

Witness Name: Amanda Pritchard

Statement No: 2

Exhibits: AP001 – AP264

Dated: 16 January 2024

**UK COVID-19 INQUIRY**

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**SECOND WITNESS STATEMENT OF AMANDA PRITCHARD**

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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 have ever responded to and therefore it drew upon NHS resources far and wide.
3. When health systems first started to learn about the novel Severe Acute Respiratory Syndrome Coronavirus 2 ("**SARS-CoV-2**", "**Covid-19**" or "**the pandemic**"), it was initially understood to affect respiratory functions, leading to high demand for oxygen therapy (including the use of intubation ventilation, normally provided in critical care settings). NHS England was asked to prepare plans to 'surge' hospital care, on the basis of modelling shared confidentially. This modelling suggested that, without mitigations in place, the NHS would be short of 700,000 beds (including 70,000 critical care beds) at the peak of a first wave. At the time, there were only 3,640 adult critical care beds available in Trusts in England (of which 79% were occupied). There were 97,612 general and acute ("**G&A**") beds available (of which 92.5% were occupied).<sup>1</sup>

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<sup>1</sup> As described further in this 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, 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.

4. 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. For example, it caused high rates of NHS staff sickness and global supplies shortages (including shortages of ventilators, laboratory reagents, and personal protective equipment ("PPE")). The increased demand for oxygen challenged the physical infrastructure of some hospital estates, as did the need to introduce new Covid-19 secure and Covid-19 positive pathways for patients. At the same time, incidents with no direct relation to the pandemic, such as heatwaves, flooding, and terrorism, still had to be managed.
5. 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.
6. A range of measures were agreed with the Government in March 2020 to respond to what we now know was 'Wave 1'. All those measures, made possible with additional Government funding, had both benefits and downsides; but the aim of NHS England was always to save as many lives as possible.
7. 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 buy more beds, they could not be used unless clinically staffed. It was not possible to fully train new clinical staff at speed, so the NHS faced difficult decisions about how to deploy the clinical staff who were available. The goodwill of students and returners who came forward and supported the 'surge' is commendable.
8. 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 issues).
9. The NHS itself is an ecosystem of thousands of organisations, including NHS bodies (such as 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). This was a major reason why at the start of the pandemic, the data needed to inform decision-making was not always readily available.

10. New data collections and classifications were developed at speed and very quickly became a source of vital information across Government. Hospital admissions data played a prominent role in the absence of data on community prevalence, but by definition, it was a lagging indicator of the spread of the virus.
11. The question of why, when, and how NHS England should have issued guidance and instructions to the wider NHS always had to be balanced. It was important not to share too much, too often, as there was a risk that frontline services would be unable to keep up with the large volumes of guidance issued by various government and professional bodies.
12. Wave 2 was, in many respects, more challenging than the first. At the peak of the pandemic in January 2021 over 34,000 NHS hospital beds were occupied with confirmed Covid-19 patients. There were almost 4,000 new Covid-19 positive admissions every day. More lives were lost in Wave 2 than Wave 1. Many things done in Wave 1 were adapted for Wave 2 but ultimately the levels of community transmission, infection and disease meant that the NHS had to surge again to record levels.
13. 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 as set out in NHS England's First Module 3 Statement.
14. Whilst the NHS was never a Covid-19 only service, 'surging' urgent and emergency care capacity impacted on routine care (as it does every winter), which is one reason why today the NHS is seeing record high levels of patients on waiting lists. Ahead of Wave 2, NHS England made every effort to ensure there was a permanently expanded bed base, but only marginal increases, predominately in critical care, were funded. Inevitably, as community prevalence spiralled, hospital admissions increased. Delivery of planned treatments was again impeded by the rising number of Covid-19 patients.
15. Throughout the response lessons were being identified and learnt 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.

16. 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.
17. 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.

## Corporate witness statement

18. 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 as set out in NHS England's First Module 3 Statement.
19. This is NHS England's Second Module 3 Statement.
20. This Statement primarily addresses the role of NHS England during the Relevant Period. Where we encompass or address the functions or response of any of the now merged legacy bodies referred to below, we highlight this.
21. 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;<sup>2</sup>
  - b. NHS Digital on 1 February 2023;<sup>3</sup> and
  - c. Health Education England ("**HEE**") on 1 April 2023.<sup>4</sup>

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

22. 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.
23. 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

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<sup>2</sup> On 1 April 2016, the Trust Development Authority and Monitor were brought together to create "NHS Improvement".

<sup>3</sup> 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.

<sup>4</sup> 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.



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.

24. 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 other Core Participants in this Inquiry within Modules 1 or 2. These are referred to by their INQ number only.

## Outline of this corporate witness statement

25. This statement contains responses to topics and questions set out in the Tranche 1 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 comprehensively.
26. Annex 5 provides a timeline which accompanies this statement to assist the reader and highlight relevant activity.
27. NHS England's First Module 3 Statement sets out information regarding NHS England's data repositories.
28. This Statement is structured in two parts as follows:
29. **Part 1** provides an overview of information regarding the months immediately prior to the Relevant Period (from January 2020) and the key events which unfolded that defined NHS England's pandemic response during the Relevant Period. It contains the following sections:
  - a. **Section 1** provides detail on:
    - i. the evolving understanding of Covid-19 as a disease;
    - ii. NHS England's Level 4 incident response, how the architecture of the NHS changed to allow a Level 4 response and the impact of those changes, including the evolution of governance arrangements from January 2020 to the end of the Relevant Period. This includes key figures and meetings; and
    - iii. communication and engagement structures.
  - b. **Section 2** examines a description of what 'capacity' means and the key components required for a 'bed' as well as staffing ratios.
  - c. **Section 3** considers the impact of Covid-19 being classified as an High Consequence Infectious Disease ("**HCID**") until 19 March 2020 following a review of its status and a recommendation by the Four Nations HCID Group.
  - d. **Section 4** considers the impact of modelling and data.
  - e. **Section 5** sets out the data available to NHS England, how the data was collected, and how modelling evolved over the Relevant Period.

30. **Part 2** provides detailed information about the key elements of the NHS response to the pandemic that involved NHS England during the Relevant Period. It contains the following sections:
- a. **Section 6** provides information regarding increasing capacity and the key activities undertaken, which will also link to later sections where the detail around specific decisions are provided in greater depth.
  - b. **Section 7** sets out information relating to discharge decisions.
  - c. **Section 8** considers legislative changes, including the Coronavirus Act 2020.
  - d. **Section 9** provides detail regarding how funding changed during the Relevant Period.
  - e. **Section 10** examines the position relating to ventilators, oxygen, continuous positive airway pressure ("**CPAP**"), extracorporeal membrane oxygenation ("**ECMO**") and haemodialysis machines.
  - f. **Section 11** provides information on workforce availability and testing.
  - g. **Section 12** sets out the position regarding the use of Nightingale Hospitals, including funding.
  - h. **Section 13** sets out the position regarding the use of the Independent Sector ("**IS**"), including funding.
31. In addition to the Sections outlined above, throughout this Statement we will address the relevant steps taken by NHS England to ensure that hospitals in England maintained sufficient capacity, incidents, ways of working (including with other organisations and communications), national policy and local solutions.
32. 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.
33. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this Statement unless otherwise stated.

## PART 1: PANDEMIC RESPONSE

34. This Part sets out information regarding NHS England's response to the pandemic from January 2020 (to provide context to the evolving pandemic response structures) through to the end of the Relevant Period.
35. Part 2 then elaborates on specific key decisions involving NHS England following the overview provided within this Part.
36. For context, it is helpful to set out the definition of each 'wave' of the pandemic (as there is no overarching definition in England)<sup>5,6</sup>:

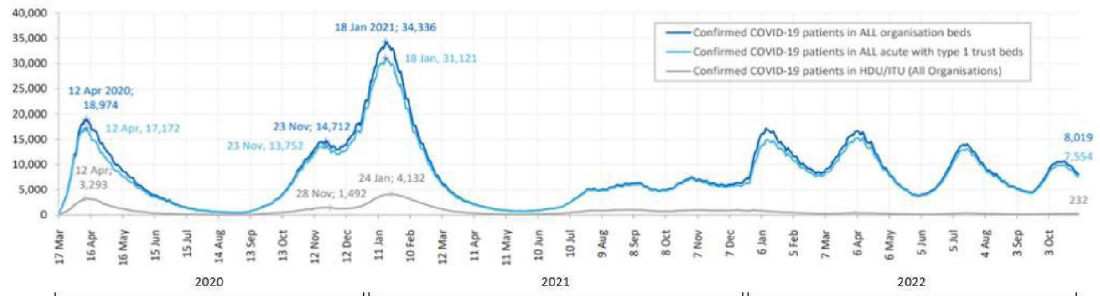
| Wave and dominant variant                             | Dates (approx.)                               |
|---|---|
| Wave 1 – Wuhan variant.                               | February – May 2020                           |
| Wave 2 – emergence of Alpha variant.                  | September 2020 to January 2021                |
| Wave 2 - reducing and the emergence of Delta variant. | February 2021 to September 2021               |
| Wave 3 – emergence of Omicron variant.                | September 2021 to end of the Relevant Period. |

37. These waves can be illustrated through the diagram below, which also provides details regarding the number of patients in NHS hospitals in England throughout the Relevant Period:

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<sup>5</sup> As set out elsewhere in this Statement, there were regional variations regarding the impact of each wave.

<sup>6</sup> There is no overarching definition of each wave in England, the above represents the definition being used by NHS England for the purposes of the Inquiry. This definition is taken from the Technical report on the COVID-19 pandemic in the UK: **INQ000177534**



38. A further timeline is provided in Annex 5 which details the timeline of weekly hospitalisations, lockdowns and key activity.

## SECTION 1: NHS ENGLAND'S PANDEMIC RESPONSE STRUCTURE

39. This section and its associated Annexes provide an overview of how the NHS was co-ordinated during the pandemic and what changed in relation to:
- the early stages of the pandemic response, including the declaration of a Level 4 Major Incident by NHS England;
  - NHS England's influenza pandemic response governance structure, and how that was adapted to respond to the pandemic; and
  - how NHS England "docked into" incident arrangements with DHSC, the rest of Government and its advisers.
40. NHS England's governance had to flex to respond to the changing nature of the pandemic. To do this, NHS England used its knowledge from previous incidents, existing plans (such as the HCID plans and the plan for managing pandemic influenza) as well as its overall EPRR structure and experience from EU Exit which was still being managed until July 2021, alongside the Covid-19 response.
41. It should be noted that there can be 'incidents within incidents' and a need to maintain multiple foci and team capacity, so that organisations in the NHS do not solely focus on one issue.

### Key figures and meetings

42. We have provided details of the key decision-makers or decision-making bodies within NHS England in relation to its pandemic response functions, including their specific areas of responsibility.

43. Details of key roles and the individuals who held them immediately prior to the pandemic and throughout the Relevant Period are provided in Annex 1.
44. Details of external meetings attended by NHS England are set out at Annex 2.
45. Details of key decision-making bodies are set out at Annex 3.

#### **Evolving understanding of Covid-19**

46. Treatment pathways develop as an understanding of any disease develops.
47. Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as Middle East Respiratory Syndrome ("**MERS**"). Some transmit easily from person to person, while others do not.
48. When Covid-19 was first identified little was known about the novel coronavirus: how it would affect the human body; what might be effective in treating it; how quickly or in what ways it could be transmitted; and to what extent it would impact on individuals and countries around the world.
49. NHS England's pandemic response necessarily relied on what was understood at various points throughout the Relevant Period (which was always changing), including knowledge of the characteristics of the disease (so far as known at the time), clinical information and by intelligence about what was happening around the world. By way of example:
  - a. Covid-19 was initially classified as an HCID on an interim basis, requiring specific treatment protocols to be used as further described in paragraphs 256 to 301;
  - b. as a virus that infects through the respiratory tract, the initial focus was on supporting respiratory function. Initially, most patients appeared to develop single organ failure, and therefore, this led to the early clinical model for the London Nightingale (as described in Section 12), which had been constructed to ventilate patients with lung failure but no other failures. As the disease became more widespread, the risk of multiple organ failure became better understood;

- c. increasingly it was realised there were Covid-19 patients with multi-organ failure requiring the response to adapt and treat patients in intensive care units; and
  - d. as the pandemic progressed alongside ongoing clinical trials it was also shown that drugs such as dexamethasone (a corticosteroid)<sup>7</sup> could be administered to reduce intensive care admission and mortality.
50. NHS England's involvement in the clinical management of Covid-19, including how NHS England developed its clinical understanding of Covid-19, how this was informed and changed over time, is covered in NHS England's Third Module 3 Statement.

## **January 2020**

### Early reports

51. On 31 December 2019, the WHO China Country Office was informed of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province of China.
52. By 2 January 2020, NHS England was aware, along with PHE and the CMO, of this cluster of cases of a novel virus in Wuhan and began monitoring the situation. At that stage, all that was known was that there were a number of people in hospital in Wuhan with pneumonitis (inflammation of lung tissue) and acute respiratory illness which had been uncharacterised. At that stage, it did not have any of the criteria of a new infectious disease, nor was it considered potentially pandemic-generating given the small number of people reported as being sick. There was no direct evidence of human-to-human transmission.
53. NHS England's National Medical Director updated the NHS Executive on the outbreak on 7 January 2020 and noted it as an issue to keep under review.
54. Two days later, senior leaders in NHS England were briefed that PHE had declared a National Enhanced Incident following a preliminary determination of a novel (or new) coronavirus by officials in Wuhan [INQ000087237].
55. At this date, there had been no reports of patients with these symptoms in the UK.

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<sup>7</sup> An anti-inflammatory medication

56. It was understood at that time that some of the cases had been associated with a seafood and live animal market in the city. The market had been closed on 1 January 2020 and there had been no reported cases since then.
57. At this time, representatives from NHS England joined a PHE communications cell. PHE had issued updated coronavirus information and laboratory diagnostic information to microbiologists, and NHS England was supporting PHE to distribute this information to a wider healthcare audience.
58. On 15 January 2020, the DHSC published clinical guidance to clinical diagnostic laboratories on the handling and processing of specimens for the detection of the Wuhan novel coronavirus and covered laboratory investigations as well as sample requirements.<sup>8</sup>
59. Covid-19 was designated as an HCID on 16 January 2020 by the Four Nations Public Health HCID Group<sup>9</sup> on a precautionary basis as it was a novel virus that was potentially similar to severe acute respiratory syndrome ("**SARS**") and MERS. During the initial phase of the outbreak, all patients who were tested positive were transferred to an HCID centre, regardless of whether or not they were symptomatic and how acutely they presented in accordance with HCID protocols.
60. In response to the early signs of the global spread of Covid-19 and before the WHO had formally declared a pandemic, on 21 January 2020, NHS England activated an Incident Management Team ("**IMT**").
61. The Government activated SAGE and its first meeting in relation to Covid-19 took place on 22 January 2020 [**INQ000087535**]. Its membership did not originally include representatives from NHS England,<sup>10</sup> but due to the nature of the health emergency NHS England requested to join, and from 25 February 2020 NHS England's National Medical Director started attending.
62. A national co-ordination call took place between representatives from DHSC, the Four Nations public health bodies and representatives from NHS England's EPRR team (including the National Director and National Head of EPRR) to discuss the

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<sup>8</sup> Wuhan novel coronavirus: guidance for clinical diagnostic laboratories published 15 January 2020

<sup>9</sup> A group made up of representatives from PHE, Public Health Wales, Public Health Scotland and the Public Health Agency (Northern Ireland).

<sup>10</sup> SAGE does not have a standing membership. Participants vary from meeting to meeting, depending on the expertise required.



emerging situation on 22 January 2020. The call confirmed that there were three suspected cases (as yet unconfirmed) in the UK; two patients in Manchester who were hospitalised in isolation units and one in London who was isolated at home [INQ000087239].

63. That same day, NHS England's National Director for Emergency Planning and Incident Response, formally commenced his role as NHS England's Strategic Incident Director for Covid-19 ("**Strategic Incident Director**"). The National IMT and the Incident Co-ordination Centre ("**ICC**") were formally established and early cells were initiated.
64. The following day, a tripartite letter, signed by the CMO for England, the Director of the National Infection Service at PHE, and the National Medical Director on behalf of NHS England, was sent to medical directors, Clinical Commissioning Group ("**CCG**") clinical leads, NHS 111 and 999. This letter contained links to the latest PHE published guidance which covered the initial assessments and investigation of cases, infection prevention and control guidance, guidance on diagnostics and guidance for primary care AP017  
A B & C [INQ000270107, INQ000087240 and INQ000087241].
65. On 29 January 2020, NHS England's EPRR and Specialised Commissioning teams wrote to chief executives of NHS providers that hosted an HCID facility, asking them to prepare to treat patients and to act as an advice resource to other providers [AP018 INQ000269891]. A COBR meeting also took place on this date. Government departments had been asked to identify any estate that the Government would be able to use as a quarantine facility, but subsequently only the NHS was able to identify suitable premises. Quarantine facilities would not normally be an NHS responsibility.
66. On 30 January 2020:
  - a. WHO declared the spread of Covid-19 to be a public health emergency of international concern ("**PHEIC**"); and
  - b. NHS England's Strategic Incident Director formally communicated NHS England's decision to declare an NHS Level 4 Major Incident.

#### **NHS England Level 4 Major Incident**

67. NHS England's First Module 3 Statement sets out NHS England's role in respect of pandemics. Part of this is to maintain an infrastructure to enable a response appropriate to the size and nature of the incident, from Level 4 (national command

and control) to Level 3 (geographical command and control) and then Levels 2 and 1 for incidents that can be responded to with more local co-ordination.

68. The EPRR Framework describes how escalation and de-escalation decisions are made. Once the incident level is confirmed, it will inform how the NHS will co-ordinate itself and respond.
69. In considering the criteria for escalation to a Level 4 Incident in accordance with the EPRR Framework [INQ000113172], NHS England took careful note of the developing context, especially:
- a. the decision of the four UK CMOs to raise their alert level to moderate (from low), enabling an escalated response from the Government;
  - b. the decision of the WHO to declare the outbreak to be a PHEIC; and
  - c. the fact that the UK was beginning to see confirmed cases of infection.
70. The recommendation to move to Level 4 was made to NHS England's Chief Executive Officer and Chief Operating Officer (in her then capacity as Accountable Emergency Officer), in accordance with the requirements of the National Incident Response Plan. They made the decision to proceed.
71. A National IMT meeting took place on the morning of 31 January 2020 informing participants that NHS England was treating this as a Level 4 Incident [AP019 INQ000269973]. The national EPRR Team informed Regional Directors of the incident level [AP020 INQ000269892], who then cascaded this information to Trusts and CCGs. Typically, this cascade is through a combination of emails and teleconference with Trust EPRR leads. The escalation to the Level 4 Incident was not communicated through a 'system letter' in the way that subsequent escalations and de-escalations were.<sup>11</sup>
72. On 2 March 2020 NHS England wrote to all Trusts, regional NHS England EPRR leads, CCGs and others, confirming the next steps regarding the Level 4 Incident and how Covid-19 had been managed to date. This letter formalised what was required of NHS organisations. [INQ000087445]

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<sup>11</sup> It was later confirmed in a system letter dated 2 March 2020 (see Annex 4).

73. Further information regarding communication methods is set out in paragraphs 123 to 164 below, and throughout this Statement.
74. A Level 4 Incident requires NHS England co-ordination, often referred to as 'Command and Control', to support the NHS response in England. A Level 4 incident had never been called before. This meant NHS England (the organisation at the 'centre') had to change its own way of working for such a role, as follows:
- a. all seven NHS England regions stood up response arrangements (previously regions would stand up arrangements as required for local incidents);
  - b. more national cells were set up with staff from across the organisation redeployed to support them<sup>12</sup> (see Annex 3);<sup>13</sup>
  - c. new decision-making and management architecture was introduced, including the set-up of the National Incident Response Board (as envisaged by the pandemic influenza plan as further described below), informed by new arrangements for data supply;
  - d. management of communications was essential, so that those needing co-ordination knew what to act upon (see paragraphs 123 to 164 below).
75. Regional teams and Trusts activated their Incident Response Plans and their 'single point of contact' or 'SPOC' for communications.<sup>14</sup> Local Resilience Forums ("LRFs") would also have stood up their Incident Response Plans.
76. The NHS England EPRR Framework is an overarching document to ensure preparedness and the creation of an organisation's Incident Response Plan (which regional teams and Trusts were required to have) i.e., it is an enabler. NHS England did not, and it was not necessary for NHS England to, direct regions or Trusts to use the EPRR Framework as part of their pandemic response.
77. Regional and Trust Incident Response Plans set out the mechanics of their incident response structure, including how they "dock into" different levels of response arrangement within NHS England and/or other organisations. As with NHS England's

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<sup>12</sup> Structures evolved throughout the pandemic see for example: **[AP021 INQ000270075]**

<sup>13</sup> Many workstreams were named 'cells' but did not feature on official governance diagrams as 'cells'

<sup>14</sup> Not all Trusts stood up arrangements which involved having someone staffing the ICC at all times during the early stages of the pandemic due to the differences in the geographical spread of Covid-19 at that time.

National Incident Response Plan [INQ000113187], they are generic plans, which are supplemented by specific plans as required e.g., pandemic influenza plans. Examples of how regional arrangements docked into national arrangements during the pandemic are set out in Part 3 of Annex 3.

78. Following this, the EPRR team worked to establish a cell structure enhanced by the 'pillar' system. Operational tasks were numerous and included increasing the number of available oxygen supplies and ventilators, supporting the creation of additional capacity (including Nightingale facilities in due course) and supporting the creation of quarantine facilities.
79. NHS England was supported by NHS leaders in Trusts and other organisations joining it to add expertise and operational capacity and insight. As well as conducting its own internal and NHS-facing daily incident meetings, NHS England docked into the DHSC's daily incident management architecture.
80. NHS Incident Levels changed throughout the Relevant Period as required to manage the response. A timeline identifying the levels is set out in Annex 4.
81. The activation of Level 4 and the governance structures throughout the Relevant Period acted as enablers. The NHS did not work alone; collaboration was seen at so many levels in the pandemic response.

### **Evolution of NHS England pandemic response governance**

82. NHS England's initial response to the pandemic was managed from a central point by the EPRR team. However, given the emerging scale and duration of the pandemic a Covid-19 Operating Model was established.
83. The pandemic and appointment of the Strategic Incident Director on 22 January 2020 changed the focus of the Potential Incident Investigation, Preparation and Recovery ("PIIPR") team. The majority of staff resources were re-focused to provide in-incident support for the pandemic response alongside the core EPRR team. The PIIPR team did continue to work with EPRR and other stakeholders to monitor a number of potential business continuity threats relating to external providers on which the NHS was dependent (e.g., potential care sector provider failures and supply chain issues). But its pandemic role expanded to include:
  - a. support with incident governance, for example: the secretariat for incident response, a subject matter experts cell structure (building on learning from EU Exit workstreams), co-ordination of inputs from cells and briefings for the

Strategic Incident Director (and papers for the NHS England Executive and Board); and

- b. support with planning for future waves and lessons identified.
84. Learning, continuity, and collaboration (both internally within NHS England and with DHSC and the wider NHS) from preparation for the EU Exit were significant contributors to the Covid-19 incident response arrangements. NHS England's First Module 3 Statement contains a brief overview of EU Exit preparations and of the ways in which EU Exit planning contributed to the pandemic response.
85. Working with the Ministry of Defence ("**MoD**") and partners, the EPRR team reorganised structures to respond to a protracted event<sup>15</sup> and as a result developed daily (initially) meeting groups: Tactical Fusion, Strategic Fusion, NIRB (all as defined below) and respective sub-groups. These groups made changes over time to the way in which NHS England delivered its functions, in response to NHS England's involvement in the response to Covid-19.
86. This system of strategic, tactical, and operational pandemic response committees was established to support decision-making and escalate and resolve issues. A system of tiered information sharing and decision-focused meetings reflects best practice from the Military and also mirrored the Gold, Silver and Bronze arrangements which were present at local level. The frequency and membership of these forums evolved in line with the priorities and intensity of the pandemic response. These forums provided a consistent set of forums to triangulate data, build learning and broker solutions and mutual aid.
87. The establishment of the structural changes was reported to have been effective; there was clarity of roles and the remit of each level of the structure to facilitate appropriate decision making. The multiplicity of different structures was not unwieldy or difficult to coordinate due to the overall structural framework established. Regional teams had a focus point for questions or concerns, a single point of contact was provided for the NHS to use, and regional teams understood that the formal route out from NHS England for correspondence was via the single point of access and that any other routes could be challenged/not prioritised.

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<sup>15</sup> Prior to the updated EPRR Framework and Incident Response Plan in 2022, NHS England did not plan for protracted multi-year incidents.

88. The governance structures are more particularly described in Annex 3. However at a high level:

*Incident Management Team (National)*

89. The National IMT was established under the EPRR Framework to support NHS England in the management of the national response to Covid-19. It cohered and co-ordinated cross-regional / workstream activity at a national level. The information collated by it facilitated timely and effective decision making by the National Incident Directors, which might include NHS England taking action, NHS England taking up a matter with another organisation to provide guidance or briefing material being produced.
90. The National IMT was also a forum for the discussion and dissemination of key messages, guidance and direction to regions and national workstreams, and a forum for escalation of issues from regions and national workstreams **[AP022 INQ000269961, AP023 INQ000270010, AP024 INQ000270011, AP025 INQ000270012]**

*Two Steps Ahead Group*

91. The Two Steps Ahead Group was conceived to provide challenge to the Strategic Incident Director and EPRR team on likely future challenges as the pandemic unfolded and potential solutions.
92. The group contained members not directly related to operational delivery and looked ahead to anticipate a number of matters including: home testing, non-ambulance transport of Covid-19 cases, POD design for coronavirus assessment services in emergency departments, clinically vulnerable patient identification, utilisation of volunteers and early system-wide exercising.
93. It provided early oversight of the NHS England epidemic preparation and epidemic modelling activities in response to the Covid-19, but it was not a decision-making group. This function was subsumed into NIRB once it was established.
94. Meetings commenced (twice weekly until 24 April 2020) to support strategic planning. Its stated aim was to minimise adverse impact to frontline NHS services and patients **[AP026 INQ000269895]**.

*The National Incident Response Board (“NIRB”) and Operational Response and Delivery Group (“OpReD”)*

95. NIRB was formally established as a committee in common of the NHS England and NHS Improvement boards on 1 April 2020, but many of its members had been meeting collectively since 18 February 2020.
96. NIRB was a requirement of the NHS England Operating Framework for Managing the Response to Pandemic Influenza 2017 (referred to as the National Pandemic Influenza Incident Response Board – see Sections 7.3; 7.4.1 of that framework) and anticipated the longevity of an influenza pandemic response. It became collectively known as the Covid-19 NIRB (referred to only as "NIRB" generally throughout the arrangements). NIRB was to support the discharge of each organisation's respective duties and powers and their combined responsibilities by setting the strategic direction and providing oversight of the response to the Covid-19 incident **[AP027 INQ000269949, AP028 INQ000269979]**. In addition, NIRB's role was to challenge and steer the Strategic Incident Director, the Incident Director, the EPRR team and national directors in relation to the pandemic response.
97. Standing invitations were issued to other organisations including DHSC, NHS Digital and NHSX, to attend NIRB.
98. NIRB approved the evolving iterations of the Covid-19 operating model (as evidenced through the revised iterations of incident governance diagram and cell structures that were presented to NIRB and set out at Part 2 of Annex 3), as well as being the central link between the response and the NHS England Executive Group and NHS England Board. Additionally, there were lines of communication through to NIRB via the Chair of each of Tactical Fusion and Strategic Fusion. The National IMT reported key updates on issues through to Tactical Fusion, Strategic Fusion, and then as required, back to NIRB.
99. NIRB was stood down on 31 July 2021 and the OpReD went live on 1 August 2021 to support the move to the recovery phase of the pandemic until 22 December 2021 when NIRB was re-established due to a change in the incident level back to Level 4 **[AP029 INQ000270024, AP030 INQ000270037, AP031 INQ000270040]**.
100. OpReD was re-established following the 25 May 2022 NIRB meeting after the transition back to Level 3.

Covid-19 Project Management Office ("PMO")

101. The PMO was established in April 2020. It provided a coordination, assurance, and insight function to improve the grip and control across such a broad incident structure. It was closed on 30 June 2021.
102. The work of the Covid-19 Operating Model was coordinated by the PMO (dealing more with process matters) and the PIIPR team (dealing with more specific incident details and expertise). The teams worked closely together but with different remits. The PMO focussed on eight process areas to assure the Incident Directors that arrangements within Cells and across the Operating Model were robust. The PMO was positioned between the incident command infrastructure and the response cells, aligned cells and cross-cutting workstreams of the Operating Model.
103. Key functions included:
- a. Cell liaison;
  - b. Reporting programme/incident status. The reporting team were responsible for developing and maintaining the programme reporting and accountability framework, collating summary reports and drafting any programme oversight updates or external requests. This did not include reports on cell delivery performance and guidance requests - these were generated directly by Cells and submitted to NIRB;
  - c. Records management;
  - d. Risk and issues management to allow the monitoring, recording and tracking of programme risks, ensuring Cell risks were clearly defined and managed and shared with Incident Directors;
  - e. Providing updates to NHS England's Chief Operating Officer's Office and the Incident Directors regarding assurance relating to the planning, management, and control of priorities in line with organisational governance and controls; and
  - f. Programme governance to manage the changes to the Operating Model (for NIRB approval) and ensuring that the Operating Model functioned in line with internal requirements.
104. A lessons learned exercise was undertaken in relation to the PMO and is exhibited at **[AP032 INQ000270140]**. Also exhibited is the PMO assurance and close down narrative at **[AP033 INQ000270141]**.



### Tactical Fusion and Strategic Fusion

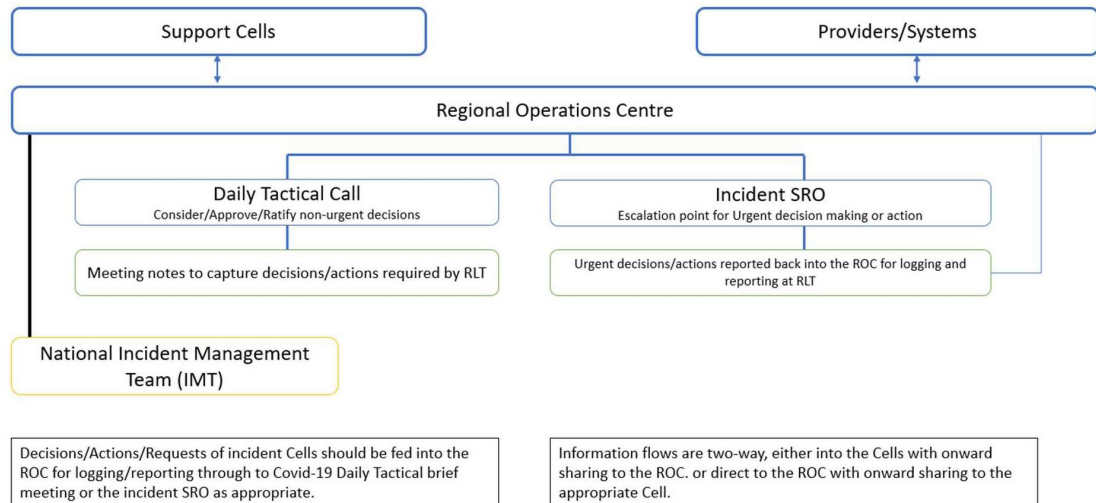
105. Tactical Fusion and Strategic Fusion were established to support the national response from 14 April 2020 as the National IMT, cell structures and NIRB needed to be supplemented **[AP034 INQ000270060, AP035 INQ000270061, AP036 INQ000270028 and AP037 INQ000269985]**.
106. Tactical Fusion was primarily a forum between EPRR leadership and leads from the national cells. The role of Tactical Fusion was to support *"NHS England and NHS Improvement in the management of the national response to the COVID-19 incident. It coheres and co-ordinates cross-cell activity at a tactical level. It contributes to the understanding of cell and national operational functions, allowing management of tactical level activity, escalation of issues where required and facilitation of information flows to contribute to situational awareness across the system."*
107. Strategic Fusion was a daily problem-solving forum between EPRR leadership and National Directors. The purpose of Strategic Fusion was stated in the ToR as to *"cohere and co-ordinate cross-cell activity at a strategic level. It contributes to the understanding of cell and national operational functions, allowing management of strategic activity, escalation of issues where required (to the National Incident Response Board (NIRB), and facilitation of information flows to contribute to situational awareness across the system."*
108. The meeting cadence of the above groups enabled the flow throughout the system and the day, for example:
- a. IMT - first thing in the morning, with information from regions;
  - b. Tactical Fusion – mid-morning check-in on information across cells providing context and background for issues raised; and
  - c. Strategic Fusion – late morning, bringing together all issues from the past 24 hours and to make decisions for the next 24 hours.

### NHS England Regional Teams

109. Regional Teams stood up their incident response structures as part of the national response to Covid-19, including Regional ICCs, Regional IMTs and appropriate cell structures.

110. Primarily, the role of regional teams was one of operationalising the planning and instruction originating from the National IMT (incorporating any national incident cells) and helping to inform national decision making by providing local intelligence and insight. Where local decisions were required (for example, due to operational pressures), regional leadership teams and daily tactical calls approved or ratified the actions required to be taken. An example of this governance process is as follows:

### Reporting and Governance Routes



111. The geography and the demographics of each region are different, and therefore, challenges and/or pressures throughout the Relevant Period varied on a region-by-region basis. Regional teams engaged directly with NHS provider organisations and CCGs (where issues and pressures could be seen at a macro level and informed strategies to deal with the pandemic). The timings, duration, severity and impact of each Covid-19 wave were also different in each region. That asymmetry was ultimately beneficial in allowing within and cross-region support and decompression (pressure reduction).
112. All regional teams were receiving daily national SitReps and had regular (sometimes daily, sometimes three times a day) meetings with their local leads. For example, Regional Directors would meet with local provider chief executive officers, and medical directors and chief nursing officers would also meet with their Trust counterparts. Regional cells had mechanisms for direct dialogue with providers and would feedback intelligence to their regional meetings, which would then get escalated to national structures (as appropriate) through subject matter expert and/or EPRR escalation channels. These pre-existing networks, strengthened via

Sustainability and Transformation Partnerships ("**STPs**") and Integrated Care Systems ("**ICSs**"), were part of the NHS ecosystem and vital to the pandemic response.

113. A further example of how regional structures operated is that of engagement with GPs. GPs received information through various structures (as set out elsewhere in this Statement) and also received information directly from CCGs (who in turn were updated by regional teams), through specific networks or through Regional Primary Care Teams.
114. Regional EPRR teams and communications teams supported the single official communication cascades to organisations' SPOCs.
115. Regional teams also attended:
  - a. national NHS England meetings; and
  - b. meetings of LRFs, which served as a further information sharing point. Conflicts between battle rhythms became a challenge for some regions who were required to attend multiple LRF meetings. The Midlands region experienced this issue and delegated attendance to their CCGs.

#### National cell structure

116. 'Cells' were set up by NHS England as a way to give a focus to particular operational issues that arose during the pandemic, with a defined task and team allocated to each cell. The cells also became the building blocks of day-to-day management and record keeping of how each task was addressed. NHS England essentially reformed itself around the cell structure required to respond to the pandemic; many existing organisational structures, roles and workstreams were placed on hold to enable complete focus on pandemic response.
117. Diagrams identifying the cells within the National NHS England Covid-19 response structure are set out at Part 2 of Annex 3.
118. At an operational level, NHS England and Government worked together through aligned cells **[AP038 INQ000270074]**. These cells consisted of multi-organisational efforts led by Government departments, reflecting the fact that policy responsibilities sit outside of NHS England but needed an operational perspective. The aligned cells were:

- a. Volunteering (vulnerable individuals and group support) (Department for Culture, Media and Sport, DHSC, Ministry of Housing, Communities & Local Government ("**MHCLG**")<sup>16</sup> and NHS England);
- b. Outbreak management (PHE led);
- c. Testing (DHSC / Test and Trace, with NHS England support);
- d. PPE (DHSC, with NHS England support);
- e. Shielding Vulnerable Individuals & Groups (MHCLG and NHS England);
- f. Medicines (DHSC and NHS England); and
- g. Vaccine Delivery and Screening (NHS England led with DHSC, HEE, Medicines and Healthcare products Regulatory Agency ("**MHRA**") and devolved administrations).

### **Military support**

- 119. As part of the Covid-19 response, the MoD provided Military Liaison Officers to support both the national EPRR team and those in the regions. This included support to produce any requests for Military Aid to the Civil Authorities ("**MACA**") for Trusts / organisations and regions. In such requests, an explanation of the clear need to act and details of the consequences of not acting were required. The completed MACAs were then submitted to the national EPRR team for approval and onward submission to the DHSC and SSHSC for final sign-off before being submitted to the MoD.
- 120. By way of example, on 21 March 2020 the national EPRR team received the first MACA from the South East region requesting support to South East Coast Ambulance Services with military co-responders due to severe staff shortages across frontline and emergency operations rooms.
- 121. By 6 April 2020, the national EPRR team put a process in place by which to capture and monitor MACA requests submitted from across the system. This included key details such as the region the request had come from, the nature of the request, any projected costs associated with the MACA and any key dates such as start/end dates and approval dates.

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<sup>16</sup> Since September 2021 this department has been known as Department for Levelling Up, Housing and Communities ("**DLUHC**")

122. NHS England undertook a review of lessons identified relating to the military support provided to NHS England in response to the pandemic [INQ000113332].

### **Communication and engagement structures**

123. Throughout the Relevant Period there were various methods by which information was transferred between different organisations, such as the networks of meetings at regional levels noted above and regular bulletins to system leaders. Whilst covered throughout NHS England's Module 3 Statements, this section sets out the key communication channels and how key messages were communicated to the system.
124. Annex 2 sets out a summary of the external meetings (at Government or other Arm's Length Body ("ALB") level) regularly attended by NHS England representatives.

### *EPRR Communications with NHS*

125. A SPOC was created throughout the incident response structures of the NHS in England, which was a mechanism for streamlining communication during the incident response. The role acted as a point of contact for incoming and outgoing telephone calls, emails and other communications into the national tier of the Covid-19 response.
126. At Level 4, national guidance was cascaded through the SPOC down to regional operations centres and out to various partners and systems. This did not stop during Level 3.<sup>17</sup> Guidance, letters to the NHS and information was sent to the NHS through a formal cascade, all correspondence as approved by a "strategic incident director" as being necessary during the pandemic, and all correspondence was reviewed by the top of the office and the communications team (publications approval committee). Once these approvals had been given, correspondence was sent to the Incident Coordination Centre ("ICC") for distribution to Regional ICC's, who would in turn send to CCGs and NHS organisations. The ICC (National) was considered the SPOC and regional teams knew that any information from this route had been approved as formal communication from the National Team. An example of a SPOC standard operating procedure is exhibited: [AP039 INQ000270002].
127. Regional teams shared national guidance and relayed information back to the National Team about requests from the front line for any specific guidance. Regions

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<sup>17</sup> The National Operations Centre is now part of the cascade structure.

also acted as an escalation point for local situations requiring external advice or support. In such situations regional communications teams would pick the issue up and cascade extra information or re-state information to ensure maximum opportunity of it being received by all those who needed to receive it.

128. In November 2020, NHS England published a communications policy in a Level 4 Incident ([INQ000113270]).

#### System Letters

129. System letters were drafted and published via the SPOC. System letters were sent to relevant stakeholders.
130. During the Relevant Period there were a number of key letters, which were relevant to NHS England's response and are discussed throughout this Statement. These were:
- a. the letter of 17 March 2020 from NHS England to the system confirming the position since the Level 4 declaration. This letter requested NHS bodies to enact urgent measures that were considered vital to free-up the necessary capacity to cope with the incoming wave of infections and prepare the NHS for the anticipated large number of Covid-19 patients in need of respiratory support (the "**Phase 1 Letter**") [INQ000087317].
  - b. the letter of 29 April 2020 from NHS England to the system confirming the start of phase 2. This letter, amongst other matters, highlighted that the NHS continued to be at Level 4 and that NHS organisations needed to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter was to set out the broad operating environment and approach that the NHS would be working within for the foreseeable future (the "**Phase 2 Letter**") [INQ000087412].
  - c. the letter of 31 July 2020 from NHS England to the system confirming the start of phase 3. This letter set out an update on the latest Covid-19 alert levels, priorities for the remainder of 2020/21 and an outline of the financial arrangements heading into autumn (the "**Phase 3 Letter**") [AP040 INQ000051407]

#### Bulletins

131. NHS England built on and developed a number of bulletins that aimed to inform a wide range of stakeholders of key clinical and operational updates regarding the spread of the virus, advancements in treatment and vaccinations, upcoming events, and key information from NHS partners.
132. An example of this is the Healthcare Leaders Update, which was stood up in August 2020. Recipients of this bulletin included CCG leads and Trust leads. Each bulletin contained a foreword from the Chief Operating Officer, the latest on Covid-19, headlines from NHS partners, details on upcoming events and webinars, and online Covid-19 guidance.

