on numerous occasions that we should have independently verified forecasts of the number of doctors and nurses we should be training for the future, but that has been blocked consistently by the Treasury…*" (HC 1035) (**[INQ000113343]**).

245. Whilst plans were being put in place to address the workforce needs of the NHS, plans were also needed to address vacancies for existing posts within the NHS. The NHS England 2018/19 Annual Report noted that, at the time of the report, there were approximately 100,000 vacancies within the NHS. In addition to vacancies, absence due to ill health also had the effect of reducing the capacity within the workforce. The Interim People Plan reported absence due to ill health within the NHS ran 2.3% higher than the rest of the economy.

246. Various schemes had already begun to address areas of shortages with a focus on the two main areas: increasing supply and improving staff retention. The Interim People Plan reported that around one in eleven staff members leave the NHS entirely every year. The reasons for staff leaving are generally like those in most professions: perceived lack of flexible working options, retirement, pay, and ill health, however NHS specific factors such as certain limitations of the pension scheme have also led to staff seeking early retirement. The initiatives being put in place before the start of the pandemic included attempts to encourage retired staff back into the NHS. However, there had been limited success in these schemes; potential returners found the pathways onerous, and employers had concerns about training/CPD standards of returners and patient safety.

247. In 2019, the UK had one of the lowest numbers of doctors per head of population among OECD countries - 7% lower than France and a third fewer than Germany.

248. There is substantial analysis of and commentary upon the workforce figures. For example, on 15 November 2018, the Health Foundation, the King's Fund and the Nuffield Trust jointly published a briefing which highlighted what they believed were the "*...scale of the workforce challenges facing the health service and the threat they pose to the delivery and quality of care over the next ten years...*" **[INQ000113317]**. The briefing stated that NHS hospitals and mental health and community providers were currently reporting a shortage of more than 100,000 full time equivalent staff (representing one in eleven posts), with key groups such as nursing, medical specialities and various geographical areas being most affected.

249. Primary care has seen a gradual reduction in the number of full-time equivalent GPs per patient, as part time working and early retirements offset increased recruitment of young doctors into GP training. Demand had continued to increase with the number of patients registered at included practices increasing from 55,898,885 in October 2018 to 58,267,784 in March 2020. There had been significant decrease in numbers of GPs following the tightening of the pension Lifetime Allowance Rules in 2015; and increasingly GPs had started moving into working patterns that provided better work-life balance. This presents particular resilience challenges.

250. Although beyond the scope of the Relevant Period, the NHS Long Term Workforce Plan was published in June 2023 by NHS England.

Estate

251. A well-maintained estate that is fit-for-purpose can improve the efficiency and capacity of a healthcare system. Capital funding fell by 19% in real-terms between 2013/14 and 2016/17, before beginning to rise again, only exceeding 2013/14 levels in 2018/19. Capital spend per worker in Trusts was estimated to be 17% lower in 2017/18 than in 2010/11 **[INQ000148430]**. During this period, the size of the maintenance backlog was growing year on year, and by 2019/20 it stood at £9 billion, larger than the total capital budget.

252. Over the past decade, the UK has had a lower level of capital investment in health care compared with the EU14 countries for which data was available. Between 2010 and 2019, average health capital investment in the UK was £5.8 billion a year. If the UK had matched the EU14 countries' average investment in health capital (as a

share of GDP), the UK would have invested £33 billion more between 2010 and 2019 (around 55% higher than actual investment during that period)." **[INQ000113320]**.

253. The OECD highlighted that "*Notably, of the G7 countries, capital spending in the United Kingdom and Italy remained below the OECD average during the period 2015-19, at 0.4% of GDP*". This investment of 0.4% was two-thirds of the OECD average, and just a third of the level of investment in Germany. The OECD further noted that for the UK health system "*capital investments in 2019 were still 10% below the level seen in 2010.*" **[INQ000148432]**

254. The age and design of the NHS estate means a certain lack of flexibility into any surge response is 'baked in'. The NHS estate is the largest and most complicated in the UK, encompassing some 17,000 buildings. The current age profile of the NHS estate varies significantly: 12% of the total estate pre-dates the founding of the NHS in 1948, around 17% is over 60 years old, and around 44% is between 30 and 60 years old. At the start of the pandemic, there were significant numbers of buildings that were not optimised for modern, digitally-enabled healthcare, and it was often difficult to change the designated function of a particular resource. Annually published data on the estate identified some of the risks associated with an ageing estate and need for investment **[INQ000148443]**.

255. The impact of the ageing NHS estate on the pandemic response was also seen in the capacity of the piped oxygen supply system in many hospitals during the pandemic. In some cases, this required emergency mitigating actions to increase the total number of oxygen capable beds. Oxygen capacity throughout the Relevant Period is discussed further in NHS England's Second Module 3 Statement.

256. The condition and layout of the available infrastructure of healthcare settings (in particular for hospitals) was and remains a constraining factor when implementing new Infection Prevention Control ("**IPC**") guidance i.e., separating Covid-19 and non-Covid-19 patients and distancing between beds. Single-occupancy rooms, as opposed to communal wards, ease separation of non-Covid-19 and Covid-19 patients. In Covid-19 wards, even if a bed is unoccupied, it would need to be regarded as 'occupied' and unavailable to a non-Covid-19 patient.

257. The requirement for significant capital investment in the NHS was recognised by the Government prior to the pandemic, as set out in the Health Infrastructure Plan of September 2019, which included the "*40 new hospital*" building projects **[INQ000148431]**.

NHS re-organisation: the Health and Care Act 2022

258. As stated above, the NHS is an ecosystem, at its best when it is working in an integrated way to provide joined-up care for patients. The following paragraphs set out, at a high level, the plan for Integrated Care Systems ("**ICS**"). These built on earlier initiatives by NHS England to increase collaboration (as opposed to competition) between local NHS organisations so that population care could be better planned, joined up and more efficient: Sustainability and Transformation Partnerships ("**STPs**"), the vision for which was published in the Five Year Forward View.

259. In December 2015, NHS England, Monitor and the NHS Trust Development Authority ("**TDA**") asked all parts of England to begin planning together in new local partnerships formed of all NHS organisations, local Government and others (for example, GPs and voluntary sector bodies), known as STPs (**[INQ000113178]**). Forty-four areas were identified as the geographical 'footprints' on which each STP would be based. Each STP was asked to develop a Sustainability and Transformation Plan for the future of health and care services in their area, and named individuals were identified to lead the development of each STP (**[INQ000113174]**).

260. In 2018, NHS England and NHS Improvement named the parts of the country where integration involving the STP was most advanced as the first ICSs, with NHS England working closely with them to pioneer best practice. ICSs were described as partnerships of organisations (NHS, local government and others) that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area (**[INQ000113191]**).

261. In January 2019, NHS England and NHS Improvement published the NHS Long Term Plan (**[INQ000113233]**), which set out the ambition for all parts of the country to become part of an ICS by April 2021, within the legal framework that applied at the time. NHS England and NHS Improvement however also recommended changes to legislation to remove barriers to integrated care.

262. While the policy which led to the 2022 Act was being developed, ICSs continued to operate and develop collaborative ways of working. Patients needed support that was joined up across local authorities, NHS and voluntary organisations, based on a common understanding of the risks and issues faced by different people. Providers of NHS care had to rapidly develop new pathways of care across multiple providers, while protecting capacity for urgent non-Covid-19 care. This was all supported by collaborative working across systems, agreements for mutual aid and the sharing of

learning. It required openness in data sharing, collaboration commitment in the interests of patients and communities, and agile collective decision-making, all of which were features of the 'system working' approach of ICSs.

263. This pre-existing collaborative working was pivotal in the pandemic response. For example, the Midlands regional team developed a data pack called the Daily Intelligence Brief **[AP015 INQ000270030]**:

a. This document contained all data sets relating to Covid-19 and the impacts on the local NHS. It included detailed data on bed availability, inpatient numbers, discharges, new admissions and staffing. It contained forecasting data (based on learning from previous waves of Covid-19 and new variants etc.), trends in bed occupancy, detail of types of bed occupied (mechanical ventilation, G&A, Covid-19 vs. non Covid-19, infection prevention & control issues identified, critical care capacity, death rates, staff absence rates, elective and diagnostic activity. This set of compiled data was built on available data and learning from Covid-19 as the country progressed through the pandemic. It was shared daily across all NHS organisations, and all LRF partner organisations across the Midlands to inform planning and support for health services and more widely across communities.

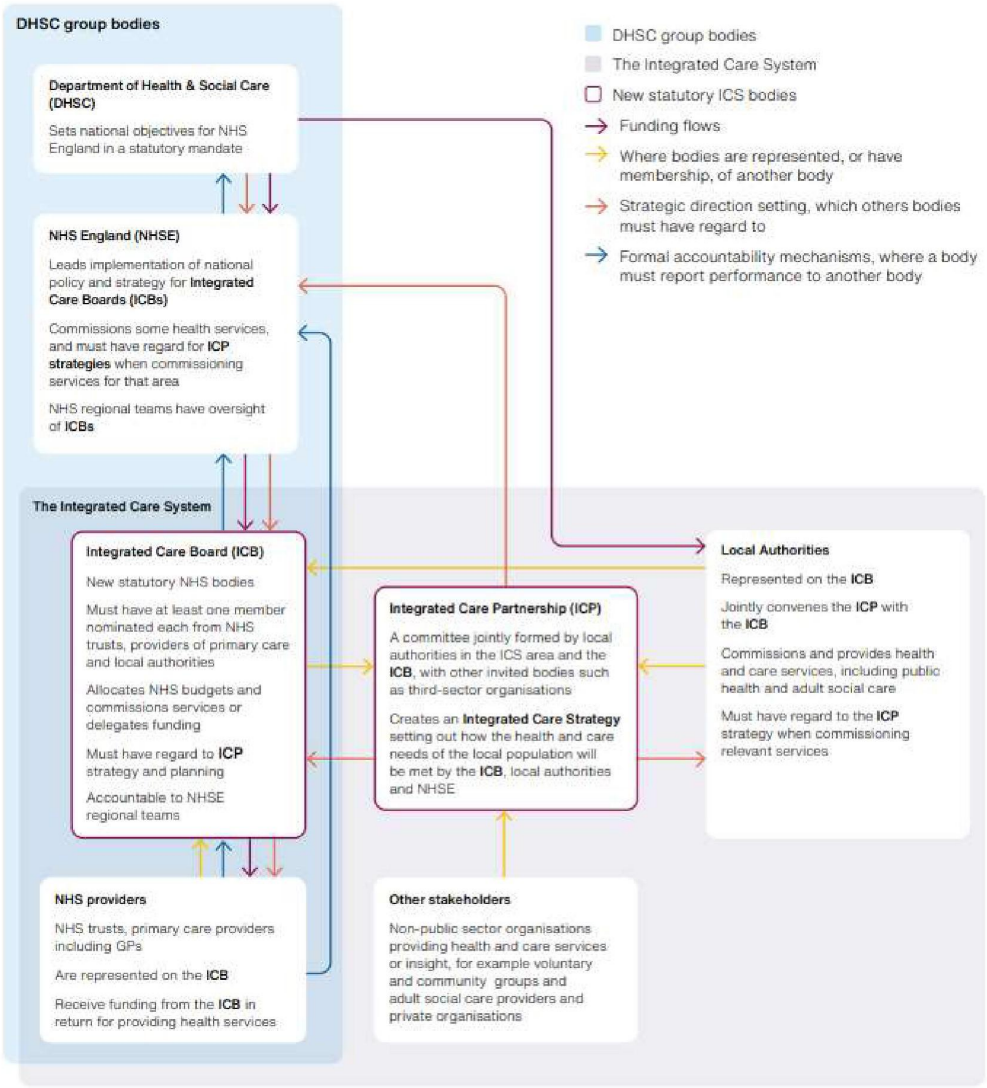
b. This supported patients as the regional team were able to monitor critical care capacity across the 21 acute hospitals within the region. If a hospital was becoming overwhelmed, they were able to use the critical care network to facilitate the step down of patients in critical care to free up critical care beds in a unit to ensure the availability of critical care for the most poorly patients needing support. This practice was commonplace during the pandemic and meant that there was less need to transfer patients out of their local hospital when they needed critical care, thereby improving patient experience and reducing the burden on families by keeping family members local to their area.