#### CAS Alerts

133. The Central Alerting System ("**CAS**"), which is managed by the MHRA, is "*a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.*"
134. Throughout the Relevant Period, CMO alerts were sent via the CAS. A significant number of alerts were distributed through the CAS ([**AP041 INQ000270106**]) and a number of these alerts were tripartite communications between the CMO, PHE and NHS England, such as the first Covid-19 alert dated 23 January 2020. This is exhibited by way of example and identifies that the recipients included regional teams, Trusts, GP practices, CCGs and Directors of Public Health [**INQ000087561, INQ000087240 and INQ000087241**].
135. Other tripartite alerts transmitted through the CAS were aimed at specific groups, such as primary care and community settings, including pharmacy. Examples of this include the 3 February alert [**INQ000087565 and INQ000087246**] and the 21 March alert ([**AP042 INQ000068544**] and **AP043 INQ000270109**), both of which provided an update to these groups on the evolving situation regarding Covid-19 and are exhibited.
136. In addition to CMO alerts, NHS England used the CAS to transmit patient safety information to the system. For example, an estates and facilities alert was issued by NHS England on 6 April 2020 regarding oxygen usage and the risk of icing due to exceptionally high draws and providing advice on the issue ([**AP044 INQ000371235**] **AP045 INQ000269927, AP046 INQ000269928 and AP047 INQ000269929**).

#### Publications and guidance

137. In addition to information being distributed via the CAS, NHS England produced a significant number of publications ranging from updates to frequently asked questions.
138. It is standard practice for the NHS to plan ahead. NHS England considers requests for advice and guidance from the system. Sometimes potential guidance is developed in collaboration with providers who are raising concerns. During the Relevant Period, some guidance that was developed in this way did not need to be issued as it had been superseded, for example, by events or data and/or new guidance was expected from Government or others. By way of example this included guidance on the following topics:
- a. enhancing risk assessments to support staff placement during Covid-19 **[AP048 INQ000269940]**, as NHS Employers had published this information **[AP049 INQ000270150]**; and
  - b. Rapid Policy Statement for long-term use of non-steroidal anti-inflammatory drugs in people with or at risk of Covid-19 **[AP050 INQ000269944]**, as the National Institute for Health and Care Excellence ("**NICE**") had published this information **[AP051 INQ000270147]**.
139. In deciding when and how to issue new guidance, NHS England also had to take into account the existing guidance and communication load being placed on the system so as not to overwhelm the system and colleagues working within it.

#### System Webinars

140. Throughout the pandemic NHS England delivered a large number of webinars to the system on a range of topics by a range of teams. Webinars commenced shortly after the notification that the NHS was responding to Covid-19 as a Level 4 Incident, for example, webinars hosted by the Strategic Incident Director commenced in early February 2020 (having been established and recognised as very effective during the NHS's EU Exit preparations).
141. Used throughout the Relevant Period, webinars were a key method for cascading strategic updates to system leaders and providing questions and answers on key topics including:
- a. strategic updates e.g., new variants;
  - b. supplies e.g., ventilators and PPE;



- c. EU Exit (ongoing response until July 2021);
  - d. winter planning and pressures;
  - e. surge planning;
  - f. vaccinations;
  - g. health inequalities;
  - h. oxygen (good housekeeping);
  - i. discharge; and
  - j. maternity.
142. Senior NHS England leaders including the NHS England's Chief Executive Officer, Chief Operating Officer, National Medical Director, Chief Nursing Officer, Chief People Officer and Chief Commercial Officer also directly communicated with NHS system leaders through the use of webinars. Presenters also included those working on the frontline in the community e.g., GPs as well as individuals from NHSX, NHS Digital, DHSC, PHE and charities.
143. By way of example:
- a. On 23 March 2020, a webinar took place on 'How to establish a remote 'total triage' model in general practice in response to COVID-19'. This session included input from a GP panel, reflecting on their experience.
  - b. On 13 October 2021, a webinar regarding Long Covid and breathlessness took place which included NHS England alongside charities' experiences **[AP052 INQ000270139]**.
144. Webinars varied in terms of invite list dependant on subject matter, the number of views<sup>18</sup> and whether they were recorded<sup>19</sup> but they were typically interactive. For example:
- a. EPRR-led "incident webinars":

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<sup>18</sup> NHS England is unable to confirm if a record was kept of all viewing figures for all webinars.

<sup>19</sup> To balance the challenge of open and honest discussion with NHS leadership not all webinars were recorded.

- i. were intended to be informative about current understanding and demand, and to be anticipatory based on the best advice at the time;
- ii. were not compulsory;
- iii. had varying numbers of views (always typically in 100s);
- iv. were interactive;
- v. were not recorded; and
- vi. were subject to tightly managed joining/invitation measures due to sensitivity of information being shared. Invites were extended to ICB and Trust chairs and chief executive officers. These webinars were typically joined by at least one representative from most organisations.

- b. Other webinars were recorded (such as the GP webinar referenced above) and remain on the FutureNHS Collaboration Platform (see below).

145. Geographical regions and national programmes (Cancer, Mental Health and Primary Care) also established regular channels of communication using video-conferencing. Each of these contributed to a richness of information, and also facilitated the rapid evolution of services in response to the demands of the pandemic. Formal communication was always via the SPOC.

146. A System Webinar Checklist was produced and is exhibited at: **[AP053 INQ000270031]**

*FutureNHS Collaboration platform*

147. FutureNHS is an online collaborative working platform that is managed by NHS England. Members of the platform can join or create workspaces and communities to connect with others, learn and share. FutureNHS is open to anyone working in, or for, health and social care. The platform supports commissioners, providers, senior management, frontline staff, clinicians, health and social care colleagues, voluntary community sector organisations and other interested stakeholders.

148. It is made up of different workspaces. Workspaces are self-contained areas within their own managed membership which are dedicated to a project, programme, or

subject area. A workspace can either be open (accessible to all members) or restricted (membership access requests must be approved).

149. The platform allows members to respond quickly to the changing health and care landscape, such as the implementation of the NHS Long Term Plan, and most recently supporting its members to collaborate at scale during the pandemic.

#### Government's Public Communications

150. NHS England did not deliver Government communications to the general public, other than when individuals appeared at the daily Number 10 press briefings and supported this messaging in general terms. It did however contribute to Government thinking about communications in respect of specific matters within its own sphere of responsibility and participated, for example, in briefings to the public in government press conferences.
151. NHS England's communications team, led by its Director of Communications, engaged with the Government in a number of respects. Until about mid-February 2020, the team attended briefings organised by the Number 10 press office at which it fed back, as requested, on information gained through the health system. Thereafter, however, it was decided that those matters were operational rather than matters of communications, such that the attendance of the team was no longer required. Alongside such meetings, there were various ad hoc meetings and communications, including providing input into briefings delivered by the CMO and one early attendance at SPI-M-O.
152. Prior to mid-February 2020, much of the work of the communications team was directed to messaging for travellers arriving from China, preparing appropriate literature in English and Chinese and relaying to Government developing information on hospitalisations and deaths. Participation in meetings at this stage was directed to relaying information and receiving messages which needed to be passed back into NHS England, rather than advising government.
153. There were, however, some specific matters in relation to which NHS England expressed opinions to Government. Part of the messaging delivered to the public by Government included the slogan "Protect the NHS". NHS England was not involved in the construction of this slogan but concerns about its use were communicated to the Government by NHS England's Communications Director.

154. For example, on Sunday 5 April 2020, there was an exchange of emails between NHS England's Communications Director, the Cabinet Office, Number 10 and DHSC ([INQ000087377]), in which NHS England flagged concerns arising from the messaging.
155. NHS England wanted to promote a message which encouraged people to come forward for medical help with non-Covid-19 problems.
156. Funding was subsequently authorised by the Cabinet Office for a campaign encouraging people to come forward. The importance attached by NHS England to encouraging patients who needed care to seek it was evident, for example, from:
- a. NHS England's National Medical Director and Chief Nursing Officer both speaking at Number 10 press conferences in early April 2020 about the importance of people coming forward; and
  - b. the slide pack recording the information campaigns run by NHS England for the four years 2019/20 to 2022/23; the Open for Business campaign is seen as especially prominent in April to July 2020 as part of the Help Us Help You theme [INQ000087545].

#### Behavioural science

157. NHS England had a Behavioural Change Unit which operated until March 2021. Its purpose was to advise NHS England on the ways in which behavioural science affected the response of people to the pandemic and to inform NHS England's approach to its own communications where appropriate. The unit was not part of the NHS England Communications Team.
158. The Unit was not an adviser to Government; the Cabinet Office had its own experts in behavioural science. It did, though, have some contact with the Government throughout its period of operation.

#### Vaccine Communications

159. In late 2020 and 2021, the communications team worked on the messaging around the vaccine programme, the campaign in support of which was funded by the Cabinet Office. There were ongoing concerns about the uptake of Covid-19 vaccines by Black, Asian and other minority ethnic people. The campaign supporting the programme deliberately gave prominence to the participation of ethnic minority people, both as those receiving the vaccine and those administering it.

### Press conferences

160. NHS England staff attended government press conferences and presented alongside others including the Prime Minister, SSHSC, CMO and Deputy CMO.
161. The daily press conferences were driven by Government, usually with an overarching theme. NHS England provided spokespeople at the request of Number 10 or DHSC; the requests were typically made through communication teams or from private office to private office. The NHS England communications team would confirm who was available and most appropriate to the theme of the Government press conference. On occasions, Government would request a specific spokesperson. Attendance of NHS England spokespeople at Government press conferences did not mean that NHS England endorsed everything that was said by other attendees. Although NHS England was not the driver of the content of press conferences, it did seek to use one early occasion to countermand publicly some of the rumours or conspiracy theories circulating to the effect that the pandemic was some sort of hoax.
162. The NHS England communications team would meet with NHS England spokespeople ahead of the Government press conference to discuss key issues and provide a verbal brief. There would then normally be another briefing session at Number 10 with the relevant Minister, special advisers and other officials who were appearing. The NHS England communications team were sometimes but not always invited to attend these sessions.
163. The NHS England communications team provided information on key issues, to both DHSC and Number 10, as requested.

### Frontline sharing of information

164. Information was being shared on a national, regional and local system basis. For example:
  - a. in London, the London Regional Director shared data with Local Authorities and the Greater London Assembly. Additionally, the London Regional Director would meet with the Chief Executive Officers of London Trusts daily; topics discussed included available data and daily consideration of the operational response.
  - b. the Midlands region rapidly developed a daily intelligence brief which captured a range of information including Covid-19 rates, death rates, critical care capacity, bed numbers and staff numbers. National data was being used to

create a Midlands-specific document. This document went to all partners, including LRFs.

- c. after the pandemic started and when NHS England saw the disproportionate impact of Covid-19 on communities from a black and Asian ethnic minority background, the Chief People Officer convened national meetings of all the black and Asian ethnic minority groups staff network leads and Equality Diversity and Inclusion leads across the NHS in order to provide support to staff from ethnic minorities.

### Ongoing preparedness

165. As part of the pandemic response, between January 2020 and February 2022, NHS England was involved in a number of emergency preparedness exercises. These were generally led by either PHE or Government, and NHS England was a participant. Outputs are summarised in reports produced by the lead organisation. These included:

- a. **Exercise Nimbus** (February 2020, Cabinet-Office led). This was a table-top exercise which simulated a fictional COBR meeting, taking place on 13 April 2020. The aim was to rehearse ministerial-led decision-making for the UK's pandemic preparedness and response within the context of the present novel coronavirus outbreak. The objective was to expose the potential scale and range of impacts arising during a pandemic, and to identify the likely type and range of decisions that would need to be made by ministers at key points during the pandemic. A further objective was to rehearse the structure, process and protocols for supporting clinical and strategic decision making in the response to the novel coronavirus outbreak in the UK. Participants worked through the context, choices and consequences for a number of topics arising from a fictional scenario. These included: caring for the sick, staff absences and communications. Attendees included representatives from Number 10, PHE, DHSC, Home Office, Go Science, the Cabinet Office and NHS England. NHS England did not receive the final report ([INQ000113252, INQ000113251 and INQ000113250]).
- b. **Novus Coronet** (March 2020, PHE led): Designed primarily for health organisations to explore the response to a novel coronavirus outbreak in England and the interdependencies with LRF partners. The scenarios, injects and question sets were designed entirely to demonstrate, test and explore the

Reasonable Worst Case Scenario (“**RWCS**”)<sup>20</sup> that might arise from an outbreak of a novel coronavirus which had the potential to escalate to a declared pandemic. While a fictional scenario, this exercise was timed to allow health organisations to test their escalation plans in the early stage of the pandemic ([**INQ000113254**]).

- c. **Exercise Gemini** (June 2020, DHSC led). The SSHSC led a pair of exercises to explore, inform and assess the progression of the NHS Test and Trace system (Gemini I and Gemini II). Exercise Gemini I was undertaken to explore the development and understanding of NHS Test and Trace approach and how it was to aid national decision making. Exercise Gemini II was used to explore progress toward the implementation of the recommendations from Exercise Gemini I ([**INQ000113260 and INQ000113266**]).
- a. **Exercise Fairlight** (September 2020, Cabinet Office led). The Prime Minister asked the Ministry of Defence to conduct an exercise to test the Government’s Operational Delivery Plans for Covid-19 ahead of winter. The exercise was delivered based on the RWCS, which included progressive deterioration of conditions over winter, and which at certain defined points would present a scenario which would require inter-departmental planning involving SROs and Programme Directors from across Government, and which will make use of the Covid-19 governance structures. There were four exercise scenarios: (i) regional lockdown management; (ii) increase in national transition level; (iii) national transmission reaches new peak; and (iv) transition to recovery. NHS England did not receive the outputs from this wider exercise ([**INQ000113265 and INQ000113264**]).
- b. **Exercise Fairlite** (August and October 2020, NHS England led):<sup>21</sup>
  - i. Exercise Fairlite I was undertaken during August 2020 prior to Exercise Fairlight and was run to test and assure ongoing preparatory work within the health system ([**INQ000113263 and INQ000113267**]).

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<sup>20</sup> RWCS planning allows plans to cover a wide range of potential scenarios within the scope of the incident that is being planned for.

<sup>21</sup> Exercises Fairlite I and Fairlite II were designed to enable local NHS organisations and partners to assess local plans and relationships. Engagement in these exercises was encouraged but not mandatory.

- ii. Exercise Fairlite II was undertaken during end of September / beginning of October 2020 and built on ongoing work around Phase 3 planning for elective recovery, Wave 2 planning to date and the then recent separate request for system surge and capacity plans ([INQ000113269 and AP054 INQ000270056]).
- c. **Exercise Asclepius** (October 2020): NHS England and partners conducted a live play field exercise, with an aim to gauge the capabilities of the POD concept for the scalable delivery of mass vaccination, and identify what steps would be needed to mitigate the issues faced by the Mass Vaccinations programme as it stepped up for the SARS-CoV-2 targeted vaccine rounds ([INQ000113288]).

#### **Continuous learning: lessons from Covid-19**

- 166. NHS England sought to identify and learn lessons from the pandemic response, and adapt plans as required. As previously stated, Covid-19 was not a single incident, but in reality a series of incidents within an overarching protracted incident (the pandemic). This section summarises ways in which NHS England sought to learn lessons as the pandemic response developed.
- 167. Throughout the pandemic individuals, teams, networks and the organisation conducted different types of reviews at different levels in the organisation. These ranged from rapid light touch after-action reviews, to evidence digests, case studies and wider, in-depth reflections. Many 'real-time' changes were made by NHS England through augmenting and pivoting approaches as NHS England learned more about Covid-19 and its specific variants (examples of learning between waves are exhibited at paragraph 169).
- 168. Examples of 'in the moment' outcomes include:
  - a. some directorates in NHS England suspending routine activity which would have had an impact on the NHS;
  - b. information relating to NHS activity, specialist beds e.g., critical care was embedded into NHS England's data platform to ensure that all decision makers had access to the same information;
  - c. the establishment of the National Critical Care Transfer Team (as discussed further in the 'Wave 2 impact' section below with more detailed information regarding critical care transfers being set out in NHS England's Third Module



3 Statement), which has been used in subsequent incidents including when NHS England was asked to 'medevac' (medical evacuation) sick Ukrainian children; and

- d. during the pandemic NHS England had Regional ICCs; they have now become Regional Operations Centres following the National Operations Centre model.
169. NHS England has undertaken a process of collation, analysis and prioritisation of lessons identified to date so that they can be assimilated into a single report. The approach has drawn from a range of source material that was developed throughout the pandemic response and continues to be built upon, including incident-wide lessons identified exercises ([**INQ000113258, INQ000113261, INQ000113275, INQ000113276, INQ000113290, INQ000113292, INQ000113330 and INQ000113331**]).
170. NHS England has prepared a Covid-19 lessons report to support further dialogue and debate to generate further insights from the pandemic response ([**INQ000226890**]).
171. A number of NHS England staff may also have participated in the reflective exercises of others e.g., NHS England's National Medical Director was involved in the *Technical report on the COVID-19 pandemic in the UK* ([**INQ000113313**]).
172. Further lessons identified activities have been conducted by regional EPRR teams, national cells and programmes, and the Beneficial Changes Network.
173. NHS England's EPRR team worked to collate wider lessons identified at key stages throughout the pandemic, which culminated in reports to NIRB to support ongoing planning and pivoting of the response. Findings were identified from group cell workshops, interviews with selected National and Regional Directors and other leads, and template submissions from cells and regions.
174. Proactive collaboration with multiple partners, including local authorities, charities, community and faith sectors has shaped and informed new approaches to vaccination and healthcare. This includes the vaccination of people in places that they are familiar with, for example, places of worship.
175. How the Vaccine Programme communicated with the public and NHS staff was extremely important to allay fears and inform people how and where they could receive their vaccinations. The programme provided focused and tailored messaging, targeted to specific audiences and continuously refined to encourage

ongoing vaccine uptake. The messaging improved throughout the pandemic with the programme rapidly responding and developing a range of communication mechanisms, for example:

- a. YouTube videos aimed at people with a learning disability **[AP055 INQ000270148]**;
- b. Letters direct to all frontline NHS and social care staff, see for example exhibit **[AP056 INQ000270001]**;
- c. Advice for local systems and local authorities to engage underserved communities, to drive up vaccine uptake **[AP57 INQ000091902 ]**;
- d. Covid-19 vaccination toolkit for Black African and Black African Caribbean communities **[AP058 INQ000270025]**;
- e. Publicity campaigns/slogans, e.g., 'Grab A Jab' weekend **[AP059 INQ000270149]**.

- 176. The learning from the NHS vaccines programme continues to positively influence work across the health sector, including through demonstrating the value of using data to identify those who can benefit from early intervention, such as those with cardio-vascular disease; providing a model for community out-reach; or providing the model for taskforce-style approaches to funding research into cancer, obesity, mental health and addiction.
- 177. In late 2021, NHS England worked with DHSC to prepare a retrospective interim economic evaluation of the Covid-19 Vaccine Deployment Programme **[INQ000087532]**, which involved assessing use of resources against the Public Value Framework Assessment. The intention of this was to inform the impact of the programme and provide insight for any similar future programmes. The final report was prepared in December 2021. We understand that vaccines and therapeutics will be considered as part of Module 4.
- 178. The Beneficial Changes Network was established by NHS England during the pandemic to support frontline stakeholders and partners from across health and social care and seek their direct input to identify, share and understand the significant change that occurred in the changed operational circumstances of the Covid-19 response. The Beneficial Changes Network is a collaborative group of health and social care stakeholders and people with lived experience sharing knowledge and learning across the health and care sector (**[INQ000113314]**).

179. In December 2020, the Beneficial Changes Network and NHS Accelerated Access Collaborative (which includes representatives from DHSC / BEIS / MHRA / Royal Colleges) jointly commissioned Frontier Economics, Kaleidoscope Health and Care, and RAND Europe, to conduct an independent review to help learn lessons from this period and recommend how potentially beneficial changes can become day-to-day practice. It was conducted between October and December 2020 and involved a range of lived experience voices and over 80 stakeholder organisations ([INQ000087494]). The report identified six core findings:

**The research identified six core findings spanning across innovation, research and collaboration**

Detail: Evidence report  
p105-108

|   |                                    |   |   |
|---|------------------------------------|---|---|
|    | Clarity of purpose                 |    | A system-wide shared understanding of the need for action mobilises partners quickly and breaks down barriers to collaboration  |
|    | Leadership and agency              |    | Beneficial change is accelerated by leadership that supports appropriate agency across organisational levels, and supports innovation and collaboration                     |
|    | Inclusion and personalisation      |    | Addressing health inequalities requires greater inclusion and involvement of diverse perspectives, and the better personalisation of services to different populations      |
|   | Skills and capability              |   | Change was enabled by those who had appropriate skills to solve problems, then adapt to new ways of working   |
|  | Data and technology infrastructure |  | Critical enablers of rapid change include the safe and timely sharing of data, and appropriate and resilient technology infrastructure                                      |
|  | Evidence-based decision making     |  | For the impacts over time to be fully understood, there is a continuing need for robust evaluation evidence to understand what works, for whom and under what circumstances |

180. In March 2021, a summary of the NHS England response to the ongoing pandemic was presented to the NHS England Board, in recognition of the clinical and operational innovations achieved during the period and our ongoing contribution to research ([INQ000087492]).

Updates to EPRR planning following Covid-19

181. The EPRR Framework (version 3) [INQ000113334] now contains a section confirming that, as part of the debrief, there should be a mechanism for sharing lessons identified across the local ICSs, through Local Health Resilience Partnerships, the wider NHS and with partner organisations. Following the response to Covid-19, numerous plans have been tested/implemented and this learning should be considered and fed back into other resilience plans as required.

182. The inequalities section during a major incident section has also been updated to confirm that, as part of learning from Covid-19 and similar incidents, specific guidance on managing health inequalities during a major incident is being developed and will be published by NHS England in due course.
183. The NHS England Incident Response Plan (National) was updated in November 2022 **[INQ000113336 and INQ000113335]**, and included:
- a. A definition of a protracted incident: An incident lasting for an extended duration, of significant complexity and which may require enhanced measures, resources and / or mutual aid over and above those required to respond to an isolated incident, using Covid-19 as an example; and
  - b. An annex for protracted incidents, which describes the arrangements that may be put in place nationally following a declaration of a protracted incident.

## SECTION 2: ELEMENTS OF CAPACITY

184. This Section provides an overview of what is required to create and maintain hospital capacity, along with the different levels of care within the rest of the health system. This includes an analysis of what is required to enable a bed to be used. It is important to recognise that different beds have different requirements, ranging from HCID units (discussed in Section 3) requiring extremely specialist equipment to G&A beds that are designed for patients who require short-term hospital care.
185. Beds are not available without staff, so the picture on staff headcount and vacancies is set out below. Broadly speaking, by 2020, 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.
186. There was little flexibility in the existing capacity to respond to a rapid and significant surge in demand due to the pandemic.
187. The ability to create capacity requires a system with a stable platform that also, ideally, has 'headroom' or the means to create headroom. Headroom which creates resilience can be made as a result of 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).
188. The NHS routinely adapts to pressures, for example, during winter, and therefore, the NHS and its staff are experienced at managing surges in activity through flexing existing capacity.
189. The NHS, however, has historically had low bed numbers and high bed occupancy levels compared with other G7 and European countries. The reason for high bed occupancy is multifaceted, and includes an ageing population, the age of the NHS

estate, historically low bed numbers and delayed transfers of care due to social care pressures.

190. NHS England's budget had risen in real terms by an average of 2.7% per 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 ageing population, with increasing levels of multimorbidity and rising public expectations.
191. During the pandemic, capacity was increased through a number of means, including workforce capacity initiatives (see Section 11), the creation of Nightingale Hospitals (see Section 12) facilitated by directions issued by the SSHSC (see Section 8) and the use of the private sector (see Section 13).

## **Description of capacity**

### Hospital Capacity

192. Capacity describes the number of beds available within the hospital sector for patient care. All beds used by patients require a number of resources to be available in addition to the physical bed itself:
  - a. clinical and non-clinical staff;
  - b. specialist equipment;
  - c. supplies (including medication, consumables and oxygen); and
  - d. the physical location of the bed and its surrounding infrastructure.
193. Different considerations apply depending on the intended use of each bed, for example between ordinary acute services and critical care. It should also be noted that capacity is not a static concept and depends in particular on the staffing available.
194. This section provides an overview of:
  - a. different types of hospital bed along with their associated requirements; and
  - b. the potential for them to be re-allocated.

195. HCID capacity is covered in NHS England's First Module 3 Statement and Section 3 below.

Bed Types

196. There are essentially five elements which make up hospital bed capacity:
- a. the physical bed, which may itself be age dependent in the sense that there are adult beds, paediatric beds and neonatal cots; some paediatric beds may be large enough for an adult patient;
  - b. the environment in which the bed is set; for example, for Covid-19 care, the availability of piped oxygen was particularly important;
  - c. the equipment required to make a bed function in its required purpose; for intensive care this would include equipment to provide support to one or more of a patient's vital organs;
  - d. the availability of staff trained in the treatment and care of the patients served by the bed type; and
  - e. what a bed is routinely used for and its consequential potential to be re-purposed.
197. The majority of ward level care is provided in G&A beds that are designed for patients who require short-term medical care and treatment for acute illnesses or injuries. These beds are typically located in medical, surgical, or speciality wards, such as orthopaedic wards and are used for a range of medical conditions and post-operative care. This level of care is described as Level 0.
198. The equipment available to G&A beds varies depending on the specific needs of the patient. However, it typically includes basic medical equipment such as oxygen therapy, suction, blood pressure monitors, pulse oximeters, and intravenous infusion pumps. These beds are also equipped with call bells, patient seating and access to bathroom facilities for patients who are mobile.
199. The staffing for G&A beds is provided by a team of nurses, healthcare assistants, therapists and medical cover round-the-clock. They are responsible for monitoring the patient's condition, administering medications and treatments, providing wound care, and ensuring that patients are comfortable and well-cared for.

200. Above Level 0 are Levels 1, 2 and 3 which are a way of describing various levels of critical care as follows:
- a. *Level 1 critical care (sometimes known as 'enhanced care')*: patients at risk of their condition deteriorating or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team. This may also include patients who require additional monitoring after undergoing major surgery. The equipment required is similar to G&A beds, the main difference is the intensity of monitoring required.
  - b. *Level 2 critical care*: patients requiring more detailed observation or intervention, including support for a single organ failure or post-operative care and those 'stepping down' from higher levels of care. These beds are equipped with advanced medical equipment and technology, such as infusion pumps, cardiac monitors and dialysis machines to support patients with life-threatening conditions. Staffing for critical care beds is typically provided by a team of highly trained healthcare professionals, including critical care nurses, respiratory therapists, and doctors with specialised training in critical care medicine. Level 2 beds are commonly co-located with Level 3 beds within Critical/Intensive Care Units where the number of each will flex according to patient need and staffing. They may also be located in separate facilities known as 'high dependency units' ("**HDU**").
  - c. *Level 3 critical care*: patients requiring advanced respiratory support (ventilation) alone or in combination with support of other organs. This level includes all complex patients requiring support for multi-organ failure. Also known as 'intensive care units' ("**ICU**") or 'intensive treatment/therapy units' ("**ITU**").
201. The data reported by NHS England on occupation of critical care beds indicates patients who required either Level 2 or Level 3 support.
202. Critical care beds are also distinguished and broken down in data reporting by reference to the age of the patient, in the form of adult critical care, paediatric intensive care and neonatal intensive care. For adult and neonatal patients Levels 2 and 3 are considered critical care, whereas for paediatric patients it is Level 3 only.
203. The Guidelines for the Provision of Intensive Care Services ("**GPICS**") standards, as more particularly described in paragraphs 223 to 231 below, state that Level 3 care



requires one registered nurse per patient and Level 2 requires one registered nurse to every two patients. Many units will flex the number of Level 2/3 beds available according to staffing levels – the availability of equipment is not normally a restriction.

204. As part of pandemic influenza planning and during the early stages of Wave 1 of the pandemic, the focus had been on single organ (respiratory) failure. However, with early clinical experience it rapidly emerged that Covid-19 was a multi-system disease and this was particularly reflected in the needs of patients with severe disease requiring critical care. In particular, the need for renal support to manage kidney failure was significant, requiring access to haemofiltration, haemodialysis or peritoneal dialysis. Different equipment and consumables were needed, depending on the procedure. Typically, in ITU haemofiltration is the preferred technique.
205. By the time of Wave 2, significant investment had been made to improve capacity in terms of equipment, consumables and the highly purified water supplies required for haemodialysis.
206. From around 12 February 2020, NHS England moved away from the way it classified and reported internally critical care beds to fit the requirement to surge critical care capacity that seemed likely. As hospitals identified surge capacity to deliver critical care outside of normal units, there was a need to use a simplified nomenclature (for Covid-19) to reflect bed capacity based on the level of respiratory support that could be offered. Therefore, for the purposes of Covid-19 planning, the following classification was used:
- a. “*V-beds*”: beds in which patients with lung failure could be treated using ventilators; some patients who would normally require Level 3 support because they had multiple organ failure might not have required a ventilator and could be accommodated in an O+ bed (see below);
  - b. “*O+ beds*”: beds with high oxygen flow (such as the ability to support CPAP);
  - c. “*O beds*”: beds with standard oxygen flow; and
  - d. “*S beds*”: beds either without oxygen or a consistent oxygen supply that could support a Covid-19 patient with symptoms who required support but who did not need supplementary oxygen.<sup>22</sup>

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<sup>22</sup> While the majority of hospital beds have an oxygen port, if too many ports are turned on at once in some hospitals the system would not be able supply demand at all ports.

207. Statistical publications retained the pre-12 February classifications.
208. Mental health and learning disability inpatients require beds which are not equipped to the same degree because they do not need to be set up to manage acute physical illness in the same way as other patients. There is treatment called 'intensive care' in psychiatric medicine for the acute phase of some severe mental illnesses but such beds do not require piped oxygen. However mental health Trusts did sometimes need to use their beds to manage Covid-19 inpatients who had been admitted for other reasons - including with oxygen support as necessary using portable oxygen concentrators (devices that increase the oxygen proportion in room air) or oxygen cylinders.
209. Paediatric beds require similar equipment to their adult equivalents with some differences such as sizing of consumables, intravenous sets, blood pressure cuffs and pulse oximetry sensors to allow monitoring appropriate to the size of children and infants. Paediatric critical care is delivered in paediatric intensive care units at Level 3. Neonatal units sit outside general/critical care paediatric provision.
210. Maternity beds require equipment specific to the care of mothers and their babies before, during and after delivery. Many of the environmental and equipment requirements are the same as G&A wards, although in addition specialist equipment for monitoring foetal well-being including cardiotocograph monitoring and ultrasound might be required. The environment also requires rapid access to theatres to perform procedures under anaesthetic and a range of equipment for assisted deliveries. These facilities are usually co-located within maternity units which are staffed by medical and midwifery staff with specialist skills and training.

#### Re-allocation of beds

211. As previously described, the NHS runs with relatively high levels of bed occupancy (in comparison to other systems internationally) and so the need to make adjustments in capacity to avoid overload is a regular occurrence – particularly during winter months when the demand for beds is at its highest. Hospitals achieve this through a variety of means: opening up spare G&A capacity on unused wards; deferring non-urgent elective care admissions to free up beds; and taking steps to improve discharge flow to free up capacity by reducing length of stay for the medically fit.
212. For Level 2/3, options are more limited given the environmental, equipment and staffing requirements. Adjustments are most commonly achieved by using anaesthetic areas or recovery wards next to operating theatres which have the right

equipment and can often utilise theatre staff with relevant skills – sometimes this can be achieved by post-operative patients spending longer in theatre recovery rather than transferring to an HDU, where capacity can then be freed up. Operating theatres themselves could be used but this happens very rarely. Some other specialist spaces have a design which accommodates other types of high dependency patients well. High dependency beds in coronary care for example are also well equipped to take patients with wider organ failure needs. All such critical care surge options impact normal practice operational efficiency.

213. To some extent, therefore, there was already a level of heightened demand (especially during winter pressures). However, the NHS went beyond that with the management of Covid-19.
214. Exercise Novus Coronet in March 2020 was designed to test this planning and asked Trusts to consider options beyond those that would normally be used as part of winter pressures. The simplified classification of beds (V/O+/O/S) introduced the previous month helped this process and gave a broader measure of surge capacity that could be achieved.
215. There were a number of overarching constraints on flexibility when seeking to re-allocate beds to accommodate Covid-19 patients. The starting point at the beginning of 2020 was that the NHS in England had a little over 100,000 G&A beds. Early analysis was undertaken to consider how beds could be freed up if hospital services except cancer and urgent and emergency treatment were postponed. It was thought that taking those steps would free up about 13,000 beds for Covid-19 patients, about 50% of which could be available within 5 days, rising to a total of 90% within 28 days. The majority of beds (up to 87%) would still be required for non-Covid-19 urgent and emergency conditions.
216. Staffing was also a major consideration. This was particularly the case in critical care where if the relevant staffing ratio for intensive care beds (see reference to GPICS below for more detail on the ratios) was applied to the planning assumption used for pandemic influenza - which was that there might be surge capacity to reach 7,000 critical care beds – there would not be enough appropriate staff to support this number of patients at accepted ratios. This might be mitigated for patients receiving single organ support to be managed on the staffing ratio used in HDUs. Providing critical care beyond these ratios would allow more patients to receive organ support with severe illness, though there was clinical uncertainty about whether this could be done safely and if this struck the right balance of risk.

217. When considering the level of surge capacity contemplated in the Nightingale hospitals, this would move well beyond usual non-pandemic NHS practice and the usual balance of risk.<sup>23</sup> The model of care here was informed by those with experience of delivering healthcare where resources are “overmatched” by demand, such as in disaster relief and military scenarios and emerging reports from countries such as Italy. In this scenario, bedside care is delivered by a team of non-clinical staff supported by clinical staff providing oversight and a response to problems. Using this model, different ratios with fewer specialist trained healthcare staff to patients were envisaged, though moving to this model would also require considerable support to staff working in this environment. While far removed from normal practice and therefore riskier, the alternatives, as seen for example in Northern Italy, were the reality of services being overwhelmed and patients unable to access needed hospital care.
218. The staffing issue was not of course limited to nurses; critical care doctors, therapists, etc., were all finite in number. Another element was how other groups of staff were or could be re-deployed and where skills could be transferred across. Within critical care settings this could include personal care, medication preparation and the use of “proning teams” when it became clear lung function could be improved by turning patients to lie in a prone position.
219. An important environmental constraint on re-allocating bed capacity was access to oxygen. There was a considerable national effort on all aspects of oxygen supply through the pandemic. This ranged from its manufacture, prioritising medical vs. industrial usage, its distribution to hospitals and finally the supply to patients within hospitals. A fuller treatment of the challenges presented by hospitals' medical oxygen infrastructure, and the steps taken during the pandemic to respond to those challenges appears in the section of this Statement dealing specifically with oxygen, from paragraph 722 onwards.
220. Notwithstanding all of these constraints, there were many successful re-allocations of beds to increase capacity for Covid-19 patients. This is dealt with below in more detail with measures taken during the pandemic to increase critical care capacity.

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<sup>23</sup> The initial intention was to only treat Covid-19 patients who were unconscious and needed mechanical ventilation.

221. There was no scope to repurpose maternity or neonatal cots. The level of demand for those services is relatively constant. Neither could mental health nor learning disability beds be readily transformed into Covid-19 or critical care beds because they were not designed to manage acute physical illness, although there were examples of patients being treated for Covid-19 while staying as an inpatient in mental health and learning disability provision.
222. Demand for paediatric beds dropped during Wave 1. It was possible to re-purpose some paediatric intensive care bed spaces for adult care, which also permitted the redeployment of skilled staff. That reduction came about in part because the numbers of accidents involving children reduced during the pandemic and also because the lack of social mixing inhibited the spread of the sort of respiratory diseases most likely to generate children's hospital admissions. As an example, the seasonal wave of admissions due to Respiratory Syncytial Virus was virtually eliminated in 2020 due to reduced social interactions. However, the increased opening of social settings, particularly schools, in 2021 led to a sharp (unseasonal) increase of Respiratory Syncytial Virus in the summer, and an overall higher than average rate for the whole year.

#### **Staffing ratios in intensive care**

223. In 2019, prior to the pandemic, the Faculty of Intensive Care Medicine and the Intensive Care Society published the second edition of GPICS - the definitive reference source for the planning, commissioning and delivery of adult critical care services in the UK and used as the benchmark by which services are assessed by the CQC. The GPICS set out standards and recommendations in respect of the structure, staffing and process of critical care.
224. The GPICS states *"Although a lower level of care will usually require a lower nurse-to-patient ratio or reduced critical care support, this may not apply in all circumstances, and the aim should be flexibility in the provision of staff resources to meet the needs of the patient."*
225. The GPICS set out standards for consultants, nursing and other healthcare staff. In respect of standards for consultants, GPICS includes the following:
- a. patients' care must be led by a consultant in intensive care medicine, who is defined as a consultant who is a Fellow/Associate Fellow or eligible to become a Fellow/Associate Fellow of the Faculty of Intensive Care Medicine;

- b. the daytime consultant to patient ratio must not normally exceed a range between 1:8 and 1:12. This ratio is complex and needs to be cognisant of the seniority and competency of junior staff, the reason for admission (e.g., standard post-operative care pathway) and the number and complexity of emergency admissions. The night-time ratio cannot be defined;
- c. the daytime intensive care resident to patient ratio should not normally exceed 1:8. The ratio may need to be reduced if local arrangements dictate that the intensive care resident is expected to provide emergency care outside of the critical care unit (e.g., wards and emergency department). The night-time resident to patient ratio should not normally exceed 1:8.

226. In respect of standards for nursing, the GPICS includes the following:

- a. Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care;
- b. Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care;
- c. each designated critical care unit must have an identified lead nurse who has overall responsibility for the nursing elements of the service e.g., a senior nurse band 8a<sup>24</sup> or above;
- d. there must be a supernumerary (i.e., not rostered to deliver direct patient care to a specific patient) senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7 in critical care units;
- e. units with fewer than six beds may consider having a supernumerary clinical coordinator to provide the supervisory role during peak activity periods, e.g., early shifts. Units with greater than ten beds must have additional supernumerary senior registered nursing staff over and above the supervisory clinical coordinator to enable the delivery of safe care (i.e., 11-20 beds +1, 21-30 beds +2, etc.).

227. In relation to nursing training, the GPICS includes the following:

- a. each critical care unit must have a dedicated Clinical Nurse Educator

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<sup>24</sup> Banding refers to NHS Agenda for Change bands.

responsible for coordinating the education, training and CPD (Continuing Professional Development) framework for intensive care nursing staff and pre-registration student allocation;

- b. all registered nurses commencing in intensive care must be working towards Step 1 of the National Competency Framework for Adult Nurses in Critical Care;
- c. a minimum of 50% of registered nursing staff must be in possession of a post-registration academic programme in Critical Care Nursing;
- d. all non-consultant medical staff commencing a post in the critical care unit must have a consultant-led departmental induction to the unit with a formal published programme;
- e. where direct care is augmented using support staff (including unregistered nursing roles), appropriate training and competence assessment of those staff is required;
- f. in addition to leadership competencies the lead nurse/matron/senior nurse band 8a or above for the critical care unit must meet, as a minimum, the same specialist critical care nurse educational standards as the staff caring for Level 3 patients.

228. In the section on cardiothoracic critical care, the GPICS stated "Ventilated patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care. A greater ratio than 1:1 may be required to safely meet the needs of some critically ill patients, such as unstable patients requiring various simultaneous nursing activities and complex therapies used in supporting multiple organ failure. A lower ratio is justified for the low acuity post-operative extubated patient."
229. The GPICS also set out standards and recommendations for other healthcare staff within critical care units including advanced critical care practitioners, pharmacists, physiotherapists, dietitians, speech and language therapists, occupational therapists and certain others.
230. GPICS indicates that critical care units were envisaged to have a range of healthcare workers with a range of qualifications and experience. For example, the reference to having one registered nurse for each ventilated patient set out above does not require that registered nurse to have the highest level of critical care nursing qualifications, skills, competencies and experience. The staffing of the critical care unit could include

a number of nurses who have no previous experience in intensive care (but who are working towards Step 1 of National Competencies for Adult Critical Care) but the unit would still meet GPICS standards if overall, the staffing on the unit complied with the relevant requirements.

231. How these were changed in the pandemic is covered in Section 10.

### **Patient Flow**

232. As noted above, bed capacity is impacted by the availability of physical and non-physical assets, but it is also affected by working methods and policies.

233. Key factors affecting the flow of patients through hospital and the ability to discharge patients from hospital included the following:

- a. *IPC*: the implementation of enhanced IPC measures within acute and community hospitals to keep patients and staff safe from Covid-19 infection (including testing, cohorting of patients into "red" and "green" areas, physical distancing requirements and enhanced cleaning protocols) had a material impact on hospital capacity, the movement of patients in hospital and the speed of treatment of patients in hospital settings. This was particularly evident at times of high community infection, when the number of Covid-19 patients was highest.
- b. *Estates*: the condition and layout of the available infrastructure of acute and community healthcare settings (in particular for hospitals) was and remains a constraining factor when implementing IPC guidance i.e., separating Covid-19 and non-Covid-19 patients and distancing between beds. Effective separation of non-Covid-19 and Covid-19 patients in "red" and "green" wards was simpler in modern hospital estates with a higher proportion of single occupancy rooms, but significantly more challenging in older hospital estates with a higher proportion of beds in communal wards.
- c. *Social care capacity*: care home and domiciliary care capacity affects the ability of hospitals to admit and discharge patients.<sup>25</sup>

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<sup>25</sup> 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),



- d. *Testing and designated settings policy*: the introduction by DHSC of a policy to test all patients before their discharge to a care home (on 15 April 2020) [AP061 INQ000327838] followed by the Government's requirement on local authorities to establish designated settings for the purpose of quarantining Covid-19 positive patients no longer in need of acute care before their discharge to a care home (introduced on 18 September 2020). The details of the new policy were set out in a letter dated 13 October 2020 addressed to directors of adult services [AP062 INQ000234564]
- e. *The staffing levels available on wards to undertake the discharge planning*: this was significantly impacted in the pandemic by staff absence through ill-health, carer responsibilities or testing positive.
- f. The reduced number of patients attending A&E departments for reasons unrelated to Covid-19 between March and April 2020.

2. Section 7 sets out further information regarding discharge decisions.

#### **Overview of capacity from December 2019 to March 2020**

- 234. The following paragraphs consider aspects of NHS capacity immediately prior to the Relevant Period, including available beds<sup>26</sup>, ventilation equipment and staffing.
- 235. Presented below are the critical care bed occupancy figures from December 2019, representing the immediate pre-pandemic position, and for the period January 2020 to February 2020. These figures come from a monthly data set called 'Critical Care Bed Capacity and Urgent Operations Cancelled' which was subsequently cancelled. Those figures represented a snapshot taken on the last Thursday of the monthly reporting period concerned.

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declaring that a patient is 'medically fit' for discharge from an acute bed, does not necessarily lead to swift discharge. 'Delayed Transfers of Care' 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 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. The Delivery plan for recovering UEC services (January 2023), confirms that *"Both delays in discharge processes and shortages of capacity in social care and community care are making it more challenging to discharge patients from hospitals and mental health services... There are currently around 14,000 patients remaining in hospital who no longer need to be there. On average...16% are awaiting residential or nursing home placements... To improve discharge there must therefore be an increase in capacity in step-down services ('intermediate care') and social care, especially domiciliary care."* [AP060 INQ000270057]

<sup>26</sup> 'Available' beds are those open for immediate use and include beds that are unoccupied or already occupied.

236. In each case, total beds available are those which are occupied or ready for occupation (excluding any which are funded but not ready for occupation because of staff vacancies, assuming those vacancies have not been filled by bank or agency staff).
237. The bed occupancy position in December 2019 across England was as follows:
- a. Adult critical care beds – 3,048, or 75.3%, of 4,048 beds were occupied;
  - b. Paediatric critical care beds – 246, or 79.6%, of 309 beds were occupied;
  - c. Neonatal care beds – 1,036, or 71.5%, of 1,449 beds were occupied;
  - d. Overnight beds, which means a consultant-led bed across specialities including G&A, mental illness, learning disability and maternity and is occupied at midnight on any given day – 111,321, or 86.3%, of 128,943 beds were occupied; and
  - e. Day only beds, which again means any consultant-led bed across specialities including G&A, mental illness, learning disability and maternity and is a bed in which treatment or care of at least one patient has taken place during the day (but is not occupied overnight) – 10,325, or 81.2%, of 12,716 beds were occupied.
238. Moving onto 2020, the position in the early months for critical care was as follows:
- a. January 2020:
    - i. Adult critical care beds – 3,423, or 83.0%, of 4,123 beds were occupied;
    - ii. Paediatric critical care beds – 247, or 79.2%, of 312 beds were occupied; and
    - iii. Neonatal intensive care beds – 1,024, or 71.2%, of 1,439 beds were occupied **[INQ000087378]**.
  - b. February 2020:
    - i. Adult critical care beds – 3,342, or 81.1%, of 4,122 beds were occupied;
    - ii. Paediatric critical care beds – 260, or 81.3%, of 320 beds were

occupied; and

- iii. Neonatal critical care beds – 1,003, or 69.3%, of 1,447 beds were occupied.

239. Inpatient overnight and day only bed data was as follows at the end of March 2020:

- a. Inpatient overnight beds – 76,641, or 64.7%, of 118,473 beds were occupied; and
- b. Inpatient day only beds – 4,952, or 50.5%, of 9,798 beds were occupied **[INQ000087542]**.

240. The tables below set out, for each of the three months January, February and March 2020, the average number of available beds in hospitals across the NHS in England in respect of (a) G&A, (b) adult critical care; and (c) paediatric critical care, in each case per 100,000 of the population. The figures in the following paragraphs 241 to 243 are compiled from the UEC daily SitReps.

241. January 2020:

| G & A | Adult Critical Care | Paediatric Critical Care |
|-------|---------------------|--------------------------|
| 173.7 | 8.0                 | 2.5                      |

242. February 2020:

| G & A | Adult Critical Care | Paediatric Critical Care |
|-------|---------------------|--------------------------|
| 173.1 | 8.0                 | 2.5                      |

243. March 2020:<sup>27</sup>

| G & A | Adult Critical Care | Paediatric Critical Care |
|-------|---------------------|--------------------------|
| 169.7 | 8.2                 | 2.5                      |

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<sup>27</sup> The Phase 1 Letter on 17 March 2020 set out a number of actions aiming to free-up the maximum possible inpatient and critical care capacity.

244. Figures for average monthly bed occupancy are set out in the table below as a percentage, using the UEC Daily SitRep figures. They relate again to the categories of G&A, adult critical care and paediatric critical care. The percentages vary from region to region but the figure given for England in the left hand column corresponds in each case to the available bed figures provided above for the relevant months.

#### Bed Occupancy January 2020 - March 2020

Source: UEC Daily Sitrep

\*figures are hardcoded

| Total G&A Beds |         |                 |        |          |            |            |            |            |
|----------------|---------|-----------------|--------|----------|------------|------------|------------|------------|
|                | England | East of England | London | Midlands | North East | North West | South East | South West |
| Jan-20         | 94.8%   | 95.8%           | 94.8%  | 95.5%    | 93.0%      | 94.4%      | 95.9%      | 94.6%      |
| Feb-20         | 94.0%   | 95.1%           | 94.7%  | 94.6%    | 91.7%      | 93.7%      | 95.5%      | 93.8%      |
| Mar-20         | 83.1%   | 83.4%           | 87.2%  | 83.1%    | 79.5%      | 83.2%      | 85.0%      | 80.0%      |

| Adult Critical Care Beds |         |                 |        |          |            |            |            |            |
|--------------------------|---------|-----------------|--------|----------|------------|------------|------------|------------|
|                          | England | East of England | London | Midlands | North East | North West | South East | South West |
| Jan-20                   | 83.2%   | 78.3%           | 88.6%  | 82.4%    | 77.9%      | 84.6%      | 85.9%      | 81.6%      |
| Feb-20                   | 81.5%   | 76.7%           | 87.4%  | 81.4%    | 75.9%      | 82.8%      | 83.1%      | 79.2%      |
| Mar-20                   | 71.1%   | 68.3%           | 79.2%  | 71.9%    | 66.0%      | 70.0%      | 71.5%      | 63.5%      |

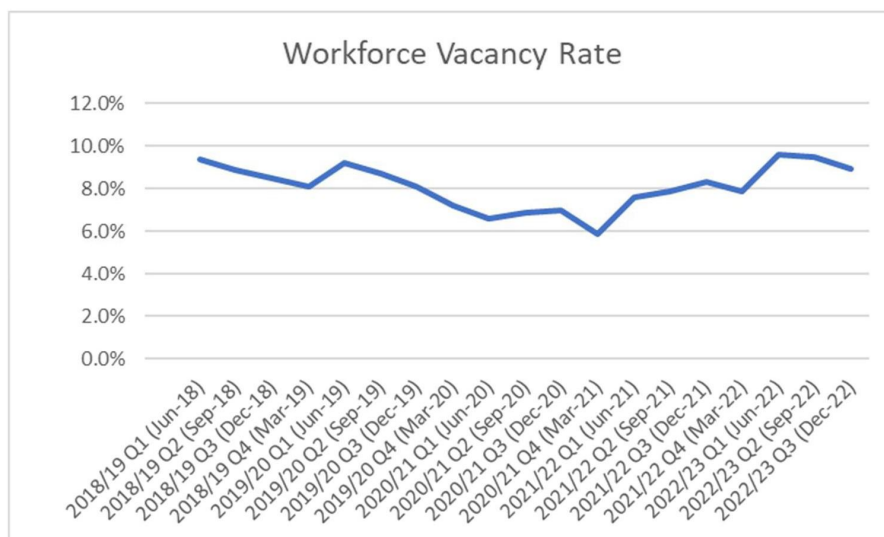
| Paediatric intensive care |         |                 |        |          |            |            |            |            |
|---------------------------|---------|-----------------|--------|----------|------------|------------|------------|------------|
|                           | England | East of England | London | Midlands | North East | North West | South East | South West |
| Jan-20                    | 79.5%   | 52.0%           | 85.2%  | 83.5%    | 68.6%      | 85.6%      | 69.5%      | 92.3%      |
| Feb-20                    | 77.8%   | 31.5%           | 85.7%  | 81.8%    | 67.6%      | 83.2%      | 74.6%      | 81.1%      |
| Mar-20                    | 69.9%   | 25.8%           | 80.3%  | 74.5%    | 59.8%      | 72.6%      | 57.3%      | 85.8%      |

245. The combined figures, although averaged across each month, reflect the fact that, by the end of March 2020, steps were under way to increase beds available to meet pandemic demand, especially in critical care as both physical beds were converted from G&A to critical care and staff redeployed to enable this.
246. In relation to ventilators, numbers are not easily or, we believe, helpfully, analysed on a per 100,000 of population basis. As explained previously, they are part of the functioning of a particular type of critical care bed, aligned with the way in which beds were re-classified from mid-February 2020. Further, the numbers include different types of machine which work in different ways for different purposes with different levels of complexity. We have therefore set out the detail of the numbers, with an explanation, in the section dealing with ventilator availability from paragraph 776 below.
247. ECMO machines are found in a small number of centres across the UK. They oxygenate the patient's blood by passing it through a circuit outside of the body. They represent invasive and highly complex care and benefit a small number of very select

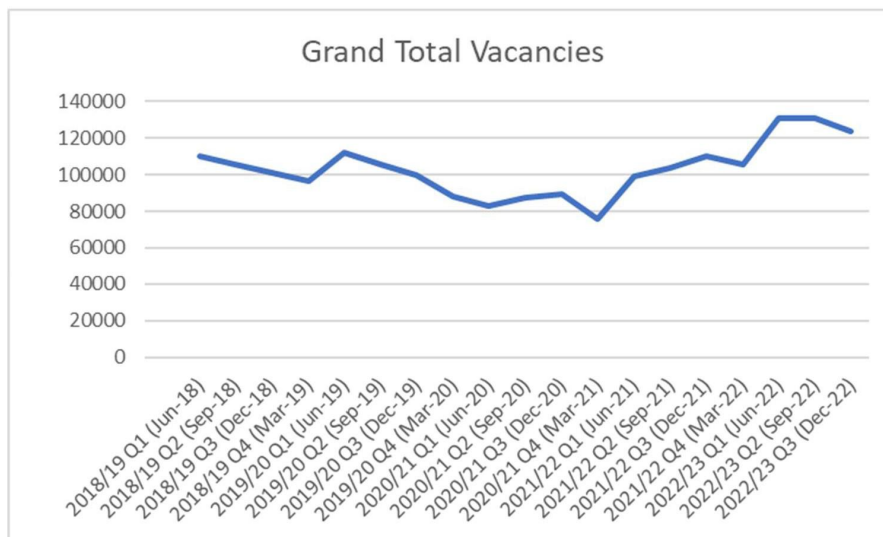
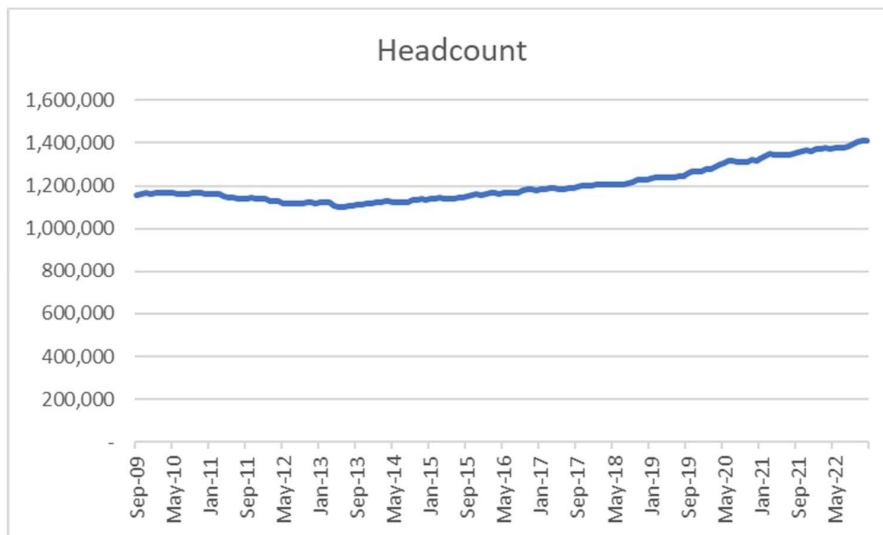
patients. Even with surge in response to the pandemic there were only around 100 across the NHS. Further detail on ECMO is provided from paragraph 819.

### Workforce capacity

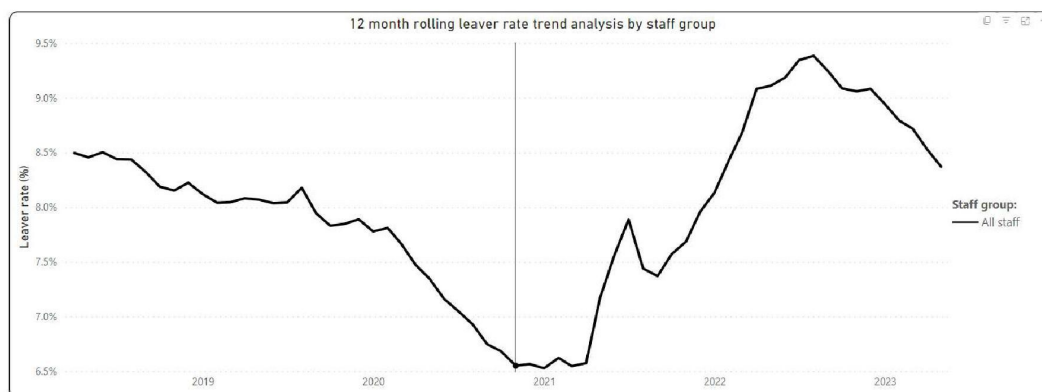
248. A fuller picture of the complexities and challenges of the workforce issues encountered during the pandemic can be found at Section 11.
249. The NHS Workforce Statistics data relating to the number of staff employed by the NHS is published by NHS Digital monthly using data from the Electronic Staff Record (ESR)<sup>28</sup>. Data refers to the “Full Time Equivalent (FTE)” standard measure with a full-time employee working 37.5 hours per week. In March 2020, the NHS employed 1,141,858 FTE (being a headcount of 1,289,793) in Hospital and Community Health Service (“HCHS”) roles, a 4.4% (or 4.2% headcount) increase from March 2019. Of that number, 53.1% were Professionally Qualified Staff [AP063 INQ000270143].
250. The following charts show the changes to the vacancy rate, headcount, and total vacancies for the Relevant Period [AP064 INQ000270076].



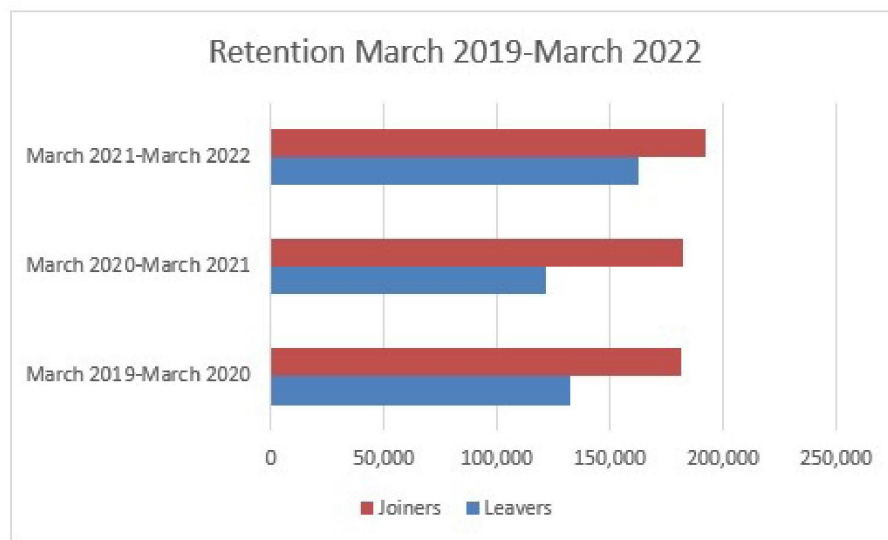
<sup>28</sup> ESR supports the delivery of national workforce policy and strategy. It provides NHS organisations with a range of tools and functions which lets them record and analyse data about their workforce. Effective use of ESR functionality helps to support workforce management and planning.



251. The number of staff leaving the NHS had fallen during the pandemic, before rising towards the end of Wave 2 and into Wave 3. A possible reason for this is delayed retirements. Following the Relevant Period, numbers of staff leaving again began to fall as illustrated by the graph below:



252. NHS Digital publishes data on turnover in HCHS on an annual basis. In the 12-month period ending March 2020, 132,032 staff left the NHS Workforce and 181,527 joined. By March 2021, that variance had increased further with 121,236 leaving and 182,453 joining, increasing further by March 2022 when, despite joiners increasing to 191,739, leavers also increased to 162,850. The following chart compares joiners and leavers during this period.



253. A snapshot of the position as of March 2020 can be found in the figures set out below:

Data sourced from NHS Digital and ONS

**WTE of Staff in Post & Vacancy**

|                                       | WTE                   |            |            |
|---------------------------------------|-----------------------|------------|------------|
|                                       | Jan 20                | Feb 20     | Mar 20     |
| <b>Staff in Post</b>                  |                       |            |            |
| Nurses & Health Visitors              | 297,407.1             | 298,632.4  | 300,497.3  |
| Midwives                              | 22,137.0              | 22,129.4   | 22,127.7   |
| Support to Doctors, Nurses & Midwives | 260,829.6             | 262,060.8  | 264,175.0  |
| Medical & Dental                      | 117,229.9             | 117,542.5  | 118,449.2  |
| <b>England Population</b>             |                       |            |            |
|                                       | 56,550,000            | 56,550,000 | 56,550,000 |
| <b>per 100k population</b>            |                       |            |            |
| Nurses & Health Visitors              | 525.9                 | 528.1      | 531.4      |
| Midwives                              | 39.1                  | 39.1       | 39.1       |
| Support to Doctors, Nurses & Midwives | 461.2                 | 463.4      | 467.2      |
| Medical & Dental                      | 207.3                 | 207.9      | 209.5      |
| <b>Vacancies</b>                      |                       |            |            |
| Registered Nursing                    | Quarterly Figure -- > |            | 36,083     |
| Medical                               | Quarterly Figure -- > |            | 8,338      |

254. The numbers relate to whole time equivalent staff, by category, with accompanying figures per 100,000 of population. The figures are given for each of the three months

January to March 2020 except in relation to vacancies where the available data is on a quarterly basis to March 2020.

255. NHS England does not maintain its own records or publish statistics of comparators with international health systems. Publications by international organisations such as the OECD or national think tanks such as the Kings Fund do however publish comparison data including countries broadly comparable to the UK (see examples in NHS England's First Module 3 Statement).



### SECTION 3: COVID-19 AS AN HCID

256. This Section considers the impact of the interim designation of Covid-19 as an airborne HCID ("HCID-A") on 16 January 2020 by the Four Nations Public Health HCID Group, on a precautionary basis as it was a novel virus that was potentially similar to SARS and MERS.
257. The decision by the UK Four Nations Public Health Service agencies to classify Covid-19 as a HCID had practical implications for the management of suspected and confirmed cases, given the small number of facilities in England due to the rarity of HClDs in the UK.
258. Whilst HCID classification and preparedness is dealt with more particularly in NHS England's First Module 3 Statement it is helpful to confirm that an HCID is defined according to the following criteria:
- a. acute infectious disease;
  - b. typically has a high case-fatality rate;<sup>29</sup>
  - 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.
259. At the time of designation there were uncertainties in respect of whether Covid-19 met the HCID criteria as set out in the exhibit ([AP007 INQ000119498]).

#### Location of treatment

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<sup>29</sup> The Expert Report of Professor Heymann for Module 1 [INQ000195846] sets out that the case fatality rate for MERS and SARS are approximately 35% and 10% respectively, although the report does state that they "are likely to be higher than the actual case fatality rates because of under-reporting of total numbers of cases, as the case fatality rate is defined as the number of reported deaths divided by the total number of reported cases." That same report states that the case fatality rate for Covid-19 is approximately 0.5-1 %. It further states that the "case fatality rate for SARS-CoV-2 has been estimated by epidemiological modelling based on a large database of reported infections, and it is possibly more accurate." Ebola case fatality rates have, by contrast, varied from 25% to 90% (with the average around 50%) in past outbreaks according to the WHO. A high case fatality rate is one of the criteria for designation as an HCID.

260. NHS England, as the national commissioner of HCID treatment centres, took steps to secure care and treatment for Covid-19 patients in HCID and other infectious disease specialist centres during the early weeks of the pandemic. In practice, this meant that early cases in the UK were dealt with in the small number of highly specialist HCID treatment centres.
261. On 10 January 2020 (and prior to Covid-19 being classified as an HCID), NHS England stood up its commissioned HCID-A Network at St Thomas' Hospital, London, the Royal Free Hospital, London, the Royal Liverpool Hospital, Liverpool and Royal Victoria Infirmary, Newcastle, in readiness; each of these routinely provide two beds. This service covered the whole of the UK.
262. The first practical implication was that suspected or confirmed cases of Covid-19 had to be conveyed to one of the designated HCID-A treatment centres in England for assessment or treatment.
263. As per the Standard Operating Procedure ("**SOP**") for HCID-A, NHS England's EPRR team established an HCID activation call, whereby the clinicians working in the HLIUs around England would meet virtually to discuss cases and to determine where best, within the Network, the patient's needs could be met i.e., in which unit. The centres work together within the Network, led by a lead clinician from one of the units (Guy's & St Thomas' NHS Foundation Trust over the Relevant Period).
264. Whilst the geographical location of the patient is one factor in placing the patient, their destination will also depend on their clinical needs and the capacity available in each centre.
265. During the initial phase of the pandemic, all patients who tested positive for Covid-19 were transferred to an HCID centre, regardless of whether they were symptomatic or how acutely they presented **[AP065 INQ000269896]**.
266. When the number of expected Covid-19 cases increased, on 28 January 2020, NHS England also brought on-board the Royal Hallamshire Hospital, Sheffield (adults only), which is routinely commissioned as a HCID-C centre. This gave a total of 10 additional beds.
267. On 29 January 2020:
- a. NHS England's EPRR and Specialised Commissioning teams wrote to Chief Executives of providers that hosted a HCID facility, asking them to prepare to treat patients and to act as an advice resource to other providers **[AP018**

- b. A COBR meeting took place and following that meeting, NHS England's National Director of EPRR was asked to confirm with the Foreign and Commonwealth Office when details of a quarantine facility for those UK nationals returning from China could be shared, although at this point none of the cases arriving were known to be positive.
268. The first two positive cases of Covid-19 were identified in Hull on 30 January 2020. They were transferred to the HCID unit at the Royal Victoria Hospital in Newcastle-upon-Tyne.

Clinical care

269. The classification of Covid-19 as an HCID at this stage determined the initial clinical management of patients.
270. In broad terms, HCID units must always have the following clinical and personnel facilities in place:
- a. service specifications for service readiness and staff training;
  - b. ability to commit to being able to admit a patient with a confirmed diagnosis within six hours of notification;
  - c. adult services must be able to care for two patients at a time as a minimum and preferably up to four;
  - d. paediatric services must be able to cope with up to two children at a time; and
  - e. co-location of adult and paediatric services.
271. For adults it envisaged that the unit would be part of a specialist infectious diseases or critical care unit. For children, the unit is to be situated in a paediatric intensive care unit, sited away from general circulation. In either case, patients are not to be admitted through A&E departments - there should be secure and direct transfer of patients from ambulance to unit. Units should allow delivery of level 3 critical care to patients.
272. Units need to be able to maintain appropriate facilities and infrastructure for patient care, ensuring clear segregation of clean and potentially contaminated areas of the special isolation unit. Clear delineated pathways through the unit for staff, patients, visitors, supplies and waste need to be integrated into the structural design. Patient

isolation suites need to be at negative pressure relative to the rest of the unit and the air needs to be High-Efficiency Particulate Absorbing or equivalent filtered before discharge into the atmosphere (and environmental monitoring was required to ensure performance). All surfaces are required to be easy to clean, impervious to water and resistant to damage from disinfectants.

273. Other requirements are that the unit should maintain a cadre of competent staff who have demonstrated through regular training and exercises that they are capable of operating a safe system of work while providing optimal care. Relevant staff groups should undergo regular training in the safe system of work, including PPE. Sufficient staff need to be trained and available to maintain an operational Specialist Isolation Unit for three weeks. Units must work closely with regional and national EPRR.
274. Although relevant to IPC rather than the treatment received by patients, there are clear guidelines about the level and type of PPE to be used when managing a suspected or confirmed HCID case, together with a donning and doffing protocol.
275. In relation to Covid-19 specifically, PHE published its first infection prevention and control guidance on 10 January 2020, outlining the PPE that should be worn when dealing with Covid-19 patients.
276. NHS England's knowledge of Covid-19 continued to be informed by PHE publications. On 20 January 2020, PHE published and NHS England distributed the latest PHE clinical guidance to medical directors, CCG clinical leads, NHS 111 and 999. NHS England did not have any involvement in drafting the guidance. At this point, the UK risk level (set by Government) was "very low." WHO published guidance on home care for patients with suspected infection from the Wuhan novel Coronavirus [INQ000087247].

#### HCID capacity – from late January 2020

277. On 30 January 2020, a statement from the Four Nations Chief Medical Officers updated the UK risk level from "low" to "moderate" [INQ000087570]. The CMOs explained that:

*"in light of the increasing number of cases in China and using existing and widely tested models, the 4 UK Chief Medical Officers consider it prudent for our governments to escalate planning and preparation in case of a more widespread outbreak."*

278. They further noted that: *"This does not mean we think the risk to individuals in the UK has changed at this stage, but that government should plan for all eventualities."*
279. By 7 February 2020, NHS England had started the process to commission additional capacity in HCID beds at the Royal Free Hospital, London and additional call handler capacity in the NHS 111 service. The Royal Free Hospital was selected for the additional bed capacity because it is one of the two hospitals in England which had been designated by NHS England as having the specialist facilities to manage HCID-C patients (the other being at the RVI in Newcastle-upon-Tyne, with back up facilities in Liverpool if required). NHS Estates were determining the need for portable units to establish Coronavirus Priority Assessment Service at the front of hospitals including NHS 111 Coronavirus Pods, which included instructions regarding admittance to hospital and management as an HCID **[AP066 INQ000269893]**.
280. On 24 February, NHS England's Strategic Incident Director highlighted to DHSC that, even with mitigation, HCID facilities would be overwhelmed.
281. On 28 February 2020, NHS England's Strategic Incident Director, met with national leads in PHE and experts from the HCID centres network **[AP065 INQ000269896 and AP067 INQ000269921]** and a request was made to the CMO in England for a review by the Four Nations HCID Public Health Group as to whether Covid-19 should remain an HCID given the greater knowledge about the Covid-19 virus. They alerted DHSC that, given the increasing numbers, the NHS would need to move away from routine hospitalisation of all positive cases, especially if the patients concerned were well or waiting in hospital for test results to become negative, and so policy around this needed to be reconsidered. This could include proposals for Covid-19 triage, to explore supported home isolation and alternative pathways based on clinical status such as admission to Infectious Disease units.
282. All of the HCID centres were asked to indicate how many additional 'surge' beds they could provide, should the need arise. The centres identified the following surge capacity:<sup>30</sup>

| Organisation | ICU | PICU | Adult | Paediatric | Total | Location      |
|--------------|-----|------|-------|------------|-------|---------------|
| St Thomas'   | 2   | 2    | 4-6   | 0-2        | 10    | Hillyers ward |
| Newcastle    | 2   | 0-2* | 2-6   | 0-2        | 8     | Ward 19       |
| Royal        | 1-2 | 0-1  | 4-6*  | 0-2        | 8     | Ward 3X;      |

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<sup>30</sup> Routine HCID capacity is set out in NHS England's First Module 3 Statement.

|              |   |   |   |     |           |   |
|--------------|---|---|---|-----|-----------|---|
| Liverpool    |   |   |   |     |           | Adult ICU                                   |
| Royal Free   | 2 | 1 | 8 | 0-2 | 10        | Adults Royal Free;<br>Paediatrics St Mary's |
| Sheffield    | 1 | 0 | 6 | 0   | 7         | Adults only                                 |
| <b>Total</b> |   |   |   |     | <b>43</b> |   |

283. The total number of beds was 43 (the total number of beds routinely provided by HCID-A centres is 8), which could be used flexibly across the sub-categories as indicated. However, if for example, a bed was being used for a paediatric patient at St Thomas', it could not also be used for an adult patient.
284. Further surge capacity was identified at six Infectious Diseases Units to supplement the HCID and HLIU network centres.<sup>31</sup>
285. The total number of additional beds that could be provided across these units was about 30, although this would reduce if the case mix of patients was complex. As noted, the number of beds available across the 11 centres depended on the acuity of the patients already admitted and those that required admission.
286. Importantly, in addition, some beds would be occupied by non-Covid-19 infectious diseases patients.
287. During the week commencing 2 March 2020, NHS England identified that, going forward, there would necessarily be a move towards looking after patients who had tested positive, but who had no or mild symptoms, in their own homes, rather than in HCID centres/ Infectious Diseases Units. This meant that the HCID centres/ Infectious Diseases Units were reserved for those patients whose symptoms required hospital admission. These, by definition, presented a sicker cohort of individuals, and some of them would require intensive care. NHS England, therefore, decided to identify further infectious disease capacity to support these admissions.

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<sup>31</sup> The centres are located at the following Trusts: Hull University Teaching Hospitals NHS Foundation Trust; London North West University Healthcare NHS Trust (Northwick Park); Oxford University Hospitals NHS Foundation Trust; The Pennine Acute Hospitals NHS Trust (North Manchester); University College London Hospitals NHS Foundation Trust; and University Hospitals of North Midlands NHS Trust.

288. By the end of 3 March 2020, NHS England's understanding was that even with additional capacity being brought online at Infectious Diseases Units in Hull, Northwick Park, Manchester and Stoke, the number of additional patients would exceed capacity.
289. On 3 March 2020, a Top of the Office ("TOTO") Briefing<sup>32</sup> confirmed that a plan had been made to separate cases into three categories:
- a. Category 1: patient must be moved to an HCID facility immediately;
  - b. Category 2: we would like to move the patient that evening; and
  - c. Category 3: patient could remain in situ for the time being, until specialist ambulance staff and bed capacity allowed them to be transported to an HCID centre.
290. On 4 March, HCID and Hazardous Area Response Team services were over-capacity, and the SSHSC was informed at a COBR meeting on that same day.
291. On 5 March 2020, representatives from NHS England attended a meeting with the SSHSC and key personnel from DHSC and PHE. The meeting was to discuss the logistics of moving from the "Contain" to "Delay" phase ahead of a meeting which the SSHSC was due to have with the Prime Minister that afternoon [INQ000087268].
292. Also on 5 March 2020, the CMO announced the first death of a patient with coronavirus in the UK [INQ000087574].
293. On 6 March 2020:
- a. NHS England agreed an interim regional HCID surge plan. This proposed a model whereby new patients would be admitted to one of the surge providers. The surge providers would offer advice to non-surge providers about patients already admitted. This might include advice to transfer the patient to the nearest HCID / affiliated infectious diseases centre.
  - b. NHS England's Strategic Incident Director gave advice to DHSC on a number

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<sup>32</sup> TOTO briefings were a concise daily summary of the fast-moving daily picture that the NHS was responding to and helped to show its evolving response to the emerging pandemic. The TOTO briefings tended to be circulated at the end of each day and encapsulated matters which had been discussed in earlier meetings during the day. They were circulated to the Chief Executive Officer, directors and senior managers.

of matters including the operational implications of maintaining the HCID classification.<sup>33</sup>

294. DHSC had confirmed there were 273 Covid-19 patients across the UK - with 244 of these being in England. There were 35 inpatients at that date across the HCID / Infectious Diseases Unit network with approximately 43 beds remaining ready for use.
295. Even with urgent expansion and assistance from several specialised Infectious Diseases Units providing surge capacity, diagnosed cases of Covid-19 exceeded the available specialist beds before mid-March 2020.
296. As cases increased still further, the model going forward was for the HCID/ Infectious Diseases Units to provide support and advice to other hospitals through a structured geographical approach, with patients treated in their own healthcare systems as envisaged by the Government's 3 March Coronavirus Action Plan INQ000057508<sup>34</sup>
297. The HCID / Infectious Diseases Unit beds were then used as part of the overall bed base in the HCID / Infectious Diseases Unit providers, with some sicker patients being triaged to these beds. They were also used, as would be usual practice, to treat patients with other infectious diseases. In the event that a patient with another HCID (such as Monkeypox<sup>35</sup> or a viral haemorrhagic fever such as Ebola) needed treatment, capacity would be secured in one of the HCID centres.
298. On 8 March 2020, NHS England wrote to Regional Directors of primary care and public health regarding the Covid Management Service for confirmed Covid-19 patients in the community **[AP068 INQ000269900]**. The letter confirmed that primary care services needed to be rapidly commissioned for all Covid-19 positive patients who did not require immediate admission, confirming the then PHE national infection service criteria for admission and clinical pathways.

#### HCID declassification

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<sup>33</sup> NHS England was not given access to notes/minutes of SSHSC meetings, but has explained within this Section 3, the operational implications of maintaining the HCID classification.

<sup>34</sup> On 3 March, the Government published a Coronavirus Action Plan, which described how patients were being supported in specialist units but when necessary the provision of care might move from specialist units into general facilities in hospital. It further stated that "*if the current outbreak takes a greater hold, we will use those lessons about effective treatment methods and apply them throughout our health services, across all hospital sites and into community settings*".

<sup>35</sup> Monkeypox classification was also changed - Clade I only is an HCID in the UK.



299. On 16 March 2020, the Four Nations Public Health HCID Group stated:

*"Having reviewed the criteria and having considered all information, taken together, the members of the Group were unanimous in their recommendation to remove COVID-19 from the list of Airborne HCIDs."* ([AP007 [INQ000119498]

300. On 19 March 2020, the Government announced that Covid-19 was no longer classified as a HCID [INQ000087332], following consideration by PHE and the other public health bodies in the UK and a recommendation from the Advisory Committee on Dangerous Pathogens ([INQ000223384, AP069 A & B [INQ000115534] and INQ000226885]):

*"Now that more is known about COVID-19, the public health bodies in the UK have reviewed the most up to date information about COVID-19 against the UK HCID criteria. They have determined that several features have now changed; in particular, more information is available about mortality rates (low overall), and there is now greater clinical awareness and a specific and sensitive laboratory test, the availability of which continues to increase."*

301. Operationally, this meant that Covid-19 patients would no longer be treated in the specialist HCID treatment centres in England.

## SECTION 4: THE IMPACT OF MODELLING AND DATA

302. Data and modelling, whilst being essential sources of operational intelligence throughout the pandemic, had their limitations, especially as knowledge regarding the disease was changing. Modelling only considered what might happen (based on a number of assumptions) with anticipated levels of demand for services.
303. A further limitation was that the tracking of Covid-19 within the population was limited. Until the expansion of PCR (polymerase chain reaction) testing capacity and the introduction of rapid point of care lateral flow devices, the pandemic was typically tracked through the volume of hospital cases. This, by definition, is a lagging indicator of viral spread in the community.
304. Early modelling predicted that the NHS would be significantly overwhelmed if there were no mitigations. The estimated peak demand rose from a need for 59,000 ventilated beds in early February 2020 to 90,000 by the end of that same month and then 138,000 by mid-March, each based on the RWCS.
305. Mitigations, for example non-pharmaceutical interventions ("**NPIs**") such as social distancing, were later included in modelled scenarios and reduced the estimated peak demand for ventilated beds based on different levels of compliance with the mitigations.
306. As set out in Section 2, the NHS went into the pandemic with little flexibility within existing capacity. Therefore, and as discussed in this Section, the Phase 1 letter on 17 March 2020 contained a number of measures to free up inpatient and critical care capacity. This was supported by the 19 March Discharge Guidance (as defined in paragraph 352 and discussed further in Section 7) that was co-produced by DHSC, MHCLG and NHS England. The impact of this guidance is set out in Section 7.
307. This was later followed by the Phase 2 Letter on 29 April 2020, recording that the measures put into place had enabled the NHS to care for 19,000 Covid-19 patients per day. This was alongside caring for patients receiving treatment for health conditions not related to Covid-19, with the Phase 2 Letter instructing organisations to step-up non-Covid-19 urgent services as soon as possible.
308. On 1 August 2020, NHS England moved from a Level 4 incident to a Level 3 incident. The Phase 3 letter was sent on 31 July and looked forward to winter preparations and accelerating the return to near-normal levels of non-Covid-19 health services.

309. Due to the emergence of the Alpha variant, NHS England would return to Level 4 on 5 November. The Alpha variant caused the largest peak in hospital admissions during the pandemic in January 2021. NHS England remained at Level 4 until 25 March 2021.
310. Facilitating all of the steps outlined above required co-ordinated and sustained efforts across the system.

Overview of NHS England's initial modelling activity with SPI-M-O

311. NHS England worked closely with SPI-M-O throughout the pandemic, to ensure alignment on approach as far as possible to take account of official epidemiological modelling by converting this into the impact on NHS resources (particularly beds). That bed capacity modelling work is described in detail in this section. Later in this Statement, the broader modelling work undertaken by NHS England is described.
312. To provide context to NHS England's working relationship with SPI-M-O, this Statement first addresses the key modelling work undertaken prior to 1 March 2020.
313. NHS England began taking steps to prepare for increased demand for NHS services and increase capacity from early February 2020, with the collation and consideration of data (SitReps), and early modelling based on SPI-M-O's RWCS. This modelling informed early decision-making on the need to increase critical care capacity to cope with anticipated demand.
314. Throughout February and March 2020, extensive work was undertaken to determine what NHS England could reasonably do to increase NHS hospital and critical care capacity. NHS England's internal modelling team shared initial modelling with its Strategic Incident Director on 12 February 2020, as part of NHS England's EPRR work. It focussed on operational pressure on the NHS by applying SPI-M-O's RWCS which at that time was based on pandemic influenza. **[INQ000087426, INQ000087427 and INQ000087428]**. NHS England had no community prevalence data to use for this exercise.
315. NHS England's National Medical Director began regularly attending SAGE meetings from 25 February 2020.
316. In early February 2020, while understanding of the virus and disease was still changing, SAGE/SPI-M-O recommended that initial modelling followed the RWCS for pandemic influenza. Some early indications were emerging from China which gave a

first indication of the possible unmitigated impact. Early model parameters on infection, hospitalisation and ventilated bed rates translated to an estimated peak demand for ventilated beds of 59,000.