264. The 2022 Act put ICSs on a statutory footing by establishing two new statutory bodies:

a. ICBs: new statutory bodies that bring together commissioners and providers of healthcare services into a single organisation, and which will take over the functions of CCGs as regards the planning and delivery of healthcare services in order to meet local health needs; and

b. Integrated Care Partnerships ("**ICPs**"): statutory committees bringing together representatives from the ICB, local authorities within their areas, and other partners (including NHS providers, public health, social care, housing services, etc), responsible for developing an integrated care strategy setting out how the wider needs of the local population will be met.

265. A diagram highlighting how the ICS landscape would look from July 2022 is set out below (**[INQ000113289]**):



Statement of Truth

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

Signed: Personal Data

Dated: 16 January 2024

ANNEX 1

Evolution of the NHS in England

1. To assist the Inquiry, it is helpful to set out, briefly, the background to the legislative framework which established NHS England and the roles and functions of those bodies which have at the date of this Statement merged with NHS England.

Lansley Reforms

2. Following the general election of 2010, the Government proposed extensive NHS reforms, known as the "Lansley Reforms" after the then SSHSC, Andrew Lansley. The proposals were set out in the White Paper "Equity and Excellence: Liberating the NHS" published 12 July 2010 (**[INQ000113304]**) and formed the basis of the Health and Care Bill introduced in the subsequent year, which became, on enactment, the 2012 Act. The proposals included an "independent and accountable" and "autonomous" NHS Commissioning Board supporting local "GP commissioning consortia" (later to be called CCGs) who would be responsible for commissioning NHS services in local areas.

3. Section 9 of the 2012 Act provided for the establishment of the NHS Commissioning Board, and its general functions, by inserting a new section 1H of the 2006 Act. The Board was legally established on 1 October 2012, albeit without its full functions at that stage, following partial commencement of section 9. The Board became fully operational on 1 April 2013.

4. As part of the preparations for the prospective NHS legislation contained in the Health and Social Care Bill, the NHS Commissioning Board Authority was established as a Special Health Authority on 31 October 2011. This Authority was established to exercise functions in connection with preparing for the establishment and operation of the Board, and was abolished on the same date as the Board itself was established (1 October 2012).

5. Shortly after it was established, the Board adopted the operational name "NHS England" with the agreement of the SSHSC (**[INQ000113148]**).

6. To understand the development of NHS England, it is helpful to understand the legal framework which preceded its establishment. Before the amendments made by the 2012 Act, the 2006 Act conferred statutory responsibility for providing or securing the provision of services for the purpose of the health service on the SSHSC, rather than

directly on national, regional or local NHS bodies (although Trusts had the general function of providing services). The SSHSC had powers to direct regional and local NHS bodies (Strategic Health Authorities and Primary Care Trusts respectively) to exercise those functions and as to how they exercised them. Those powers were used to confer responsibility on those bodies for administering the health service and commissioning services, subject to SSHSC control via further direction.

7. At a national level, DHSC's functions in relation to the NHS were performed by part of DHSC known as "the NHS Executive", headed by a civil servant known as the NHS Chief Executive. Within DHSC there was a team known as NHS Operations who had an Emergency Preparedness Function.

8. At the regional level, the Strategic Health Authorities were responsible for overseeing and managing the health service.

9. At a local level, NHS services were provided under arrangements made by Primary Care Trusts in exercise of the directed SSHSC functions, with a combination of statutory NHS providers (Trusts) and independent or third sector providers. Primary Care Trusts also provided some services, such as community health services, using their own staff and facilities.

10. The 2012 Act provided for an extensive reform of the health service legislative structure, implementing the proposals set out in the 2010 White Paper. A core part of this reform was the separation of the health service into NHS and public health services, with the SSHSC and local authorities being responsible for public health.

11. NHS England was a key part of that reform, with responsibility for the commissioning of NHS services – both to commission certain NHS services itself and to oversee the operation of CCGs. This role of NHS England was set out in section 1H of the 2006 Act, which provided that, concurrently with the SSHSC, NHS England had a general duty to promote a comprehensive health service, except in relation to the part of the health service provided pursuant to the public health functions of the SSHSC and local authorities.

12. In other words, NHS England is not responsible for public health services; local authorities and DHSC, and its executive agencies (PHE (now UKHSA)), are responsible.

13. Section 1H went on to provide that the general functions of NHS England are to:

a. arrange the provision of services for the purpose of the health service in accordance with the 2006 Act; and

b. to exercise functions in relation to CCGs, so as to secure that services for the purpose of the health service are provided in accordance with the Act.

14. In relation to the first function, the other provisions of the 2006 Act which confer on NHS England the responsibility for arranging the provision of specific services (often referred to as its 'direct commissioning' functions) are:

a. Section 3B, which provides that NHS England is responsible for commissioning such dental services, services for the armed forces and their families, services for prisoners and other detained persons, and certain other services which SSHSC considers is appropriate for NHS England rather than CCGs to arrange (often referred to as "specialised services"), as set out by the SSHSC in regulations. The relevant regulations are contained in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).

b. Section 4, which requires NHS England to commission hospital accommodation and services for persons detained under the Mental Health Act 1983 and who in the opinion of the SSHSC require treatment under conditions of high security on account of their dangerous, violent or criminal propensities – referred to as "high security psychiatric services".

c. Parts 4 to 7, which provide for primary care services. This includes primary medical services (often referred to as GP services), primary dental services, primary ophthalmic services and pharmaceutical services.

15. The commissioning of all other NHS health care services, including hospital, ambulance and community health services as listed in section 3 of the 2006 Act, were the responsibility of CCGs. The former local commissioning bodies, Primary Care Trusts, and regional bodies, Strategic Health Authorities were abolished, and replaced by those CCGs and NHS England respectively. A key feature of the CCG framework was that their members were the providers of primary medical services for the area of the CCG – i.e., the GP practices which served the CCG's population. CCGs were therefore intended to deliver a 'clinically-led' approach to the commissioning of local NHS services. CCGs were not responsible for local public health services, with statutory responsibility for those services transferring to local authorities.

16. NHS England is not a provider of any patient services but does establish transformation programmes and work alongside the providers and wider NHS to work out how these programmes are operationalised.

17. Their functions were conferred directly by the 2006 Act or regulations under the 2006 Act. The SSHSC's general duty to provide or secure the provision of services for the purposes of the health service was changed to a duty to exercise the SSHSC functions so as to secure the provision of services (see section 1 of the 2006 Act as substituted by section 1 of the 2012 Act). The stated policy aim was that there should be more independent management and operation of the NHS, with less direct political control and influence, and the 2012 Act provided a different framework of statutory oversight and control.

18. Regulations made by the SSHSC could impose requirements (to be known as "**standing rules**") on NHS England and CCGs (section 6E of the 2006 Act). These could, for example, include requirements as to: arranging for specified treatment to be provided in a specified way; arrangements for making decisions about treatments or other services that are to be provided; NHS England preparing draft standard terms and conditions for CCGs to use when commissioning NHS services. The relevant regulations are set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).

19. The SSHSC had a power to give directions to NHS England if in the SSHSC's opinion it was failing to discharge one or more of its functions, properly or at all (section 13Z2 of the 2006 Act), but these have never been exercised. NHS England had a similar power with respect to CCGs (section 14Z21 of the 2006 Act), which it did exercise.

20. For completeness it is highlighted that on 1 July 2022, CCGs were abolished and their commissioning responsibilities now fall on ICBs.

NHS Improvement

21. NHS Improvement was established on 1 April 2016, bringing together Monitor, TDA, Patient Safety (from NHS England), National Reporting and Learning System, Advancing Change Team and Intensive Support Teams.

22. Acting together as NHS Improvement, Monitor and the TDA were therefore responsible for overseeing and supporting providers of NHS services. This included issuing guidance to Trusts about how they performed their responsibilities, and taking

steps to ensure those trusts operated effective governance arrangements to comply with relevant health care standards set by other bodies (such as CQC, NHS England or the statutory regulators of health care professions).

23. The NHS Improvement rules of procedure set out the joint governance arrangements for NHS Improvement. They constitute both rules of procedure for Monitor under paragraph 12 of Schedule 8 to the 2012 Act and standing orders of the NHS TDA under Regulation 12(2) of the National Health Service Trust Development Authority Regulations 2012 (SI 2012 no 922, as amended).

24. Monitor was originally (from 2006) the independent regulator of NHS Foundation Trusts - a category of health care provider with greater freedoms and 'independence' from central administration than NHS Trusts. Under the 2012 Act, Monitor's role was expanded and it became an independent regulator for NHS health care services in England, and in exercising its functions was required to protect and promote the interests of patients by promoting the provision of health care services which are economic, efficient and effective and which maintains or improves the quality of the services. A key part of this regulatory role was to licence providers of NHS health care services, and to enforce the conditions of the licence, under Chapter 3 of Part 3 of the 2012 Act. In this role, Monitor worked alongside the CQC to take action, using its licence enforcement powers, when the CQC reported that a hospital trust was failing to provide good quality care.

25. The TDA was a Special Health Authority established by the SSHSC by order under section 28 of the 2006 Act. The TDA was established primarily to exercise such functions as the SSHSC may direct in connection with the management of the performance and development of NHS Trusts (a category of health care provider subject to greater SSHSC oversight), in particular with a view to those NHS Trusts becoming NHS Foundation Trusts.

26. From 1 April 2019, NHS Improvement and NHS England came together to work as a single organisation to help improve care for patients and provide leadership and support to the wider NHS. They were collectively referred to as "NHS England and NHS Improvement" or "NHSE/I".

27. In February 2021, the Government confirmed its intention to formally merge NHS Improvement into NHS England in its *Integration and innovation White Paper*. The merger took place on 1 July 2022.

NHS Digital

28. NHS Digital was established as the 'Health and Social Care Information Centre' pursuant to section 252 of the 2012 Act was the. The organisation came to be known (and is referred to throughout this statement) as 'NHS Digital'; this has been the case since 2016.

29. NHS Digital's statutory functions were principally set out in Chapters 2 and 3 of Part 9 of the 2012 Act. Its core statutory functions being summarised as:

    a. Establishing and operating information systems for the collection and analysis of data, where directed by the Secretary of SSHSC or NHS England under section 254, or requested by other eligible bodies under section 255 of the 2012 Act;

    b. Publishing data under section 260 of the 2012 Act and in accordance with the Code of Practice for Statistics;

    c. Disseminating data under section 261 of the 2012 Act and other relevant legislation, including in relation to the pandemic, under Regulation 3 of the Health Service (Control of Patient Information) Regulations 2002 ("**COPI Regulations**");

    d. Exercising IT system delivery functions of the SSHSC or NHS England when directed to do so under Regulation 32 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social care Information Centre (Functions) Regulations 2013/259 ("NICE Regulations"); and

    e. Supplying digital, data and technology services under section 270(1)(d) of the 2012 Act.