317. At this stage, the focus was on admissions, critical care demand, oxygen and ventilation because of what was known about the virus i.e., that it was primarily considered to cause respiratory complications and single organ (lung) failure. Very unwell patients (particularly those with multi-organ failure) would be likely to require ventilation and/or oxygen support.
318. At that time, RWCS modelling clearly and consistently indicated that the NHS would not have sufficient critical care or general bed capacity to treat the possible numbers of patients requiring hospitalisation.
319. SAGE and SPI-M-O produced 'official' modelling to advise the Government because they had the expertise to do so, and NHS England used their outputs to model impacts of demand for NHS services (particularly beds). Further, NHS England wanted to support and align with SAGE as much as possible. NHS England acted to confirm the variables with SPI-M-O to model NHS demand.
320. As set out above, NHS England's National Medical Director attended his first SAGE meeting on 25 February 2020. In advance of that meeting, he was provided with the latest modelling projection prepared by NHS England's internal team (which was an update to the version originally circulated on 12 February 2020). During that meeting, he suggested to SAGE that SPI-M-O modellers should meet with NHS England's own analysts, to ensure coordination of the approach to modelling.
321. A report produced to SAGE on 27 February 2020 confirmed that, without action, the NHS would be unable to meet all demands placed on it and that demand on beds would overtake supply before the peak was reached. A new RWCS was agreed by SAGE on that same date and confirmed / refined on 1 March 2020 during the workshop described below. The new RWCS translated into a peak demand of 90,000 ventilated beds.
322. On 1 March 2020, an all-day workshop took place at Imperial College London ("**Imperial**"), co-chaired by NHS England's National Medical Director and the Deputy CMO. NHS England's Strategic Incident Director, members of SAGE and SPI-M-O, analysts from DHSC and NHS England lead modellers were also in attendance. The aims of the meeting were to reach a common understanding between SPI-M-O and

the NHS on what was known and discuss a range of potential values for key parameters likely to impact the NHS, such as:

- a. *Infection Hospitalisation Rate*: the proportion of people infected with Covid-19 that will go on to require hospital care for Covid-19;
- b. *ALOS*: the average length of stay for a patient hospitalised for Covid-19;
- c. *Critical Care Use*: the proportion of those patients requiring hospital care also requiring critical care; and
- d. *Deaths*: the proportion or rate of those with Covid-19 that will die from Covid-19.

323. It was important to establish a set of common model parameters upon which to work out what would need to be done for the NHS to cope with the rising number of cases.<sup>36</sup>

324. In that meeting, attendees put together data that Imperial had produced on potential deaths and hospital admissions. Imperial had not initially modelled how many beds would be required, as they had not calculated the likely length of stay. At that stage, it was estimated to be 10 days. By the end of that meeting, attendees had produced models for admissions, the types of beds required by patients, length of stay and the number of beds required. The modelling indicated a RWCS for Wave 1 that the NHS could need up to 1 million beds at the peak, and there could be 500,000 deaths cumulatively throughout the wave, without mitigation to reduce case numbers. Outputs from the meeting were sent to NHS England's National Medical Director that evening [INQ000087265 and INQ000087266].

325. The modelling, now based on an agreed set of model parameters, clearly demonstrated that if the RWCS played out in reality, even partially, demand would undoubtedly exceed NHS capacity. Plainly, the consequences of this would have been catastrophic. The NHS would have been unable to treat Covid-19 and non-Covid-19 patients requiring emergency treatments including life-saving critical care. Many would have died, where treatment would have saved their lives and many more would have been harmed. Clinicians would have been required to make unacceptable choices about whom to try to save.

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<sup>36</sup> The same applied to Government departments to ensure that they could cope with the rising number of cases.

326. SPI-M-O continued to develop the models over the first two weeks of March; all illustrated that the NHS would be under extreme pressure, without mitigation to reduce numbers.
327. NHS England's modelling team liaised with SPI-M-O and Imperial to ensure a consistent approach was adopted in respect of the input model parameters used and population base. Based on RWCS, even with differing modelled NPIs, the number of beds and ventilators required exceeded the capacity within the NHS many times over. The shared (NHS England, Imperial and SPI-M-O) input model parameters were reflected in the SAGE modelling presented to the Prime Minister around 16 March 2020.
328. Anticipating initiatives on supporting capacity by improving average lengths of stay, on 9 March 2020 NHS England established the Discharge and Community Services cell with the key objectives of ensuring the timely discharge from hospital beds of patients no longer in need of hospital care, ensuring effective NHS care in community services and ensuring effective NHS support to the care sector. The main component of staff within the cell from the date of creation were from the NHS England Ageing Well Programme team established in mid-2019. During the pandemic the team expanded significantly both in size and scope by taking responsibility for a longer-term portfolio covering hospital discharge and rehabilitation, community transformation (digital and workforce) and the implementation of the NHS Long Term Plan commitments on community care.
329. Measures to free up hospital and critical care capacity were discussed with and agreed by Government in the week beginning Monday 9 March 2020, ahead of issuing NHS operational guidance in the Phase 1 Letter (described below) setting out these measures on 17 March 2020.
330. On 11 March 2020, Ministers agreed a wide range of policy, legislative and budgetary measures aimed at freeing up hospital capacity to prepare the NHS for an anticipated wave of Covid-19 patients. Those measures included, among other things:
- a. the prompt and efficient discharge of patients medically fit to leave hospital, to be supported by an injection of new funding to CCGs to support early discharges and legislative measures to defer the requirement to conduct NHS Continuing Healthcare ("CHC") and Care Act assessments; and
  - b. legislative measures to facilitate the temporary registration of health and social care workers (e.g., those who had recently retired) and the

indemnification of healthcare staff in respect of activities connected with the diagnosis, care and treatment of Covid-19.

331. That same day, the Chancellor presented his Budget in which he committed additional resources for the NHS and social care.
332. On the evening of 12 March 2020, NHS England's Chief Executive Officer and National Medical Director attended a meeting with the Prime Minister focussed on what the NHS was doing to increase hospital inpatient and critical care capacity.
333. NHS England papers for that meeting included a slide deck entitled "*NHS bed demand for the reasonable worst-case scenario and impact of non-pharmaceutical interventions*". It provided modelling of the impact of three NPIs (home isolation, household quarantine and social distancing for age 65+) on NHS bed demand based on SAGE model assumptions for the RWCS and also on a comparison infection rate of 20%. **[INQ000087304, INQ000087305 and INQ000087306]**
334. The modelling showed that for most of the models, demand would exceed the numbers of beds available. The second slide showed what work was being undertaken to maximise the availability and effectiveness of oxygen.
335. The meeting of 12 March considered mitigating measures that the NHS could take to increase critical care capacity, the number of G&A beds available and discharge plans. Plans included stopping non-urgent operations, considering those on long stays, increasing the aggregate supply of oxygen, reconfiguring hospitals as required and getting the right numbers of machines and trained staff to operate them. NHS England also requested a drive to support manufacturing of ventilators.
336. Information was provided on how NHS expansion would look and attendees discussed potential expansion into recovery areas and theatre spaces. The slides also described in broad terms the limits of the NHS's ability to absorb the projected rise in hospitalisations and highlighted, among other things, that whilst the NHS is highly dependent on social care for patient discharge "*further surge or displacement capacity into the independent sector or discharge to social care would be limited*".
337. On 12 March 2020, the UK Government announced that it was moving from the 'Contain' to the 'Delay' phase of its response to Covid-19. People with symptoms were told to stay at home for 7 days and that they did not need to be tested.
338. Covid-19 bed daily SitReps started to come through from 13 March 2020, with Trusts providing figures on the numbers of beds occupied by Covid-19 patients, with a

breakdown of those in G&A beds and those in critical care beds. Information from the Covid-19 SitRep was relayed to the CMO.

339. Evidence from other countries, and particularly from Northern Italy, was that without interventions to reduce the spread of the virus, health systems were being overwhelmed.
340. On 16 March 2020:
- a. Imperial College published its report titled "*Impact of non-pharmaceutical interventions (NPIs) to reduce Covid-19 mortality and healthcare demand*". SAGE advised that there was clear evidence to support additional social distancing measures to be introduced as soon as possible and that this should be accompanied by a significant increase in testing. SAGE confirmed it would further review whether school closures should be required to prevent NHS capacity being exceeded. NHS England was asked to look at the impact of school closures on NHS staffing.
  - b. A meeting took place between NHS England officials, the DHSC Permanent Secretary and other officials with the SSHSC and other ministers to discuss, among other things, plans for the rapid expansion of hospital and "step-down" capacity, the publication of the Government's "*Covid-19 Hospital Discharge Service Requirements*" and the simplification of the financial regime for the funding of hospital discharges.
341. On 17 March 2020, new evidence from SPI-M-O gave a lower overall hospitalisation rate but with a higher proportion of those hospitalised requiring mechanical ventilation. Models were beginning to emerge that estimated more systematically the impact of different mitigations. With no mitigations, this RWCS model had a peak demand for ventilated beds of 138,000. The output also included a modelled scenario, including 75% compliance with social distancing, which reduced the estimated peak demand for ventilated beds to 2,400-11,300, depending on what other mitigations were implemented alongside it. The main planning scenario at the time was the Imperial-modelled RWCS with a combination of the following mitigations: home isolation, household quarantine and wider social distancing. This scenario was associated with peak demand for ventilated beds of 11,300.
342. By 23 March 2020, cases were rising rapidly and Imperial provided updated advice on the two week lag of mitigations on hospitalisation rates. Based on this, NHS England issued a set of regional scenarios that were calibrated to give a doubling of



hospitalisations every three days between 23 March and 5 April 2020, before gradually merging with the detailed runs from Imperial, based on different levels of compliance with social distancing. The modelled levels of compliance all had peak demand for ventilated beds of around 17,500 in mid-April 2020, driven by infection growth before lockdown was announced, but then had very different rates of decrease. For the end of April, the models predicted demand for ventilated beds of between 6,300 and 11,700.

343. On 31 March 2020, two scenarios of future infection growth were provided by Imperial and via the SAGE secretariat labelled “Good compliance” and “Poor compliance”, with reference to adherence to social distancing rules. By early April, NHS providers had reported a reasonable time-series of SitRep data, allowing model outputs constrained to these levels. These showed that concerns of an initial period of three-day doubling were abating. When fitted to the SitRep data up to 1 April 2020, the latest good compliance scenario had a peak in the second week of April of 2,200 ventilated beds. The poor compliance scenario had a peak of around 4,000 ventilated beds in early May.

#### **March 2020 and the Phase 1 Letter**

344. A key requirement of any response is to act on available information, and to seek out or arrange for access to that information. Work continued in March 2020 to establish the required capacity. New data categories continued to be added to the SitReps throughout the Relevant Period (see Section 5).
345. The three models predicted demand for V beds by the end of April, of 11,700, 8,700 and 6,300 respectively, all of which substantially outnumbered available capacity excluding the occupancy by non-Covid-19 critically ill patients.
346. Initial estimates of consumables (i.e., items required other than drugs) were also provided at this stage, based on initial clinical estimates of likely usage per admission or per bed day, depending on the nature of the consumables. These were based solely on demand for direct Covid-19 care. Partly for these reasons, partly to avoid deterring people from coming forward for essential non-Covid-19 care, and partly because of the risk of incentivising unhelpful local stockpiling, consumable estimates were not shared with the wider NHS system at this point.
347. Data based on community testing which would have been the optimal mechanism for tracking Covid-19 population incidence was limited until the DHSC / PHE expansion of PCR (polymerase chain reaction) testing capacity and the introduction of rapid

point of care lateral flow devices. This meant that the course of the first stages of the pandemic was largely tracked using a 'rear-view mirror' proxy, namely the volume of hospital cases. Notwithstanding the efforts described above to ensure alignment with SAGE/SPI-M-O on input model parameters, NHS England's outputs did diverge from theirs on occasion. This is addressed in further detail below.

#### Phase 1 Letter

348. In line with the agreed government strategy [INQ000056135], NHS England sent the Phase 1 Letter to NHS leaders on 17 March 2020.
349. The Phase 1 Letter [INQ000087317] was unprecedented in its request for a common and co-ordinated response. The measures designed to free up inpatient and critical care capacity had the operational aim to expand critical care capacity to the maximum and free up at least 30,000 of England's 100,000 G&A beds by:
- a. Postponing all non-urgent elective operations by 15 April 2020, and for a period of at least 3 months<sup>37</sup> (with emergency admission, cancer treatment and other clinically urgent care remaining unaffected). This measure alone was estimated to free up between 12,000-15,000 hospital beds across England.
  - b. Urgently discharging all hospital inpatients medically fit to leave. This measure was estimated to have the potential of freeing up to 15,000 beds currently occupied by patients awaiting discharge or with length of stay over 21 days. The discharge strategy was designed to reduce delays for patients who were able to leave hospital. That meant that those patients who were ready to be discharged into (or back home to) a care home, were able to get there more quickly. It did not mean that any patients were discharged to care homes who would not otherwise have been, and was not designed to increase the overall number of patients discharged into care home.
  - c. The block purchase of independent hospital capacity, which was expected to be completed within a fortnight.
350. To prepare for and respond to large numbers of inpatients requiring respiratory support, the Phase 1 Letter described the following priorities:

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<sup>37</sup> This restriction on elective surgery was withdrawn on 29 April 2020.

- a. Ongoing work at national level to secure a step change in oxygen supply and distribution to hospitals, with hospital estates teams reporting about their internal oxygen piping, pumping and bedside availability. ;
  - b. A national procurement effort in conjunction with DHSC for assisted respiratory support capacity and in particular mechanical ventilation and ongoing work to bring new manufacturers online. ;
  - c. Ongoing work to resolve PPE distribution issues;<sup>38</sup>
  - d. Refresher training to all clinical and patient-facing staff on supporting patients with respiratory needs;
  - e. The segregation of all patients with respiratory problems and cohorting patients who have tested positive to Covid-19;
  - f. Mental Health, Learning Disability and Autism providers to draw up plans for Covid-19 patients at all inpatient settings.
351. The letter also referred to a range of measures to: support NHS staff and maximise staff availability, including enhanced wellbeing and support for frontline staff; a request to PHE to establish targeted testing for symptomatic NHS staff, remote working, and deployment measures; and reduce routine burdens, including the temporary cancellation of CQC inspections, emergency legislative measures being introduced in Parliament to increase regulatory flexibility and the move to block-contract payments (as described further in Section 9).

#### 19 March Discharge Guidance

352. On 19 March 2020, the Government published the “COVID-19 Hospital Discharge Service Requirements” (“**the 19 March Discharge Guidance**”), a guidance document co-produced by DHSC, MHCLG and NHS England (with input from the CQC, local government bodies, care home associations and a number of NHS providers) aimed at setting out the details of the hospital discharge guidance outlined in the Phase 1 Letter. This is discussed further in Section 7.

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<sup>38</sup> PPE demand, supply and distribution is covered in NHS England's Third Module 3 Statement.

## April 2020 to July 2020

353. On 15 April 2020, NHS England wrote to all NHS hospitals and community health providers to inform them of the Government's commitment to test all hospital inpatients prior to their discharge from hospital into a care home. The letter emphasised that the new testing requirement should not hold up timely discharges, because hospitals were asked to plan the testing of patients due to be discharged up to 48 hours before the scheduled discharge time. At this time NHS England was focussing on re-starting elective (planned) care alongside the uncertainty as to whether accident and emergency admissions would rebound.
354. As a result, NHS England gave further guidance on steps to enable hospital recovery from Covid-19, and to minimise the interruptions to non-Covid-19 care.
355. On 29 April 2020, NHS England sent the Phase 2 Letter to NHS leaders setting out the second phase of the Covid-19 response. The letter noted that:
- a. the measures set out in the Phase 1 Letter had been the fastest and most far-reaching repurposing of NHS services, staffing and capacity in the NHS's 72-year history.
  - b. such measures had enabled the NHS in the space of six weeks to go from zero to caring for 19,000 Covid-19 patients per day. Alongside this, the majority of patients that the NHS was caring for were receiving treatment for other important health conditions.
  - c. while Covid-19 hospitalisations had reached a peak, the NHS would face an increased demand for Covid-19 aftercare and support in community health services, primary care and mental health, and a likely rebound in demand for A&E activity, which had significantly reduced in previous weeks likely as a result of a combination of a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes.
  - d. given the uncertainties about the timing and extent of the likely rebound in emergency demand, the NHS would need to maintain the ability to quickly repurpose and surge capacity locally and regionally should it be needed again.

356. In light of the above, the Phase 2 Letter instructed all NHS local systems and organisations to:
- a. step up non-Covid-19 urgent services fully as soon as possible over the following six weeks, with sustained attention to infection prevention and control as the guiding principle;
  - b. work across local systems and with regional teams over the following 10 days to make judgements on whether local providers had further capacity for at least some routine non-urgent elective care.
357. On 1 May 2020, NHS England followed up on the Phase 2 letter with a letter to GP practices and primary care networks, CEOs of community health providers, Regional Directors of primary care and CCG accountable officers setting out service expectations to support care homes.
358. The letter set out a clinical service model which was already established and being implemented in much of England but which NHS England was now asking to be immediately rolled-out as part of the Covid-19 response by CCGs alongside: (i) continued NHS testing of all patients prior to discharge to care homes; (ii) CCG directors of nursing assisting local authorities with training in infection prevention and control; and (iii) supporting different staff groups to take up opportunities in care homes. NHS England was requesting primary care and community health services help, building on what practices were already doing, to support care homes.
359. This service focused on the following areas:
- a. delivery of a consistent, weekly 'check in' – primarily remotely, and usually by a multi-disciplinary team, to review high priority patients in care homes, including but not limited to those with suspected or confirmed Covid-19 symptoms and support the provision of care for those patients identified as a clinical priority;
  - b. support the introduction and use of remote monitoring of Covid-19 patients using pulse oximeters and other equipment (which might be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated;
  - c. development of personalised care and support plans for care home residents; and

- d. pharmacy and medication support to care homes – including medication reviews, and support with supply of medication.
360. The letter further explained that the service would be underpinned by an identified clinical lead for each home.
361. On 3 June 2020, NHS England sent a letter to CCGs, Trusts and community providers (*"Restoration of Community Services for Children and Young People"*) setting out the framework to partially or fully restore each service for children and young people, superseding the March Prioritisation Letter.
362. The Phase 1 Letter and Phase 2 Letter demonstrate how NHS England co-ordinated a national response. Its role in operational decision making was one of requiring services to be provided in a consistent and co-ordinated way (as a commissioner), but not to organise the operations on the ground. How hospitals, wards, staff and rotas were organised was for providers to decide; the treatment pathways relevant to individual patients were decisions that rested with clinicians.

#### **July 2020 to January 2021**

363. On 31 July 2020, NHS England sent the Phase 3 Letter to NHS leaders setting out the third phase of the NHS response to Covid-19 [AP040 INQ000051407].
364. The Phase 3 Letter noted that Covid-19 hospitalisations had fallen from a peak of 19,000 per day to about 900 – which had led the decision (agreed with Government) to move the NHS EPRR incident level from Level 4 (national) to Level 3 (regional) from 1 August 2020.
365. The Phase 3 Letter set out the following priorities for the following months:
- a. accelerating the return to near-normal levels of non-Covid-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter by:
    - i. preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid-19 spikes locally and possibly nationally; and
    - ii. doing the above in a way that takes account of lessons learned during the first Covid-19 peak to lock in beneficial changes; and explicitly tackle fundamental challenges including support for our

staff, and action on inequalities and prevention.

366. The Phase 3 Letter noted that returning to near-normal levels of non-Covid-19 health services entailed:
- a. restoring full operation of cancer services (urgent care had never stopped);
  - b. recovering the maximum elective activity possible before winter, making full use of the NHS capacity currently available, including re-contracted private hospitals, noting that to further support the recovery and restoration of elective services, a modified national contract would be in place giving access to most private hospital capacity until March 2021;
  - c. restoring delivery in primary care and community services; and
  - d. expanding and improving mental health services and services for people with a learning disability and/or autism.
367. In respect of the preparation for winter pressures alongside a possible second wave of Covid-19, the Phase 3 Letter instructed NHS leaders, among other things, to:
- a. continue to follow good Covid-19-related practice, including in particular PHE guidance on IPC, ensuring continued access to and use of appropriate PPE and following PHE / DHSC Covid-19 testing policies, with a view to enabling patients to access services safely and protect staff, whilst also preparing for localised Covid-19 outbreaks or a wider national wave;
  - b. sustain current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing IS capacity, Nightingale hospitals, and support to the timely and safe discharge of patients from NHS hospitals through to March 2021;
  - c. expand the 'NHS 111 First' offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from NHS 111 to local services, such as direct referrals to same day emergency care and specialty 'hot' clinics, as well as ensuring all Type 3 A&E services are designated as Urgent Treatment Centres. DHSC would shortly be releasing agreed A&E capital to help offset physical constraints associated with social distancing requirements in A&E departments;

- d. appropriately optimise the use of 'Hear and Treat'<sup>39</sup> and 'See and Treat'<sup>40</sup> pathways for 999 demand, to support a sustained reduction in the number of patients inappropriately conveyed to Type 1 or 2 A&E departments;
  - e. continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Service and the partnership with British Red Cross, Age UK and St. John Ambulance which was set to be renewed;
  - f. continue to work with local authorities, given the critical dependency of patients – particularly over winter - on resilient social care services; and
  - g. ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC / PHE policies.
368. Over summer and early Autumn of 2020, via a range of meetings or commissions from various Government departments including DHSC, the CCS and Cabinet Office, NHS England produced and shared regional information about admissions and bed capacity, to help inform Government decision-making around NPIs adjusted by location.
369. The national 'Severe Covid Response Cell' was established in September 2020 to help inform ongoing policy and operational decision-making around critical care capacity and care more generally for severely ill Covid-19 patients. A new daily Critical Care Capacity Panel ("CCCP") was established, reporting to the Severe Covid Response Cell. The purpose of the CCP was to provide a national forum for the monitoring of pressure upon critical care units and co-ordination of inter-regional transfers.
370. Using a data dashboard and intelligence from medical directors in each region, these forums informed decision-making on transfers and escalation to ensure sufficient critical care capacity and equity across and within regions.

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<sup>39</sup> 'Hear and treat' describes the scenario when 999 calls are successfully completed ("closed") without despatching an ambulance vehicle response. This may include advice, self-care or a referral to other urgent care services. Hear and treat services have been developed over recent years, largely led by ambulance Trusts in response to increasing 999 call demand.

<sup>40</sup> 'See and treat' describes where clinical assessment of a patient is provided at the patient's location, following by appropriate immediate treatment, discharge and / or referral.



371. On 22 October 2020, SAGE met (attended by NHS England's National Medical Director) and amongst other things, specifically discussed winter modelling and seasonality. At this point, SAGE considered that several factors were likely to combine to exacerbate the epidemic during winter, including the continued susceptibility of the population; the direct effect of environmental variables (such as temperature and UV light); the indirect effect of poor weather leading to people spending more time indoors; and other seasonal changes in contact rates due to school opening and seasonal festivals. Changes in susceptibility were likely to have a greater impact on transmission than environmental factors (high confidence).
372. On 13 November 2020 slides were produced by NHS England and the Covid-19 Taskforce in response to a Number 10 commission on NHS Capacity. The request related to establishing a common understanding of current capacity, including all available surge and bed occupancy for input into NPI decisions and the slides were to be presented at a meeting with the Prime Minister on 16 November 2020.
373. On 3 December 2020, Cabinet Office's Covid-19 Secretariat formally commissioned DHSC to work with NHS England to jointly prepare and present a paper on the NHS's capacity over the January to February 2021 period. The paper was discussed at the COVID Operations Committee meeting on Monday 14 December 2020, which was attended by NHS England's Chief Operating Officer.
374. The slide deck from that meeting set out that the peak of 14,712 Covid-19 inpatients on 23 November 2020 had dropped off slightly, but it was starting to rise again. The current number of Covid-19 inpatients was only currently 1,000 lower than this peak and it was expected that a potential further wave of Covid-19 hospitalisations would see an extra 15,000 Covid-19 patients on top of current levels meaning that Covid-19 occupancy would far exceed levels seen in Wave 1.
375. On 24 December 2020, NHS England provided an update to Number 10 (via the SSHSC) on the demand and capacity picture in London as well as data on mortality of patients in hospital with Covid-19 and length of stay. NHS England identified that there was a potential shortfall in available critical care and G&A beds based on projected demand. NHS England confirmed its plan to increase, which included:
- a. expanding beds within existing estates and sites;
  - b. enhancing timely discharge and reducing hospital admissions through the use of community services and home monitoring such as pulse oximeters;

- c. leveraging 10-20% nursing/care home vacancies to support early discharge;
  - d. making use of independent sector capacity;
  - e. reducing length of stay in rehabilitation beds to 14 days on average; and
  - f. re-activating the London Nightingale South Hall as a step-down facility.
376. In a joint statement on Monday 4 January 2021, the four UK CMOs recommended that the UK alert level should move from level 4 to level 5 and that *“without further action there is a material risk of the NHS in several areas being overwhelmed over the next 21 days.”*
377. In light of the above, on 13 January 2021, NHS England issued further operational guidance outlining the steps that organisations and systems working together with regions were required to take to ensure maximal use of available capacity (*“Operational Guidance: using all of our national healthcare system, people and resources”*) [AP070 INQ000269994]. Among other things, the operational guidance:
- a. requested regions to continue to work with systems and Trusts to optimise surge capacity and enact regional critical care surge plans;
  - b. updated systems on plans for the national coordination of inter-regional transfers of patients to ensure patients were not conveyed to hospitals where there was constrained inpatient capacity;
  - c. instructed ICSs, via their regional team, to propose surge plans to maximise the use of independent sector capacity; and
  - d. instructed organisations and systems to take a number of steps aimed at improving the discharge of patients who did not have a reason to reside in hospital.
378. On the same day, NHS England issued a letter to all ICSs CEOs recommending that all ICSs immediately establish Covid-19 virtual wards to support the earlier and safer discharge of Covid-19 inpatients [AP071 INQ000193212] by providing eligible Covid-19 patients with a pulse oximeter at home, alongside remote monitoring arrangements and additional home care and support as required.
379. The second wave was, in many respects, worse than the first. At the peak of the pandemic in January 2021 over 34,000 NHS hospital beds were occupied with

patients with a Covid-19 diagnosis, with almost 4,000 new Covid-19 positive admissions every day.

380. As a national service, particularly during the second wave, the NHS was able to co-ordinate the transfer of admissions regionally between hospitals as needed, preventing hospitals from being over-run. In January 2021, the CCCP moved to a 7-day a week meeting cadence to deal with the demand of the required patient transfers between regions. Following discussions in late December 2020, pressure reduction initially focused on the Midlands and the South East regions.
381. As Covid-19 admissions grew, with the Alpha variant impacting the south of the country first, on 13/14 January 2021 a daily rhythm of decompression moves from London and East of England to the Midlands commenced to relieve pressure on critical care units in these areas. This was expanded to the East of England on 17 January 2021. Hotspots were Kent, East Surrey, and South Essex, as well as a number of London hospitals.
382. On 20 January 2021, NHS England issued a letter to CCGs, local authority directors of adult social care and system discharge leads (*"For action: Improving discharge patient flow from acute settings"*) setting out three schemes<sup>41</sup> that systems were asked to immediately implement for the purpose of supporting a reduction in the length of stay for people in hospital. These options were funded from the £588m hospital discharge 'scheme two' fund up until 31 March 2021.
383. By 22 January 2021, the London region need for decompression ceased as did the South East region on the 25 January 2021, with the focus shifting to supporting critical care units under pressure in the Midlands, with hospitals in the South West, North East and North West regions receiving patients. On 22 February 2021, the last inter-regional critical care capacity transfer was made, and on 30 March 2021, the final meeting of the CCCP took place.

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<sup>41</sup> Hotel accommodation, independent sector provision for hospitals at home services and designated care home facilities indemnity cover.

## SECTION 5: EVOLUTION OF DATA COLLECTION, USE AND MODELLING

384. This Section sets out how the data infrastructure evolved throughout the Relevant Period. It begins with an overview of the different entities involved in the use of data and modelling, and considerations around the data which was collected prior to the pandemic, the type of data collected and how it was used to enable effective decision making.
385. Data and modelling were essential sources of operational intelligence throughout the pandemic, providing both a rear-view mirror (albeit with obvious limitations) about what was happening on the ground as well as a forward look into what might happen with anticipated levels of demand for services.
386. The data required for responding to the pandemic was dramatically different from that required to manage the NHS in ordinary circumstances, and accordingly this functionality had to be built at pace, as described further below. Once established this largely functioned well in terms of enabling key national and regional decision-makers to make informed assessments as to what was needed to ensure services were able to stand up to demand.
387. The emphasis during the pandemic was to ensure secure, reliable and timely data was available to enable informed and effective decision-making, whilst appreciating what was known about Covid-19 was evolving. The Covid-19 Data Store, discussed within this Section, was developed by NHS England and NHSX to meet this requirement. It brought together a number of key data sources, including the daily Covid-19 SitRep collection from providers (as also discussed in this Section).
388. Functionality was developing at pace, with the Covid-19 Early Warning System being developed to forecast the likely Covid-19 demand in particular areas. It helped forecast admissions and the availability of equipment two weeks in advance, and to make informed preparatory decisions as a result.
389. Further innovation provided insight into the uptake of the Covid-19 vaccines by cohort, geography, ethnicity and level of deprivation. The Vaccine Equalities Tool enabled NHS England to take decisions based on data and insights about where to focus efforts on vaccine distribution at a local level. This tool was not just useful for uptake data but also provided insight into effective communication routes for different cohorts – see paragraph 175 above for examples of different types of communication strategies.

390. NHS data was also used extensively within clinical trials. The results of such trials included the discovery that a drug (Dexamethasone) could cut the number of deaths by a third for critically ill Covid-19 patients - by March 2021 it was estimated that it had saved around 22,000 lives in the UK and more than one million worldwide.

## **Data Collection and SitReps**

### Existing data infrastructure

391. To understand the use of data and modelling across the NHS system it is helpful to first describe the role of a number of different entities. Further detail is provided in NHS England's First Module 3 Statement; however, from a data and modelling perspective during the Relevant Period:
- a. *NHS England:* NHS England was essentially a commissioner of healthcare services, making arrangements for the provision of certain healthcare services which were then provided by other bodies (such as Trusts). As such, the data NHS England arranged to be routinely collected pre-pandemic was limited to that reasonably necessary to discharge those particular functions;
  - b. *NHS Improvement:* NHS Improvement's functions were the oversight and regulation of NHS healthcare services in England, and it collected data to fulfil this role;
  - c. *HEE:* HEE led and coordinated education and training for the NHS workforce. It collected data in connection with this role.
  - d. *NHS Digital:* NHS Digital's functions related to information, data and IT collections and systems, for both the NHS and social care. NHS Digital operated separately from NHS England throughout the Relevant Period, albeit with close working and coordination between the two. In particular, NHS England commissioned NHS Digital to collect a range of SitRep data from providers before the pandemic, as detailed above, and those data collections evolved during the pandemic (as detailed further below); and
  - e. *NHSX:* NHSX was formed in February 2019 by the SSHSC as a joint unit of DHSC, NHS England, and NHS Improvement, with responsibility for setting national policy and best practice on technology, digital and data. It was not a legal entity in its own right, and its role was an advisory one such that it did not collect or otherwise disseminate data itself.

392. Before the pandemic NHS England arranged for, or itself collected, data for the purposes of its remit i.e., to ensure oversight and coordination of the NHS system. It is always important to ensure that NHS England's data collection requirements are proportionate to its needs, and so the frequency and granularity of data collection varies from topic to topic in line with the need for NHS England to support operational matters. On the non-elective side, for example and as in NHS England's First Module 3 Statement, the Urgent and Emergency Care ("UEC") SitRep was in place as a daily collection during Winter so that NHS England could understand the day to day pressures in this area, such as ambulance handover delays, A&E attendances, bed numbers or waiting times in A&E. The daily frequency allowed timely feedback of near real-time pressures and an understanding of the different pressures on different days of the week. The UEC data collection has a rapid turnaround from providers submitting their data, and its rapidity allows for minimal validation. However, the data reported is nonetheless considered fit-for-purpose.

393. By contrast on the elective side, when information such as waiting times was collected, there was no requirement for the same frequency in data collections due to a lesser real-time need for potential interventions. Data was collected on a monthly or quarterly basis, with each collection having a slightly different focus. The quarterly data covers all specialties but only looks at elective activity whereas monthly data focuses on G&A and shows the split between elective and non-elective data and the elective split between ordinary admissions and day cases.

394. A further relevant factor to the pre-pandemic picture is the various information law obligations that all NHS organisations, including those outlined above, had to navigate when using data to respond to the pandemic. During the pandemic, the legal collection, use and dissemination of data throughout the NHS system was greatly assisted by notices issued by the SSHSC under the Health Service (Control of Patient Information) Regulations 2002 ("**COPI Notice**") to the health and care system, including NHS England, NHS Improvement and NHS Digital.

These notices were initially issued on 17, 20 and 23 March 2020, and renewed sequentially until June 2022 when they expired. They were published on the gov.uk website on 1 April 2020.

They provided a legal gateway through which NHS bodies could access and use data more broadly and widely than might typically be the case for the purpose of responding to the pandemic. This provided an important foundation to enable NHS England to establish the data and modelling infrastructure that it subsequently did.

395. The pre-existing framework provides a further important contextual note to the data collected and used by NHS England before the pandemic, and in particular the extent

to which it could permissibly collect personal data. Pre-pandemic datasets were aggregated and specific to a particular clinical pathway, such as A&E attendance, critical care and elective care, and with no meaningful way to combine them so as to understand a particular patient episode in full, for example, how many patients presented to A&E then required critical care support. The implications of the pandemic were such that existing data collection arrangements would not provide a sufficient understanding of the impact of Covid-19 on NHS services and capacity. There was an urgent need to expand data collection and analytical capability rapidly.

396. In addition, and again prior to the pandemic response, the data held and used by NHS England was held across a number of repositories, generally with datasets serving the need for key operational measures such as monitoring performance against targets and clinical standards set by government (A&E waiting times and cancer referral, for example). The existing infrastructure gave rise to the following obstacles to its fitness for use in the context of a pandemic:
- a. *Frequency* – SitReps were collected from providers on a daily, monthly or quarterly basis depending on the specific data set and as described above. This was appropriate in pre-pandemic times when data was used primarily by NHS England to manage the NHS system but was insufficient to provide the real time strategic information required to make informed and rapid decisions about operational delivery of healthcare, particularly so in the context of the NHS being at Level 4 and responding to a fast-developing and all-encompassing pandemic;
  - b. *Data consistency*: data received from provider organisations varied and so needed to be standardised to inform and assess clinical workflow accurately;
  - c. *Data linkage and operability*: New capabilities were required to enable data linkage across the NHS system at scale and in real-time.
397. These factors added to the challenge of establishing a data infrastructure which provided data never required before.

#### Covid-19 Data Store

398. In March 2020, the Government commissioned NHS England and NHSX to develop a data platform that would provide national organisations responsible for co-ordinating the Covid-19 response with secure, reliable and timely data to make informed, effective decisions. This data platform was developed using 'Foundry', a technology

platform product developed by Palantir.<sup>42</sup> The data was held within NHS England Azure infrastructure known as the 'Covid-19 Data Store', Foundry used data from the Covid-19 Data Store, to create analytics products.

399. The NHS Covid-19 Data Store was established to bring together multiple data sources from across the health and care system in England into a single, secure location. One of those key data sources was the daily Covid-19 SitRep collection from providers, which is described in further detail below.
400. Bringing the data together in the data store and platform allowed NHS England to:
- a. track the use of hospital services by Covid-19 patients;
  - b. supplement health and care resources in emerging hot spots;
  - c. ensure critical equipment was supplied to the facilities with the greatest need;
  - d. divert patients/service users to the facilities that were best able to care for them based on demand, resources, and staffing capacity;
  - e. inform strategic decision-making by senior NHS England officials;
  - f. undertake research, for example NHS England was able to use the data store functionality to help understand initial differences in Covid-19 vaccine uptake. Anonymised information from Foundry was made available to research groups.
401. A SPOC was established for policy makers, commissioners, planners and researchers to request access to health and care data held both within and outside of the Covid-19 NHS Data Store by NHS England, NHS Digital, PHE and open-source data to support the response.
402. The Prime Minister viewed a demonstration of the Covid-19 data platform from NHS England and NHSX on 21 May 2020 [INQ000087429]. It was subsequently demonstrated to the Minister for the Cabinet Office, who requested a note summarising the lessons learned by NHS England in establishing the platform. NHS England provided the note on 1 July 2020, which contained a high-level summary of how to replicate the approach [INQ000087443 and INQ000087444].

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<sup>42</sup> Palantir is a private sector company specialising in data analytics.



403. The initial functionality of the data platform comprised three dashboards, as follows:
- a. the Strategic Decision Makers Dashboard, which was used by senior national and regional NHS England officials;<sup>43</sup>
  - b. the Operational Dashboard, which was available to NHS England regional teams as well as Trusts to support decisions for their local areas; and
  - c. the Public Dashboard, which provided the public with regular updates on the national and local incidence of Covid-19 to allow them to track and understand the progress of the pandemic.
404. As the pandemic progressed, further functionality was developed to include:
- a. the Covid-19 Early Warning System, or “**EWS**”, to forecast likely Covid-19 demand in particular areas; and
  - b. vaccination capability, to help manage the deployment and distribution of vaccines across the country.
405. The EWS was a useful tool to help forecast admissions and availability of equipment two weeks in advance, and to make informed preparatory decisions as a result. It used a range of sources, including SitReps, PHE testing data, NHS 111 telephony data on the number of calls which resulted in Covid-19 specific outcomes as well as aggregated Google and Apple mobility data related to footfall in particular types of location (such as parks, retail, grocery, transit stations and workplaces) and rates of driving, walking and other forms of transit. This was used to produce short term forecasts of Covid-19 hospital activity at an individual Trust level.
406. There were a number of key benefits of the EWS when compared with official SPI-M-O modelling (and the bed capacity modelling derived by NHS England from that). In particular, users were able to see the extent to which forecasts for their particular region or Trust were influenced by recent historical admissions data as compared to local testing data. Further, all of the EWS forecasts were validated statistically by comparing forecasts with real-time data and the dashboards incorporated a reliability indicator through which users could consider the confidence of particular projections.

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<sup>43</sup> The Strategic Decision Makers Dashboard broke down information on Covid-19 testing and deaths by age and gender.

407. In addition, forecasts were generated using Bayesian hierarchical modelling, which allowed the model to learn from trends within regions from data reported by hospitals on a daily basis. For example, if a few geographically close Trusts were experiencing an uptick in Covid-19 admissions but another geographically close Trust was not, this information would be incorporated into the forecasts of all of the Trusts.
408. The EWS was recognised as the 'Best Healthcare Analytics Project for the NHS' in the HSJ Partnership Awards 2022, and in so doing the HSJ noted that "*the technology allowed the NHS to make life-saving interventions, plan the delivery of care and allocate scarce resources with a degree of accuracy and confidence previously considered impossible to achieve*". For example, during January 2021, the EWS predicted that pressure on London and South East beds would be extremely high. Capacity analysis using the EWS forecasts determined only 9 of the 55 large acute providers in England were unlikely to exceed their available bed capacity in the next 21 days. This enabled recipient locations for inter-regional transfer of patients to be identified with a degree of confidence that would not put the receiving Trust in a capacity predicament.
409. Throughout the pandemic there were several methods of monitoring EWS accuracy, both on a scheduled Business as Usual ("**BAU**") and on an as-needed basis. These are briefly summarised below, and were also documented through the annual NHS England business critical models quality assurance review process:
- a. Scheduled BAU validation comprised the following:
    - i. Daily Quality Assurance (QA) by an analyst/data scientist before forecast publication to identify any areas where the model failed to run as expected or where assumptions being used may no longer be suitable; forecasts were not published if obvious/serious quality issues were identified on a given day.
    - ii. Regular validation reports produced for internal monitoring, assessing how the currently deployed model version would have performed over the previous eight weeks.
    - iii. Model performance information published to users daily on the front-end, showing both statistical performance checks and every forecast made in the past three months alongside actual reported data.
  - b. Conducted as needed:

- i. Regular comparison against outputs from other modelling groups e.g., SPI-M consensus forecasts when available.
- ii. Retrospective analysis of performance during specific waves once concluded.
- iii. For all model changes, testing and validation prior to deployment including comparison between different update options, back-validation against the currently deployed model and validation over the previous two weeks.
- iv. If any data quality issues were suspected as part of Quality Assurance, liaised with relevant teams to investigate potential issues with underlying data.

410. Reflecting on EWS accuracy, retrospective analysis shows that overall it performed well both in comparison to a simpler baseline model and to examples from literature review.<sup>44</sup> This was particularly the case for admissions forecasts, which showed consistent and substantial predictive power relative to the baseline. For bed occupancy forecasts there were periods of time where model performance was below the baseline, but overall performance was improved on average across the pandemic.

411. Another key innovation developed using the Foundry platform was the Vaccine Equalities Tool, which provided insight into vaccine uptake by cohort, geography, ethnicity and level of deprivation. This enabled NHS England to take decisions based on data and insights about where to focus its efforts on vaccine distribution at a granular, local level. Using this tool allowed NHS England to identify that some ethnicities and areas of higher deprivation had a significantly lower rate of vaccine uptake. For example, vaccination rates for people from a Black African background were 38% in January 2021; these rates were increased through focussed deployment measures to 70% in May 2021. One specific instance of this related to South East London, where it was identified that vaccination uptake was much lower in Peckham when compared to Dulwich. The location of a vaccination centre in the latter but not the former was felt to be a contributing factor and led to a drive to increase centres in

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<sup>44</sup> The baseline model was constructed, and examples from literature were identified, retrospectively, and were not in live use for comparison at the time.

Peckham which resulted in increased vaccination rates. NHS England understands that inequalities in relation to vaccines will be explored as part of Module 4.

412. The Vaccine Equalities Tool was available to national and regional NHS England leadership, senior ICS leads as well as Directors of Public Health in every Local Authority. In addition to the functionality described above to identify differential vaccine uptake across different demographic and local areas, the tool could also be used to share best practice on effective communication routes for particular population cohorts.
413. The success and impact of the Vaccine Equalities Tool was recognised by a 2021 Analysis in Government Award for impact and was a finalist in 2021 and 2022 for the HSJ Partnership Awards in both the 'Best Healthcare Analytics Project for the NHS' and 'Most Impactful Project Addressing Health Inequalities' categories.
414. Finally, it is worth noting that the utility of NHS data was seen across several clinical trials particularly through the NHS DigiTrials service. Those contributions included:
  - a. Enabling access to data to support the RECOVERY trial led by researchers at the University of Oxford to determine the efficacy of a number of treatments for Covid-19, the first of which was Dexamethasone. The trial was first conceived in March 2020 and utilised NHS DigiTrials, to draw together clinical trials, NHS and other datasets. By the middle of June 2020 the trial had shown that use of the drug could cut deaths by a third for critically ill Covid-19 patients, and by March 2021 it was estimated that it had saved around 22,000 lives in the UK and more than one million worldwide;
  - b. Support to the PRINCIPLE trial, which aimed to find Covid-19 treatments that could be taken at home to avoid hospitalisation. Although the study commenced in April 2020, the participant numbers over the first 6 months were low because it was hard to find and engage with patients in the community when they were feeling unwell. The window for recruiting relevant participants following a positive Covid-19 test was only seven to ten days. By providing the PRINCIPLE team with a daily flow of Covid-19 test data records as well as access to the Summary Care Record, NHS Digital helped them to identify suitable trial participants and enable efficient and safe prescribing of trial treatment, resulting in recruitment into the trial doubling to 200 per week. DigiTrials also provided outcomes data to enable the trial to quickly and efficiently analyse their results;

- c. Provision of demographics data to Imperial College to enable recruitment of a nationally representative cohort of participants for the REACT study, which was established in May 2020 by Imperial College London on behalf of DHSC. It provided monthly estimates of the prevalence of the virus and bi-monthly estimates of the prevalence of antibodies to the virus in the general population of England (using data collected from home test kits). NHS Digital subsequently shared health records of consenting participants in the study. These records were linked to study data to advance understanding of the risks of infection and reinfection with Covid-19 and people's future health following Covid-19 infection; and
- d. Development and administration of the Covid-19 Vaccine Registry, working closely with NIHR. This comprised a database of individuals who had registered via NHS.UK to volunteer to be contacted about opportunities to participate in Covid-19 Vaccine trials. This enabled suitable trial cohorts to be easily and rapidly identified and quickly recruited.

415. NHS England's role in clinical trials is covered in more detail in NHS England's Third Module 3 Statement.

#### **Situation Reports (SitReps)**

416. We have set out below an overview of NHS England's use of SitReps during the pandemic, particularly by reference to what those SitReps included, how this developed over time, as well as the role of SitReps in informing relevant decision-makers within the healthcare system. As set out above and in NHS England's First Module 3 Statement, NHS England had collected data and SitReps for many years prior to the pandemic, to fulfil its role in overseeing the NHS system. This also resulted in published data providing headline figures on occupancy of critical care beds both nationally and by individual NHS providers. However, the nature and regularity of that data reporting was insufficient for a Level 4 incident such as the pandemic. This led to NHS England commissioning NHS Digital to collect, through its Strategic Data Collection Services, a number of Covid-19 specific SitReps as well as, from time-to-time, one-off or bespoke SitReps for information not covered by those existing collections (for example mortuary capacity).
417. The Daily NHS Provider SitRep, as described further below, was a primary source of information on factors such as bed occupancy, critical care and workforce absence.

This was also the main dataset routinely shared with the Government, at least initially.

418. Additional Covid-19 SitReps, above and beyond the Daily NHS Provider SitRep, were established by NHS England to receive additional information from providers across the country which was not otherwise covered by the Daily NHS Provider SitRep. By way of overview, the supplementary Covid-19 SitReps established during the pandemic were as follows:

| <b>Name of collection (and template)</b>                            | <b>High level summary of collection</b>  | <b>Commencement Date</b> |
|---|--|--------------------------|
| Daily Patient Discharge SitRep <b>[AP072 INQ000270126]</b>          | Data showing the number and setting into which patients were discharged.   | 8 April 2020             |
| Daily NHS Provider MHLDA SitRep <b>[AP073 INQ000270125]</b>         | Data showing the number of mental health and learning disability beds occupied by Covid-19 and other patients, the number of patients receiving oxygen or ventilation, the number of beds with oxygenation support and non-invasive ventilation available, and staffing absence broken down by reason. | 24 April 2020            |
| Weekly Independent Provider SitRep <b>[AP074 INQ000270127]</b>      | Data showing activity by independent sector providers broken down by speciality.   | 1 May 2020               |
| Daily Independent Provider MHLDA SitRep <b>[AP075 INQ000270124]</b> | As per the NHS MHLDA Daily SitRep, but for   | 6 May 2020               |

|   |  |                  |
|---|--|------------------|
|   | independent sector providers.  |                  |
| Weekly NHS Provider SitRep <b>[AP076 INQ000270123]</b>                          | Data showing diagnostic activity.  | 19 May 2020      |
| Daily Community Discharge SitRep <b>[AP077 INQ000270122]</b>                    | Data showing discharge activity for community providers.   | 2 June 2020      |
| Monthly Community Health Services SitRep <b>[AP078 INQ000270121]</b>            | Data showing the waiting list times for patients and the reasons preventing reductions in waiting lists. | 17 November 2020 |
| Daily NHS Staff Lateral Flow Testing SitRep <b>[AP079 INQ000270120]</b>         | Data showing the available stock of LFT testing kits.  | 25 November 2020 |
| Weekly Long Covid Assessment Clinic Activity SitRep <b>[AP080 INQ000270119]</b> | Data relating to post-Covid assessment services.   | 5 January 2021   |

419. Focussing now on the Daily NHS Provider SitRep, this was changed over time to collect data which reflected the progressive understanding of Covid-19, and in particular the clinical support patients needed (and in turn the key capacity indicators that NHS England needed to monitor) **[INQ000087382]**. In the early weeks of the pandemic, it was unclear what the hospitalisation rate might be for those contracting Covid-19 and what the rates of utilisation would be for the different treatment modalities (ventilation and non-ventilation). It was also unclear what the fatality rate would be for those requiring hospital treatment and, for this reason, hospital mortuary capacity became more relevant than would be the case in normal circumstances. Bespoke collections were put in place to give timely updates to NHS England. As such, incremental changes were made to the Daily NHS Provider SitRep by adding or slightly re-focussing elements of the data collection, as it was important to ensure that

there was always a consistent baseline for comparative purposes (monitoring trends and such).

420. It quickly became apparent that more detailed information was required about a bed's capability, once staffed, to deliver different types of treatment for Covid-19. Prior to the pandemic, NHS England collected information on acute bed capacity which was sub-divided into its particular setting i.e., G&A capacity and critical care. NHS England's focus swiftly switched from the bed's setting to its capabilities, so that beds were subdivided into their capacity to deliver mechanical ventilation, non-invasive ventilation or oxygenation (i.e., V, O or O+ beds).
421. Before the pandemic, NHS England did not need to know local staffing absence levels in real-time. However, this became an important piece of strategic intelligence to understand the pressures Covid-19 was placing on individual Trusts, and in particular their ability to maintain services.
422. The broad context set out above provides an overview of the manner in which data collection evolved over the course of the pandemic, and the underlying reasons. A brief, focussed, timeline of the key phases to that evolution of the Daily NHS Provider SitRep is as follows (although should be read alongside the summary of the other Covid-19 specific collections summarised above to appreciate the full data collection picture):
- a. from January 2020 to mid-March 2020, PHE took the lead for daily SitRep reporting on Covid-19 cases. During this time NHS England assisted PHE with the establishment of testing and reporting arrangements from a limited number of 'sentinel' sites (specific ICUs and GP practices) to provide an early readout on transmission of Covid-19. On 11 March 2020 PHE established the Covid-19 Hospitalisation in England Surveillance System, or "**CHES**", to collect epidemiological data (demographics, risk factors, clinical information on severity, and outcome) on Covid-19 infection in persons requiring hospitalisation and ICU/HDU direct from NHS providers;
  - b. between 10 and 16 March 2020, NHS England's existing SitRep reporting was expanded to include the numbers of patients in hospital with Covid-19 and of these how many were in HDU or ITU beds. These figures were shared with DHSC;
  - c. 17 March 2020 – daily Covid-19 specific collections from Type 1 A&E departments commenced. These were shared with DHSC on a daily basis



and, from 21 March 2020, directly with the CMO;

- d. 20 March 2020 – daily collection expanded to include community providers and mental health Trusts;
  - e. 26 March 2020 – the scope of SitReps expanded to specify the number of patients receiving oxygen, non-invasive and mechanical ventilation, and to include reporting from independent sector providers on the number of NHS patients that providers were treating in both critical care and non-critical care beds [INQ000087447];
  - f. 2 April 2020 – the scope of SitReps expanded to include the number of available beds which could provide mechanical ventilation, non-invasive ventilation and oxygenated support (O, O+ and V respectively);
  - g. 14 April 2020 – daily collection expanded to include reporting from independent sector providers on ventilator availability (both mechanical and non-invasive) [INQ000087394 and INQ000087395];
  - h. 27 April 2020 – daily collection expanded to include the number of suspected Covid-19 cases [INQ000087411];
  - i. 5 June 2020 – daily collection expanded to include staffing absence and time between admission and diagnosis of Covid-19;
  - j. 13 October 2020 – daily collection expanded to include reporting breakdowns by reference to ethnic background, more granular age brackets, surge bed availability and repeat admissions/diagnosis; and
  - k. June 2021 – daily collection expanded to include whether the Covid-19 positive patients were primarily treated for Covid-19 rather than something else e.g., hip fracture, heart attack etc.
423. NHS England also asked Trusts to submit notification of patient deaths, staff deaths and data on protected characteristics, via the Covid-19 Patient Notification System ("CPNS"). Initially, from 15 March 2020, this was a manual reporting system whereby providers reported daily on any deaths to NHS England. On 18 March 2020 NHS England commissioned an online CPNS portal, an early version of which was launched on 24 March 2020 and which was subsequently refined over the following months. We cover this further in NHS England's Third Module 3 Statement.

424. The data reported through the Daily NHS Provider SitRep was then collected every morning, collated and sent to a wide circulation list which included the CMO, the National Medical Director, the Strategic Incident Director and the Chief Executive Officer's office (the latter of which then provided the data to DHSC on a daily basis). Providers consistently submitted their returns as required, with very few failing to do so. This meant that NHS England always had access to a comprehensive and well-informed picture about what was happening on the ground.
425. On or around 17 March 2020, the Cabinet Office commissioned a daily 'dashboard' from a number of bodies, including DHSC and MHCLG, devolved administrations and NHS England. NHS England was responsible for inputting data on the number of Covid-19 cases admitted to hospital and deaths by region, as well as a high-level summary of the impact on the health system (again broken down by region). This dashboard was initially circulated manually to a wide audience across Government. From 23 March 2020 or so onwards, the dashboard was digitised, and NHS England's data was automatically fed to the Cabinet Office and latterly to the Joint Biosecurity Centre. NHS England also responded, from time to time, to specific data requests from Number 10 and the Cabinet Office which fell outside the BAU reporting.
426. The data collected through SitReps was used, as described below, to develop strategic intelligence and briefing documents and was also shared widely across both the NHS as well as with central government agencies.
427. For example, NHS England's data reporting team worked with MHCLG to enable Local Authorities to access data that it was collecting through daily SitReps. Initial discussions took place about this in early April 2020, and by 9 April 2020 a manual data feed of daily SitRep data for inclusion in the LRF dashboard which individual Local Authorities could access had been established. That data included staffing absences, occupancy and non-occupancy (by both Covid-19 and non-Covid-19 patients) of MV beds, total number of confirmed Covid-19 cases (split by bed type) and Covid-19 discharges in the previous 24 hours. NHS England subsequently established a direct feed, negating the need for manual data sharing (with the exception of the staffing absence numbers).

#### **Dissemination and use of data**

428. The data collected via SitReps was helpful in capturing the raw picture as to what was happening across the country, including by reference to regions or individual

Trusts. However, it was equally important for this data to be analysed and presented to key decision-makers in a format which aided strategic decision-making. As such, the data was used to help produce several daily briefings. These are summarised below, together with information on the periods for which they were produced. The briefings were generally shared with senior NHS England officials, including the Chief Executive Officer, Chief Operating Officer, National Medical Director, Chief Nursing Officer, and the Strategic Incident Director. In some cases, they were sent direct to Regional Directors, but in other cases information would be cascaded via National IMT meetings or otherwise sent directly as appropriate.

429. Examples of each briefing, each produced daily, from across their respective periods of existence, are:
- a. TOTO briefing which ran from 9 January 2020 until 30 March 2022. This was issued by the EPRR team and contained an increasingly detailed description of the latest position with regards to community prevalence, impact on NHS resources and capacity, as well as the international picture;
  - b. Covid-19 SitRep which ran from 31 March 2020 until 30 August 2020. This was issued by NHS England's Data Analytics team and took the form of aggregate-level data on the numbers of patients with Covid-19, those in critical care beds (as defined at the relevant time) and staff absences (both in total and due to Covid-19);
  - c. TOTO Outbreak SitRep which ran from 8 April 2020 until 1 November 2022. It was issued by the EPRR team and contained a summary of the regional picture (by reference to areas of concern, interventions and mitigations), NHS outbreaks by region and organisation, nosocomial infection data, care home outbreaks, staff absence and forecasted admissions. This was shared on a daily basis with senior NHS England officials as well as Regional Directors and Regional Heads of EPRR;
  - d. Incident End-of-Day report which ran from 20 April 2020 until 4 April 2022. This was signed off and issued by TOTO and the Chief Operating Officer's office and was included in the slide packs for Tactical Fusion meetings. It included a summary from the Chief Operating Officer or Strategic Incident Director (or deputy) as well as updates on incidents, summary data from SitReps, live incidents and updates from particular cells. This briefing was shared with a wide circulation list, including Regional Directors and Regional

Heads of EPRR; and

- e. Covid-19 Daily Update which ran from 25 September 2020 until 31 October 2022. This was issued by the EPRR team and took the form of a detailed presentation pulling together key strategic information across a number of areas, including community prevalence, admissions, critical care capacity, nosocomial (hospital acquired) infection and EWS forecasts.
430. The summary above illustrates both the volume and regularity with which data and strategic intelligence was being collected, analysed and disseminated within (and outside of) NHS England on a daily basis. There was a comprehensive information cascade system managed by the EPRR team nationally, with an 08:30 IMT daily meeting with the National Incident Director and all key Departmental leads and all regions. This was accompanied by an information cascade process that went from the National Operations Centre to Regional ICCs and from them to ICS ICCs and onward to NHS providers. Those daily meetings were the mechanism through which regional incident leads received the latest national and international information and data. NHS England regional colleagues then shared data as appropriate within their region, including to providers.
431. NHS England began regional rollout of the Covid-19 Data Store (see paragraph 398 onwards) in April 2020 and by 14 July 2020 all NHS England regions had access to it. This meant that instead of a daily cascade, regional NHS England colleagues were able to use the Covid-19 Data Store, populated and refreshed on a daily basis with the latest SitRep data. This was to help inform local analysis or modelling, particularly around some of the forecasting that was required to identify potential future local bed capacity at Trust level to cope with the increasing Covid-19 numbers. This facilitated richer management of the incident within the particular region. During December 2021, for example, when the Omicron variant first emerged and placed pressure on the acute sector the London region was able to use data available through the data store to analyse the position and develop local forecasts with colleagues in the South East, and which, in turn, informed London planning.

### **Modelling: Interaction between SPI-M-O and NHS England**

432. It is important to note and understand the utility and the limitations of modelling. Modelled scenarios provide outlines of possible future developments, but these are subject to the specific model assumptions, inputs and caveats; they cannot predict exactly (or necessarily accurately) what will happen in the future. However, those

scenarios are operationally useful at key timepoints to guide and assist operational planning when there is little available data on the effect of policy changes and new interventions.

433. NHS England scenarios were reviewed regularly within the multidisciplinary NHS England Covid-19 Modelling Cell, with senior clinical decision-makers and cross-validated against published SPI-M-O scenario modelling. Over time, as new SitRep data emerged the least plausible scenarios were discounted. Stakeholders were informed that scenarios were unlikely to hold any forecast accuracy beyond 4–6 weeks (not least because of unforeseen changes to interventions such as NPIs); over time the longer data history allowed for planning discussions to focus upon a range of evidence-informed potential futures.

#### Use of SPI-M-O modelling

434. As explained above, NHS England worked with the key assumptions and RWCS provided by Imperial and Warwick University, usually received through SPI-M-O but on occasion directly from Imperial. NHS England used and enhanced those SPI-M-O models of hospital admissions and converted them into estimates for bed occupancy (categorised by the level of oxygen therapy needed). The models were therefore planning scenarios based on RWCS projections, and not real-time projections. In essence, NHS England used epidemiological outputs of infection rates, and of those infected the proportion requiring hospital treatment, to estimate demand on beds in hospitals. Those estimates became more sophisticated over time, for instance by taking account of variable potential rates of compliance with NPIs and by reference to more granular regional pictures.
435. NHS England worked closely with SAGE and SPI-M-O throughout the pandemic to calibrate and align core input assumptions. It was particularly important to understand the key and most sensitive parameters to be used for modelling.
436. We have been asked to address the extent to which NHS England modelling diverted from other sources of modelling data.
437. Notable divergences in modelling output between NHS England and SPI-M-O were largely by exception, and further subject to the respective function and purpose of those outputs.
438. An example of divergence arose in late March 2020, when NHS England identified a difference between SPI-M-O and NHS England in the projected numbers of patients

requiring ITU beds. NHS England identified reasons for the difference, which included that the implied overall hospitalisation rate (by combining individual age bands) in the Imperial model used by SAGE was 5.2%, but NHS England used the implied 4.4% rate which had been referenced in previous SAGE papers and from our analysis provided a better fit to the latest data.

439. Initially SPI-M-O modelling groups used an age-increasing probability of critical care use. SPI-M-O later approved, on 6 March 2020, an age-increasing probability with a decreasing probability for the oldest age groups following a presentation from NHS England's Head of Forecasting.
440. In July 2020 the Cabinet Office commissioned three variants of new Reasonable Worst-Case scenarios from SPI-M-O modelling groups, based on expected Covid-19 incidence levels from the end of July 2020 to the end of November 2020 and measures to reduce non-household contacts from the end of November 2020 until March 2021 to (A) 25%, (B) 35% and (C) 50% of normal pre-lockdown levels (with variation within this latter scenario to account for the alternative of all school contacts being maintained and not maintained respectively). This was consistent with SPI-M-O's practice of commissioning alternative modelling to understand the differences which may arise when modelling the same scenario.
441. Imperial, Warwick University and NHS England all responded to that commission. NHS England did so in collaboration with Faculty and the Oxford Big Data Institute Pathogen Dynamics Group.<sup>45</sup> NHS England developed the 'Oxford Simulator' modelling of the Cabinet Office scenarios described above and submitted them to SPI-M-O for consideration [INQ000103595]. SPI-M-O considered those three responses to their commission, as documented in its published paper on 29 July 2020. That paper acknowledged that: *"It is important to note that these scenarios are not forecasts or predictions. They do not represent the full range of possible outcomes and no likelihood is attached to any of these scenarios at this stage. The timings of peaks in infection and demand on healthcare, in particular, are subject to significant uncertainty."*
442. All three models submitted to SPI-M-O were aligned in showing that different proportions of non-household contacts led to different rates of decline in Covid-19

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<sup>45</sup> The Big Data Institute is an interdisciplinary research institute run by Oxford University that focuses on the analysis of large and complex data sets for use in research into the causes, consequences, prevention and treatment of disease.

transmission. There were, however, differences in the shapes of peaks produced by the models; to some extent this reflected the differing levels of starting Covid-19 incidence used by each model. Further, the three models all took a different approach. The Oxford Simulator was developed to simulate the spread of Covid-19 in a city and was for England only. Both the Warwick and Imperial models were for the UK more widely. SPI-M-O used all three various modelling outputs to inform its decisions in respect of the RWCS going forward.

443. From July 2020 onwards, NHS England rapidly developed capability to begin to use the Oxford Simulator in its own modelling, calibrated to NHS England SitReps as well as the Imperial RWCS and other input assumptions specified by SPI-M-O. The Oxford Simulator was completely opensource meaning that it could be calibrated more specifically to NHS England's purposes.
444. This provided NHS England with greater modelling flexibility in terms of frequency of modelling runs and testing of alternative scenarios than was available to it via official SPI-M-O outputs and the RWCS. NHS England was also able to ensure that its modelling outputs fitted SitRep data to maximise their potential accuracy for operational purposes. Nonetheless, NHS England ensured that modelling assumptions and scenarios were aligned with, and included comparisons to, the SPI-M-O projections in shared outputs.
445. The Oxford Simulator was used to develop England-wide and regional modelling on 27 August 2020, which was presented by NHS England's Director of Performance Information the following day (including a comparison to SPI-M-O modelling) to NHS England's Chief Executive's Office, Chief Operating Officer, National Medical Director, Chief Finance Officer and National Strategic Incident Director [INQ000103587]. At or around that time, NHS England's Director of Performance Information requested that SPI-M-O produce medium term projections to assist with modelling impacts on NHS resources (particularly beds). SPI-M-O began producing medium term projections of hospital admissions from October 2020, which NHS England's Modelling Cell then converted into occupied beds. This was a key requirement from an NHS England perspective, as it was faced with a particularly virulent respiratory virus (Covid-19) at a time when all respiratory illnesses surge i.e., winter.
446. In one iteration of NHS England's modelling, it predicted lower figures of bed occupancy than SPI-M-O models although the SPI-M-O and NHS England curves broadly tracked each other in terms of shape. The higher figures produced by the

combination of the Oxford Simulator and NHS Beds models were attributed to SPI-M-O's assumed proportion of V patients, which was higher than NHS England's assumption. For context NHS England saw an age adjusted decline in the proportion of V patients (to 12%) over the course of the pandemic. By analysing the latest data NHS England was able to adjust its modelling to reflect changing V bed utilisation.

447. In the absence of updated modelling from SPI-M-O during November 2020, NHS England continued to use the Oxford Simulator to project the potential impact of mixed scenarios on Covid-19 admissions from December 2020 [INQ000103588]; this was to highlight the questions and analyses which NHS England should request from SPI-M-O. That modelling was presented to NHS England's Chief Executive's Officer, National Medical Director and National Strategic Incident Director on 20 November 2020. None of the scenarios were projected to avoid a second peak in hospital admissions.
448. During November and December 2020 NHS England identified misalignment between the medium-term (6 week) projections being produced by SPI-M-O and real-time SitRep data, which culminated in our modelling of the same on 11 December 2020 [INQ000103592]. For context, unlike SPI-M-O official modelling medium term projections are meant to be 'predictive' based on real time data and projected for the forthcoming two weeks. The misalignment was attributed to the fact that the pandemic was developing so quickly, such that by the time that NHS England received SPI-M-O projections they were by definition out of date.
449. By 11 December 2020 NHS England (using the Oxford Simulator model) had also modelled the combined effect of tiered lockdowns and the proposed relaxation of NPIs over the festive period [INQ000103593].
450. On 17 December 2020, NHS England updated its 11 December 2020 modelling to take account of the 16 December 2020 government announcement regarding changes to local tier restrictions [INQ000103596]. By that time the outputs of the Oxford Simulator and SPI-M-O modelling were relatively well aligned.
451. In January 2021, NHS England began modelling the impact of vaccine rollout and from late February 2021 the long-term implications of the Government's roadmap out of lockdown (as published on 22 February 2021) [INQ000103594]. Its initial long term-modelling, dated 26 February 2021, was broadly consistent but more optimistic than the SPI-M-O assumptions (albeit the models were consistent in projecting much slower increases in bed occupancy than in previous waves) [INQ000103589]. This



was because, at the time, the Oxford Simulator could only apply a single effectiveness assumption of the impact of vaccine efficacy on transmission and hospitalisation (to mean it was not calibrated to model the impact of a first and then second vaccine dose). SPI-M-O models, on the other hand, allowed for lower effectiveness of the first vaccine dose than the second one. NHS England therefore understood that this made its modelling more optimistic than SPI-M-O models and as a result caveated this appropriately when communicating modelling outputs.

452. Those differences in long-term modelling continued to apply in subsequent modelling undertaken in March 2021 [INQ000103590], but by April 2021 NHS England and SPI-M-O's roadmap modelling were more closely aligned [INQ000103591]. This was partly because NHS England had been able to develop the Oxford Simulator to account for the respective efficacy of a first and second vaccine dose, and also due to the greater certainty NHS England had by the time as to details of the Government's Covid-19 recovery roadmap.
453. As referenced above, NHS England developed a new Susceptible, Infected, Recovered and Vaccinated or "SIRV" model in December 2021, the outputs of which were shared with senior colleagues alongside medium term projections from SPI-M-O. The SIRV model was particularly good at modelling when growth in infections would begin to slow down because it explicitly modelled depletion of the pool of susceptible individuals.

#### Impact of divergences

454. Broadly, and on reflection, NHS England and SPI-M-O models worked most effectively once the Government made available regular Covid-19 incidence and prevalence data based on community testing surveillance. This is because hospital admissions data is necessarily a lag indicator reflecting infections that have occurred in the preceding week or two (and as such is a measure which provides a 'rear view mirror' of the development of the pandemic). Generally, there was a two-week lag from infection to patients requiring hospital treatment, and then a further lag of five to seven days until the majority patients were typically past the worst of the virus.
455. As explained above NHS England and SPI-M-O modelling was produced for different purposes which, of itself, is likely to prompt differences in output. Further, variation in modelling is fundamentally helpful as it prompts discussion about the potential reasons for any differences but also understanding the range of potential scenarios is very important.

456. In light of that, NHS England's perspective is that any divergences did not have a material impact on its modelling work and/or operational planning.
457. Insofar as availability of SPI-M-O modelling is concerned, NHS England was able to use the Oxford Simulator to produce the outputs required for its own purposes. NHS England along with UKHSA and University of Oxford colleagues have since published the Oxford Simulator work in a special issue of the peer reviewed journal *Epidemics*.

#### **NHS England use of modelling**

458. NHS England produced modelling throughout the pandemic for its own operational purposes (to supplement the bed capacity modelling). This section provides an overview of that modelling in broad terms rather than its specific outputs, which are referenced where relevant throughout the statement as context to particular decisions or events.
459. NHS England's key modelling work comprised the following:
- a. throughout the pandemic the bed capacity modelling, as described above;
  - b. from Summer 2020 through to early 2022 the Oxford Simulator, again as described above;
  - c. also from Summer 2020 through to early 2022, the EWS. This is described in further detail above; and
  - d. from September 2020 through to April 2021 the bed occupancy scenario tool which was available to users of the Covid-19 data store to project both Covid and non-Covid bed projections based on their selected criteria (such as the EWS and the doubling rate for admissions);
  - e. from December 2020 through to March 2020 the case reporting tool, which was a daily report of both regional and national case rates; and
  - f. from December 2021, the SIRV model to project the potential impact of the emerging Omicron variant. This modelled the England population in five 20-year age bands and included information on the number of people vaccinated and estimates from the ONS survey on the number of people who had previously had Covid-19. The model produced projections on the number of infected and hospitalised people by calibrating outputs to the latest data on prevalence from the ONS survey, sequencing data on variants and

admissions from SitReps.

NHS England use of modelling: regions

460. NHS England shared the modelling it produced centrally, as described above, with regional teams. In general terms, and wherever possible, central modelling was used by the regions to forecast the potential future numbers of Covid-19 patients to be admitted to hospital and how many of these would need a critical care bed. Central modelling was most useful to the regions between waves when they could be used as part of strategic decision-making in preparation for future increases in Covid-19 transmission i.e., when there was more time available in which to plan services.
461. In many instances central modelling was supplemented with local modelling to give additional granularity based on local circumstances. This was due to the central modelling not always being suitable for regional planning due to a combination of the following factors:
- a. prolonged intervals between production of SPI-M-O official modelling for conversion into regional scenarios for bed capacity;
  - b. delays in NHS England's central modelling teams receiving official SPI-M-O projections, and so in turn by the time they could be converted into regional projections they were out of date by the time they were received by regional teams, particularly during surges for demand. Central modelling was helpful for general regional planning purposes between waves when the need for modelling was less urgent; and
  - c. lack of granularity for use by regional teams.
462. In light of the above, regions often supplemented central information with their own modelling solutions to develop tactical models that could be updated daily, based on their understanding of current demand trends and to forecast bed requirements for the coming weeks. Those models could also be overlaid with general assumptions around new variants which were harder to introduce in some other national models (which largely used SPI-M-O modelling).
463. Particular examples of this include:
- a. the East of England collaborated with the University of Cambridge to develop a dynamic system demand model, which was used to determine the likely demand for beds, oxygen, and critical care. They more than doubled the

supply of critical care beds to meet this likely demand and used most of that capacity at the peak.

- b. In London, models were used during the summer and autumn of 2020 to plan for winter 2020 which set out planning scenarios by considering likely winter bed demand overlaid by further Covid-19 specific demand. It was translated into likely G&A and ITU bed requirements by system and Trust. Those local models were used during the first two waves of Covid-19 to produce tactical scenarios which were updated daily. They drove key decisions regarding how much new ITU capacity to open, when and where. They also supported planning and decisions in relation to oxygen supply and PPE distribution.

464. Workforce modelling is covered in Section 11.

## **PART 2: KEY ELEMENTS OF THE NHS RESPONSE**

465. This Part 2 considers some of the specific key decisions made during the pandemic, alongside legislative changes through the Coronavirus Act 2020 (Section 8) and additional funding to support the response (Section 9).
466. It does not cover all activities in what was an intense period of work, at pace and scale, in the early pandemic as these are covered across NHS England's Module 3 Statements. The timelines in Annex 5 are provided to give an indication of intensity.

## **SECTION 6: INCREASING CAPACITY AND KEY ACTIVITY**

### **Hospital and Critical Care Capacity Overview**

467. The following paragraphs provide an overview of hospital and critical care capacity, considering both scalability and input factors, as well as the headline impact of IPC measures.
468. Critical care capacity is discussed from March 2020 onwards, supported by exhibited monthly SitReps across the Relevant Period. Critical care capacity up to March 2020 is discussed in Section 2 above.
469. Typically, fluctuations in critical care capacity followed community prevalence, albeit with a lag between infection and the need for more serious health interventions, and measures to prevent or slow the spread of Covid-19 (notably NPIs). There were also regional variations, with some regions being days or weeks ahead in terms of prevalence of a particular wave, as is usual in epidemics and pandemics.
470. Other factors which impacted capacity included:
- a. Seasonality; that is, the NHS deals with increased pressures at winter, and that was equally the case during the pandemic. Waves 2 and 3 occurred during winter periods, with Wave 2 being the most severe wave; and
  - b. vaccine uptake; the majority of those in critical care during Wave 3 were unvaccinated.
471. Critical care staffing ratios are covered in paragraphs 476 to 479 below.

### **Hospital capacity throughout pandemic**

472. When assessing overall hospital bed capacity during the pandemic it is important to appreciate that not only was its scalability affected by a range of 'input' factors, but

also that any capacity that there was post surge was reduced by the need to comply with enhanced IPC measures designed to prevent the spread of infection and keep staff and patients safe.

473. The following IPC measures all had a material impact on the available capacity in hospitals, patient flow and the speed of treatment of patients in hospital settings:
- a. *admission of patients*: once DHSC had secured the necessary testing capacity and set the relevant testing policy, before patients could be placed in appropriate clinical areas they had to be tested via PCR for possible Covid-19 infection. Additional space was required to hold patients while awaiting these results;
  - b. *cohorting of patients*: while awaiting test results and also once these results had been obtained, patients had to be placed into separate cohorts in different rooms/wards, reflecting their suspected/confirmed Covid-19 status. This impacted capacity, for example areas set aside for positive patients could not always be fully utilised when there were insufficient positive patients.
  - c. *physical separation/distancing*: As with all public settings, physical distancing of 2m was recommended, which led to reductions in the numbers of beds which could be accommodated in multi-bedded bays or wards; and
  - d. *physical environment*: enhanced cleaning measures introduced to clean beds and rooms between occupants took additional time and impacted on patient flow. In cases where aerosol generating procedures took place, additional time (fallow time) was required before re-use of the space to reduce infection risk. In some areas, additional physical infrastructure (partitions etc.) was created to separate Covid-19 and non-Covid-19 areas, which had an impact on the available space.
474. The aims of these measures were twofold i.e., to:
- a. increase capacity in critical and acute care; and .
  - b. increase cohorting areas for Covid-19 positive (or negative) patients.
475. On 25 March 2020, NHS England issued a joint statement with the Governments of Scotland, Wales and Northern Ireland, Royal College of Nursing, Unite, Unison, Nursing and Midwifery Council, and other stakeholders entitled “*Joint statement on*

*developing immediate critical care nursing capacity*". The statement explained how the:

*"demand for critical care capacity in the United Kingdom will grow faster, and will not allow the time for traditional approaches to training, skill mix and capacity management. Critical care nurses will be required to work, think and respond in very different ways to how they have become accustomed. This will include participating in advanced decision-making on end-of-life care and decisions around providing or stopping advanced life support sometimes much earlier than they have been used to".*

It further stated:

*"the immediate focus of healthcare services in the next week and sustained over the following months is to, as safely as possible, make additional critical care capacity available to meet demand. This will require staff with associated expertise such as those currently working in operating theatres, respiratory and emergency care to work in the critical care centres and units and to be supported and supervised in practice alongside experienced and critical care nurses".*

476. Emphasis was placed on a flexible, pragmatic, staged approach to critical care nursing which was in line with national surge escalation plans, and team working would replace ratios in staffing models. Many of the stakeholders included additional statements within this joint statement, recognising how different this approach would be for critical care nurses. Some of these key statements included:
- a. how critical care nurses supporting the redeployed workforce would provide supervision and expertise in delivery of critical care nursing;
  - b. that critical care nurses would be required to take a team-working approach rather than a ratio approach to patient care to deal with a surge in patients requiring critical care support;
  - c. that critical care nurses would need to be supported to manage increased numbers of patients while supervising non intensive care colleagues.
477. Speciality guidance published by NHS England detailed how non-critical care staff would be required to deliver nursing care under the supervision of critical care trained nurses. Staff in a very broad range of roles were to be asked to care for the critically ill. These included nurses both with and without previous critical care experience or

transferable skills, pharmacists, Allied Health Professionals ("**AHPs**") and nursing support workers. Roles were grouped and categorised with parameters set for expectations and mitigations:

- a. Nurses/AHPs with recent/previous critical care experience or some transferable skills (category 'A'):
  - i. Suspension of elective surgery would allow the delivery of training programmes including simulation training, which should be designed using the supernumerary competencies from the 'step 1: national competency framework for registered nurses in adult critical care';
- b. Registered nurses with no critical care skill (category 'B'):
  - i. Training should be designed for non-critical care staff in critical care using 'non-critical care staff in critical care – emergency induction' document;
- c. Nursing support workers (category 'C'):
  - i. Training and simulation to focus on team working for turning/washing/proning;

478. A phased response was outlined to expand the workforce:

- a. Phase 1 (training and preparation): 1x critical care nurse with 1x 'A' staff and/or 1x 'B' staff + 1 healthcare staff per 4 patients (theatre HCAs can buddy with critical care HCAs to familiarise themselves with the environment and procedures);
- b. Phase 2 (double capacity) – for 2 patients: 1x critical care nurse with 1-2 x 'A' staff + 1 healthcare staff per 4 patients;
- c. Phase 3 (treble capacity) – for 4 patients: 1x critical care nurse with 2 x 'A' staff, 1x 'B' staff – and consider introduction of 'C' staff x 4 (to help with care activities);
- d. Phase 4 (quadruple capacity) – for 6 patients: 1x critical care nurse with 2x 'A' staff, 2x 'B' staff (6 patients) + team of 4x 'C' staff.

479. Guidance was further updated on 28 March 2020 with the publication of a "*Clinical guide to adult critical care during the coronavirus pandemic: staffing framework*"



which set out principles for redeployment, indicative staffing ratios and competencies, and professional groups that could potentially form part of the new workforce during times of surge and super surge. The following ratios were set:

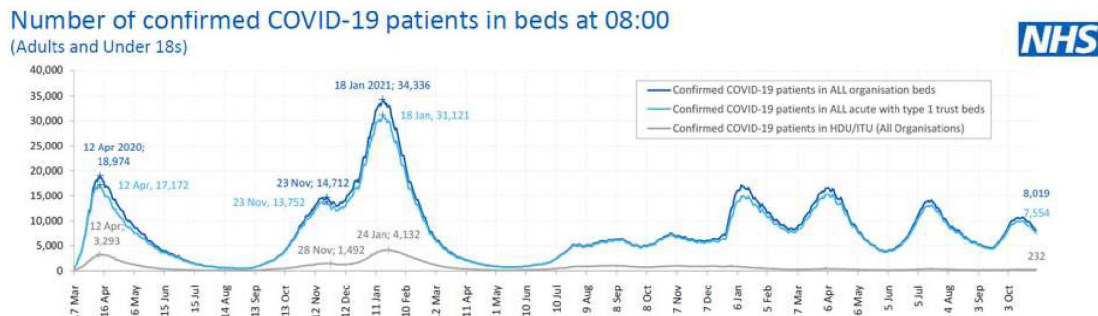
- a. Nurse staffing ratios for critical care:
  - i. Critical care lead nurse/matron (1:32)
  - ii. Senior critical care nurse (1:16)
  - iii. Critical care nurse (1:6)
  - iv. Category 'A' (registered nurses with some previous knowledge / transferable skills) (1:4)
  - v. Category 'B' (non-critical care nurses / multi-professionals) (1:1)
- b. Medical staffing ratios for critical care:
  - i. Co-ordinating consultant (not providing front-line care, liaising with other services)
  - ii. Supervising consultant (1:60)
  - iii. Senior clinician (1:30)
  - iv. Senior middle grade (1:15)
  - v. Junior middle grade (1:15)
  - vi. Desk coordinator (1:30)
- c. Additional allied health professional support needed:
  - i. Physiotherapists
  - ii. Speech and language therapists
  - iii. Dieticians
  - iv. Occupational therapists
  - v. Operating department practitioners
- d. Cross-cutting teams
  - i. Cardiac arrest (at least one team per hospital)

- ii. Transfer (at least one team per hospital)
- iii. Mobile emergency rapid intubation (at least one team per hospital)
- iv. Renal support (at least one team per hospital)
- v. Intravenous Lines team (at least one team per unit of 30+ critical care patients)
- vi. Critical care outreach team (at least one per hospital)
- vii. Palliative care team (at least one team per hospital)
- viii. Comfort/hygiene team (at least one team per unit of 30+ critical care patients)
- ix. Proning team (at least one per hospital)
- x. Runners team (at least one team per unit of 30+ critical care patients)
- xi. Pharmacy care team (at least one team per unit of 30+ critical care patients)
- xii. Equipment and preparation team (at least one team per hospital)

*Hospital Capacity and Critical care from March 2020 onwards*

480. The chronology of how demand for NHS services, including critical care, ebbed and flowed between March 2020 and June 2022 is outlined in this Statement by:
- a. An exhibited time series of SitReps from March 2020 to June 2022 (**[AP081 INQ000269897, AP082 INQ000269919, AP083 INQ000269942, AP084 INQ000269948, AP085 INQ000270083, AP086 INQ000269965, AP087 INQ000269967, AP088 INQ000270085, AP089 INQ000269977, AP090 INQ000270084, AP091 INQ000270079, AP092 INQ000269991, AP093 INQ000270086, AP094 INQ000270154, AP095 INQ000270018, AP096 INQ000270087, AP097 INQ000270088, AP098 INQ000270089, AP099 INQ000270029, AP100 INQ000270090, AP101 INQ000270091, AP102 INQ000270092, AP103 INQ000270093, AP104 INQ000270094, AP105 INQ000270095, AP106 INQ000270046, AP107 INQ000270050 and AP108 INQ000270096]**); and

- b. A number of graphs plotting key metrics from March 2020 to June 2022, for example:

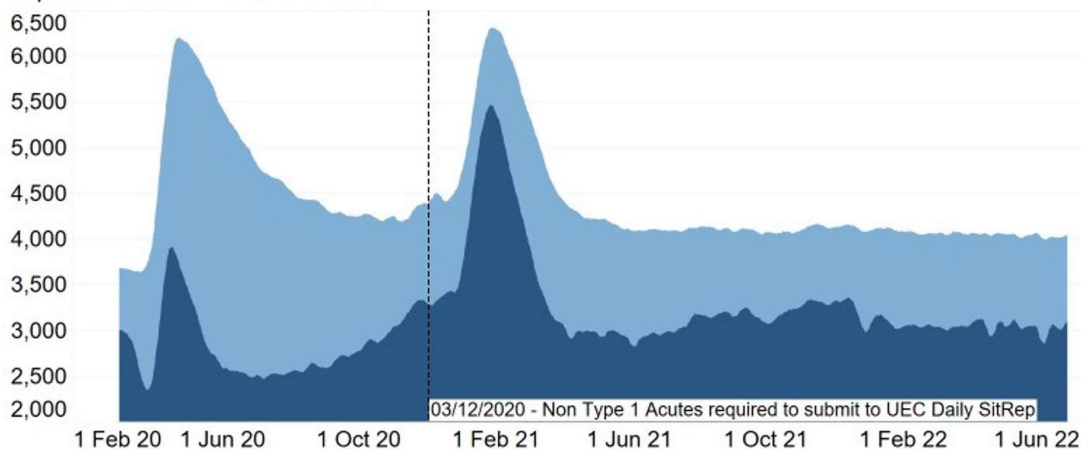


481. The next graphs show the availability and occupancy of adult critical care and G&A beds throughout the Relevant Period. These were produced using the UEC SitRep Data which, as detailed above, were rapid collections with minimal validation; due to the nature of the specific data collected NHS England is unable to differentiate between Covid-19 and non-Covid-19 patients in the occupancy figures. Further, acute Trusts without a Type 1 A&E were not required to return the UEC SitRep until 3 December 2020, and so they are not accounted for in the counts prior to that data. For reference, however, their addition from 3 December 2020 onwards only accounts for a small number of additional critical care beds (roughly 130):

### Adult Critical Care Beds - Occupied and Unoccupied

All Acute Trusts - 1st March 2020 to 28th June 2022 - All figures reflect a 7 day rolling average

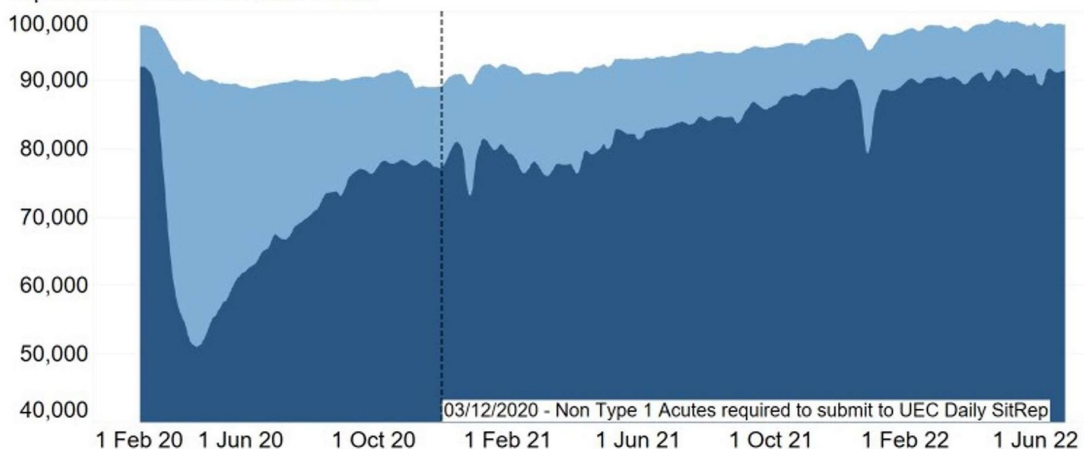
\*Note scale on axis - Please note that only Acute Trusts with a Type 1 A&E Department were required to submit to the UEC Daily SitRep prior to the 3rd December 2020, at which point the collection was then expanded to include all Acute Trusts.