Health Education England

30. HEE was established as an Executive NDPB pursuant to section 96 of the Care Act 2014 on 1 October 2014 and the Special Health Authority, known by the same name, established in 2012 pursuant to the Health Education England (Establishment and Constitution) Order 2012 (S.I. 2012/1273) was abolished.

31. HEE's function was to provide national leadership and co-ordination for the training and development of the workforce. HEE was responsible for planning, education and training of the future workforce, and development of the existing workforce working alongside commissioners and service providers.

32. HEE served the wider healthcare system (including private and third sector providers) but had no remit over social care.

33. HEE had six levers to achieve its purpose of improving the quality of patient care:

    a. Workforce planning: each year they identified the numbers, skills, values and behaviours that employers told them were needed for future. Ensuring that the shape and skills of workforce evolve with demographic and technological change.

    b. Attracting and recruiting the right people to the education and training programmes they plan to commission: using mechanisms such as Health Careers Oriel and Come back

    c. Workforce Transformation: Supporting the work of Local Workforce Action Boards in workforce transformation activities.

    d. Commissioning education and training programmes for medical students: using commissioning levers to best effect so that medical students can learn to provide safe, high-quality care for patients

    e. Lifelong investment in people: encouraging employers to continue to provide high quality care for patients through on-going training

    f. Leadership Academy Developing better leaders, delivering better care: To develop outstanding leadership in health, in order to improve people's health and their experiences of the NHS

34. Additionally HEE supported healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards ("**LETBs**"), which were statutory committees of HEE.

35. LETBs were responsible for education and training at regional level. Their main role was to:

    a. plan and commission high quality education and training in order to secure future workforce supply with the right numbers and right skills to improve health outcomes

    b. identify the local education and training needs of health and public health staff required to build skills and meet future service needs

c. bring providers and relevant stakeholders together to develop the workforce in line with local health needs and the service transformation agenda.

ANNEX 2

Key NHS England EPRR Policy and Guidance Documents

The key NHS England EPRR policy and guidance documents for the Relevant Period were:[50]

Document[51]	Date	Description
Key National NHS England EPRR Documents		
NHS England Emergency Preparedness, Resilience and Response Framework	November 2015	This was the strategic national framework in place during the Relevant Period that contained the principles for health emergency preparedness, resilience and response for the NHS in England at all levels including NHS provider organisations, providers of NHS-funded care, CCGs, GPs and other primary and community care organisations. All NHS-funded organisations are required to meet the requirements of the CCA 2004, the 2006 Act, EPRR Core Standards and NHS England Business Continuity Management Framework. **[INQ000113172]**
NHS England Emergency Preparedness, Resilience and Response Framework	July 2022	Framework describes how the NHS in England will go about its duty to be properly prepared for dealing with emergencies. It provides the framework and principles for effective Emergency Preparedness, Resilience and Response (EPRR), to help all NHS-funded Organisations in England meet the requirements of the Civil Contingencies Act 2004 (CCA 2004), the 2006 Act, the Health and Care Act 2022 and the NHS Standard Contract. **[INQ000113334]** (This was not in place during the Relevant Period, however, it is included for completeness)
NHS England Incident Response Plan (National) (version 3)	July 2017	The was the NHS England Incident Response Plan (National) (IRP(N)) in place during the Relevant Period. It was the overarching generic plan that details how NHS England, as a single organisation, reviewed and responded to any health related

[50] Updated documents which postdate the Relevant Period have been included for completeness, where this applies this has been flagged.
[51] Operational documents not included.

Document[61]	Date	Description
		incident or emergency at the national level. It was intended for use by NHS England Executive Management Team, the Director of NHS Operations and Delivery and the National Head of EPRR and acts as a reference and signposting document to provide appropriate guidance in planning and response. The IRP(N) recognised that the NHS follows the principles of subsidiarity in that the management of an incident should be at the level closest to the people affected by the incident as is reasonably practical. **[INQ000113187]**
NHS England Incident Response Plan (National) (version 4)	November 2022	The Incident Response Plan (National) is the overarching generic plan that details how NHS England prepares for, reviews and responds to any health-related incident at a national level. It is for use by the NHS Executive Group, directorates and teams, and the Director of EPRR (National). The plan acts as a reference and signposting document to provide appropriate guidance in planning and response, and recognises that the NHS follows the principles of subsidiarity in that an incident should be managed at the level closest to the people affected so far as is reasonably practicable. **[INQ000113336]** Following the pandemic the updated Plan contains an Annex to describe the arrangements that may be put in place nationally following a declaration of a protracted incident. **[INQ000113335]** (This was not in place during the Relevant Period, however, it is included for completeness)
NHS England EPRR Annual Assurance Guidance	June 2019	The purpose of the EPRR Annual Assurance Process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. **[INQ000113226]**
Resilience and Response (EPRR): Resilient Telecommunications Guidance for NHS England and the NHS	January 2019	This document provides guidance to NHS England and NHS-funded organisations in England of the minimum requirements to support resilient telecommunications to help meet the statutory requirements of the CCA 2005 and the 2006 Act. **[INQ000113213]**

Document[51]	Date	Description
in England		
EPRR Core Standards	June 2019	The purpose of the EPRR Core Standards is to; enable health agencies across the country to share a common approach to EPRR, allow co-ordination of EPRR activities according to the organisation's size and scope, provide a consistent and cohesive framework for EPRR activities, and inform the organisation's annual EPRR work programme. The core standards are updated from time to time. The 2019 version is included as an example to assist the Inquiry. **[INQ000113227]**
Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR)	June 2022	This document sets out the minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve in order to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD) and maintaining personal development portfolios (PDPs) in accordance with EPRR Core Standards. **[INQ000113286]** (This was not in place during the Relevant Period, however, it is included for completeness)
Operating Framework for Managing the Response to Pandemic Influenza (version 2)	December 2017	Revised Operating framework for NHS England in managing the response to a Pandemic Influenza outbreak. This should be read in conjunction with the NHS England Emergency Planning Framework 2015 and the NHS England Incident Response Plan (National) 2017. **[INQ000113189]**
HCID-A Standard Operating Procedures prior to January 2020		**[INQ000184173] [INQ000184163] [INQ000184164] [INQ000184165] [INQ000184166] [INQ000184167] [INQ000184168] [INQ000184169] [INQ000184170]).**

ANNEX 3

NHS England Governance

1. During the Relevant Period the NHS England Board is comprised of:

   a. The Chair, appointed by the SSHSC, and who is responsible for the leadership and effectiveness of the Board, the Board's governance, the Board's performance and stakeholder engagement.

   b. At least five non-executive directors appointed by the SSHSC, whose role includes the support of executive management, while providing constructive challenge and rigour, sound judgment and objectivity to the Board's decision-making process.

   c. The Chief Executive Officer ("**CEO**"), who is responsible for the day-to-day leadership of the organisation and the delivery of the strategy. The NHS England CEO's role is jointly accountable to the Board of NHS England, DHSC, and to Parliament in respect of the delivery of services funded via the NHS England's annual budget. The CEO is supported by their senior leadership team and together they are responsible for the implementation and execution of NHS England's strategy.

   d. Five executive directors (including the CEO) appointed by the non-executive members (whose number must not exceed the number of non-executive directors), whose main role is to support the CEO in leading the organisation to deliver its strategic objectives.

   e. NHS England operates by way of a national NHS England team under the overall leadership of the CEO of NHS England, and a single Chief Operating Officer ("**COO**").

   f. The COO is responsible for operational delivery of the NHS in England including performance standards across all systems. This included oversight of the NHS emergency response to Covid-19 and other EPRR incidents, ensuring that appropriate plans are in place to support the delivery and recovery of NHS services. They are also responsible for the Delivery of National programmes for Urgent and Emergency Care, cancer, mental health and learning disabilities, and other major clinical and operational strategies to address health inequalities and improve outcomes.

g. The Chief Financial Officer is responsible for strategic financial management of NHS England's resources. They provide the development and administration of financial policy levers, and lead financial and corporate performance management to ensure we know that objectives are being met.

h. The Chief Nursing Officer for NHS England is employed by NHS England to provide expert clinical and workforce advice to the Board and is formally the Chief Nursing Officer providing advice to the Government and DHSC. The role also provides professional leadership for all Nurses and Midwives in England (with the exception of public health nursing), including the c360,000 nurses and midwives who work for the NHS and who make up the largest group of the total NHS workforce.

i. The National Medical Director is the most senior doctor in the NHS in England and provides clinical governance across the health system. He/She/They sit on the Board of NHS England.

j. The Chief People Officer is responsible for ensuring that the NHS has a cohesive and deliverable people strategy; one that reflects strong values to enable the NHS as a whole to recruit, retain and develop the best healthcare workforce and leaders in the world. During the Relevant Period, this required close working with a wide range of stakeholders, including HEE in relation to their role in ensuring the NHS workforce had the right numbers, skills and values.

2. The NHS England Board is supported by:

a. the NHS Executive Group, which included the corporate and regional directors of each of the directorates of NHS England and Improvement during the Relevant Period. The group was chaired by the Chief Executive of NHS England and advised on the development and implementation of national policies and programmes, NHS performance and performance of the joint organisation, and any other matters that required executive-level oversight. The group was supported by several other management groups and processes; and

b. committees which undertake detailed scrutiny in their respective areas of responsibility and provide it with regular reporting and formal assurance. Examples of the structure are set out below from NHS England's 2020/21 and 2021/22 Annual Reports:

NHS England Board governance framework and committees

NHS England Board

Committees operating as a committee-in-common with NHS Improvement

Audit and Risk Assurance Committee	People, Remuneration and Nominations Committee	Digital Committee	Quality and Innovation Committee	COVID-19 National Incident Response Board
Main responsibilities				
• Provide an independent and objective view of internal control, governance and risk management including overview of internal and external audit services, governance, risk management, counter fraud and financial reporting.	• Oversee the delivery of the overall people strategy for the NHS. • Oversee the implementation of key provisions in the NHS People Plan. • Approve the framework and policy for executives for submission to DHSC. • Approve individual executive remuneration packages. • Approves employee policies. • Review employee engagement initiatives.	• Ensure effective delivery of the digital commitment of the NHS Long Term Plan. • Ensure alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	• Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. • Oversee implementation of innovation strategies.	• Oversee the organisation's response to the COVID-19 incident and EU Exit Programme. • Oversee NHS operational delivery and performance in relation to incident recovery in light of the commitments publicly set out in the NHS Long Term Plan and the NHS People Plan.

Executive HR Group

Joint Finance Advisory Group (NHS Improvement and NHS England)	The group has no executive responsibility and has been formed to ensure that both organisations are working from a common understanding of the financial targets and financial performance of the entire health system.

NHS England Board governance framework and committees

NHS England Board

Committees operating as a committee-in-common with NHS Improvement

Audit and Risk Assurance Committee	People, Remuneration and Nominations Committee	Digital Committee	Quality and Innovation Committee	System Oversight Committee (from 1 August 2021)	COVID-19 National Incident Response Board (to 31 July 2021)
Main responsibilities					
• Provide an independent and objective view of internal control, governance and risk management including overview of internal and external audit services, governance, risk management, counter fraud and financial reporting.	• Oversee the delivery of the overall people strategy for the NHS. • Oversee the implementation of key provisions in the NHS People Plan. • Approve the framework and policy for executives for submission to DHSC. • Approve individual executive remuneration packages, • Approves employee policies. • Review employee engagement initiatives.	• Ensure effective delivery of the digital commitment of the NHS Long Term Plan. • Ensures alignment of technology initiatives and spend across the system to ensure they are focused on commitments of the NHS Long Term Plan.	• Determine whether the NHS is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan. • Oversee implementation of innovation strategies.	• Ensure consistent approach to oversight of ICSs and constituent organisations. • Oversee the development and delivery of oversight and regulatory policy. • Approve mandated support for ICS and CCGs where appropriate. • Approve applications for the establishment of CCGs.	• Oversee the organisation's response to the COVID-19 incident and EU Exit Programme. • Oversee NHS operational delivery and performance in relation to incident recovery in light of the commitments publicly set out in the NHS Long Term Plan and the NHS People Plan.