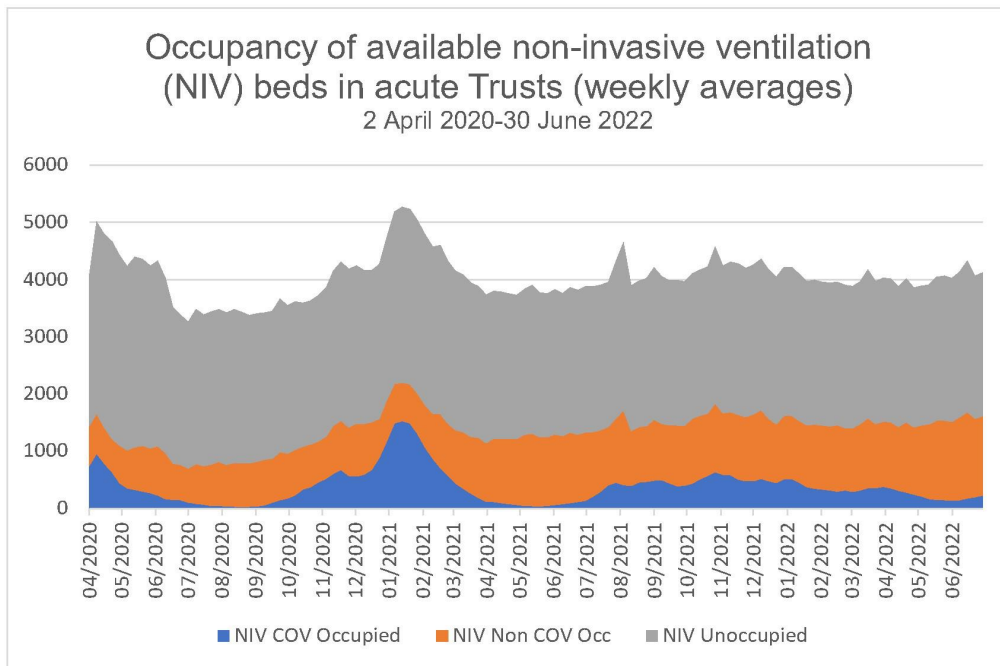
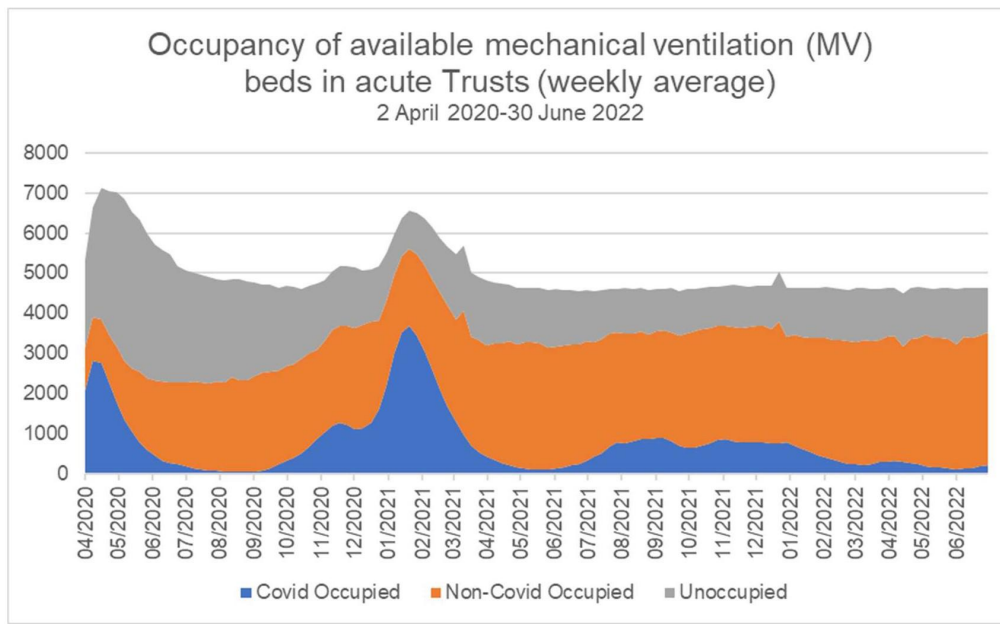
## General & Acute Beds - Occupied and Unoccupied

All Acute Trusts - 1st March 2020 to 28th June 2022 - All figures reflect a 7 day rolling average

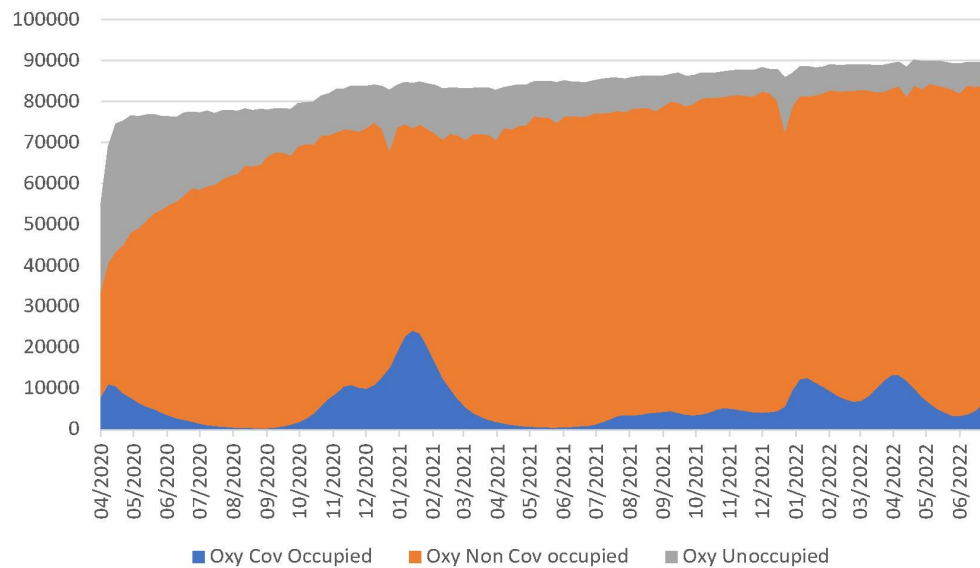
\*Note scale on axis - Please note that only Acute Trusts with a Type 1 A&E Department were required to submit to the UEC Daily SitRep prior to the 3rd December 2020, at which point the collection was then expanded to include all Acute Trusts.



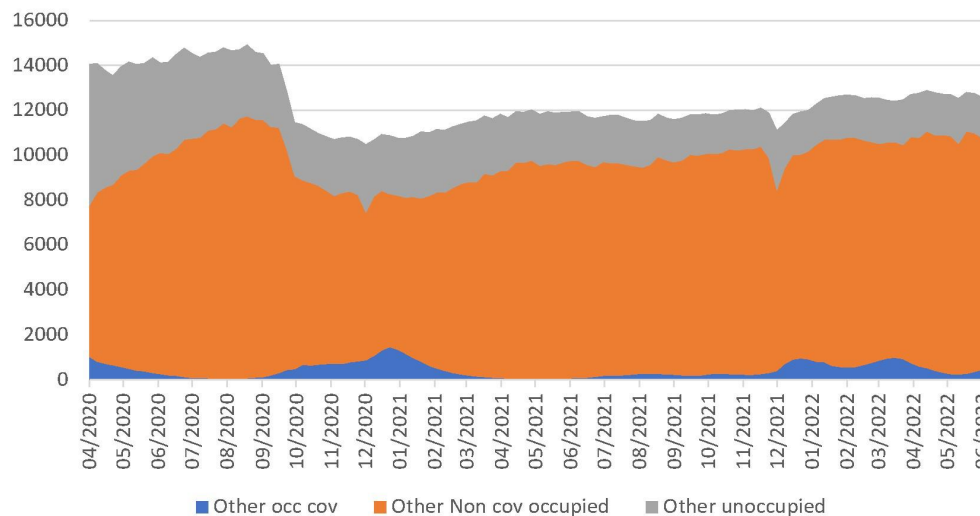
482. The following series of graphs shows the occupancy and availability of mechanically ventilated (MV), non-invasive ventilation (NIV), oxygenated (O), non-oxygenated (non-O) and total beds in NHS acute Trusts. These graphs have been produced using the raw data collected by the Daily NHS Provider SitRep. These particular graphs reflect, as explained at paragraph 206 above, the change in classification applied by NHS England to monitor bed capacity, and in particular the need to understand the type of respiratory support a bed could offer rather than its setting (i.e., G&A or Critical Care).
483. Due to the way in which data was collected the applicable time period is from:
- 2 April 2020 until the end of the Relevant Period for MV, NIV and O beds; and
  - 27 April 2020 until the end of the Relevant Period for non-O and total beds.

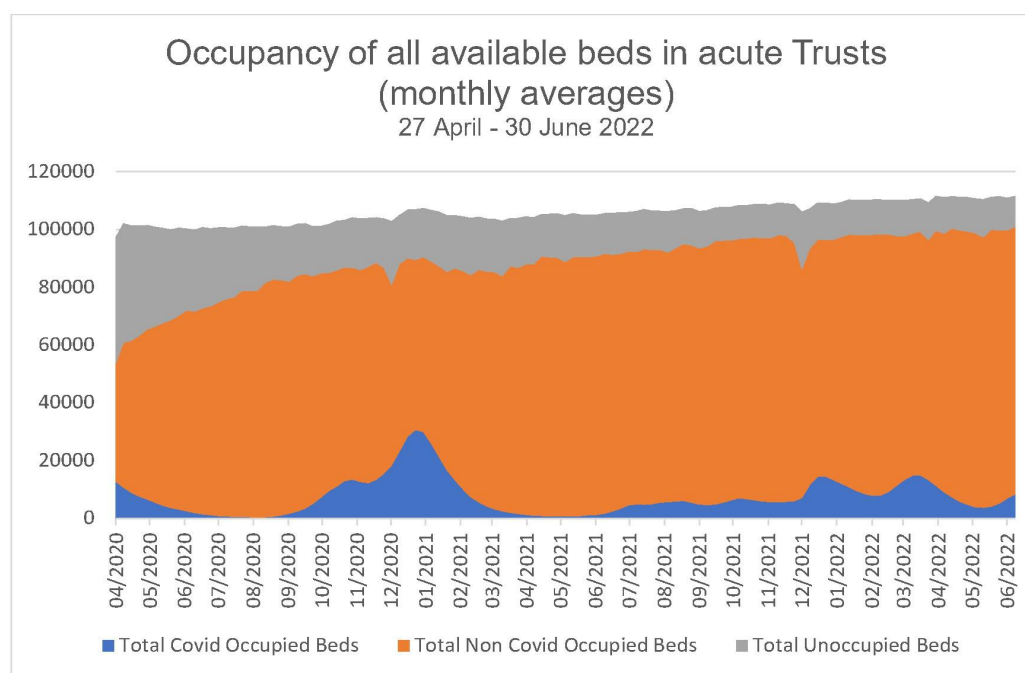


Occupancy of available oxygen (O) beds in acute  
Trusts (weekly averages)  
2 April 2020-30 June 2022



Occupancy of all available non-oxygen beds in  
acute Trusts (weekly averages)  
27 April 2020 to 30 June 2022





484. The data set out above provides the context to the following section of the statement, which addresses critical care capacity. The Statement discussed the occasions when NHS England was concerned that demand for critical care would exceed capacity, both nationally and in particular regions. Such concerns arose on several occasions. They are set out in further detail below, including by reference to regional incidents, but in broad terms concern was most heightened over the following periods:

- a. in February/March 2020 when SAGE-endorsed modelling suggested that the NHS would be overwhelmed, potentially many times over. That anxiety was compounded by the actual experience at the time in Chinese and Northern Italian hospitals, and how little, in relative terms, was known about the virus and its characteristics at that stage;
- b. winter 2020/21, which was the most challenging time for the NHS in terms of the strain on critical care demand. Alongside winter pressures, the NHS had to cope with the fact that the Alpha variant was the most prevalent during this period; there was an increased community prevalence of infection and the variant caused more severe illness. A number of regions, notably the Midlands, London, East of England and the South East all exceeded their critical care capacity and were caring for many patients in surge arrangements. Everyone who needed to be treated in a critical care bed had been given a critical care bed, but this precipitated a need for patient transfers between hospitals and regions to balance demand; and



- c. in the run up to winter 2021/22, when there was significant concern based on modelling, that the Omicron variant would cause huge strain on the NHS. Relatively little was known initially about the clinical risk presented by Omicron, by reference to the severity of symptoms,. In time, it turned out that community immunity and the vaccination campaign resulted in less impact on critical care than in Wave 1. Although particular regions, notably London and the Midlands, still all experienced huge demand for services in light of high admission numbers, critical care was, in broad terms, able to cope due to interhospital transfers decompressing to other hospital critical care units within or across regions.
485. Trends across the country, in terms of fluctuations in critical care capacity, typically followed community prevalence. There was generally a lag between infection and the need for more serious health interventions and measures to prevent or slow the spread of the virus (notably NPIs). In broad terms, therefore, the following were all key contributing factors:
- a. community prevalence;
  - b. seasonality, with waves 2 and 3 occurring in Winter 2020/21 and 2021/22 respectively along with the annual pressures at such time of year due to the impact of other respiratory illnesses; and
  - c. vaccination, with the majority of Covid-19 patients in critical care during wave 3 being unvaccinated.
486. Regional variations during epidemics and pandemic are normal. For example, London was often days or weeks ahead in terms of prevalence of a particular wave.
487. Socio-economic and ethnicity factors are likely to have played a role in particular regions. For example, over Summer 2020 some areas in the Midlands, notably Leicester and Birmingham, were affected by numbers of Covid-19 patients which did not follow the broad trends seen across the rest of the region (such that numbers frequently and consistently remained higher). Leicester was placed into a local lockdown in June 2020 despite the national lockdown having been lifted. Multi-generational living and a higher rate of ethnic minority groups in these communities were thought to be playing a key part in those higher Covid-19 rates.



## Wave 2 Impact

488. The NHS was even more severely impacted by Wave 2 than it was in Wave 1. As shown by the summary graph above at paragraph 37, the peak of Covid-19 patients in Wave 2 was nearly double that experienced in the first wave. To prepare and plan for Wave 2 a planning commission was sent out to national cells and regions on 3 August 2020, followed by a series of planning workshops throughout August 2020 and into early September 2020. Regions, in turn, worked with their ICSs.
489. In August 2020 NHS England also issued a National Service Model for Adult Critical Care Transfer Services, which was a framework for regional teams to follow to develop adult critical care transfer services. It was developed in line with inequalities considerations. The Model noted that transfer of critically ill patients due to capacity restrictions had become particularly relevant as a result of Covid-19, and sought to bring consistency to the approach for critical care transfers (albeit not just for Covid-19 patients) [AP109 INQ000269966].
490. Modelling produced by NHS England on 28 August 2020, developed using the Oxford Simulator but based on the Cabinet Office's RWCS, suggested that there could be a second wave of the same magnitude as the first wave, if not slightly larger ([INQ000103587]). It projected a steep rise in admissions as well as numbers of patients with Covid-19 in beds and V-beds from the beginning of December 2020 which would not start to fall until the end of January 2021.
491. Initial work of the cell in September 2020 included the following:
- a. exercises Fairlite 1 and 2 (see paragraph 165 above) in conjunction with NHS England regional teams to test key areas of the NHS's operational response to Covid-19 over the Winter; and
  - b. assurance of surge plans, with Trusts commissioned on 25 September 2020 to set out their readiness for increases in hospital admissions as a result of Covid-19. They were asked to do so against three different scenarios of sustained demand, in the form of a peak of 5%, 20% and 35% of G&A beds being occupied by Covid-19 patients. The key aim was to ready the NHS to manage Covid-19 specific demand alongside safely maintaining elective activity and other Winter critical services for as long as possible.
492. From the CCCP's inception on 29 October 2020, it held daily weekday meetings to monitor regional capacity in terms of both beds and workforce, and also ongoing

assurance against surge plans. The CCCP managed bids from regions for support to move critical care patients from areas where capacity was, or was expected to be, exceeded, to areas of the country where capacity could be made available ([INQ000087493]).

493. The requesting region would be expected to have exhausted local options; and reduced elective cases where possible. Other regions, based on current data, would be asked to accept cases and secure that with recipient Trusts and to identify a retrieval team if needed. This was a daily balancing discussion of demand and any decisions to transfer would then be tasked to National Ambulance Resilience Unit ("NARU") to identify ground or air ambulance transfer capability. The first request for patient transfers was submitted by the Midlands in November 2020, although they did not subsequently take place.
494. NHS England modelling on 20 November 2020 considered the potential scenarios once the national lockdown in place at the time came to an end on 2 December 2020, and did so against a variety of different scenarios based on variable levels of increased social contact (including over the festive period) ([INQ000103588]). Even the most optimistic scenario was assessed to be insufficient to prevent a second peak in hospital admissions, which would start to rise sharply from mid-December 2020. This information was made available to the Government.
495. Throughout December 2020 regional focus meetings took place between Regional Directors, COO, EPRR and National Director for Urgent and Emergency Care to discuss surge plans. Specific calls were held with London, the South East, and the East of England regions and the EPPR and UEC national teams to discuss mutual planning for Covid super surge demand. On 3 December 2020 the East of England was the region with the highest level of bed occupancy at 87.2%. The peak of admissions for London was flattening but not as quickly as the rest of the country, and London also had the highest number of Covid-19 patients requiring critical care. The national picture was one of 88% critical care bed occupancy (in the expanded bed base), with 40% of these occupants being Covid-19 patients. Although admissions, as reported through SitReps, had fallen from a peak in early November they were still tracking above all modelled forecasts, including the RWCS which was projected to rise throughout December 2020 and January 2021 ([AP090 INQ000270084]).
496. On 6 December 2020 a briefing outlined the steps which had been taken to date or to prepare for and manage pressure on critical care, and also outlined potential next steps

to mitigate further demand. It noted that load levelling transfers to manage capacity had taken place within all regions, particularly London, albeit at that stage with limited need for out of region transfers. Measures taken to date to increase critical care capacity included:

- a. Increased use of step-down facilities and reduced elective surgery for less urgent cases;
- b. More critical care beds in other areas of hospitals, such as wards and endoscopy suites;
- c. Successful procurement and stockpiling of equipment, consumables and medicines; as a result, these were not assessed to be rate-limiting factors to provision of surge critical care capacity; and
- d. Allocation of £237m to 70 schemes via the critical care resilience fund.

497. The briefing also enclosed the surge plans for each region, and noted that further measures (such as independent sector collaboration, further reduction in elective activity, and change to critical care staffing ratios) might all need to be considered.
498. A paper entitled 'Lessons ID from Wave 2 and prep for Wave 3 at NIRB' also went to NIRB on 9 December to update on preparedness for Christmas and January surge. On 11 December 2020, a call took place between NHS England's Chief Operating Officer, the Strategic Incident Director and Regional Directors for the East of England, London and the South East. This reflected growing concern about the growth in demand for NHS services because of increasing numbers of Covid-19 patients (particularly in Kent). That call challenged the existing regional surge plans. The South East's was not felt to be strong enough, with the result that it was agreed that arrangements for the immediate decompression of critical care would need to start taking place.
499. On 23 December 2020, NHS England's Chief Operating Officer and Chief Finance Officer jointly issued a systemwide letter outlining the operational priorities for the rest of the Winter period and into 2021/22. This confirmed that the NHS would be likely to remain at Level 4 for the rest of the financial year. To alleviate capacity concerns, Trusts should continue safely mobilising surge capacity alongside use of the independent sector and mutual aid. They should also utilise specialist hospitals and hubs to protect urgent cancer and elective activity. The availability of Nightingale

hospitals and Seacole services (specialist rehabilitation care) was also highlighted,<sup>46</sup> along with the need to prioritise timely and safe discharge. At this time over half of critical care units across the country were at full occupancy, and half of those were in surge areas. The CCCP was considering the possibility of longer range transfer of critical care patients from the South East, but as this was not easy to organise and implement, discussions were ongoing. Both SitRep-reported admissions and the RWCS showed a marked and rapid increase at this time ([AP091 INQ000270079]).

500. On 23 December 2020, NIRB also considered and approved Regional Directors' plans relating to preparedness for Christmas and January 2021 surge ([AP110 INQ000269972] and AP111 INQ000269988]). Those plans included:

- a. *North West*: Development of minimum and upper thresholds for elective activity to be implemented as necessary so as to avoid overwhelming critical care;
- b. *East of England*: implementation of critical care surge plans, if needed, from January 2021 to create an additional 213 beds;
- c. *Midlands*: review of staffing ratios, expansion of mutual aid, cancellation of elective care and outpatient activity and full potential conversion of beds to V beds; and
- d. *London*: elective care had been postponed in the previous week leading to a 14.4% fall in non-Covid demand but a projected shortfall of critical care beds by 28 December 2020 required a need to surge capacity.

501. By 31 December 2020, 1,050 additional adult critical care beds had been opened and national occupancy for critical care had passed 100% of the standard footprint, i.e. the surge capacity that had been opened was required. 3% of critical care patients across the country were being cared for in surge capacity. London, the East of England and South East were particularly affected; all of these regions had to use surge capacity because they had exceeded normal critical care capacity. In particular, 28% of London critical care patients were in surge capacity, and 22% and

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<sup>46</sup> The NHS was seeing a substantial need for local, community-based rehab and aftercare for patients recovering from Covid-19. While in many cases those services could be delivered by or within existing NHS facilities, some local areas required the use of other temporary facilities. Seacole Centres were established with the aim to provide the necessary temporary rehabilitation service in the areas that needed it. The services brought together a wide range of specialist staff, including doctors and nurses but also mental health staff, pharmacists, dieticians, speech therapists, physios, occupational therapists, psychologists and social workers, with the aim of helping people return home safely as soon as they were able to. [AP112 INQ000270134]

14% in the South East and East of England respectively. All core critical care units in the East of England were at 100% capacity, and 17 of their 21 units were using surge capacity. In the Midlands there were only 21 critical care unoccupied beds available across the region, and only 4 of their 28 units had less than 100% occupancy.

Regions were taking steps to facilitate intra-regional transfer to balance the load, for instance moving patients from Cumbria to Newcastle in the North East. Kent was being actively 'decompressed', i.e., transferring patients to other less-affected regions, by moving patients to Oxford ([AP113 INQ000269990]).

502. The CCCP met on 31 December 2020. The South East requested transfers for 8 patients, 2 of which had been offered within the region, leaving 6 to be fulfilled. Offers of support were received from a number of the regions, and it was agreed that the CCCP would follow up with South East colleagues to discuss transport options for the agreed transfers.
503. A National Critical Care Transfer Cell<sup>47</sup> was set up and an attendant Standard Operating Protocol (January 2021) was agreed in addition to a standard Transfer Request Form. The Cell brought together a group of clinicians and transfer network experts who worked with sending and receiving Trusts and regional networks to coordinate long-distance (i.e., out of region) Covid-related patient transfers from 4 of January 2021 ([AP114 INQ000269999 and AP115 INQ000270000]).
504. By 2 January 2021 London, the East of England and the South East had all now exceeded normal critical care capacity, with each having to use surge beds to provide critical care. London had 33% of critically ill patients being cared for in surge beds, with 25% and 18% in the South East and East of England respectively. All of those regions, as well as the Midlands, were seeing high numbers of new hospital cases. Across the country, the number of patients in critical care beds had risen steeply since the middle of December 2020 and were still rising. At this stage SitRep-reported data on admissions were tracking well above the RWCS ([AP092 INQ000269991]).
505. On 13 January 2021, NHS England issued an 'Operational Note' to regions requesting that systems and Trusts create surge capacity and support cross-regional

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<sup>47</sup> The National Critical Care Transfer Cell (including Regional Medical Directors, national incident team and expert clinicians) was set up to operationalise any inter-regional transfers agreed at the CCCP, working with transfer services, ambulance, and air ambulance partners. The purpose of these transfers was to minimise risk to the patient and operational impact by "level-loading" critical care pressures across regions.

transfer of patients where necessary. Those messages for systems were reiterated in a webinar for system leaders the same day, hosted by NHS England's Strategic Incident Director. This was in the context of an increasingly dire picture across the NHS, with the national picture being of critical care occupancy that was 21% above the normal footprint for that time of year. 122 out of 208 critical care units across the country were having to use surge capacity, and the proportion of ventilated patients continued to increase. The number of daily admissions reported through SitReps since early January had been at least 1,000 above the projected RWCS.

506. The following day, 14 January 2021, the CCCP met and agreed a number of actions which were communicated out to regions via the SPOC ([AP116 INQ000269995]). In brief they were:
- a. Midlands region to continue to surge its capacity to receive Critical Care patients, in line with communications to Systems/Trusts earlier that week;
  - b. North East and Yorkshire region to surge its capacity to provide capacity in receiving units for a minimum of 4-6 patients per day from the Midlands region;
  - c. A daily rhythm of decompression moves from London and East of England to the Midlands to commence;
  - d. Surge capacity in Southampton and Oxford to be urgently realised to provide support for Kent and Sussex;
  - e. All regions to work with Trusts to secure staffing for an increased number of regional transfer teams;
  - f. Regions to continue to load level as usual between ITUs and within/across systems in their region using existing transfer services; and
  - g. All inter-regional transfers to be co-ordinated with the National Critical Care Transfer cell, with new transfers supported using the additional capacity created by enhancing existing regional transfer teams/services.
507. On 19 January 2021 NHS England issued a set of 'Principles for out of region mutual aid transfers'. This set out the principles to be applied at a national, regional and hospital-level, as well as the hierarchy of clinical prioritisation for transfers ([AP117 INQ000269998]).

508. In total the National Critical Care Transfer Cell coordinated around 270 out of region patient transfers in January 2021. Roughly a third of these were from the London and East of England, and the rest from the Midlands and South East.
509. Moving into February 2021 NHS admissions were falling, albeit still with significant pressure on critical care (**[AP093 INQ000270086]**). London and the Midlands were particularly affected, with 174% and 179% of critical care occupancy against baseline capacity respectively. All regions were showing a much higher proportion of patients receiving mechanical ventilation than would typically be the case for the time of year, and of 5,123 patients in critical care across the country, 3,670 of them had Covid-19. By this time the SitRep reported numbers of admissions had fallen below the RWCS. Throughout February 2021 there were ongoing measures to decompress regions most affected by demand, particularly the Midlands and East of England. In total around 110 out of region transfers took place, primarily from the Midlands. The final transfer took place on 22 February 2021.
510. The East of England was one of the regions particularly affected by demand for services during Winter 2020, where critical care activity was at its highest for the region during the course of the pandemic. Historically, the East of England and the South East have had lower numbers of critical care beds because patients were often transferred to London, which had higher than average critical care capacity compared to other regions. In Winter 2020 some Trusts in the East of England (for example Mid and South Essex Foundation Trust) had very large numbers of patients and therefore staffing and equipment provision was a challenge. There was considerable variation in demand for care across the region at different times during the pandemic. The East of England region has a varied demography. Each hospital also had a different capacity to cope with increases in activity due to size, space, staffing and equipment, which varied at each part of the pandemic. The NHS England regional team instigated procedures and processes to move patients to less pressurised units.
511. In light of falling numbers of patients the CCCP's final meeting took place on 30 March 2021. This was in the context of critical care occupancy having reduced to levels well below the critical care baseline and the fact that NHS England had transitioned to Level 3 on 25 March 2021.
512. The Severe Covid Response Cell was stood down on 12 April 2021, albeit subsequently re-engaged alongside the CCCP once planning for wave 3 started.

513. On 30 June 2021 NIRB considered wave 3 planning, in light of SPI-M-O modelling scenarios which predicted a third wave. Surge plans remained in place, including for critical care, and at that stage no changes were proposed to the plans. It was anticipated that, in the first instance, NHS organisations, systems and regions would move through steps in their operational/tactical responses independently as pressures started to build – with increasing levels of national oversight (review of plans, NIRB updates, and check and challenge sessions).
514. On 11 August 2021 NIRB received an update from the Strategic Incident Director, who noted that although there had been a plateau in case numbers, in most regions the level of activity was such that it was still resulting in significant impact on critical care. At or around that time roughly 27% of critical care cases were due to Covid-19, although the proportion was higher in the North West, North East and Yorkshire and the Midlands. National bed occupancy was still high at 90.4%. On 8 September 2021 NIRB received an oral update confirming that pressures on critical care were still high, with Covid-19 patients accounting for 31% of all critical care and overall bed occupancy at 88%.
515. In early October 2021 there was a fall in critical care demand, but by 13 October 2021 (as per an update to NIRB to this effect), that reduction had begun to level off with a slow increase starting to take place in some areas. Overall normal critical care occupancy was at 100% with a further 1% in surge capacity. Numbers of Covid-19 patients were beginning to rise, and accounted for 22% of critical care beds. Around 12% of critical care beds were unavailable, largely due to staffing issues. At this time the Midlands was the most affected region.
516. By 25 October 2021 critical care demand caused by Covid-19 had risen further, now accounting for 27% of critical care cases (**[AP118 INQ000270033]**). The Midlands had 36% of beds occupied by Covid-19 patients. On 27 October 2021, the National Director of Emergency and Elective Care and the Director of UEC Transformation presented a Winter planning paper to NIRB, which noted the significant pressure likely to be faced by the NHS in the coming months due to the typical seasonal demands and pressures alongside the ongoing impact of Covid-19. Further risk factors included workforce absence and burnout, unprecedented levels of emergency demand and reduction in the elective backlog. NIRB noted the proposed recovery plan across several key areas, which included expansion of available capacity to respond to surge demand and facilitating mutual aid where possible. The CCCP would continue to



monitor the national position and provide strategic direction on the transfer of patients to manage capacity at a national level.

517. Concerns regarding critical care capacity continued to grow over the following weeks. They were particularly prevalent in the Midlands where (according to an update to NIRB from the EPRR Director on 10 November 2021), consideration was being given to using military personnel to alleviate pressures. Overall bed occupancy in that region was at 106% with 37% of beds occupied by Covid-19 patients. A number of Trusts were operating significantly above baseline bed capacity, and close to surge capacity. The National Critical Care Transfer Cell met on 11 November 2021 to consider potential options for mutual aid. But options were quite limited because all regions were coming under increasing pressure such that transferring patients to load bear from more to less affected regions was difficult ([AP119 INQ000270080]).
518. By mid-November 2021 pressures on the Midlands continued, albeit slightly abated. Critical care occupancy had also slightly improved. However, there were concerns about the levels of G&A bed occupancy, particularly moving into December 2021, as there was unlikely to be a rapid turnover in Covid-19 occupancy ([AP120 INQ000270034]).
519. In early December 2021 concerns about the Omicron variant, and its implications for NHS capacity, continued to grow. On 7 December 2021 NHS England shared its 'Covid-19 Omicron planning' document with the SSHSC. This set out NHS England's readiness to cope with a surge (albeit noting at that time that there remained considerable uncertainty about the severity of Omicron in terms of clinical symptoms). The planning document noted the return to near normal, pre-pandemic levels of emergency activity, so that there were fewer beds available to cope with a surge in Covid-19 demand (and particularly so from a critical care perspective). It also confirmed the measures in place to maintain activity across several areas; from a critical care perspective there were escalation arrangements in place from Trusts through regions to make use of mutual aid where necessary (and available). Other measures included the use of accelerated discharge arrangements, surge bed capacity where possible, virtual wards and the use of independent sector capacity.
520. That readiness note formed the basis of a meeting between the SSHSC and several senior officials from NHS England, including the Chief Executive Officer, National Medical Director and Strategic Incident Director. The meeting discussed and noted the need for close working between SPI-M and NHS England modelling teams, as current modelling suggested significant numbers of admissions by the end of December 2021,

and models would indicate decision points over mitigating actions to be taken. The meeting also agreed that DHSC and NHS England would work on a note to update the Prime Minister on the developing situation plus NHS England's strategic approach to it ([AP121 INQ000270035]).

521. On 8 December 2021 the Strategic Incident Director provided an update to NIRB which noted the following ([AP122 INQ000270036]):
- a. the national case rate was climbing at 7% per week overall, albeit declining in the 60s age group (but at a decreasing rate of declination);
  - b. there were no known admissions relating to Omicron in the NHS, but there were indications that the numbers of cases were doubling in a 2-3 day period and this was likely to extend in the coming days;
  - c. the modelling team had met with UKHSA to look at a number of options relating to Omicron, but modelling was limited as the impact on the NHS was yet to be determined; and
  - d. to ensure the NHS was able to respond appropriately to the new variant, immediate action to stand up incident cells was considered. Regular check-ins with cells were happening, but with more focus on certain cells (such as Oxygen and Ventilation, PPE and Workforce).
522. Notwithstanding those concerns, regions had reported a reduction in the number of Covid-19 patients in critical care at this stage, including the Midlands but excepting London which had reported a slight increase. Bed occupancy was at 79% overall, albeit with significant numbers of beds unavailable due to staff shortages ([AP123 INQ000270081]).
523. On 9 December 2021 the framework to support inter-hospital transfer of critical care patients was updated. This updated the indications for, and circumstances necessitating, critical care capacity transfers ([INQ000113402]).
524. NHS England's Chief Executive Officer met with the Prime Minister and the Cabinet Office on 13 December 2021 to brief them on planning for Omicron. This confirmed the immediate actions already taken by the NHS to free up as many beds as possible. This included the move back to Level 4. NHS England was asked to provide a plan outlining the process through which Trusts would escalate through those processes, and the trigger points for doing so. NHS England's Chief Executive Officer and Chief

Finance Officer also met with the SSHSC on 14 December 2021, and asked for SPI-M modelling to be shared ([**AP124 INQ000270038 and AP125 INQ000270039**]).

525. On 17 December 2021 the Strategic Incident Director reported to NIRB that there were increasing numbers of Covid-19 infections. In light of this, daily calls had been set up between the SSHSC and NHS England. A further update to NIRB on 20 December 2021 noted a doubling rate of infection of less than two days in all regions, except the South West where it was just over two. Pressure on the NHS remained steady but a substantial increase in case numbers was expected over the following days, with concern about the impact this would have for admissions and critical care. London had reported a 10% increase in critical care cases in the previous seven days, but otherwise there had been no surge in critical care numbers across the country.
526. Following on from the meeting on 14 December 2021, as described above, NHS England provided its 'NHS: Preparedness for Omicron' plan to DHSC on 21 December 2021. It included a range of measures which were already happening (such as using pulse oximeters to monitor people at home to reduce unnecessary hospital admissions), and those which would be activated by Trusts if needed. Those measures included reduction in non-urgent care and/or use of independent sector support for elective activity as well as surge capacity plus Trusts surging internally into all potentially useable clinical spaces which would create an additional 2,000 beds over and above the 5,000 already created since December 2020. The accompanying slides to the plan also set out the key decisions to be taken in an escalation model, and the level at which those decisions should be taken i.e., local, regional NHS England and/or DHSC ([**AP126 INQ000270041 and AP127 INQ000270042**]).
527. On 29 December 2021, the Strategic Incident Director briefed NIRB on the current picture. This was a significant increase in the number of admissions, particularly in London; but critical care demand was not as high as previous waves (76% of critical care beds were occupied). The CCCP also provided a similar update to that effect, noting that increases for the rest of England were not as high as for London. The NHS England Early Warning System suggested that admissions could reach levels similar to the Wave 2 peak within three weeks. The main critical care pressures were in smaller general hospitals, where transfers were taking place to help with load bearing.
528. A further NIRB briefing took place on 31 December 2021, first by the Strategic Incident Director who reported rising case numbers but there was a tentative emerging picture that the Omicron variant caused milder symptoms such that critical care capacity remained stable. Patients who required critical care were largely unvaccinated. The

Regional Director for London also briefed NIRB on the regional picture, which was that there was an increased number of hospital admissions (**[AP128 INQ000270043]**).

529. By 10 January 2022 critical care numbers had started to fall, and thereafter continued steadily to do so, albeit most regions remained under considerable pressure with other services due to the high admission rates. A stocktake meeting took place with the Prime Minister on 11 January 2022, which provided an update on the situation and the impact of Omicron across other NHS services (**[AP129 INQ000270044 and AP130 INQ000270045]**).

## SECTION 7: DISCHARGE DECISIONS

530. Decisions about hospital discharges require a multidisciplinary assessment of the patient's health and social care needs, including appropriate communication with patients regarding their care needs.
531. Prior to the pandemic, the NHS had been working for some time to reduce older and vulnerable patients' length of stay in hospital. Acute Trust clinicians and discharge teams could rely on a large body of literature, studies and best practice guidance on hospital discharge.
532. In May 2016 the NAO reported its findings on the discharge of older people from hospital. Among other things, the report noted that:
- a. Nearly two thirds of hospital bed days were being occupied by patients over 65 with an 18% rise in emergency admission for older people over the previous four years.
  - b. 1.15 million hospital bed days had been lost due to delays in transfer of care in 2015, with an estimated 2.7 million bed days occupied by people no longer in need of acute hospital care.
  - c. For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Older people can quickly lose muscle strength, mobility and the ability to do everyday tasks such as bathing and dressing. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS.
533. Following-up on the NAO report, in September 2016 NHS England published a quick guide on D2A **[AP131 INQ000269885 and AP132 INQ000270098]** aimed at supporting local health and social care systems to reduce the time people spend in hospital at the point that they are no longer in need of acute care. This was designed to be read alongside the 2015 NICE Guidance on "*Transition between inpatient hospital settings and community or care home settings for adults with social care needs*" **[AP133 INQ000270117]**.
534. The D2A quick guide noted that:

*Wherever possible, people should be supported to return to their home for assessment. Implementing a discharge to assess model where going home is*

*the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do.*

535. In March 2018, NICE published guidance on discharge planning for emergency and acute medical care in over 16s. It set out scientific evidence about the role of discharge planning in improving clinical outcomes for adults in secondary care **[AP134 INQ000269887]**.
536. In June 2018, the SSHSC announced a national ambition to lower bed occupancy in hospitals by reducing the number of long stays (21 days or more). This ambition was originally set at a reduction of 25% by December 2018; however this was being extended to a stretch target of 40% by March 2020. The rationale behind that ambition was that by ensuring patients returned to their usual place of residence, or another care setting, as soon as it was safe to do so patient flow would improve right through the system; beds would be freed up for those needing admission for emergency care or a planned operation. Following this announcement, the 'Reducing Length of Stay' programme was established as a priority within the NHS England Emergency and Elective Care Directorate to provide strategic direction and support local delivery.
537. Also in June 2018, NHS Improvement published a "*Guide to reducing long hospital stays*" **[AP135 INQ000269888]** aimed at acute and community Trusts. The guide noted, among other things, that:
- a. Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning).
  - b. A stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk: 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.
  - c. Extensive use of audit tools has shown 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care.

- d. 39% of people delayed in hospital could have been discharged using different, usually lower dependency, pathways and services more suited to meeting their assessed needs.
  - e. Typically these audits show that up to half of the reasons why patients are not discharged earlier are under the direct control of the hospital itself and often relate to ineffective internal assessment processes, lack of decision-making and poor organisation of care management.
538. In terms of clinical criteria for discharge, the NHS Improvement guide defined:
- a. The "expected date of discharge" ("**EDD**") as the date *"set by the consultant and based on their [clinical] judgment of when the patient is likely to have recovered sufficiently to return home"*.
  - b. The "clinical criteria for discharge" ("**CDD**") as the functional and physiological criteria that the patient must achieve to leave hospital.
539. The guidance noted that the EDD and CCD are linked care co-ordination tools that can be applied in both acute and community bedded settings. They must be clearly defined and consistently used together if they are to work effectively, and should be set by a consultant within 14 hours of the patient's admission as part of the clinical care plan.

19 March Hospital Discharge Guidance

540. As referenced in Section 4, on 19 March 2020 the Government published the 19 March Discharge Guidance.
541. This guidance was published alongside:
- a. the announcement from DHSC and MHCLG of £1.3 billion of additional funds to support the NHS discharge process so patients who no longer needed urgent treatment (but may have ongoing health or social care needs) could return home safely and without unnecessary delay.
  - b. a letter from NHS England to Trusts, CCGs, Directors of Public Health and Community Health Providers setting out guidance on the prioritisation ("**March Prioritisation Letter**") of specific community health services to release capacity to support hospital discharges, subsequently updated on 2 April 2020 [AP136 INQ000269920].

542. The cover letter to the 19 March Discharge Guidance explained that:

*...One of the most important tasks will be to ensure we have the capacity to support people who have acute healthcare needs in our hospitals. To do this we need to organise the safe and rapid discharge of those people who no longer need to be in a hospital bed. The new default will be discharge home today.*

*...Each system will tackle this challenge from a different starting position and should take account of their local workforce and care home/domiciliary care supply dynamics, together with awareness of the capacity of family carers and volunteers in the community to continue to support local action. Supporting and sustaining social care will never be more vital to these efforts.*

*A range of virtual resources and live interactive sessions have been developed to support every sector to work through how to achieve this new way of operating and are detailed in the document.*

543. The 19 March Discharge Guidance promoted a “Discharge to Assess” (“D2A”) model based on four pathways:

- a. Acute hospitals were put in charge of discharge “pathway 0”, namely ensuring that the estimated 50% of patients that can leave hospital and only need minimal support do so on time;
- b. Providers of community health services, working together with social care colleagues, the care sector and the voluntary sector, were tasked to lead on providing support following discharge on pathways 1 to 3:
  - i. Pathway 1, namely the estimated 45% of patients able to return home with support from health and/or social care;
  - ii. Pathway 2, namely the estimated 4% of patients in need of rehabilitation in a bedded setting;
  - iii. Pathway 3, namely the estimated 1% of patients for whom home is not an option at the point of discharge from an acute hospital.

544. The guidance noted that for patients, the D2A model would mean that while they would still receive high quality care from acute and community hospitals, they would not be able to stay in a bed as soon as that was no longer necessary. For 95% of patients leaving hospital that would mean that, where needed, the assessment and



organising of ongoing care would take place when they are back in their own home. For patients whose needs were too great to return to their own home (about 5% of patients admitted to hospital), a suitable rehabilitation bed or care home would be arranged.

545. The guidance instructed acute hospitals, among other things, to conduct twice daily clinically-led reviews of all patients in acute beds, with involvement of social care colleagues, to determine which patients were no longer required to be in hospital.
546. Community health services were instructed, among other things, to:
- a. coordinate and manage the post-discharge arrangements and care for all patients from community and acute bedded units on pathways 1, 2 and 3;
  - b. ensure patients on all three pathways were tracked and followed up to assess for long term needs at the end of the period of recovery;
  - c. maintain the flow of patients from community beds including reablement and rehabilitation packages in home settings, to allow the next sets of patients to be discharged from acute care.
547. Local authorities were entrusted with coordinating their work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery, and to take the lead contracting responsibilities for expanding the capacity in domiciliary care, care homes and reablement services in the local area paid for from the NHS Covid-19 budget.
548. Care home providers were asked to maintain capacity and identify vacancies that could be used for hospital discharge purposes and adopt and implement a care home “capacity tracker” tool to provide real time bed vacancy information to NHS and social care colleagues,<sup>48</sup> and roll out the NHSmail secure encrypted email service to facilitate communication and information sharing between NHS and social care.<sup>49</sup>

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<sup>48</sup> The care home capacity tracker tool had been developed prior to the pandemic by the North of England Commissioning Support Unit in collaboration with NHS England and the Better Care Fund to enable the system to better manage hospital discharges by identifying available capacity in care homes, hospices, inpatient community rehabilitation providers, substance misuse providers. During the pandemic, the tracker tool was adapted and scaled up to cover the whole of England.

<sup>49</sup> From 13 April 2020 domiciliary care providers were asked to complete a similar tracker tool developed by the CQC (“Update CQC on the impact of Covid” form). From 30 November 2020, domiciliary care providers transitioned from the CQC tracker tool to the Capacity Tracker [AP137 INQ000235454]

549. Lastly, the guidance also announced the suspension of usual patient funding eligibility criteria (such as CHC assessments), alongside the Government's agreement to fully fund the cost of new or extended out-of-hospital health and social care support packages for people being discharged from hospital to enable quick and safe discharges and more generally reduce pressure on acute services. The new funding, distributed by NHS England, would enable CCGs and their local authority partners to commission the enhanced discharge support outlined in the guidance.

550. In line with the 19 March Discharge Guidance, the quick guide defined D2A as follows:

*Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.*

*Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.*

*This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement.*

551. The guide defined "clinically optimised" as "the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge'...".

552. Fundamentally, the D2A model introduced by the 19 March Discharge Guidance echoed and built upon existing best practice guidance on hospital discharge. It required acute Trusts to conduct twice daily rounds to determine which patients were "medically optimised" to be discharged home or to less acute settings.

553. The main differences between the 19 March Discharge Guidance and the previous discharge guidance referred to above included:

- a. the context of the pandemic and the imperative of freeing up as many acute beds as possible to help cope with the incoming first wave of Covid-19

hospitalisations; this introduced a significant degree of urgency to the implementation of the D2A requirements;

- b. Annex B to the 19 March Discharge Guidance, which set out, for the first time a specific list of clinical reasons to reside in hospital to assist clinical teams across all Trusts in identifying patients no longer in need of an NHS bed; and
- c. the Government's decision to suspend CHC assessments and directly fund the costs of out of hospital health and social care packages for patients who no longer required an NHS bed; this removed significant barriers to timely discharge.

- 554. On 21 August 2020 DHSC published an updated version of the Hospital Discharge Service Guidance setting out detailed guidance to the system (with input from NHS England) on the implementation of the "home first" D2A model introduced by the 19 March Discharge Guidance, supported by new hospital discharge funding arrangements that supported free care, rehabilitation or reablement for a limited period of up to six weeks following discharge. Health and social care systems were expected to build on the work conducted until then to embed discharge to assess across England as the default process for hospital discharge during the funded period (September 2020 – March 2021).
- 555. For people discharged between 19 March and 31 August 2020 with a care package, their care would be funded from a ringfenced fund from the remainder of the emergency Covid-19 funding until assessments for long-term care were completed. For people discharged from 1 September 2020, the Government provided an additional £588 million to supplement existing CCG and local authority spend on post-discharge support to cover the cost of this care for up to six weeks.
- 556. As set out in more detail in separate guidance, from 1 September 2020 the requirement to conduct CHC and Care Act assessments for individuals discharged from hospital was to be reintroduced but was to be undertaken during the individual's six-week period of funded recovery services. CCGs and councils were instructed to work together to develop a robust, fair and transparent approach to undertaking all assessments that had been deferred since 19 March, and to ensure all assessments restarted from 1 September were undertaken in good time **[AP138 INQ000270064]**.
- 557. Through a combination of embedding the D2A model and utilising the national discharge fund, there was an expectation that performance would continue to reduce the unnecessary length of stay for people in acute care, thereby increasing hospital

inpatient capacity, improving patients' outcomes following a period of rehabilitation and recovery and minimising the need for long-term care at the end of a person's rehabilitation.

*Impact of the measures introduced by the Phase 1 Letter and the 19 March Hospital Discharge Guidance*

558. An initial assessment of the impact of the measures introduced by the Phase 1 Letter and the 19 March Hospital Discharge Guidance on patient flow over the course of Wave 1 of the pandemic was conducted by the discharge cell towards the end of April 2020 and presented to NIRB on 1 May 2020 **[AP139 INQ000270099]**.
559. While the analysis noted a significant variation across regions in England, the data indicated an overall significant reduction in long length of stays in hospital. Since the introduction of the hospital discharge requirements in March 2020:
- a. daily numbers of occupied beds by adult patients in an acute hospital for over 7 days dropped from 42,666 to 19,833;
  - b. daily numbers of occupied beds by adult patients in an acute hospital for over 14 days dropped from 25,075 to 10,506; and
  - c. all regions achieved significant reductions ranging between 62-72% (against their 2018 March baseline) in hospital long length of stays of over 21 days.
560. The analysis identified the following "key enablers":
- a. additional funding for new or extended out-of-hospital health and care support packages for people being discharged or who otherwise would have been admitted to hospital which allowed the suspension of CHC eligibility assessments under section 14 of the Coronavirus Act 2020 (a common cause for delays in hospital discharge);
  - b. flexible use of NHS workforce to support implementation of new discharge service e.g., re-deployment of around 1,000 CHC staff; acute staff supporting individuals in alternative settings as needed;
  - c. the reasons to reside tool set out in the 19 March Discharge Guidance to aid discharge decision making;
  - d. ongoing national clinical and operational support for regions and systems;

- e. daily data returns from discharge SitRep data and bed capacity tracker information;
  - f. emergency legislation including, in particular, the suspension of the duty on CCGs and Trusts, both in a community setting and for those on the acute hospital discharge pathway, to assess for eligibility for CHC and for FNC and the suspension of the discharge notification process under the Care Act.
561. NIRB was asked to support actions to create a new D2A model post pandemic that would entrench some of the key benefits of the new service model, namely:
- a. the timely discharge of all hospital inpatients who did not meet the clinical criteria to reside in acute care (thus freeing up hospital beds for patients in need of inpatient healthcare);
  - b. the assessment of short term rehabilitation, reablement and (if required) longer term support to be made outside hospital;
  - c. ensuring patients were discharged on a "home first" principle and do not enter long-term care home settings unnecessarily; and
  - d. ensuring that cross system working to ensure appropriate health and care support was provided in the right setting following discharge from hospital.
562. The NAO report *"Readying the NHS and adult social care in England for Covid-19"* published on 12 June 2020 set out further detail on hospital capacity and patient flow during the first months of the pandemic and on the impact of the March 2020 hospital discharge requirements. The headline findings of the NAO report on hospital discharge and patient flow data can be summarised as follows:
- a. Further to the instruction to postpone elective services whenever possible, *"elective activity fell by 24% in March 2020 compared with March 2019"*.
  - b. *"The NHS additionally increased capacity through a deal to access up to 8,000 beds in independent hospitals, and by establishing temporary Nightingale hospitals, although use of these was limited up to mid-May."*
  - c. *"Between 17 March and 12 April, the number of available acute hospital beds increased from 12,600 to 53,700, while the proportion of these beds occupied by a Covid-19 patient peaked at 29% on 7 April 2020. The proportion of critical care beds occupied by Covid-19 patients in England was highest*

*between 5 April and 14 April, at 50% or just over."*

- d. Demand for emergency services and other clinically urgent services also decreased. In April, attendances at Type 1 A&E<sup>50</sup> departments "*were down 48% on the previous year, and indicative statistics for GP appointments also dipped by 31%, with a large increase in the proportion done by telephone. However, ambulance activity rose in March, with an accompanying increase in response times: for example, the response time for emergency calls (category 2 incidents) was 51% higher than in March 2019...*"

- 563. An updated analysis of the impact of the D2A policy on patient flow and hospital capacity was produced on 25 February 2021 in connection with a winter resilience meeting between NHS England and the SSHSC [AP140 INQ000270006].
- 564. The analysis noted how the £588 million additional D2A funding provided for the period between September 2020-March 2021 had demonstrably generated major and sustained improvements in hospital length of stay in both acute and community beds, by freeing up an estimated:
  - a. 6,702 NHS beds over the relevant period – the equivalent of almost thirteen and a half additional hospitals – via reduced hospital length of stays for patients aged over 70;
  - b. 624 NHS community rehabilitation beds; and
  - c. 11,000 members of staff, including 6,800 registered nurses, who were able to turn to other priorities such as tackling the elective backlog built up during the pandemic
- 565. The analysis also noted that now that hospital occupancy had returned to near pre-pandemic levels after an initial drop due to reduced engagement with health services,

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<sup>50</sup> A&E services are defined by reference to four 'types':

Type 1 is a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Type 2 is a consultant led single specialty accident and emergency service (e.g., ophthalmology, dental) with designated accommodation for the reception of patients.

Type 3 are other type of A&E/minor injury activity with designated accommodation for the reception of emergency care patients. The department may be doctor led, GP led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of patients with minor illness or injury. Includes Urgent Treatment Centres (UTC).

Type 4 are NHS walk in centres

the D2A policies and associated funding had ensured sustained gains in efficiency with reduced length of stays in hospital figures across the board.

Testing prior to discharge

566. This section considers the advice or guidance about whether a patient should be tested for Covid-19 prior to discharge from hospital to a care home or other destination during the Relevant Period.
567. While NHS England was consulted by the Government in connection with early decisions on Covid-19 PCR testing prioritisation, throughout the pandemic testing policy has always been determined by DHSC, on advice from PHE. Any NHS England guidance has followed this direction.
568. In response to the anticipated wave of Covid-19 infections and hospitalisations, on 11 March 2020 PHE identified a prioritisation list for Covid-19 tests for periods when demand for diagnostic testing might exceed local laboratory capacity and triaging of requests would be required **[AP141 INQ000270014 and AP142 INQ000270015]**.
569. Given the limited national testing capacity at that point in time, the list recommended by PHE prioritised the use of testing capacity on the basis of clinical need. Accordingly, the list focused on case detection in symptomatic patients requiring critical care or hospital admission (Groups 1 and 2) and did not include, at that time, the testing of asymptomatic patients discharged from hospital:

*Group 1 (test first): patient requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI)†, or an alternative indication of severe illness has been provided e.g., severe pneumonia or ARDS*

*Group 2: all other patients requiring admission to hospital for management of pneumonia, ARDS or ILI*

*Group 3: clusters of disease in residential or care settings e.g., long term care facility, prisons, boarding schools*

*Group 4: community patient meeting the case definition and not requiring admission to hospital - over 60 years or risk factors for severe disease (recognising that this is challenging); over 60s should be prioritised over other risk factors*

*Group 5: community patient meeting the case definition and not requiring admission to hospital – under 60 years and no risk factors for complications*

*Group 6 (test last): contacts of cases*

570. Given the constrained testing capacity, PHE's testing prioritisation was accepted by the CMO, the Deputy CMO, and senior clinicians in PHE and NHS England and was endorsed at a meeting with the SSHSC.
571. On 12 March 2020 PHE responded to a query from DHSC in connection with the potential extension of Covid-19 testing to care home workers. PHE's email reiterated that testing capacity at that point in time was limited to 3,000 tests per day, increasing by 500 tests per day each week, with testing priority being accordingly given to "clinical need" (i.e., the diagnosis of incoming patients) **[AP142 INQ000270015]**.
572. As set out in the draft minutes of the NIRB meeting held on 17 March 2020 to discuss and approve the draft Hospital Discharge Guidance (published by the Government on 19 March), NIRB requested that further consideration be given to introducing Covid-19 testing practices at discharge to support safe care home admissions **[AP143 INQ000269992]**. Ultimately, however, for the reasons set out above, at that time DHSC and PHE considered that testing capacity was insufficient to support the introduction of a policy requiring the testing of patients before their discharge from hospital into a care home.
573. On 24 March 2020, in response to a query on behalf of the Minister for Social Care arising from reports of care homes refusing to admit patients who had not been tested for Covid-19, DHSC, PHE, BEIS, NHSX and NHS England engaged in email correspondence to determine, among other things, whether sufficient capacity could be made available for the purpose of testing patients being discharged out of hospitals into care homes.
574. In that correspondence, NHS England noted that because those patients were not included in PHE's prioritisation list, such patients could only be prioritised locally if there was spare capacity **[AP144 INQ000270151]**.
575. At that time, capacity was unevenly distributed across NHS labs – in the main dependent on what PCR platforms the labs had previously, and availability of supplies for those particular platforms. PHE had issued guidance as to who should be tested, and this was being followed by the NHS. However, given the imbalance between testing capacity and demand in local hospitals as capacity was being increased at pace and the supplies pipeline was – at that stage – unclear, it was possible that, for a limited time, local capacity could become available for the testing of patients falling outside the prioritisation list.



576. On 1 April 2020, NHS England was asked to review a draft copy of a DHSC-led guidance to care homes on the admission and care of residents during the pandemic (*"Admission and Care of Residents during COVID-19 Incident in a Care Home"*) (**"2 April Guidance"**). The draft guidance suggested that because any patient who had exhibited Covid-19 symptoms whilst in hospital would be tested, and the test result would be communicated during the process of transfer to a care home, negative tests prior to transfer to or admission into a care home would not be required.
577. Internal inquiries were made with the NHS England Testing Cell to determine whether the testing of symptomatic hospital inpatients likely to be discharged to a care home reflected existing testing practice. The view expressed by the Testing Cell was that, in practice, a large number of hospitals (but not all) may have already moved to test all symptomatic (and some asymptomatic) patients before discharging them to a care home; therefore the impacts of the DHSC proposal on testing capacity would likely be minimal.
578. While there were benefits from this practice, the proposed national policy proposed by DHSC officials was inconsistent with the CMO advice and the testing prioritisation rules which NHS hospitals were required to follow, and any formal change to testing prioritisation fell outside NHS England's remit. In light of this, NHS England suggested that the additional draft wording on testing should await pending changes to the CMO advice and testing prioritisation rules.
579. The Government's testing policy in respect of the discharge of hospital inpatients into care homes was ultimately set out in DHSC's Adult Social Care Action Plan (**"DHSC Action Plan"**) – published 15 April 2020. Among other things, the DHSC Action Plan introduced for the first time a requirement on all acute hospitals to test all patients for Covid-19 prior to their discharge in a care home.
580. On 15 April, the NHS also promised to use the Government's hospital discharge funding to fund any necessary local authority accommodation needs for patients who had tested positive for Covid-19 (or awaiting a test result), and were still shedding the virus, if they could not be safely discharged to a care home but no longer needed NHS bedded care.
581. Following publication of the DHSC Action Plan, by a letter dated 16 April 2020 NHS England informed all acute hospitals of the new Government policy to test all patients being discharged from hospital to a care home [AP145 INQ000358460 ].

582. The DHSC policy to test all hospital inpatients before being discharged to a care home further developed in the lead up to Wave 2 with the announcement of a designated settings scheme as part of the DHSC Adult Social Care Winter Plan 2020-2021 published on 18 September 2020.

583. The details of the new policy were set out in a letter dated 13 October 2020 addressed to directors of adult services ("*Winter Discharges: designated settings*") setting out the following requirements [AP062 INQ000234564]

*Anyone with a COVID-19 positive test result being discharged into or back into a registered care home setting must be discharged into appropriate designated setting (i.e., that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.*

*These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.*

*No one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding or without having been tested within the 48 hours preceding their discharge.*

*Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital. The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement.*

584. On 16 December 2020 DHSC, PHE, the CQC and NHS England issued new joint guidance for local authorities, CCGs and care providers on discharging hospital patients with a Covid-19 positive test result to designated care [AP146 INQ000234652] Building on the DHSC letter of 21 October 2020, the guidance provided further advice on the establishment of designated settings and set out the expectation that every local authority would need to have access to at least one designated setting or suitable alternative premises. The guidance also explained the process by which the CQC would "assure" that each designated setting had the policies, procedures, equipment, staffing levels, appropriate skill mix, and training in place to maintain infection control and support the care needs of residents.

585. The 16 December guidance also provided further information on discharge arrangements, with reference to the discharge service policy and operating model published by DHSC on 21 August 2020 and the need for settings to provide appropriate clinical support. Local authorities were required to work with NHS providers and CCGs to ensure that designated settings could support the diverse care needs and cultural backgrounds of the community.
586. Despite significant efforts and mobilisation by local authorities, the social care sector, and support by local NHS bodies, progression to set up or make available designated care facilities in every part of England was difficult, with full local authority coverage not being achieved until seven months after the introduction of the policy **[AP147 INQ000270073]**. The CQC data illustrates the practical difficulties of making available or setting-up adequate alternative care facilities for isolating elderly people with Covid-19, with appropriate staffing, equipment and infection control measures in place **[AP148 INQ000270020]**.
587. In the lead up to the introduction of the requirement to test all patients before their discharge to a care home (set out by the DHSC Action Plan) ("**the DHSC testing policy**"), NHS England raised a number of operational concerns with DHSC in respect of earlier drafts of the policy .
588. In particular, initial drafts suggested that NHS facilities, including Nightingales, might need to be used for the purpose of quarantining hospital inpatients who tested positive for Covid-19 upon discharge (or were awaiting a test result).
589. Operationally, in early April the NHS still needed the Nightingale critical care capacity and community beds for potential critical care surge capacity and intensive care discharge step-down. Accordingly, it was imperative that any introduction of Covid-19 testing and/or quarantining requirements upon discharge would be operationally deliverable and unlikely to cause any significant delays to NHS discharge pathways, which were vital for maintaining sufficient hospital care capacity for both acutely ill Covid-19 and non-Covid-19 patients across the system **[AP149 INQ000270152]**.
590. Nightingale hospitals were also highly inadequate for the purpose of quarantining frail and elderly persons. They were "field hospitals" initially designed and equipped solely for the provision of Covid-19 critical care, where elderly and frail patients would have been exposed to a noisy open plan environment, with no individual isolation facilities to prevent cross-infection between patients, no privacy and inadequate access to toilets or washing facilities (as critical care facilities did not need extensive toilet or

washing facilities, given the nature of care provided in a critical care unit) and no staffing to look after such a patient cohort. Similarly, the use of facilities such as supported hotels for quarantining Covid-19 positive patients posed safety and welfare concerns for patients and appropriate facilities would be difficult to scale up at speed. This is because significant work and resources would be needed to make any hotel physically appropriate for a care home resident to use (e.g., with specialist equipment being moved into every room) and recruit enough staff skilled in older people's care.

591. The final version of the DHSC Action Plan as published largely addressed these operational realities. It placed primary responsibility for the accommodation of patients who tested positive for Covid-19 on local authorities, and those care providers who had the ability to safely isolate Covid-19 patients within a care home. Further work was subsequently conducted over winter to establish and accredit appropriate quarantine facilities for the purpose of quarantining patients who had either tested positive for Covid-19 or were awaiting a test result before their discharge into a care home.
592. At the relevant time, Acute Daily Discharge SitRep data collected by NHS England from Trusts on daily hospital capacity and discharges did not include specific criteria to reside data related to Covid-19 testing, as at the time the SitRep data collection was introduced the DHSC testing policy had not yet been implemented.
593. The DHSC Action Plan provided that, in the absence of local care providers with appropriate isolation or cohorted care facilities to accommodate people who had tested positive for Covid-19, local authorities would be asked to secure alternative appropriate accommodation and care for the remainder of their isolation period (which could be funded by the £1.3 billion enhanced discharge funding).
594. In an internal report to NIRB on hospital discharges and isolation requirements dated 6 November 2020, the Discharge Cell noted that key barriers to acute hospital discharges being reported by regions including a lack of confidence in test results, with care homes requesting two negative tests before discharge, care homes with IPC or outbreak concerns, challenges with working outside core hours or weekends, care home and domiciliary care providers being reluctant to take patients who had not undergone 14 days of isolation and care agencies being unwilling to take on Covid-19 positive patients **[AP150 INQ000270142]**.
595. Around the same time, NHS England started to collect data via the care home capacity tracker as to the number of instances where patients were discharged from

hospital to a care home without a Covid-19 test. This was undertaken with a view to investigating any breaches of the DHSC designated facilities and Covid-19 testing policy and holding Trusts accountable for any such breach of the policy. The data was collected and reported to NHS England on a daily basis between 2 November 2020 and 22 April 2022, with the Discharge Cell promptly following up with Trusts, via regions, on all potential breaches of the policy [AP151 INQ000270116].<sup>51</sup>

596. On 23 December 2020 NHS England circulated a letter to all Trusts setting out a number of changes to Acute Daily Discharge and Community Daily Discharge SitReps with a view to obtaining more granular hospital discharge data to monitor the impact of the Government's recent designated settings guidance ("*Discharge into care homes: designated settings*") and the mandatory arrangements introduced in it to support safe and timely discharges and protect care home residents and staff from Covid-19 throughout winter [AP152 INQ000269989], namely:

- a. the requirement that every patient discharged to a care home must have a Covid-19 test within 48 hours prior to discharge (unless they have tested positive in the previous 90 days); and
- b. the requirement that every patient with a Covid-19 positive test being discharged to a care home be first isolated into a designated setting.

597. In light of the above, the letter requested all Trusts to collect, from 30 December 2020, daily data in respect of (among other things) the following questions:

10. *Of the people who are to be discharged to a care home:*

- a. *The total number who continue to reside in hospital because they have not received a Covid-19 test result within 48 hours of their prospective discharge (unless this is not required under the terms of "Discharge into care homes: designated settings")*
- b. *The number who continue to reside in hospital because they have not received a Covid-19 test result within 48 hours of their prospective discharge (unless this is not required under the terms of "Discharge into care homes: designated settings"):*

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<sup>51</sup> During the relevant data collection period, NHS England confirmed only 25 breaches of the testing and designated facilities policy.

- i. Who have a length of stay of 14 days and over*
- ii. Who have a length of stay of 21 days and over*

...

*11. Of the people who are to be discharged to a care home:*

- a. The total number who have received a positive Covid-19 test result and who continue to reside in hospital because they are awaiting a place in a designated setting*
- b. The number who have received a positive Covid-19 test result and who continue to reside in hospital because they are awaiting a place in a designated setting:*

- i. Who have a length of stay of 14 days and over*
- ii. Who have a length of stay of 21 days and over*

598. The datasets (**[AP153 INQ000270114 and AP154 INQ000270115]**) contain the above discharge delay data collected respectively via Acute Discharge Daily SitReps (between 29 December 2020 and 28 June 2022) and Community Discharge Daily SitReps (between 29 December 2020 and 18 April 2022).

599. Broadly, the data suggests that from the end of December 2020, delayed hospital discharges due to patients:

- a. still residing in hospital because they had not received a Covid-19 test result within 48 hours of their prospective discharge; or
- b. because they were awaiting a place in a designated setting,

constituted a very limited proportion of overall hospital discharges.

600. By way of example, in January 2021:

- a. Delayed discharges from acute beds due to either of the above reasons in England only amounted to approximately 0.3 to 0.4% of all acute bed discharges (i.e., approximately 200-300 patients / day), and dropped to approximately 0.2 to 0.3% in February 2021.
- b. Delayed discharges from community beds due to either of the above reasons in England only amounted to approximately 1.1 to 1.7 % of all community bed

discharges (i.e., approximately 60 to 110 patients / day), and dropped to approximately 0.7 to 1.1 % in February 2021.

## SECTION 8: CORONAVIRUS ACT 2020 AND SSHSC DIRECTIONS

602. The following paragraphs set out details regarding the Coronavirus Act 2020 and directions issued by the SSHSC.
603. The Coronavirus Act 2020 was passed on 25 March 2020, the Bill having been first introduced and published on 19 March 2020. A Draft Pandemic Flu Bill had been prepared following Exercise Cygnus, which was held ready and substantially converted into the Coronavirus Bill 2020. NHS England contributed to the Draft Pandemic Flu Bill as part of the pandemic influenza preparedness work following Exercise Cygnus.
604. NHS England's role within the wider civil contingencies regime is covered in NHS England's First Module 3 Statement. This includes the ability for NHS England nationally to take command and control by triggering a Level 4 response (see Section 1), enabling NHS England to co-ordinate the direction of the NHS to increase capacity. New legislation was not required for this.
605. As explained within this Section, the SSHSC did issue a number of directions which allowed NHS England to exercise the functions of CCGs under sections 3 and 3A of the 2006 Act. This enabled NHS England to commission health services from independent providers and to support the provision of services by NHS bodies to address Covid-19.

### The Coronavirus Act 2020

606. The Coronavirus Bill was considered in Quad meetings attended by the SSHSC and NHS England's Chief Executive Officer before the Bill became the Coronavirus Act 2020. NHS England did make suggestions and proposals for legislative change and a high level summary of key suggestions and proposals is set out in the following paragraphs.
607. On 13 February 2020, DHSC sought input from NHS England in relation to a proposed clause on mandatory (flu) vaccination [INQ000087253, INQ000087256], and NHS England officials attended a call to discuss on 17 February 2020 [INQ000087255], and by 20 February 2020, NHS England had been provided with a list of possible clauses [INQ000087257].
608. On 2 March 2020:
- a. NHS England's Chief Executive Officer attended a meeting with ministers in



which it was agreed, as part of RWCS planning, to bring forward emergency legislation led by the DHSC.

- b. DHSC provided NHS England with a copy of the draft Pandemic Influenza Bill (as amended in 2018), with a steer that the new Coronavirus Bill would incorporate temporary amendments to the Mental Health Act 1983. These would offer flexibilities to practitioners and decision makers in terms of the number of doctors needed to make decisions and extend some of the timelines applicable to statutory responsibilities as set out in that Act. NHS England provided suggestions around the easing of CHC assessment requirements to improve discharge flow. NHS England's Mental Health, Learning Disability and Autism team continued to engage on the mental health provisions that were ultimately included in the Coronavirus Act 2020.

609. On 4 March 2020, NHS England's Chief Executive Officer attended a meeting of COBR(M) at which it was agreed that Government engagement with trusted stakeholders and operational partners on the proposed contents of the legislation should begin on a confidential basis to ensure the operationalisation of the Bill's powers.

610. NHS England was provided with an overview of the proposed Bill on 6 March 2020 and invited to comment [INQ000087282], and it was considered in a Quad meeting on 9 March 2020 attended by NHS England's Chief Executive and the SSHSC [INQ000087283].

611. On 11 March 2020:

- a. NHS England's Chief Executive Officer attended a meeting of COBR(M) in which the committee agreed that no further measures would be included in the Coronavirus Bill following that meeting.
- b. NHS England's Strategic Incident Director attended a DHSC Covid-19 Oversight Board meeting, in which the agreed list of Bill provisions was on the agenda. DHSC provided an update on the Bill and it was noted that the date of the Bill had been agreed [INQ000087318].
- c. NHS England's National Director for Primary Care, Community Services and Strategy sent DHSC a list of NHS England's 'legislative asks' [INQ000087301, INQ000087302 and INQ000087303]. .

612. The list sets out 14 proposals, under the following headings:

- a. *enhanced capacity and flexible deployment of staff*: this included a proposal for temporary Nursing and Midwifery Council ("**NMC**") registration of student nurses in the final six months of their education and proposals to relax the requirement that clinicians providing primary medical services (i.e., GP services) must be on the Performers' List (a list maintained by NHS England);

52

- b. *easing of legislative and regulatory requirements*: this included a proposal to suspend 'continuing healthcare assessments', with the aim of improving the flow of patients being discharged from hospital by eliminating unnecessary delays caused by the assessment and determination of who should pay for ongoing care support. It also included a proposal to suspend CQC inspections during the course of the pandemic, to alleviate pressure on NHS providers, and a proposal to enable NHS England to provide assistance or financial support directly to NHS providers of secondary care; and
- c. *managing the deceased*: this was a proposal to extend the role of advanced nurse practitioners in death certification.

613. In response, DHSC explained that the clause list for the Bill had been agreed before NHS England's submission, but in fact, several of the provisions suggested by NHS England had been provided for.

614. In particular, the Coronavirus Act 2020 provided for the suspension of CHC assessments to further the objectives of expediting safe discharge of patients from acute hospital beds, reducing the CHC assessment burden, and releasing clinical and support staff to support the system to manage the Covid-19 outbreak. The explanatory notes to the Act explain that:

*Currently, patients with social care needs go through a number of stages before they are discharged from hospital. For some patients, one of these stages is a CHC Assessment, a process that can take a number of weeks. The Bill will allow the procedure for discharge from an acute hospital setting for those with a social care need to be simplified.*

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<sup>52</sup> The National Performers List service is a list of approved GPs, opticians and dentists who satisfy a range of criteria necessary for working in the NHS.

615. The relocation of CHC assessments, alongside DHSC's ringfenced discharge funding, significantly facilitated timely hospital discharges throughout the pandemic.
616. NHS England and DHSC colleagues attended a Covid-19 Legal Oversight Group for Mental Health, Learning Disability and Autism, in which participants discussed key legal issues.
617. On 30 March 2020, NHS England duly published legal guidance for Mental Health, Learning Disability and Autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic. This provided an explanation of relevant provisions in the Coronavirus Act 2020, for the benefit of service providers in the Mental Health and Learning Disability and Autism sectors [INQ000087365] as they responded to the outbreak.
618. On 9 April 2020, the NHS (Performers Lists) (England) Coronavirus) (Amendment) Regulations 2020 were made. These dealt with an issue raised by NHS England on 11 March 2020 – the relaxation of the requirement for GPs to be registered on a Performer's List maintained by NHS England. As the explanatory note to the Regulations explains:

*Currently medical practitioners cannot provide general medical practitioner services for the National Health Service unless they are general medical practitioners on a performers list ("the medical performers list") maintained by the NHS Commissioning Board. These Regulations change so that medical practitioners who are not general medical practitioners can provide such services without being on the medical performers list if they are employed by or are registered with bodies designated by the Medical Profession (Responsible Officers) Regulations 2010, or are granted permission to practise as medical practitioners in hospitals owned or managed by such bodies. These are bodies such as NHS bodies, the Department of Health and Social Care and the armed forces.*

619. On 11 August 2020, NHS England wrote to DHSC with proposals for further legislation to support ongoing reform of CHC and hospital discharge approaches, following expiry of the time limited provisions of the Coronavirus Act 2020 [INQ000087446]. The letter was sent in advance of the six month scrutiny debate in Parliament on the Coronavirus Act 2020, to prepare for the possibility that the time limited provisions may be repealed following that debate. The provisions were not repealed until they expired on 25 March 2022.

### Directions

620. Under section 253 of the 2006 Act, SSHSC may give directions to a number of NHS bodies (including NHS England), if it considers that by reason of an emergency it is appropriate to do so. The directions may, among other things, require the relevant body to carry out its functions in a particular way, or exercise any functions conferred on another body or person under the 2006 Act.
621. From 20 March 2020, SSHSC issued a number of directions allowing NHS England to exercise the functions of CCGs and Trusts in respect of the commissioning or provision of healthcare services for any purposes related to the prevention, diagnosis or treatment of Covid-19. NHS England had considerable operational input into the content of these Directions.
622. NHS England was also directed to exercise the support functions of SSHSC under section 254A of the 2006 Act for the purpose of assisting any person exercising functions in relation to the health service, providing services for its purposes or for any purposes directly or indirectly related to the prevention, diagnosis or treatment of Covid-19.
623. These directions empowered NHS England to take specific actions to further agreed policy objectives, such as directly commissioning the services to be provided in Nightingale Hospitals (which would ordinarily have fallen within the remit of CCGs).

### Indemnity arrangements

624. The SSHSC exercised the new powers under section 11 of the Coronavirus Act 2020 by the establishment of two new schemes: Clinical Negligence Scheme for Coronavirus ("**CNSC**"); and Coronavirus Temporary Indemnity Scheme, which were the responsibility of NHS Resolution (an arms-length body of DHSC that is formally entitled the NHS Litigation Authority) ("**NHSR**"). The purpose of these schemes was to support redeployment, return and volunteer arrangements to reflect the concerns of practitioners that they would be operating in exceptional circumstances where things were not 'normal'. NHS England supported these schemes and on 2 April 2020 wrote jointly with DHSC, NHSR and NHS Improvement (as it then was) to healthcare workers to explain the additional indemnity cover under CNSC [**AP155 INQ000269923**].

## SECTION 9: FUNDING – RESPONSE TO COVID-19

625. This section provides a description of the processes in place by which requests for additional funding for the NHS in England were submitted during the pandemic. It also sets out:

- a. what additional funding had been requested;
- b. where additional funding was made available; and
- c. whether there were any conditions or stipulations on how those funds could be spent.

626. This includes how:

- a. NHS England requested additional funding from DHSC/Government/ HM Treasury ("HMT") for immediate response actions and resources;
- b. NHS bodies' requirements were processed by NHS England; and
- c. the Spending Review process operated in the pandemic.

627. An overview of the funding position prior to the pandemic is set out in NHS England's First Module 3 Statement.

## Summary of Overall Funding Position

628. During the Relevant Period, the table below shows the evolution of NHS England funding from 2019/20 to the Spending Review 2021 ("SR21") settlement:

| NHSE funding (£m)  | Spending Review 2021 |                |                |                |                |                |
|--|----------------------|----------------|----------------|----------------|----------------|----------------|
|  | 2019-20              | 2020-21        | 2021-22        | 2022-23        | 2023-24        | 2024-25        |
| <b>Original Long Term Plan</b>   | <b>120,807</b>       | <b>127,007</b> | <b>133,283</b> | <b>139,990</b> | <b>148,467</b> | <b>-</b>       |
| <b>Long Term Plan flat in real terms - Spending Review 2021</b>                              | <b>-</b>             | <b>-</b>       | <b>-</b>       | <b>-</b>       | <b>-</b>       | <b>151,629</b> |
| Maintain c3% real terms growth in 2024/25 in line with Long Term Plan - Spending Review 2021 | -                    | -              | -              | -              | -              | 4,669          |
| Pay/employer NICs/inflation - Spending Review 2021   | -                    | -              | -              | 1,627          | 707            | 77             |
| Mental health recovery programme - Spending Review 2020                                      | -                    | -              | 366            | -              | -              | -              |
| Elective recovery programme (multiple settlements)   | -                    | -              | 1,160          | 2,270          | 3,008          | 3,060          |
| Other transfers of funding   | (281)                | (373)          | (1,815)        | -              | -              | -              |
| Pensions revaluation funding   | 2,851                | 2,851          | 2,851          | 2,851          | 2,851          | 2,851          |
| <b>Additional Covid funding (multiple settlements)</b>                                       | <b>-</b>             | <b>19,988</b>  | <b>14,769</b>  | <b>6,199</b>   | <b>2,370</b>   | <b>355</b>     |
| System Covid funding   | -                    | 7,822          | 9,356          | 5,092          | 2,370          | 355            |
| Independent Sector National Contracts  | -                    | 2,632          | -              | -              | -              | -              |
| Enhanced discharge programme**   | -                    | 2,208          | 1,072          | -              | -              | -              |
| Funding to replace lost non-NHS generated income   | -                    | 2,440          | 800            | -              | -              | -              |
| Funding to replace lower income from dental charges  | -                    | 696            | 190            | -              | -              | -              |
| Flu (additional cohorts/call and recall service)**   | -                    | 310            | 130            | -              | -              | -              |
| Other central costs  | -                    | 733            | 444            | -              | -              | -              |
| Testing  | -                    | 412            | 401            | 192            | TBC            | TBC            |
| Covid vaccinations   | -                    | 950            | 2,376          | 915            | TBC            | TBC            |
| Nightingale Hospitals  | -                    | 466            | -              | -              | -              | -              |
| Community Pharmacy Support Fund  | -                    | 370            | -              | -              | -              | -              |
| Hospices capacity  | -                    | 249            | -              | -              | -              | -              |
| PPE*   | -                    | 521            | -              | -              | -              | -              |
| Covid medicines/medicines delivery**   | -                    | 181            | -              | -              | -              | -              |
| <b>NHSE RDEL***</b>  | <b>123,377</b>       | <b>149,473</b> | <b>150,614</b> | <b>152,937</b> | <b>157,403</b> | <b>162,641</b> |
| Remove testing funding not reflected in settlement   | -                    | -              | -              | (192)          | -              | -              |
| Remove vaccines funding not reflected in settlement  | -                    | -              | -              | (915)          | -              | -              |
| <b>NHSE RDEL*** - Spending Review 2021</b>   | <b>123,377</b>       | <b>149,473</b> | <b>150,614</b> | <b>151,830</b> | <b>157,403</b> | <b>162,641</b> |
| <b>NHSE CDEL****</b>   | <b>260</b>           | <b>365</b>     | <b>337</b>     | <b>330</b>     | <b>TBC</b>     | <b>TBC</b>     |

\*Part way through 2020/21, DHSC began directly supplying NHS orgs with PPE, hence why there is no NHSE PPE funding from 2021/22

\*\*NHSE has/will received funding in 2022/23 and 2023/24 for additional flu costs and Covid therapeutics/antivirals, which are not reflected in the settlement figures above

\*\*\*Revenue departmental expenditure, other than depreciation and impairments

\*\*\*\*NHS England's capital budget as shown here is a small part of the overall capital resources spent by the NHS. Most capital is spent by providers and accounted for at national level against the DHSC rather than NHS England as a statutory entity

629. Generally, at the start of the pandemic the NHS in England received the funding that was needed to respond to the pandemic's immediate pressures. Given the structures in place, NHS England was able to quickly arrange for funding to be allocated where it was required within the NHS in England to respond to the pandemic.