Executive HR Group
Appointments & Approvals Committee

Joint Finance Advisory Group (NHS Improvement and NHS England)	The group has no executive responsibility and oversees and provides advice to the Boards on the financial position across the NHS, including delivery of system-wide efficiency savings, and implementation of NHS England/NHS Improvement's national productivity programme.

Internal and external assurance mechanisms

3. As set out in more detail in NHS England's Annual Reports and Accounts, NHS England relies on a number of internal and external assurance mechanisms to manage and review key risks including, among other things:

   a. **Internal audit:** The internal audit service reports to the Audit and Risk Assurance Committee, and plays a significant role in the independent review

of the effectiveness of management controls, risk management, compliance and governance by: auditing the application of risk management and the internal control framework, reviewing key systems and processes, providing advice to management on internal control implications of proposed and emerging changes, guiding managers and staff on improvements in internal controls and focusing audit activity on key business risks. Our internal audit service, provided by Deloitte LLP, operates in accordance with Public Sector Audit Standards and to an annual internal audit plan approved by the Audit and Risk Assurance Committee. The internal audit service submits regular reports to the Audit and Risk Assurance Committee on the effectiveness of our systems of internal control and management of key business risks, together with recommendations for improvement by management (including an agreed timetable for action).

b. **External audit by the NAO**: The work of external audit sits outside our governance arrangements but independently informs our consideration of control, compliance, governance, and risk. The work of external audit is monitored by the ARAC through regular progress reports. These include summaries of the value for money work that is either directly relevant to our work or may provide useful insights to the committee.

c. **Business critical models**: in line with the recommendations in Sir Nicholas Macpherson's review of quality assurance of Government analytical models (2013), NHS England operates a register of business critical models and audit of the quality assurance strategy associated with them, overseen by a committee of experienced analysts. To date all relevant NHS England models in the register have passed.

d. **Financial Performance Monitoring**: the financial position across the commissioning system is reported monthly using the Integrated Single Financial Environment system and supporting information collections. The financial position across NHS Providers is reported monthly using the Provider Financial Monitoring System and supporting information collections. This reporting enables a detailed monthly review by regional and national finance leadership teams, and the Chief Financial Officer ("**CFO**").

e. **Service auditor reporting and third party assurances**: NHS England relies on a number of third-party providers (such as NHS SBS, NHS BSA, NHS Digital and Capita) to provide a range of transactional processing services

ranging from finance to data processing. Our requirements for the assurance provided by these organisations are reviewed every year. During 2021/22 service auditor reports were specifically commissioned to provide assurance over the operation of our control environment and we are working, where appropriate, with our suppliers to implement International Standard on Assurance Engagements (ISAE) 3402 or similar standards to make sure that the relevant internal controls and control procedures operated by our service organisations have operated effectively. Service providers are requested to address any control weaknesses identified during the ISAE 3402 reporting process within an appropriate timescale.

f. **Cabinet Office efficiency controls**: As part of the Government's control of expenditure, we are subject to specified expenditure controls. These controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (including professional services and consultancy), onward approval is also sought from DHSC and for some cases this also requires approval from the Cabinet Office and/or HMT. If Government makes changes to these spend controls, this is communicated along with updated guidance and training, and the changes are reflected in the commercial and procurement systems to ensure the correct workflow is being followed.

g. **Internal counter fraud:** NHS England directly employs a counter fraud team which investigates allegations of fraud related to our functions and ensures that appropriate anti-fraud arrangements are in place. The Audit and Risk Assurance Committee receives regular updates regarding the counter fraud function, including on prospective counter fraud work, the outcomes of reactive investigations and an annual Counter Fraud Report. The Director of Financial Control has day-to-day operational responsibility for the internal counter fraud function, and the CFO provides executive support and direction.

h. **External counter fraud:** The NHS Counter Fraud Authority ("**NHSCFA**") is an independent health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. The NHSCFA also undertakes an annual high-level estimate of the amount vulnerable to fraud, bribery and corruption, affecting the whole of the NHS.

ANNEX 4

EU Exit

EU Exit – Governance

1. The UK voted to leave the European Union ("**EU**") in June 2016. The Prime Minister triggered Article 50 of the Treaty on European Union in March 2017. The UK left the EU on 31 January 2020 at 11pm (Greenwich Mean Time ("**GMT**")) and entered into a transition period. The transition period ended on 31 December 2020 at 11pm (GMT).

2. Prior to August 2018, the Strategy Group (a team within the then Strategy and Innovation Directorate under the National Director of Strategy and Innovation), led by the Strategy Group Director, ran the initial work to consider the policy implications on the health system in parallel to DHSC's contingency planning for EU Exit.

3. NHS England's role was to support DHSC who were responsible for EU Exit planning in relation to health (**[INQ000113241]**).

4. In the Government's 2019-20 Mandate, published a year prior to the pandemic, NHS England had two main objectives:

    a. Ensure the effective delivery of the NHS Long Term Plan by:

        i. laying the foundations for successful implementation of the NHS Long Term Plan;

        ii. achieving financial balance;

        iii. maintaining and improving performance, and improving the quality and safety of services, particularly by improving prevention and ensuring that technology is harnessed effectively; and

        iv. establishing a joint NHS England and NHS Improvement operating model to deliver integrated system leadership of the NHS.

    b. Support the Government in managing the effects of EU Exit on health and care by working with DHSC, Government and wider system partners to mitigate and manage any adverse impacts of EU Exit, as well as identifying and making a success of opportunities that may emerge (**[INQ000113255]**)

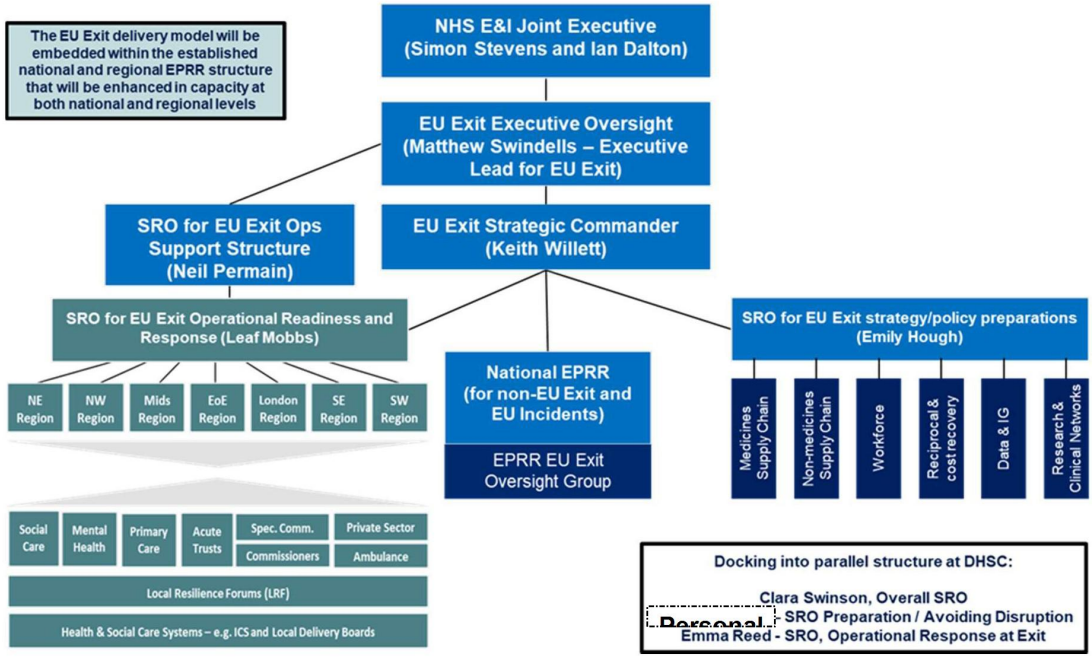
5. During this period NHS England interacted with the bodies for whom it was responsible, as part of its business as usual operations, to gather intelligence and data around impacts and possible geographical differences, so that it was well-placed

to feed such issues back to Government, but without, at this stage, the level of structured engagement which followed later.

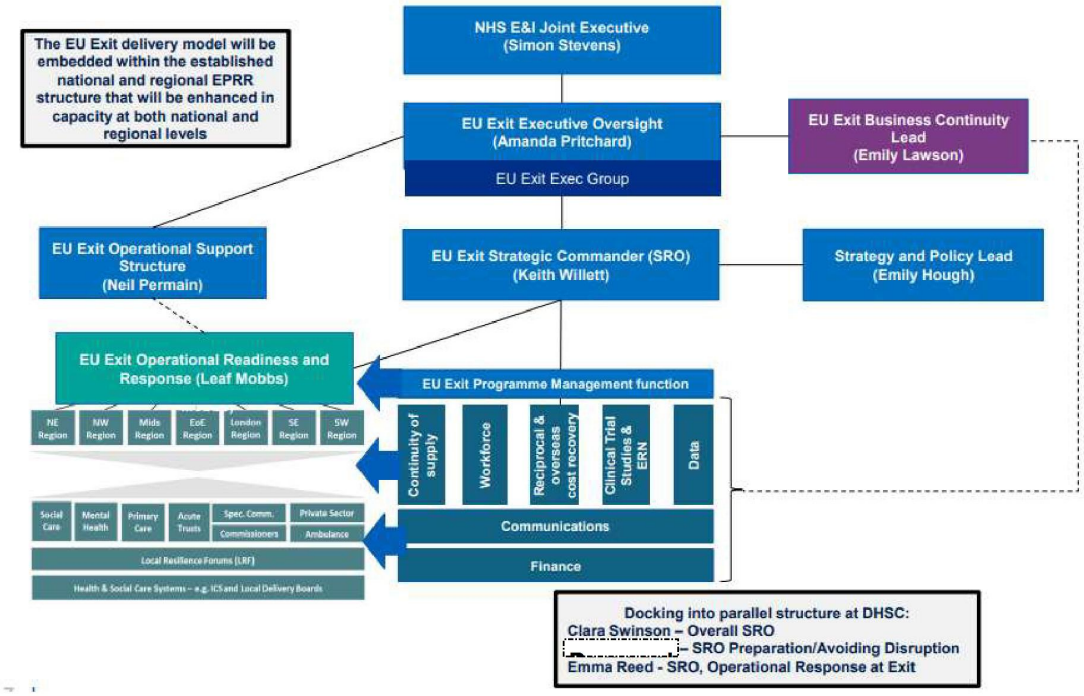
6. In August 2018, NHS England established an early governance model for EU Exit preparations.

7. When the possibility of a "no deal" EU Exit became clearer an Operational Incident response was established. The NHS England Strategic Commander for EU Exit was appointed ("**Strategic Commander**") in December 2018. The Strategic Commander started to assemble a team, formalise workstreams and seek appropriate leads and inputs from across NHS England, building on the work started by the Strategy Group.

8. By early 2019, the NHS England Governance structure had developed as set out below (**[INQ000113207]**):



9. By August 2019, the EU Exit governance structure for NHS England had evolved in accordance with the diagram set out below. The EU Exit Oversight Group – which became known as the EU Exit Executive Oversight Group during 2019 – was chaired by the Strategic Commander (with the COO as co-Chair). The Directors of the workstreams established reported into that Group.



([**INQ000113234**])

10. NHS England representatives attended externally-led meetings chaired by Government including an EPRR Partnership Group (which became the Operational Response Board to prepare for EU Exit). The Strategic Commander attended the DHSC EU Exit Assurance Board throughout the operational phase for EU Exit.

11. NHS England aligned its workstreams to DHSC's workstreams to enable NHS England to test and challenge Government planning assumptions. The workstreams were:

    a. Medicines supply (including vaccines);

    b. Non-Medicines supply (including medical devices and clinical consumables and non-clinical goods and services);

    c. Blood and Transplant (led by NHS Blood and Transplant);

    d. Workforce;

    e. Reciprocal healthcare and cost recovery;

    f. Research and clinical trials;

    g. Data and information governance; and

h. Operational Readiness (which was aligned to the DHSC workstream "Operational Response").

12. A dedicated operational readiness workstream was established to focus on preparing the NHS system, utilising established EPRR protocols as the basis for response arrangements.

13. Consideration was given to the potential impact of EU Exit on pandemic influenza preparedness and response. A pandemic influenza briefing was given to Sir Chris Wormald, Permanent Secretary DHSC on 30 November 2018. This reflected on stockpile purchasing, maintenance and importation, advance purchase agreements for vaccines and academic networks. Further work was undertaken with DHSC within wider Brexit planning to consider these aspects (**[INQ000113202]**).

14. In early 2019, a number of pandemic influenza preparedness workstreams within NHS England, DHSC and other government departments were slowing while attention was directed to more immediate concerns around EU Exit (**[INQ000113208]**).

EU Exit – Preparations

15. In order to contextualise NHS England's preparations for EU Exit, it is important to highlight that there were a number of different dates which NHS England had to work to in order to anticipate possible 'no deal' withdrawal. Initially NHS England was working towards 29 March 2019 but later had to aim preparations at 31 October 2019 and then 31 January 2020. For each date NHS England 'stood up' its own regional teams and all NHS organisations to address the consequences of a 'no deal hard Brexit', only to then be stood down shortly before each deadline (**[INQ000113211]**)

16. NHS England had to be prepared for any implications for the NHS arising from the end of the transition period, including monitoring and managing minor disruptions through to summer 2021.

17. On 21 December 2018, DHSC issued a letter and accompanying Operational Readiness Guidance (**[INQ000113204]**, **[INQ000113206]**).

18. NHS England responded to the DHSC Operational Readiness Guidance by building on its work to date. Examples of specific concerns included workforce, given the anticipated end to free movement of workers between the UK and the EU; the need to avoid local stockpiling of supplies; assurance of medicines supply (responsibility with DHSC); and mutual aid plans for ambulance services impacted by traffic

congestion resulting from border delays. NHS England produced an Operational Incident Response Plan to govern its approach to specific incidents of varying degrees of severity arising from EU Exit.

19. A Board paper prepared by the Strategic Commander and submitted on 26 September 2019 summarised for the NHS England Boards' information, the steps taken to that point to be ready for a possible no deal exit on 31 October 2019 (**[INQ000113236]**). It covered the following in particular:

    a. The phases in which NHS England's response had developed;

    b. A series of webinars with Trusts and CCGs highlighting the work being done by Government;

    c. The co-operation with DHSC in its National Supply Disruption Response;

    d. Regional workshops during September 2019 with trusts, CCGs and social care representatives, explaining local actions required and accompanied by exercises to test response arrangements;

    e. Surging capacity by recruiting to EU Exit and EPRR teams and to teams dealing with the workstreams highlighted above, targeted to create a group of about 200 people in the centre and the regions, and establishing a cadre of trained reservist staff to respond to surges;

    f. Risks to social care staffing (noting that any loss in social care bed capacity would directly impact the NHS);

    g. Dependencies on Government departments for border flow – especially the maintenance of the movement of supplies across the short straits, namely those between Dover and Folkestone and Calais and Dunkirk;

    h. The impact of a winter EU Exit date on NHS England's management of winter pressures; and

    i. Additional administrative duties arising from the recovery of costs of in-patient care from non-eligible EU nationals visiting England.

20. Maintaining and refreshing these arrangements across a number of potential EU Exit dates presented its own challenges.

NHS England and the NHS

21. NHS England required assurance from those NHS bodies for whom it was responsible, in line with its duties, to ensure they had sufficient plans in place.

22. NHS England conducted three local temperature check/assurance exercises ahead of the March 2019 exit date which confirmed a high level of system readiness (against actions in a letter from the Strategic Commander dated 4 February 2019) and followed up with areas of concern. Similar assurance of readiness was undertaken for subsequent key dates.

23. Regional exercises were also carried out. A report dated 22 October 2019 reflected on those exercises (**[INQ000113303]**). The social care sector gave rise to the most immediate concern because of the risk to staffing presented by changes in the status of EU nationals. It was concluded, however, on the basis of assurances from local authorities, that they would be willing to step in and use their powers to manage the risks effectively. Other risks included the food supply chain and the movement of ambulances in the event that traffic disruption spread from the Channel Ports beyond Kent. Those risks were mitigated by additional continuity measures and the plans of the ambulance service.

NHS England and Government

24. In June 2018, NHS England participated in Exercise Aurora. The exercise was sponsored by the DHSC EU Exit team to consider the challenges that the EU Exit poses to the safe and timely supply of products to the NHS. **[INQ000113200]**

25. The Strategic Commander also supported DHSC on the cross government Life Sciences EU Relationship Group informing the major health commercial and trade partners of the implications for, and the preparations of the NHS.

26. NHS England joined DHSC in challenging other government departments on the NHS operational implications, risks and mitigations as well as supporting the DHSC Adult Social Care national steering group.

Reservists

27. In September 2019, teams across NHS England was asked to nominate volunteers to train as reservists to support EPRR (**[INQ000113237]**),[52] business continuity or EU Exit related incidents. The aims of the NHS England reservist model were to:

a. provide a trained cohort of individuals to deliver surge capacity to support core EPRR, Business Continuity and EU Exit teams if needed;

b. embed within specific policy and commissioning teams the skills and knowledge to manage incidents within the NHS for which they have responsibility, increasing the operational capacity, resilience and capability of the organisation;

c. enable NHS England colleagues to develop/ maintain operational resilience and leadership skills aligned to front line operational NHS health and care system roles, in turn informing substantive job roles; and

d. develop enhanced BAU business continuity functionality for NHS England.

Impact and lessons of EU Exit

28. The EU Exit Executive Oversight Group was the key governance group for EU Exit which brought together the learning from the various Workstream Directors. The group oversaw the lessons identified in exercises for EU Exit. Once the pandemic started the transferability of the EU Exit work and learning relevant to the Covid-19 response became clear.

29. In July 2021 the Strategic Commander recommended to the NHS Executive Group the closure of the NHS England EU Exit programme (with transfer of ongoing activities to business as usual within NHS England directorates), reporting on the impact of EU Exit and steps taken and on matters to be addressed for the future (**[INQ000113333]**) .

30. Learning, continuity, and collaboration (both internally within NHS England and with DHSC and the wider NHS) from EU Exit preparations were significant contributors to the Covid-19 incident response arrangements. For example:

a. The cell/workstream structure used to underpin the Covid-19 response drew heavily on the workstream architecture established to support EU Exit

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[52] Prior to the establishment of the formal 'reservist' programme, volunteers were trained and exercised to support incident management team from 2013.

preparations. The Strategic Commander was appointed as Strategic Incident Director for Covid-19 ("**Strategic Incident Director**") and a number of senior policy-makers and Workstream Directors moved across into Covid-19 response planning.

b. Existing relationships were strengthened with partners throughout EU Exit preparations (both centrally and across numerous workstreams), providing a foundation for many aspects of the Covid-19 response; examples included relationships between national bodies such as PHE and NHS Blood and Transplant, as well as NHS England's own regional teams. Similarly, direct communication channels established between NHS organisations and stakeholders during EU Exit preparations transitioned into the Covid-19 response.

c. Establishment of the Commercial and Procurement Cell for EU Exit was subsequently key in supporting the response to PPE and other supply disruptions during Covid-19 (and other supply disruption incidents).

d. Expediting digital staff passporting (which enabled easier staff movement and sharing, and flexible workforce arrangements between NHS organisations) began during EU Exit and was piloted during Covid-19.

e. A reservist model for supporting multiple major incidents and business continuity threats was initially implemented during EU Exit preparations and provided trained individuals across national and regional teams to support the effective resourcing of the ICC during Covid-19.

f. Establishment of a Clinical Triage Group for EU Exit transformed into the Clinical Cell during Covid-19 - a core element of the single operating model providing clinical advice to underpin incident response supported by seven clinical shortage response groups.

g. Learning from the approach established for national ambulance mutual aid (in anticipation of congested roads in Kent as a result of border delays) informed the Covid-19 response as well as other mutual aid situations e.g., the critical care panel.

h. Communication channels and direct contact style approach with NHS organisations and stakeholders, established and rehearsed during EU Exit preparation, transitioned directly into Covid-19 response.

Impact on capacity

31. During the initial response to the pandemic, NHS England staff working on EU Exit (both within PIIPR, EPRR teams at national and regional level, and across cells/workstreams) were re-directed to priority Covid-19 response activities as required. As there had been significant learning from EU Exit preparations, staff who had worked on EU Exit preparations were well placed to pick up Covid-19 response (under the direction of EPRR personnel) activities given their training, knowledge, and relationships. Where residual work was required to manage the implications of the EU Exit transition period this was generally complementary to Covid activities i.e., the cause (Covid-19 or EU Exit) of the supply disruptions itself became irrelevant to the response. It should, however, be recognised that whilst the Covid-19 response drew heavily on the workstream/cell model from EU Exit preparations, it was considerably enlarged in cell numbers and scope.

Supply chain

32. The Supply Chain workstreams of EU Exit provided an understanding of certain vulnerable lines, but with a particular focus: for example, on materials that were vulnerable from port border bottlenecks as they could only be brought in by sea and not air; and on the need to understand all parts of a supply chain (such as raw material to assembler to seller to importer). It also meant that consideration had been given to how to deal with disruptions. As such, in January and February 2020, NHS England was able to adapt the structures that it had established to manage potential supply issues for EU Exit to begin the process of responding to the challenges that the pandemic was beginning to raise.

Medicines

33. The NHS England Medicines Supply team handled both EU Exit planning and managed the Covid-19 (Medicines Cell) activity, working collaboratively with colleagues from the NHS England Commercial Medicines Unit (CMU) and DHSC colleagues from their Medicines Supply Branch.

34. This commonality meant that the Covid-19 Medicines Cell built on some of the foundations (processes, knowledge, contacts) that had been created to support medicines supply issues as a result of EU Exit planning. For example, shortage mitigation actions such as stockpiles were implemented for EU-Exit and were then also used for assuring the supply of priority Covid-19 medicines. This included: understanding what medicine support Covid-19 patients may require, possible issues

in the medicine supply chain due to Covid-19, sourcing additional stock, stock visibility in the NHS and wider supply chain and governance structures needed to support the response.

35. In the pandemic, an Allocation & Distribution Group (ADG) was established to allocate supplies of medicines where there were known shortages relating to Covid-19 priority medicines. Overarching governance to ADG was provided by the Medicines Shortage Response Group, which was NHS England chaired, but DHSC administered. This was a pre-existing joint group for managing medicines supply issues.

36. Medicines are discussed further in NHS England's Third Module 3 Statement.

ANNEX 5

Incidents

The table below contains a non-exhaustive list of incidents, at different EPRR Framework Levels, involving the NHS England EPRR function at its related team levels. Many of these incidents involved both nationally-based as well as regionally-based teams, to differing degrees.

Code:

Blue: National EPRR team led on incident
Purple: Incident regionally led with **significant** National EPRR team involvement
Pink: Incident regionally led with **limited** involvement from National EPRR team

Year	Event	Description (where applicable)
2017	**Terror attack outside Palace of Westminster (Westminster Bridge Attack)**	Major Incident was declared on 22 March 2017 due to a terrorist attack on Westminster Bridge.
2017	**New Ferry explosion**	Major incident with 81 people injured. Protracted response and recovery for NHS England, Trusts, police, fire, ambulance, local authority.
2017	**Avian Influenza Outbreak**	Lincolnshire.
2017	**WannaCry ransomware attack (WannaCry Cyber Attack)**	Worldwide cyberattack by the WannaCry ransomware crypto worm, which targeted computers running the Microsoft Windows operating system by encrypting data and demanding ransom payments in the Bitcoin cryptocurrency. Major Incident was declared by the National Director: Operations and Information at 16:00 on Friday 12 May 2017. Ops and Delivery in NHS would lead the response. The incident stood down at 17:30 on Friday 1 May 2017.
2017	**Manchester arena bombings**	At 22:33 hrs Monday 22 May 2017, Greater Manchester Police were called to reports of an explosion outside the Manchester Arena, in Manchester city centre. An improvised explosive device was detonated near an exit. The explosion was timed to coincide with egress from a pop concert with many young people in attendance. National established their ICC in support of the response. NHS England London region supported National ICC. 22 deaths and many injured. Major Incident with regional response.
2017	**London Bridge Attack**	Attackers started driving van into pedestrians on both sides London Bridge followed by knife attacks in Borough Market at 21:58 on 4 June 2017. Metropolitan Police Services and London Ambulance Service ("**LAS**") declared major incident.
2017	**Grenfell Tower fire**	Catastrophic fire took hold of the 24-floor Grenfell Tower in the

		borough of Kensington and Chelsea in the early hours on 14 June 2017. LAS declared major incident at 02:26. NHS England London stood up the London Incident Coordination Centre ("**LICC**"). Following hospitals received casualties: St Marys Hospital, Kings College Hospital, Chelsea and Westminster Hospital, Royal Free Hospital and St Thomas Hospital. Humanitarian assistance was set up. Work also involved primary care providers. NHS England London stood down the LICC.
2017	**Finsbury Park Attack**	Significant incident declared at 00:43 on 19 June 2017 as a van driven into crowd of pedestrians in Seven Sisters area. London Region activated LICC Room. Patients taken to following hospitals: Royal London Hospital, Whittington Hospital and St Marys Hospital. Incident stood down by LAS at 04:49. LICC stood down.
2017	**Parsons Green Tube Explosion**	LAS was alerted to an explosion on a train at Parsons Green underground station at 08:22am on 15 September 2017 involving 2 tube trains injuring 30 people. The scene evacuation was complete by 11:01. NHS England London stood up the LICC. Several hospitals received patients.
2018	**Product Recall**	A Field Safety Notice was issued and as a result all suppliers were contacted by the relevant entity and given advice to avoid patients receiving suboptimal treatment around false negatives. In order to ascertain the impact on patients being assessed and treated for cancer across each region, all trusts were contacted to establish whether they were using the affected products, and to review the potential for any 'false negative' results.
2018	**Op Athens**	Provider failure. In North West, significant impacts due to building of new Royal Liverpool Hospital construction being halted.
2018	**Malicious parcels to UK hospitals**	Suspicious packages containing an unknown liquid were sent to hospitals across the UK.
2018	**Op Hypocaust**	Loss of Offices at Wharf House, business continuity incident involving NHS England and CCG
2018	**Novichok Poisoning Salisbury**	
2018	**Beast from the East**	Severe weather (prolonged snow). Multiagency & NHS response (Major Incident declared by LRFs).
2018	**Commonwealth Meeting in London**	Commonwealth Meeting in London, support provided to meeting.
2018	**Project Axis**	Progressed into national home care business failure.
2018	**Ops Lyceum**	Royal Wedding, support to LRF response and national structures.
2018	**Extreme hot weather**	2018 was the joint hottest summer on record for the UK as a whole, and the hottest ever for England, the Met Office

	in UK	announced (as of 2018).
2018	**POTUS visit to UK, supporting national structure with SitReps**	Related to the coordination of a visit of POTUS (President of the United States) and FLOTUS to the UK (FLOTUS – First Lady of the United States)
2018	**Clinical waste disposal incident**	Supplier was found to be breaching its environmental licencing permits and failing to process NHS waste to destruction. Data collection and information dissemination were conducted by London EPRR.
2018	**Operation Fortis**	On Saturday 30 June 2018, two individuals were contaminated with a military grade nerve agent in Amesbury, Wiltshire.
2018	**Suspicious Packages Not Declared**	Suspicious packages sent to health locations, involved NHS England, trusts, PHE and Police.
2018	**Middle East Respiratory Syndrome**	Case of MERS in UK.
2018	**Monkeypox**	Monkeypox outbreaks in UK.
2018	**Shortage of Epi-Pens**	Shortage of Epi-Pens.
2018	**Op Lumis**	Royal Wedding, support to LRF and national structures.
2018	**Breast Screening data incident**	The national breast screening incident, announced in May 2018, was in response to a system failure of the NHS Breast Screening Programme (NHSBSP) to offer over 120,000 women their final screen in the 36 months before their 71st birthday (that is up to age 70 years and 364 days), a requirement set out in national service specifications from November 2013 onwards. This issue was initially identified by PHE when investigating concerns about the operation of the Age X trial. Further investigation carried out jointly between PHE, NHS England and the DHSC identified that the principal cause of the incident was not the Age X trial itself. Rather it was a mismatch between how age is expressed in national service specifications and how age is defined by the underlying IT and other operational systems that choose which women to invite for a screen.
2018	**Severe Weather: Snow and ice**	
2019	**EU Exit**	Not declared but significant resource committed.
2019	**Severe Weather: Heavy snow and ice**	
2019	**Warehouse Fire**	A huge fire swept through a warehouse in Hampshire. Major Incident, involved Fire and Rescue, Ambulance Service,

		Police, PHE, Local Authority, Met Office, Water Utility Provider, Voluntary Agencies, Highways England, Environment Agency, NHS England.
2019	**Listeria Contamination**	The contamination of hospital sandwiches with Listeria.
2019	**Outage Business Continuity Incident**	Impact on NHS111 services nationally, involved advice and coordination by NHS England, CCGs, ambulance service, supplier and NHS111.
2019	**Operation Amber**	Closure came after report into an adult social care service by the CQC, which rated it as "inadequate".
2019	**Whaley Bridge dam collapse concerns**	LRF incident but cross-boundary implications.
2019	**Outbreak of Legionella**	
2019	**Fishmongers' Hall terrorist attack**	Terrorist attack at Fishmongers Hall, London Bridge, 29 November 2019. LAS was called to the scene and informed NHS England (London) at 14:19 via pager message. LAS Declared a major Incident at 14:48. NHS England- London Declared a major incident at 15:06. There were 3 casualties and 2 members of the public lost their lives. The Perpetrator also died.
2019	**Defective Products**	An inspection by the MHRA identified a need to permanently change some aspects of manufacturing process design to meet current MHRA guidance. While there was no defective product on the market, the changes led to supply problems which could risk increased admittance to hospital as supplies run short.
2019	**Reinforced Autoclaved Aerated Concrete (RAAC) and building concerns**	Ongoing since November 2019.
2019	**Monkeypox**	Monkeypox case confirmed in Exeter. An individual who flew into the UK from Nigeria was confirmed as testing positive for Monkeypox. They were being treated at Royal Devon and Exeter, but were moved to Guys and St Thomas' later in the day.
2019	**Measles Outbreak**	39 confirmed cases in Greater Manchester reported over 3 months, with confirmed cases in residents of Salford, Manchester, Bury, Bolton and Oldham.
2019	**International support and reconnaissance in Australia for major bushfires**	
2020	**Covid-19**	PHE declared National Enhanced Incident in relation to novel coronavirus.

2020	**Covid-19**	World Health Organisation declare Covid-19 a PHEIC.
2020	**Repatriation of Wuhan expatriates**	
2020	**Arrowe Park Covid-19 Isolation Facility**	Not formally declared as an incident but incident structures stood up. Set up at the request of HM Government when looking for space for an isolation facility.
2020	**Notification of urgent set up of evacuation and isolation centre in Kents Hill Park in Milton Keynes (returning UK dependents from Wuhan)**	Expatriates from the Covid-19 virus epicentre in China spent 14 days at Kents Hill Park conference centre in Milton Keynes. The centre was set up with two days' notice.
2020	**Storm Dennis**	Storm Dennis impacted the UK on Saturday 15 and Sunday 16 February, just a week after Storm Ciara which also brought strong winds and heavy rain to the whole of the UK.
2020	**Communicable disease: Listeria outbreak**	
2020	**Large Event Planning: EU Exit**	
2020	**Supply disruption**	National disruptions to the supply of reagents and kits were alerted to NHS England (London) on 06 October 2020. NHS England London committed resource from the team including that of handling data collection, top of the office briefing and representation at meetings.
2020	**Potential industrial action/fuel strikes**	
2020	**NEL Thames Water**	Around 4pm on 6th October, a 42” main burst in woodland near Hackney Marshes, flooding the area and putting 150,000 property’s supplies at risk. It took Thames Water until late evening to find the location. Data collection for those impacted trusts.
2020	**Issues with clinical waste and provider**	Increased use of PPE to deal with the pandemic, coupled with problems at an external supplier, led to a number of trusts experiencing significant problems with waste backlog. NHS England worked with the Cabinet Office and DHSC to ensure it was fully aware of the issues faced by the Provider. NHS England London Region shared communications.
2020	**Avian Influenza**	
2021	**Managed Quarantine**	

	Hotels	
2021	**Large Event Planning: G7 Summit**	The G7 Summit was held in Carbis Bay, Cornwall on 11-13 June 2021.
2021	**Storm Christoph**	Storm Christoph brought some exceptionally wet weather to North Wales and northern England from 18 to 20 January. 100mm of rain or more fell across upland areas, and parts of Cheshire, Greater Manchester and Lancashire received around the January whole-month long-term average rainfall from this event. For north-west England and North Wales this was one of the wettest 3-day periods on record. Storm Christoph also brought some strong winds, particularly across eastern England and Scotland, and as the storm cleared eastwards, it brought some significant snowfalls with blizzard conditions across upland in the north-east.
2021	**Supply Disruption**	Supplier informed the NHS of a supply disruption with a range of its Administration Sets including gravity and dedicated pump (volumetric) administration sets and consumables. NHS England-London committed resource from the team including that of handling Data collection.
2021	**Operation Forth Bridge**	Death of the Duke of Edinburgh.
2021	**Supply Disruption**	Supplier identified an issue with their third party supplier specifically around sterilisation. There was a field safety notice issued for products. The NHS England London EPRR team was involved in data collection and collation.
2021	**Heat Health Alert Amber**	The Met Office announced that there was a 90 % probability of Heat-Health Alert criteria being met between 0900 on Sunday and 0000 on Tuesday in parts of England. NHS England London shared relevant heat and weather alerts with trusts.
2021	**Product Recall**	Supplier issued a Field Safety Notice about various devices and the devices were recalled. NHS England London share the information with trusts.
2021	**Supply Disruption**	Due to Covid-19 there was a significant increase in global demand for blood test products. It was advised that significant pressure would be put on the supply chain and there was a risk that some stocks would be critically reduced. NHS England London committed resource from the team including that of handling Data collection, top of the office briefing and representation at meetings. NHS England London Worked closely with colleagues across NHS England both regionally and nationally. A large amount of resources were committed to this incident for a period of months.
2021	**Afghanistan**	As part of the relief effort in response to the situation in Afghanistan, the UK Government arranged to evacuate people from the country and the Home Office was working to resettle these people in Britain. The NHS worked with Managed Quarantine Services to ensure those in Quarantine and then

		Bridging Hotels have access to healthcare as needed. LRF's were asked to stand up Strategic Coordination Groups whilst Afghans were repatriated and settled in the UK. The NHS England London team coordinated communications to the system, including checks needed, such as that for tuberculosis. The EPRR Team committed significant resource for data collection, meeting attendance, communications and partnership working.
2021	**Fuel Disruption**	As a result of a shortage of HGV drivers receiving a significant amount of media attention the public began panic buying fuel. NHS England London conducted the collection of data for sitreps, communication to trusts and supported a request for mutual aid from ambulance services. South East regional coordination of data collection and support to Incident Management Team.
2021	**Active Shooter: Operation Lilypad (Plymouth)**	A gunman in Plymouth killed his mother and four other people.
2021	**Flooding and severe weather**	
2021	**Royal Liverpool Hospital Armed Siege**	Armed siege outside Royal Liverpool Hospital. Multi agency response.
2021	**Liverpool Womens Hospital Explosion (Operation Kipling)**	NHS England and trust involved in recovery until incident was stood down.
2021	**Log4J Vulnerability Assurance**	A vulnerability was detected in the Java Logging Library Apache Log4J. Assurance was requested from all trusts by NHS England London region that systems were updated so that the risk of incidents and exploitation of the vulnerability. This was managed through the on-call team.
2022	**Project Beacon**	Worked nationally and in particular with the South West region to manage the insolvency of a Provider and ensure safe transfer of patients and patient data.
2022	**Supply Disruption**	Due to the Covid-19 related shut downs in Shanghai, and global shipping issues companies reported challenges with freight. Typically, they ship via sea but both companies in question were seeking air freight solutions - sea shipping was taking around 3-4 months.
2022	**Bomb threat: Southmead hospital (North Bristol NHS Trust)**	
2022	**Storms Eunice/Franklin**	Three named storms affected the UK within the space of a week, the first time this has occurred since storm naming was introduced in 2015/2016. Two rare red warnings were issued for

		storm Eunice, the most severe and damaging storm to affect England and Wales since February 2014. Winds gusted at over 70Kt (81mph) in exposed coastal locations and a gust of 106Kt (122mph) was recorded at Needles Old Battery, Isle of Wight, setting a new England gust speed record. Winds gusted widely at over 60Kt (69mph) across southern England. These storms formed part of a turbulent spell of wet and windy weather for the UK, associated with a powerful jet stream. Storms Dudley and Franklin also brought significant weather impacts.
2022	**Lassa Fever**	Confirmed cases of Lassa fever in the UK. Patients were initially treated out of region but transferred to the Royal Free using HCID protocol. East of England region had declared a Major Incident due to staffing but this was stood down. The London region communicated to HCID centres and attended Incident Management Meetings.
2022	**OKTA Cyber Security**	Suspicious phishing activity connected to the OKTA system. Actions were taken to provide additional security and ensure further investigation of other systems that may be affected have been conducted. Assurance was collected from the London region around cyber security. The London region disseminated the request and co-ordinated the responses.
2022	**Ukraine refugee support**	As part of the relief effort in response to the situation in Ukraine, the UK Government arranged to support those leaving the country. Regional teams undertook preparation including the maintenance of clinical services and supply chain assurance. Children in need of care were flown to the UK, some of those children were transported to London region Hospitals for care. London regional coordination of a healthcare response to support this situation was put in place including operational planning and response to the situation. The NHS England London team coordinated communications to the system, including checks needed, such as that for tuberculosis. The EPRR Team committed significant resource for data collection, meeting attendance, communications and partnership working.
2022	**Crimean-Congo Haemorrhagic Fever (CCHF)**	An England-based individual with recent history of travel tested positive for CCHF. The patient was treated as having an HCID. The patient was transferred from Addenbrookes Hospital in Cambridge to the Royal Free in London for specialist care. London Region oversaw the transfer of the patient with the HCID protocol.
2022	**Extinction rebellion Protests**	Extinction rebellion planned disruption across London. NHS England Involved in strategic multiagency calls.
2022	**Supply Disruption**	There was a disruption to supply of Epidural and Combined Epidural/Spinal products containing the Portex Loss of Resistance (LoR) syringe. This was due to a shortage in a dye required for the plastic and led to a temporary disruption in production and supply. NHS England London Conducted data

		collection and collation for this.
2022	**Monkeypox**	
2022	**Supplier**	There was a cyber-attack against a supplier which provides frozen meals for over 450 hospitals. This affected their ability to operate over the short term. Data collection and collation was carried out by the London EPRR team.
2022	**Heatwave 1**	The Met Office amber extreme heat warning and UKHSA level 3 heat health alert on the 12 July. Three days later a level 4 warning was issued. All trusts were paged to ensure they shared contact details for the period. The London EPRR Team attended multi-agency Strategic Coordination groups. During this time several trusts suffered from incidents connected to the heat. • St George's had an electric outage due to a fire, leading to the site being closed to incoming ambulances for a few hours. • At UCL an operating theatre temperature exceeded 28C causing concerns around risk of surgical site infections, a PET scanner went offline, and 3 MRI scanners went down. • Elective care at Barts was ceased on Monday, with minimal elective work on Tuesday. • Guy's and St Thomas' declared a critical incident, due to their data centre overheating causing a widespread IT outage and move to paper based working and ambulance diverts. • Hillington Hospital had a Patient Record System outage due to overheating which also moved them to paper based. • London fire Brigade declared a major incident due to the number of fires they were responding to.
2022	**Operation Silver Puncture (Cyber Attack)**	Cyber-attack on NHS Supplier Advanced (Level 3). An incident management team was established. 111, mental health and urgent care was impacted as well as other services. All services impacted activated their Business Continuity Plans in order to continue working effectively. NHS England provided regional representation on calls as well as facilitating data collection and ensuring communications were sent out.
2022	**Heatwave 2**	Heat Health Alert Level 3 was issued. London EPRR communicated with trusts and shared information as well as attending partnership calls.

ANNEX 6

Records Management - Background, Structure, Volume and Searchability

1. This covers NHS England and not its legacy bodies.

2. NHS England provides national leadership for the NHS, promoting high quality health and care for all and supporting NHS organisations to work in partnership to deliver better outcomes for patients and communities. NHS England is split across seven integrated regional teams covering East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. The executive group, comprising the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Finance Officer (CFO), Chief Nursing Officer (CNO) and the seven regional directors amongst others, provide executive leadership. NHS England's board comprises non-executive directors who bring a range of complementary skills and experience in areas such as finance, governance and health policy and some of the senior executive group, such as CEO, CFO and CNO.

3. NHS England's seven regional teams are responsible for the quality, financial and operational performance of all NHS organisations in their region, drawing on the expertise and support of NHS England's corporate teams to improve services for patients and support for local transformation.

4. NHS England is obliged to comply with the legal and professional obligations set out for records. In accordance with these obligations, records are created by NHS England to provide information about what happened, what was decided, and how to do things. Therefore, as part of their daily work, NHS England staff must keep a record; by updating a register or database, writing a note of a meeting or telephone call, audio recordings of customer interaction or filing a letter or email in order to ensure that they and their successors have something to refer to in the future.

5. Since inception in October 2012, NHS England (NHS Commissioning Board) has not had one single electronic records management system as part of its IT platform(s). Prior to the pandemic, teams and individuals worked off a variety of servers and systems transferred from legacy organisations. This included TDA, Monitor, DHSC, and the NHS Commissioning Board servers.

6. No standard process was in place, with documents saved on personal, corporate shared-drives and SharePoint sites, as well as external "data lakes" – across multiple platforms (MS Teams, Office 365, Microsoft Outlook etc).

7. There was no one system for saving emails as records, with nhs.net email accounts being hosted externally by NHS Digital (who are now part of NHS England).

8. The volume of data held across these multiple platforms equates to around 300TB (crudely 1TB = 18 million plain text documents or 84 million word pages). No "back end" or ability to search across all NHS records existed (this includes the ability of a third party to access).

9. In order to provide some consistency of record management across disparate teams and IT systems, NHS England has, for some time, had a Corporate Records Team. Pre-pandemic the Corporate Records Team consisted of four staff members. The Corporate Records Team produces and owns the Corporate Document and Records Management Policy (the "**policy**"), which sets out advice and guidance to all NHS England staff regarding creation, management, storing and disposal of records. The current version of the policy is 4.0 which was updated in June 2022 (from October 2021).

10. All NHS England directorates fall within the scope of this document. This includes staff who are employed on a permanent or fixed term basis, contractors, temporary staff and secondees.

11. The policy states that NHSX staff and hosted bodies are to follow the principles of the policy when managing their records and information, with the only differences being the systems to which records and information are saved and the support network available. Where organisations have merged with NHS England (most recently Health Education England and NHS Digital) alignment to our policies is expected going forward. NHS England is the 'receiver' organisation of records that were previously owned by merged organisations.

12. The policy is mandatory and relates to all documents and records held by NHS England, regardless of format, including, but not limited to, email, paper, digital, instant messages, social media, videos and telephone messages. The policy covers all stages within the information lifecycle, including create/receive, maintain/use, document appraisal, declare as a record, record appraisal, retention and disposition.

13. Staff members must not alter, deface, block, erase, destroy or conceal records with the intention of preventing disclosure under a request relating to the Freedom of Information Act 2000 or the Data Protection Act 2018.

14. NHS England's approach to records is that they are a valuable resource because of

the information they contain. High-quality information underpins the delivery of high-quality evidence-based healthcare. Information has most value when it is accurate, up-to-date and accessible when it is needed. An effective records management function ensures that information is properly managed and is available whenever and wherever there is a justified need for that information, and in whatever media it is required.

15. Records management is about controlling records within a framework made up of policies, standard operating procedures, systems, processes and behaviours. Together they ensure that reliable evidence of actions and decisions is kept and remains available for reference and use when needed, and that the organisation benefits from effective management of one of its key assets, its records.

NHS England's approach to document management and procedures once the pandemic began

16. NHS England requested in March 2020 that all operational team structures which provided a response to the pandemic retain relevant Covid-19 records and a Decision Register of critical and important decisions made during the pandemic. The principle behind this was to ensure that all of NHS England's Covid-19 records and information were securely recorded, captured, stored and accessible in line with NHS England Corporate Records Management Policy. Decision Registers are discussed further below.

17. In response to the pandemic NHS England established a "cell" governance structure. This worked initially in parallel to existing structures, and then gradually all-but-replaced it. Cells were flexible and new, recruiting from across the organisation from different teams. i.e., they were not pre-existing policy teams, but essentially new "project teams". They predominantly established new file structures and document repositories. These cells are now closing rapidly, and individuals returning to business as usual ("**BAU**") teams and leaving records behind them. We have identified 385 Covid cells and sub cells.

18. The set up and subsequent changes to operational structure, and therefore location of 'cell' records within NHS England during the pandemic is a significantly different approach, and is unique, to that of other organisations. This poses a challenge for single point of contact and Senior Responsible Officer ("**SRO**") responsibility for records within cells that are closed and, in light of this, we have developed a tracking and assurance approach to Covid records.

19. Early on in the pandemic, two factors (inability to search, and temporary nature of cell structure) were recognised as a significant risk; in that it would not be possible to locate a significant proportion of relevant documents for any future inquiry. Steps were taken to ensure that Covid-19 records were secured. This included taking the following steps:

a. A records repository (Covid Electronic Records Management System - CERMS) was developed in Office 365 to capture Covid-19 records (this is a bespoke document repository for Covid-19 records. It holds a duplicate of the records held in each cell's source SharePoint site, together with their meta data (by export to CSV file). CERMS is discussed in further detail below.

b. Standardised "Decision Registers" created to log actions in each team, with the ability to link to core documents and decisions via a database built in "ServiceNow" to hold all the decision registers to support searching. Decision Registers are Excel documents containing a summary of the decision made, the date of the decision, who was involved and containing a hyperlink to the documentation which supports those decisions. They provide an index of 'critical and important' decisions made by cells/teams during the pandemic.

c. Communicating that all cells ensure relevant Covid-19 records and decision register of critical and important decisions made be kept.

d. Workforce trackers were also requested to ensure that those working in a cell could be identified if needed. SRO roles and responsibilities around record retention were also clearly set out.

e. Training 100s of Records Information Management Co-Ordinators (RIMC) on records management. This was an additional role in a team which was taken on by an individual in addition to a post holders' substantive role.

f. Changing/updating mandatory records management training and Corporate Guidance. NHS England's corporate guidance states that all NHS England records should be saved to a central repository (Office 365/SharePoint) as a 'declared' record. Personal email folders or mobile devices are not records repositories and corporate guidance dictates that this should not be the only place that records are recorded. This guidance was updated to ensure that Covid-19 specific records would be retained. Guidance was issued on what is a record and what should be included in decision registers and the migration to CERMS. This included emails, apps and paper records. This was for all

relevant records that met the guidance criteria. SROs for operational team structures (cells, teams, regional offices, private offices) were asked to sign off records saved centrally for copying to CERMS.

g. In September 2020 a blanket hold on deletion of all records was rolled out across NHS England's Office 365 environment, in June 2021 NHS England developed and cascaded its own 'Document Preservation Notice'.

h. Identification of key persons of interest and holds on email accounts, information gathering on paper records, data-lakes (logging this and SPOC), guidance and identification of TOTO WhatsApp groups. Leavers process and retention of IT hardware of key named individuals (CAT 1 VSMs).

i. Securing access agreements with private offices and data lake SROs (in progress)

Data sources and volumes

20. NHS England now has a vast amount of information that it generated during the Covid pandemic. This presents NHS England with a challenge in terms of searching and extracting information in order to supply it to the Inquiry.

21. The global volume of emails and email traffic during the pandemic will be vast. NHS England has approximately 9,000 staff (this has increased to over 20,000 posts with the merger of Health Education England and NHS Digital, this revised figure will reduce as part of a process of organisational change). (On a purely headcount basis, NHS England is over eight times the size of DHSC). Most, if not all, of these staff have individual email accounts and each staff member has 50GB of email storage built into their account. NHS England also utilises a number of shared inboxes, allowing a group of people or a team to receive and send email communications from that shared facility. Shared inboxes have c100GB of email storage. This does not include online archive which staff can also use. Additionally, there are then the email accounts of people who have left the organisation. Our initial assessment of unexpanded email data volume for 14 very senior key individuals was over 1Tb (these key individuals have been given larger mail box sizes than standard users to ensure as part of a targeted litigation hold emails can't be deleted). The exported data value is 1.5TB of data. 1Tb = approximately 18 million plain text documents or 84 million word pages).

22. A targeted approach to records held in emails has been taken to identify and apply a

hold to approximately 280 key individual NHS.net accounts, hosted externally by NHS Digital. Our estimate is that these 280 email accounts equate to > 16.5Tb of data (mean data – 61GB per user).

23. In relation to data volumes within CERMS, as of 6 June 2023 there is 9TB of data, this is estimated to equate to 95% of all cells/teams records that are to be migrated (copied) to CERMS. We anticipate c.10Tb of data in CERMS once full migration has occurred.

24. For ServiceNow there are a total of 206 Decision Registers that record 1000s of lines of decisions made by each cell/team that are all to be uploaded to ServiceNow. Currently on ServiceNow we have 40,751 decisions identified, for decisions up to the end of June 2022. ServiceNow provides an added ability to search using key word searching for 'relevant' decisions.

25. Wider data sources will be outside CERMS. These include: Covid-19 records held by BAU teams should be saved into 0365/SharePoint and can be searched; data lakes (databases held on a system outside NHS England O365 tenancy; including on servers being held outside the NHS), records on devices (that have not been transferred to 0365 as per corporate policy), paper records (corporate policy that the is team is the owner but these should be indexed and securely stored).

26. Requests for records from BAU corporate teams (national and regional) are being managed by a targeted approach for records where required for Inquiry preparation or to respond to an Inquiry Information request. These BAU teams are based in over 43 offices (quantity undefined), and corporate guidance is that any Covid-19 records should have been identified and saved in a separate folder to aide searching for records. Most teams will be saving these records on their respective 0365/SharePoint site (Microsoft Azure), these are indexed and categorised in accordance to filing structure on SharePoint with limited content search functionality.

27. Large data lakes and SPOCs have been identified across multiple teams. A targeted approach has been taken to identify critical data lakes such as complaints, communications, Freedom of Information Requests and large data warehouses that hold raw and processed data as well as analytics visualisations and dashboards. Key identified data warehouses and platforms hold terabytes of data/datasets (unquantified number) and are indexed/categorisation according to system, usually by dataset or dashboard name. NHS England's corporate records management team has identified 112 externally hosted systems that hold records. In reviewing these we

have identified circa 30 systems that hold Covid-19 records outside of our O365 environment, these systems are considered to be data lakes. We have established contacts for each of the systems and agreements in place for when the systems need to be searched and in scope Covid-19 material provided to us within the Inquiry Team.

28. Emails are unstructured records and corporate guidance is that all critical emails should be saved centrally into a formal records repository and where Covid-19 specific, are recorded as part of a Decision Register as the index to key emails that will be held in CERMS. As noted above, a targeted approach to records held in emails has been taken because of the sheer volume of email traffic across the organisation during the pandemic.

29. All NHS England staff have a second email account @england.nhs.uk which is used to access Microsoft Office 365 applications (including but not limited to OneDrive, SharePoint, MS teams, Yammer). These are all separate repositories which are not indexed or categorised in any structured format.

30. A targeted approach has been taken to physical retention of devices (e.g., iPhones) for any leavers; currently 14 very senior key individuals. Corporate policy is no records should be solely held on devices and where critical decisions have been made these should be saved centrally in formal records repositories.

31. A targeted approach has also been taken for identification of specific instant messaging groups used by key individuals to ensure these are exported and saved centrally as a record by the source team to be requested in due course by the NHS England Inquiry Team where deemed relevant as part of responding to an Inquiry Information request. To date this is circa 200 groups. Export, indexing and categorisation of, for example WhatsApp groups, does require a significant level of manual intervention, because further limitations are placed on the interoperability of systems by the corporate IT/cyber tech policies on devices.

32. A targeted approach has been taken for records held in paper format for key teams/individuals. These include central collation and digitisation of formal incident log books (issued by EPRR) and any dedicated notebooks held by key individuals. Any ad hoc notes made should have been followed up in an email or recorded in formal minutes as per corporate guidance. We have located formal incident log books which have been completed and are reviewing these. We believe there are 70-80 in scope which will be collated and digitised for purposes of searching. Indexing

and categorisation is conducted post digitisation. The output will be searchable PDF documents, with optimal character recognition-OCR applied.

33. NHS England will also have some legacy records held on network shared drives that have not yet been migrated to 0365/SharePoint (NHS England's long term formal records repository). Some NHS England BAU teams still work from network drives so any requirement to identify material, index and categorise these records is a significant task and would require IT/technical input to achieve this.

Searchability

34. In consideration of the different data repositories and platforms there is a significant amount of data that is held by NHS England. Some of this will be held in CERMS as Covid-19 records but other records are held across multiple other platforms and repositories. As noted above, previous estimates from IT were that this could equate to around 300Tb (crudely 1TB = 18 million plain text documents or 86 million word pages). No "back end" or ability to search across all NHS England records repositories existed.

35. CERMS is organised by region (which aligns with the National Covid Operating Model). There are various search functions; by region, cell, subject matter and a limited means of searching by date range (i.e., created before x date). There is an enhanced search function which allows searches by key word, wild cards and filtering. Search results can be exported to an excel spreadsheet with links to the file system. It is also to show how many search results for each particular search.

36. Having undertaken some initial key word search testing, key word searches produce significant numbers of "hits". The limited ability on CERMS to search by date range is also problematic when trying to narrow down search parameters.

37. In Service Now, the searching capabilities are better – it is possible to search for dates on, before, between and after, responsible cell, SRO and via a key word search to filter Decision Registers down.

38. Given the volume of data and complexity it would be impossible at significant scale to index and categorise material held in various repositories and platforms as outlined above. Because of this, there would be some merit to searches being focused on key dates, events, people and decisions as recorded in the Decisions Registers and then looking for the key records related to those search results in CERMS. Essentially the Decision Registers would act as a main index to key records held in CERMS, in

addition to other searches for records held by BAU teams or in the other data repositories as outlined in this statement.

Limitations

39. NHS England recognises that the quality of Decision Registers and the associated pandemic records contained in CERMS is reliant on cells having followed Guidance, feedback given by the CRMT in spot checks, self-assessment checklists and the judgment of SROs about what documents should be stored to support critical or important decisions taken. The majority of returns have been signed off by SROs and 'declared' as records. However, some cells disbanded prior to sign off of their records.

40. Decision Registers require completion of all fields and dates in template format prior to upload to Service Now, which can then be filtered by fields. Although guidance has been given about completion of Decision Registers, we cannot guarantee that all fields have been completed and we recognise that some Decisions Registers will be less detailed than others.

41. Furthermore, Decision Registers are not designed to capture all surrounding and contextual debate and correspondence in respect of any one decision. Instead they capture the documentation in support of the decision made, including links to key board/group meetings where such decisions were taken. Records are linked from Decision Registers into CERMS. This relies on hyperlinks to repositories in SharePoint being maintained and work is ongoing to ensure this occurs.

42. There are currently fifteen licences for Service Now (Decision Registers) across the Covid Records Team. Two people have Super Admin or Admin rights (to view, search, upload, edit and delete). Thirteen people have User rights (view and search only). No-one other than the two people with Super Admin or Admin rights can alter or delete documents.

43. CERMS is a SharePoint (Office 365) site and although it is locked down (so users have Read Only access), there is no ceiling on how many people can be given access to it. CERMS functionality provides full control and audit measures.

44. A further limitation of CERMS is that when search results include emails, attachments to those emails can only be viewed by downloading the email itself. There is, therefore, no easy way of viewing the email attachment within CERMS and this makes identification and review of relevant emails time consuming.

45. As noted above, further limitations are placed on the interoperability of systems by the corporate IT/cyber tech policies on devices. There are technical issues with NHS England's corporate security settings on mobile devices. We carried out a forensic test of this, by employing a forensic company who were unable to download data from the organisation's mobile phones (if a device is plugged in to download phone content, the phone is automatically wiped). This test was repeated in March 2023 with the same outcome. This applies to all phones pre-February 2021. We have gone back to Apple in California for assistance with this but they have been unable to find a resolution. All new phones, rolled out post February 2021 do not have these security settings on them. We have a list of key individuals' phones affected by this. Corporate policy places the onus on the individual to retain and store records of decisions.