630. In the summer of 2020, NHS England (with the support of DHSC) sought funding to secure an additional 10,000 non-temporary beds to increase capacity to deal with both recovery and future surge issues. The aim was to reduce the impact on non-Covid-19 patient care in the event that Covid-19 again spiked over Winter 2020-21 or in future years along with recovery of historic levels of other non-elective demand.

This funding request was not approved by HMT. ICU capacity increased marginally from capital allocations above.

631. The NHS is still dealing with Covid-19; it has not disappeared. The NHS continues to treat a significant number of Covid-19 patients each year, including dealing with additional pressures such as Long Covid. This has increased the pressures on A&E services, sickness absence and waiting lists for elective activity. Even with the success of the vaccination programme, there have been further waves of Covid-19. Surging capacity for Covid-19 patients each time displaces other activity. Accordingly, the lack of additional bed capacity has meant that full recovery of NHS services has been slower with reduced capacity for admitted elective care than pre-pandemic.
632. Funding returned to a multi-year settlement in 2022/23 to cover the periods to 2024/25, with the withdrawal of funding provided to deal with Covid-19.
633. Given the additional pressures faced during winter months, NHS England has reduced other investments (in technology and long-term prevention programmes) to prioritise marginal funds and capital to make available 4,000 extra permanent beds in the acute sector to increase capacity to deal with emergency care. NHS England also has plans to make available a further 3,000 beds/bed equivalents. This necessarily has implications for resource spend to keep those beds available.
634. Funding conditions spreadsheets for the financial years 2020/21 and 2021/22 are exhibited **[AP156 INQ000270130, AP157 INQ000270131 and AP158 INQ000270129]**.
635. Amended financial directions for the years 2019/20, 2020/21, 2021/22 and 2022/23 are exhibited **[INQ000113390, AP159 INQ000399107, AP160 INQ000391364 and AP264 INQ000270059]**

### **Processes with Government**

636. The annual budget setting process for NHS England is normally conducted alongside the agreement of NHS England's Mandate. These budgets are agreed beneath the wider multi-year funding envelopes of the Spending Review, negotiated with HMT and DHSC in the first instance, but meetings are nearly always held tripartite with NHS England. The process of agreeing budgets is always an iterative negotiation.
637. During the pandemic normal processes were disrupted, and the funding of the health system needed to adapt to meet the needs of its exceptional pressures and response.

638. Funding channels remained the same HMT to DHSC to NHS England – except for some Covid programmes, where DHSC owned the allocated budget and a portion was issued to NHS England to manage costs incurred, for example in relation to testing and PPE.
639. DHSC confirmed additional funding settlements through both main estimates (documents setting out the proposed maximum spending of each Government department for a particular financial year, starting on 1 April) and supplementary estimates (proposals for amending the departmental spending the House has previously authorised via the main estimates) which would be formally devolved to NHS England via the Financial Directions.
640. Conditions were often attached to formal approvals of spend and/or could be contained in emails from HMT or DHSC. Conditions mean funds are ring fenced, approvals are lengthier and underspend is therefore not uncommon.
641. Conditions attached to capital expenditure are usually issued to and sit with DHSC. Depending on the request, approval may also be required from HMT.

#### **March 2020 – March 2021**

642. As set out in NHS England's First Module 3 Statement, the NHS in January 2020 was already facing significant pressures in relation to bed capacity, workforce and its estate. The early modelling produced by SAGE then consistently and clearly indicated that the NHS would have insufficient bed capacity to treat the possible number of patients requiring hospitalisation if the pandemic followed the RWCS.
643. Throughout February and March 2020, NHS England provided information to SAGE on its potential surge capacity so that the modelling could consider what further interventions might be needed so that capacity would not be exceeded.
644. In February 2020, NHS England had conversations with central government departments about the likely need for additional bed capacity in the NHS.
645. To ensure there was sufficient resource available to the end of the financial year, NIRB minutes of 10 March 2020 record that regional EPRR leads were to be contacted to request costings on a weekly basis to be reflected back to the IMT on a regular basis. This was to support a process with DHSC for reimbursement of costs to Trusts and to provide regular financial reports both internally and to DHSC **[AP161 INQ000269901]**.



646. Conversations took place between NHS England and HMT, in which NHS England was reassured that funding would be made available to increase capacity as needed.
647. On 11 March 2020, Ministers agreed measures to free up hospital capacity, including legislative action to support the discharge of patients from hospitals. The same day, the Chancellor presented his Budget, a £5 billion Covid-19 response fund for pressures on the NHS and other public services. In his speech to the House of Commons he committed to make additional funding available to the NHS as required, *"First, whatever extra resources our NHS needs to cope with coronavirus – it will get. So, whether its research for a vaccine, recruiting thousands of returning staff, or supporting our brilliant Doctors and Nurses...whether its millions of pounds or billions of pounds...whatever it needs, whatever it costs, we stand behind our NHS."*
648. On 16 March 2020, NHS England also discussed a range of things, including the simplification of the financial regime for the funding of hospital discharges, (a key enabler of the drive to maximise available existing bed space in acute hospitals for the wave of Covid-19 patients forecast) [INQ000087491].
649. This led to daily meetings between NHS England's finance team and officials at DHSC and HMT from 16 March 2020. These continued throughout the early phase of the pandemic, as the teams worked closely to ensure that financial issues did not block (or slow) urgent measures required in response to the pandemic.

#### NHS Providers' funding changes

650. The Phase 1 letter [INQ000087317] set out changes to how NHS providers would be funded, as NHS England realised that to respond quickly to the requests of NHS providers the current financial regime would need a simpler approach. NHS England, with DHSC and HMT, agreed rules and processes for how the extra costs would be claimed.
651. In summary, this approach materially simplified the usual Trust sector financial framework. All Trusts moved to block-contracts which provided a guaranteed monthly income, based on a national methodology, to remove the need for local negotiation. A top-up mechanism was also introduced to fund NHS secondary care providers for the difference between their net cost base and their block-contract income consisting of both a projected top-up (paid in advance to fund providers for their expected level of net expenditure) and a retrospective top-up after month-end (to true up any actual spending in the month including Covid-19 costs). The additional funding required above the previously planned NHS England budget for 2020/21 would be provided by

HMT (and ultimately reflected in the final NHS England Mandate/Financial Directions for 2020/21). Costs in respect of which NHS England was uncertain of at the time including temporary staffing costs to cover sickness absence, loss of income from other sources, costs of PPE (before Government confirmed that this would be covered nationally), extra cleaning and security costs.

652. NHS England wanted to ensure approval processes were proportionate and by way of example applied the following early approaches:
- a. a Finance Covid PMO Cell was formally set up (23 March 2020) to help manage and co-ordinate the new areas of work and new requests for financial support that NHS England was receiving. The Finance PMO linked into other cells established by NHS England to respond to the pandemic to develop policies with a significant financial aspect. The Finance PMO had a direct reporting line into the CFO's office to ensure continuity.
  - b. capital spending at amounts less than £250,000 would require only retrospective approval – e.g., small scale infrastructure to facilitate infection controls or IT to help working from home;
  - c. a fast-track process to secure national approval for capital spending over £250,000 was issued – e.g., putting in modular wards to create separated escalation wards.
653. Funding requests from NHS providers were collated by NHS England's regional teams who would firstly undertake their own analysis of business cases received, prior to forwarding to the national team for approval.
654. At the start of the pandemic, NHS England was having regular daily meetings with HMT and DHSC on funding requests. Once those were in place, there remained regular meetings with HMT and DHSC addressing specific national issues, arrangements and funding issues. For example this would have included IS providers and vaccines. Additionally, Senior Finance Leadership team meetings (called End of Day or SLT) initially took place after the HMT and DHSC meetings at the start of the pandemic and dealt with specific NHS England issues. Once the funding flows were agreed, management of NHS operations then moved to NHS England and the Senior Finance Leadership meetings.

655. On 26 March 2020, NHS England published "*Revised arrangements for NHS contracting and payment during the COVID-19 pandemic*" to provide further information following the Phase 1 Letter **[AP162 INQ000269915]**.
656. In April 2020, more communications and guidance were provided covering changes to the financial framework to better align with the Long Term Plan and further guidance on how block payments would be managed **[AP163 INQ000269922, AP164 INQ000269924, AP165 INQ000269925, AP166 INQ000269914, AP167 INQ000269909, AP168 INQ000269911 and AP169 INQ000269938]**.
657. NHS England sent the Phase 2 Letter **[INQ000087412]**. At this point in the pandemic, NHS hospitals were treating over 19,000 patients per day with Covid-19. This letter maintained the procedural position in relation to funding as had been set out in the Phase 1 Letter but sought to look ahead. It was anticipated that, at the right time and following decision by Government, the NHS would need to move into the phase 3 recovery period for the balance of the 2020/21 financial year.
658. Consideration then turned to the funding regime for the second half of the financial year once it was clear that the country was past the first wave. At this point, NHS England wanted to start re-introducing a return to something that resembled the usual financial procedures in place with providers **[AP170 INQ000269945]**. The UK Alert Level was downgraded on 19 June 2020.
659. On 31 July 2020, NHS England sent its Phase 3 Letter which, amongst other things, set out the key principles of the financial framework for the period 1 October to 31 March 2021 and the intention to move towards a revised financial framework for the latter part of 2020/21 once finalised with Government **[INQ000113391]**. Guidance with further details and to give effect to the principles in the letter was issued in September to take effect in October 2020 entitled "*Contracts and Payments Guidance October 2020 – March 21*" **[AP171 INQ000269969]**.
660. In summary, the revised guidance introduced a different financial framework with fixed system level funding envelopes comprising:
- a. CCG allocations and block-contracts – CCG allocations would continue to be non-recurrently adjusted based on expected expenditure provisions including the national calculation of opening block-contract values for services commissioned from NHS providers within and outside of the CCG's home system;

- b. System top-up – additional funding to support delivery of a system breakeven position, consistent with the principles of the projected top-up in the first half of the year. This funding would now be issued by a lead CCG within each system rather than directly by NHS England;
- c. Growth funding – additional funding allocated to systems to support underlying growth in the cost base, linked to allocations growths of CCGs in the system. It was intended that this funding would cover new services and capacity growth since the reference period baseline and over the remainder of the year;
- d. Covid-19 allocation - additional funding to cover Covid-19 related costs for the remainder of the year (noting exclusions); and
- e. directly commissioned services from NHS providers – formally specialised commissioning and other directly commissioned services remained commissioned outside of the system but system envelopes would take account of funding inflows to NHS providers for these services and deficit costs incurred in delivering all services. Systems were expected to manage full costs within the envelope issued. Nationally calculated block-contract values for these services would be issued and regional commissioners would receive fixed allocations for the remainder of the period.

661. On 7 August 2020, it was confirmed that Covid-19 revenue business cases would no longer be approved unless they were exceptional and that Trusts should now identify funds within their own re-prioritised resources.

### **The Spending Review 2020 ("SR20")**

- 662. HMT undertook a spending review process for the financial year 2021/22. The original bid provided by NHS England in September 2020 had been for a multi-year settlement, following which the Government decided to limit SR20 to only one year given the uncertainty.
- 663. In addition, a separate thread of finance work commenced in April 2020 and continued through to the SR20 regarding NHS England's concerns for future waves of community prevalence and the impact they could have on hospital capacity.

### Capacity concerns

664. NHS England proposed an expansion of overall bed capacity so that if Covid-19 inpatients increased again, they could be looked after with less disruption to non-Covid-19 services, e.g., treatment of those already on NHS waiting lists (often referred to as 'the elective backlog').
665. NHS England's Chief Financial Officer engaged in ongoing discussions with Government about the need for additional funding for non-temporary bed capacity.
666. On 26 April 2020, NHS England sent slides to the Prime Minister's Private Office setting out capacity scenarios for the next four – six weeks **[AP172 INQ000088479]**
667. On 30 April 2020, NHS England's Chief Financial Officer attended a meeting with Cabinet Office, DHSC and HMT spending lead for the health sector and presented those slides which set out amongst other items, the NHS proposal and what winter would mean for NHS planning and the sorts of work that would be needed for this (e.g., retaining critical care capacity through to next winter).
668. On 14 May 2020, NHS England shared a slide pack with The Prime Minister's Private Office setting out capacity planning. Part of the slide deck suggested that up to 14,000 extra permanent beds may be required based on the highest Covid-19 inpatient levels. Extra community bedded and rehabilitation capacity was also suggested for every region to support recovery and provide step-down and step-up care based on the Seacole Centre model.
669. This was followed in mid-May by correspondence from DHSC to NHS England stating that Number 10/HMT were inviting DHSC "to pitch for new capital investment", as well as subsequent correspondence from the Prime Minister's Private Office asking for NHS England to prepare a capacity plan **[AP173 INQ000269946]**. This was to be discussed with the Prime Minister for decision by Ministers. It asked for it to be agreed first with the SSHSC and the Chancellor and to set out multiple costed options, to cover staffed critical care and G&A bed capacity; staffed use of Nightingales, staffed independent sector beds and any other surge capacity. It also asked for proposals on how any increases could tackle recovery priorities.
670. On 10 June 2020, NHS England sent a slide pack to Number 10 and HMT which set out NHS capacity planning for the remainder of 2020/21 **[INQ000087437 and INQ000087438]**. The slides were discussed at the Covid-O meeting on 11 June 2020. A request was made by the Healthcare Capacity C-19 Task Force (Cabinet Secretariat) for detail to be shared on outcomes, including how the package could help tackle waiting lists and other benefits such as the impact on health inequalities.

671. These slides indicated that to manage the pandemic, there was a need for capital/infrastructure investment. The slides set out amongst other things that NHS England wanted to close the acute capacity gap by building 15,000 – 20,000 G&A beds over the next two years and 2,000 critical care beds, whilst also retaining the Nightingale and IS capacity of 10,000 beds over this period at a CDEL<sup>53</sup> cost of £5 - £7 billion.
672. On 19 June 2020, following further collaborative correspondence, a summary paper on capacity was sent to Number 10 and DHSC which contained adjustments based on a revision of the IPC factor from 15% to 10% and adjustment to the Covid baseline based on what was being seen in hospitals **[AP174 INQ000269950 and AP175 INQ000269951]**. This paper confirmed that 7,000 G&A beds and 1,000 critical care beds should be built to manage capacity in 2020/21 whilst also maintaining the Nightingale and IS bed capacity.
673. On 24 June 2020, a revised slide pack was sent to Number 10 **[AP176 INQ000269952, AP175 INQ000269951 and AP177 INQ000269953]** in which NHS England recommended that 7,000 G&A beds and 1,000 critical care beds should be built to manage capacity in 2020/21 whilst also maintaining the Nightingale and IS bed capacity. The slide pack estimated the total cost of this to be £3,900 million in 2020/21. NHS England said "*without additional bed capacity the NHS is not able to manage the ongoing demand pressures that arise from Covid 19*".
674. On 29 June 2020, the Prime Minister's Private Office sent a letter to NHS England, DHSC and HMT requesting a detailed plan on managing Covid-19 through winter, which should include the continuation of Nightingale and IS capacity and that medically fit patients are discharged quickly **[AP178 INQ000269960]**.
675. The requested plan was provided on 13 July via DHSC **[AP179 INQ000269955, AP180 INQ000269956, AP181 INQ000269957 and AP182 INQ000269958]**. Both the covering letter and attached plan stated that the NHS would need approximately 10,000 beds to deal with any scenario in which Covid was still at large.
676. Ultimately, the request for additional beds was not approved. An email, dated 14 July 2020 from the Prime Minister's Private Office confirmed that "*additional 10,000 beds*:"

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<sup>53</sup> Each department of HMT has a departmental expenditure limit (DEL) which can be separated into capital and revenue DEL. The Government controls overall expenditure by deciding each department's DEL. DHSC sets a capital departmental expenditure limit (CDEL), which covers the capital spend of Trusts and is used by DHSC and HMT to monitor and manage capital expenditure within the sector.

*the previous steer from the PM, as per the 29 June letter, was that we should focus on the measures above [i.e. Nightingales, IS capacity; discharge and flu vaccinations] and any additional permanent capacity should be considered in the SR [Spending Review]" [AP178 INQ000269960].* At that time, tackling community prevalence was a key Government priority and investment was needed elsewhere, for example, to establish Test and Trace, which government announced on 17 July 2020 stating that it would provide the NHS "with advance notice of any expected surge in Covid-19 demand and this would help manage local and regional public health mitigation measures to prevent national resurgence".

677. DHSC responded by letter dated 17 July 2020 to confirm that it was disappointed not to be given funding for the additional 10,000 beds but would plan on the basis of the Prime Minister's and Chancellor's decision **[AP183 INQ000269962, AP184 INQ000269963 and AP185 INQ000269964]**.
678. The NHS used Summer and Autumn 2020, with Covid-19 inpatients down, to expand inpatient and critical care capacity as far as possible, and also to treat more non-Covid-19 patients so that the median wait for routine hospital care fell from 19 weeks in July 2020 to under 11 weeks by November 2020.
679. However, in addition to the immediate pressures created by Covid-19 waves and UEC demand over Winter 2020 and thereafter, the decision not to invest in additional bed capacity, has meant that recovery from the pandemic has been slower with reduced capacity for admitted elective care than pre-pandemic and non-elective admissions with resulting pressure on ambulance services and emergency departments.
680. In NHS England's Annual Report 2021/22 **[AP186 INQ000270058]**, NHS England's Chair commented that: *"the ongoing effects of the COVID-19 pandemic continue to put pressure on services and, while many areas are delivering at higher than pre-pandemic levels, creative solutions will be required to meet increasing demand. It is also true to say the NHS entered the pandemic years already facing severe operational stresses and missing its targets in several delivery and service areas."* He also noted that *"the fundamental issue that the NHS faces is starkly insufficient capacity, be it workforce or beds or scanners and at the same time facing fast growing demand from a population which both grows but also ages."*
681. NHS England's Chief Executive Officer commented:

*"COVID-19 was, and is, still with us. We will continue to feel its effects – directly and indirectly – for years to come, with the most complex challenges only now emerging. It is worth taking a moment to remember that over the course of financial year 2021/22, by the Government's official measure, more than 34,000 people died in England within 28 days of a positive COVID-19 test, with each of those individual lives lost touching many more. The NHS therefore continued to operate in an extraordinary way – simultaneously working to recover from the disruption of 2020/21, while also remaining the front line of the national response to an ongoing pandemic.*

682. From the outset of SR20, NHS England worked with DHSC to set out the priorities for the NHS. NHS England contributed to a letter which was sent from SSHSC on 24 September 2020 to the Chancellor, which set out that *"the impact that Covid has had on healthcare services including the NHS, both in terms of the costs of delivering services, and the unmet need that has built up during the course of the pandemic"* could not be ignored [INQ000087455].
683. Through late October into November, the data was now indicating a further wave. HMT signalled they were unlikely to agree Covid-19 costs and potentially other aspects of funding for 2021/22 until the new year due to the uncertainty meaning that SR20 did not deal with the direct costs of dealing with Covid-19. The Quad meeting on 9 November 2020 discussed this in anticipation of a meeting with the Prime Minister to discuss secondary care capacity [AP187 INQ000269980].
684. NHS England continued to negotiate in November 2020 for additional funding for capacity, including extending the six-week discharge scheme, additional diagnostic capacity, additional G&A beds, and additional funding to respond to demand as elective care demand recovered. Ahead of the SR20 publication NHS England set out its request for assurances on the settlement [INQ000087475, INQ000087472 and INQ000087473].
685. On 23 November, the Chancellor announced the SR20. SR20 contained, amongst other things, additional funding of £3 billion to help with backlog recovery and to maintain operational capacity at the 2020/21 level (subject to stretching efficiency assumptions) and based on assumptions about pay and non-pay inflation. It did not allocate funding for the up to 10,000 additional beds originally sought. As set out above, HMT also deferred funding decisions on direct Covid-19 costs closer to the start of 2021/22.
686. NHS England's Chief Executive Officer commented on the SR20 stating:



*"As well as caring for seriously ill and vulnerable coronavirus patients, our hardworking nurses, doctors, therapists and other NHS staff are looking after many other patients, some of whose care has been disrupted by these two large waves of COVID. This extra funding will therefore rightly enable them to tackle longer waits for care by carrying out up to one million extra checks, scans and additional operations. And because COVID takes a mental as well as physical toll, it's particularly important that we will be able to continue to expand mental health services too."*

#### Total funding for 2020/21

687. For the period 2020/21, additional funding of £19,988 million was provided for the NHS, of which £17,995 million was provided by HMT with the remainder provided by DHSC directly from its Covid-19 budget. This is recorded in the amended Financial Directions 2020/21 and summarised in the table at paragraph 628 above.

688. Ultimately, there was underspend on the total funding allocated of £5,373 million. Given the level of uncertainty on operational demands and with the establishment of a new set of programmes through the year there was a much higher level of uncertainty on forecasts and a focus on spending only what was required for the circumstances. As set out in NHS England's Annual Report 2020/21, £2.567 million was due to underspends on ring-fenced budgets; for example, there were significant uncertainties about the costs of delivering the first phase of the vaccine programme; the Nightingales were not significantly used. In turn higher Covid-19 demand meant that there was, for example, less elective care and spend on medicines which reduced core service costs compared to initial forecasts. As the 2020/21 Annual Report noted:

*"This year we delivered an underspend of £5,373 million against the increased revenue resource budget. Of this, £2,567 million was against specific budgets which were not available to support general spending. The remaining £2,806 million underspend was against non-ringfenced budgets. These levels of underspend reflect the unprecedented complexity and difficulty in producing accurate estimates of expenditure in a context of fluctuating activity levels and the fast-changing and uncertain operational environment."* [INQ000113281]

#### **Financial Year Two of Covid – April 2021 – March 2022**

689. As set out above, whilst SR20 had been agreed by November 2020, negotiations for funding for Covid for 2021/22 did not commence with HMT until January 2021.

690. On 17 September 2020, a paper was presented setting out changes to be applied to the financial framework to take effect from the next financial year 2021/22 as the NHS was anticipated to revert to more "business as usual" financial regimes **[AP188 INQ000269968]**.
691. The proposal was to move towards system level allocations, and for payment and contracting proposals to expand the use of payment models that used both 'block-contract' and where relevant 'payment for activity models' as the NHS sought to recover elective care. The overarching strategies of the 2021/22 financial framework were to:
- a. support recovery and restoration of NHS services;
  - b. deliver an affordable position within the NHS mandate;
  - c. build on the learnings of the Covid-19 emergency financial framework; and
  - d. encourage and enable effective system working.
692. However, given that SR20 did not settle the additional funding required for the direct costs of dealing with Covid-19, a significant proportion of funding for 2021/22 was unresolved although HMT committed to agreeing funding for these costs early in 2021. Accordingly, it was not possible for NHS England to set out system funding envelopes for 2021/22 nor to confirm its internal budgeting position. This created further pressures on NHS providers as they could not plan with confidence.
693. Minutes of NHS England's Joint Finance Advisory Group on 13 January 2021 noted the current pressures on the system and that to ensure that funding did not become an obstacle in recovery of the backlog, baseline funding would need to be in place and so existing system revenue envelopes and the current financial framework would be rolled over for the minimum of the first three months with the aim to issue planning guidance in April with systems asked to plan for the remaining months of the year in the first quarter **[AP189 INQ000270008]**.
694. Operational guidance was issued to providers on 13 January 2021, which included the following paragraph on financial planning:
- "Due to current pressures we are planning to roll-over current financial block contracts for Q1 2021/22 and therefore will not be initiating a planning and contracting round with a changed financial framework before the start of the year. We cannot confirm total funding for Q1 as that will be subject to discussion with the government*

*but systems should not take any steps that would reduce capacity and the ability to respond to COVID-19 in anticipation."*

695. In March 2021 and in addition to the SR20 settlement, a further £6.6 billion was agreed by HMT and DHSC for the first half of 2021/22 ("**H1 of 2021/22**").
696. In summary, the figures for H1 of 2021/22 comprised (sums below rounded for convenience):
- a. £1.8 billion for the cost of rolling over H2 2020/21 funding envelopes. This related to managing the recurrent impact of the 2019/20 system deficits (which could not be recovered because of Covid-19) and loss of planned efficiencies in 2020/21 and the first half of 2021/22.
  - b. £4.6 billion for the direct costs of Covid-19, which included:
  - c. the incremental cost to systems (providers, CCGs and direct commissioning) of Covid-19. This included:
    - i. Costs of treating patients with Covid (excluding PPE);
    - ii. The impact of Infection Prevention Control measures on capacity and productivity;
    - iii. Additional funding for primary care capacity; and
    - iv. Central programme costs additional pension costs, 111 Covid-19 demand and workforce programmes e.g., student deployment,
  - d. £0.5 billion for the hospital discharge programme; and
  - e. an offsetting efficiency requirement of approximately £0.3 billion. This was the first time since the start of the pandemic the NHS was asked to deliver efficiency on an increasing trajectory per quarter.
697. Guidance was subsequently issued by NHS England setting out the details of the finance and contracting arrangements to 30 September 2021 [**AP190 INQ000270100**] which replaced the guidance issued in January 2021.
698. A bid for Q3 and Q4 of 2021/22 was first shared with DHSC in mid-June 2021. This totalled approximately £5.9 billion and included assumptions on increased efficiency and reduced Covid costs.

699. The second iteration of the bid in early July 2021 was also for £5.9 billion but included £1 billion for elective recovery funding, offset by the release of £0.5 billion activity funding from the H1 of 2021/22 settlement and increasing the efficiency requirement. Discussions continued throughout July/August 2021. HMT asked a range of questions on the bid, including on reserves, SDF budgets (investment in national service improvement programmes), elective recovery performance and other bid assumptions.
700. A settlement totalling £5.42 billion (inclusive of capital investment of £500 million) was announced by HMT in early September 2021 for the second half of the year ("**H2 of 2021/22**"). The main elements of the settlement for H2 of 2021/22 were:
- a. Maintaining the levels of core funding for systems based on the envelopes issued for H1 of 2021/22, an efficiency requirement of £786 million on core costs and a reduction in Covid costs of £650 million - meaning 2.2% efficiency savings were required of systems from H2 of 2021/22.
  - b. An additional £200 million to be used to enhance productivity in the longer term; £80 million of this funding was switched to capital/CDEL budget at Supplementary Estimates.
  - c. An additional £1 billion for elective recovery, on top of the £1 billion secured at SR20;
  - d. Continuing the Hospital Discharge Scheme on the current basis (funding 4 weeks of costs) until the end of 2021/22;
  - e. Funding to offset the impact of lower dental fee income in Q3, with Q4 to be discussed with the Government at a later date;
  - f. Costs for central Covid programmes, primary care and provider income losses would need to be contained within funding already secured for H1;
  - g. £500 million of additional capital funding, with £250 million to fund capacity and productivity enhancing schemes and £250 million to fund technology to assist in delivering elective recovery.
701. Funding for testing, vaccines and flu did not form part of this settlement, which was provided on a retrospective basis by DHSC.
702. Revised guidance was subsequently issued to the system [**AP191 INQ000270101**].

703. Alongside the SR20 funding (£3 billion), the additional in-year funding settlements for 2021/22 totalled £14,543 million. Post settlement adjustments of £1,155 million (of which £1 billion was returned to HMT – see below) alongside additional funding for Covid-19 vaccinations, additional flu costs and testing, resulted in additional funding for the year totalling £16,295 million<sup>54</sup> (see table at paragraph 628 above).
704. There were also ring-fenced funding envelopes set out in the 2021/22 Financial Directions for 2021/22 as follows for the year 2021/22:

| <b>Ringfenced funding</b>                        | <b>£m</b> |
|--|-----------|
| Elective Recovery Funding                        | 1,160     |
| Enhanced Discharge Programme                     | 1,072     |
| Funding for COVID-19 impact on dental services   | 190       |
| Mental Health Recovery funding                   | 366       |
| Other central costs and support for Primary Care | 358       |
| COVID-19 Vaccines                                | 2,376     |
| NHS COVID-19 Testing                             | 401       |
| Expansion of Seasonal Flu vaccination programme  | 130       |

705. In 2021/22, agreed adjustments were made during the Supplementary Estimates process to reflect updated financial forecasts. These reduced the total funding across the settlements by approximately £2.3 billion. This figure was comprised of £1.3 billion for "business as usual" underspends, and approximately £1 billion of ringfenced Covid-19 funding, of which £840 million was for elective recovery funding and £160 million was for dental loss of income funding. Due to a spike in Covid-19 over the course of the winter months in 2021/22, the figures confirm that the NHS did less elective work during this time, reducing the forecast outturn compared to the ringfenced funding envelope. The NHS also started to recover a higher proportion of dental income than originally anticipated. Furthermore, the NHS was able to bring down overall system costs at a faster rate than the levels assumed when the 2021/22 funding settlements were agreed. It was therefore agreed with HM Treasury during the Supplementary Estimates process that the NHS budget would be adjusted to reflect the updated forecast financial position.

### **The Spending Review Process 2021 ("SR21")**

706. Ahead of SR21, NHS England again liaised with DHSC, including during August 2021. A slide deck sent to DHSC stated that *"the conditions under which [the NHS*

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<sup>54</sup> £14,769m (additional Covid funding), £1,160m (elective recovery programme) and £366m (mental health recovery programme)

*operates] are not going to return to those that existed pre-pandemic over the next six or even likely eighteen months."* The information also set out that NHS England was dealing with new demands i.e., Covid-19 and Long Covid, and these created new pressures or exacerbated existing ones e.g., need for more staff and higher drugs spend **[INQ000087513]**.

707. HMT issued a letter to DHSC on 7 September 2021 **[AP192 INQ000270097]** setting out the terms of a 3-year settlement. The SR21 was subsequently published on 27 October 2021 with a return to a multi-year settlement to 2024/25 and was premised on the basis of NHS England making significant savings to prioritise elective recovery, in turn impacting commitments set out in the Long Term Plan, whilst protecting funding for mental health, primary and community care. There was also a reducing budget for Covid-19 over this three-year period as set out in the table above at paragraph 628.
708. The budget represented a cut in real terms based on assumptions that Covid-19 costs would reduce. Funding for underlying cost pressures reduced significantly against the run rate expended by systems and represented the equivalent of a total efficiency requirement of approximately 2.2% compared to the 1.1% outlined in the Long Term Plan. In fact, the efficiency requirement was much higher than this given the reduction in Covid-19 funding. This meant that systems had to deliver higher efficiencies to live within their funding envelopes and deliver to plan. Accordingly, the risk of system deficits became more likely than it would have been had the 1.1% efficiency set out in the Long Term Plan been kept.
709. In NHS England's Board meeting of 6 October 2022 **[AP193 INQ000270055]**, NHS England Chief Financial Officer presented a paper which, amongst other things, commented on the 2022/23 year, confirming that the SR21 settlement *"required a total efficiency from NHS systems of around 5% (£5.6bn) taking account of managing elective recovery and other service demands."*
710. In the Annual Report 2021/22 **[AP186 INQ000270058]**, NHS England's CFO noted that the agreed funding represented *"a real terms cut in total funding for 2022/23 as the NHS seeks both to boost activity, deal with new demands from the pandemic, recover backlogs and reduce long waiting times, vaccinate the population as directed by the Government as well as reduce the costs inevitably incurred in seeking to respond to the COVID-19 emergency over the last couple of years. By 2024/25 funding will have returned to the Long Term Plan trend allowing for additional funding*

*to deal with elective backlogs, any ongoing vaccine programme and enduring higher costs where we are still dealing with higher COVID-19 demands."*

711. SR21 allocated no further funding for the Hospital Discharge Programme to continue from April 2022, which meant that from H2 of 2021/22, it was wound down. This removed a mechanism that the NHS had used to facilitate discharge of medically fit patients from hospitals to optimise bed capacity.
712. During SR21 negotiations, DHSC indicated that the Covid-19 testing regime would be fully funded, as it had been in previous years. However, HMT subsequently declined to fund these costs, which required a reprioritisation exercise across DHSC group budgets to fund UKHSA. NHS England contributed £330 million to UKHSA at the start of the 2022/23, through reprioritising/reducing other budgets.
713. Additional DHSC pressures in 2022/23 totalled approximately £0.5 billion. This was comprised of (figures simplified):
- a. £0.3 billion for investment in additional workforce initiatives including cancer, mental health and diagnostics (this funded the HEE budget which was owned by DHSC in 2022/23);
  - b. £0.2 billion policy commitments and unfunded pressures is as follows:
    - i. £70 million per annum arising from not receiving a PDC Mandate/budget uplift for the impact of the debt write-off;
    - ii. £40 million arising from DHSC/Government decision to stop funding the medical examiner programme and not to introduce planning charging regime from 22/23;
    - iii. £20 million from decision to freeze prescription charges
    - iv. £40 million<sup>55</sup> relating to core flu programme pressures(2019/20 cohorts per DHSC policy decision):
      - 713.b.iv.1 £20 million relating to increased uptake compared to 2019/20; and
      - 713.b.iv.2 £20 million arising from higher vaccine costs;

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<sup>55</sup> Note that this pressure does not relate to the flu expansion which was decided in-year and funded by DHSC.

- v. NHS Improvement flat cash allocation has also generated a smaller recurrent pressure, rising to £9 million by 24/25.

#### **Funding – Hospice sector**

714. On or around 21 March 2020 it was communicated to NHS England by Hospice UK that the hospice sector was struggling, particularly charitable hospices. NHS England was advised that a number of hospices were likely to need to close due to a downturn in charitable giving as a result of Covid-19.
715. A briefing paper sent to NHS England's Director of Strategic Finance on 25 March 2020 noted that Hospice UK had calculated that hospices would require up to £200 million per quarter to ensure that usual service levels were met and that a further £66 million would need to be distributed to those hospices at risk of closing within the next seven days (five had been reported to have been in this position) with another £134 million to be distributed over the next 14 days to those hospices at risk of closure in the following three months **[AP194 INQ000269913 and AP195 INQ000269912]**.
716. At the time, hospice provision was being factored into the End of Life Care plans to provide step-down care which also supported discharge from hospitals. The hospice sector would receive equal access to funding as other providers of additional capacity. However, this funding was not sufficient for hospice services to maintain normal business levels.
717. Following NHS England approval, HMT and DHSC approval followed after considerations as to the most effective way for the funds to be provided quickly in light of the urgency. The Chancellor announced on 8 April 2020 that hospices would receive £67 million that day with allocation to those hospices which require the funds urgently to be allocated funds within 48 hours with a further £200 million to be invested by HMT for the quarter to be reviewed in June 2020. The terms of the arrangement required hospices to return any funds which were not required due to the availability of charitable donations.
718. As part of the Government's Covid-19 Winter Plan, in November 2020 HMT confirmed a further allocation of up to £125 million for charitable hospices. The agreement was backdated to 1 April 2020 and would run until 31 March 2021 to secure and increase NHS access to this capacity. Up to £25 million was available per month.



719. A further grant was made available in December 2021 of up to £80 million to be distributed monthly until March 2022. In January 2022 updated information as to the available capacity in the hospice sector and how this capacity was being utilised showed that hospice usage was higher than originally estimated. DHSC and HMT confirmed that from mid-February 2022 the maximum level of expenditure would increase from £80 million to £148 million.

## SECTION 10: EQUIPMENT

720. This Section examines the position relating to ventilators, oxygen, continuous positive airway pressure (“**CPAP**”), extracorporeal membrane oxygenation (“**ECMO**”) and haemodialysis machines.
721. As a virus that infects through the respiratory tract, the initial clinical focus was on supporting respiratory function. As the disease become more widespread the risk of multiple organ failure became better understood, this included acute kidney injury requiring renal replacement therapy. The right equipment was essential to enable the appropriate clinical response.
722. Covid-19 infection can lead to pneumonia, compromising oxygen exchange from the lungs to the blood. One method of treatment was providing patients with oxygen to improve blood oxygen saturation. Demand for oxygen therapy varied throughout the pandemic; however, given the severity of Wave 2 in relation to other waves, the demand was higher in winter 2020/21.
723. Early modelling suggested that the RWCS with no mitigations could result in a demand of 138,000 ventilated beds. Ventilators require oxygen as well as specific infrastructure and consumables.
724. Prior to the pandemic Trusts were responsible for purchasing the ventilators they required. During the pandemic the DHSC took responsibility for sourcing and procuring ventilators (and associated consumables) and NHS England was responsible for the allocation of ventilators within England.
725. The need for ventilators decreased during 2020. By Autumn 2020 ventilation was still being used where clinically necessary but other treatments had been identified that prevented many infected patients from becoming ill enough to need a ventilator.
726. As the need for equipment to deal with kidney injury became clear, national systems were put into place to manage demand.

### Oxygen

727. As a result of the nature of Covid-19, and initial treatments, oxygen supply was identified early in the pandemic as presenting a particular risk. There was a concern that demands for oxygen would far exceed previous oxygen usage and supply norms, such that it would place existing infrastructure under unprecedented pressure.

728. NHS hospitals typically use bulk liquid supply of oxygen through piped systems, delivered through a Vacuum Insulated Evaporator (or "**VIE**" system). The VIE turns the liquid oxygen into gas, and then pumps up through the hospitals pipework to the areas they need to draw on it. Those systems usually operate at around 40% of their maximum capacity. They are generally reliable, using simple mechanical engineering. They also have a secondary system for back-up which is in line with the normal 40% operating capacity of the primary system.
729. All NHS providers must comply with the Health Technical Memorandum (HTM) 02-01) Medical Gas Pipeline Systems', which is mandatory guidance that was issued by DHSC in May 2006. That guidance deals with:
- a. design, installation, validation and verification of systems;
  - b. management of medical gas pipeline systems; and
  - c. dental compressed air and vacuum systems.
730. Compliance with this guidance is not monitored centrally as Trusts are locally responsible for its implementation; there are not sufficient resources available to monitor centrally. Through the NHS Premises Assurance Model (NHS PAM), NHS organisations provide assurance regarding their medical gas systems. This is a self-certification process, and therefore, limited as certification will be generally undertaken by those who have implemented the system.
731. Compliance with guidance issued by the NHS Estates Division is referenced by the CQC under Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as relevant guidance.<sup>56</sup> In addition, non-compliance can be considered in legal proceedings as evidence of failure to provide a safe environment for patients, visitors and staff.
732. Due to the age and condition of some hospitals (one in eight are older than the NHS and 30% are more than 50 years old), their pipework presented problems for them in terms of being able to deliver oxygen across their site to full capacity. Further, it became apparent during the pandemic that a significant number of hospital sites which reported issues or concerns in relation to their oxygen supply had not fully implemented and assured compliance with the 2006 guidance – particularly in terms

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<sup>56</sup> It is listed within a section dealing more generally with the Health technical memoranda series - including Policies and principles of healthcare engineering (HTM 00) (Department of Health, 2014).

of maintaining infrastructure and establishing local governance arrangements for medical gas safety. Hospitals and Trusts were often able to resolve any concerns or incidents directly with regional teams or with commercial suppliers. The central NHS England team was notified of some incidents, typically via regional teams, and normally only where the problem was significant enough to require NHS England's central team to intervene (principal examples of which are outlined further below). Consequently, not all local incidents or concerns have been documented centrally.

733. As a result, and as set out further below, there was considerable activity to monitor and respond to oxygen-related incidents throughout the pandemic. This included a frontloaded programme of work to identify and support priority oxygen infrastructure projects during Wave 1, when the demand for oxygen therapy was significantly less than in Wave 2. Those efforts were significant in creating additional capacity across the NHS.
734. To the best of NHS England's reasonable knowledge and belief, no patient suffered harm from being unable to receive required oxygen.
735. The supply of bulk liquid oxygen itself was less of a concern as national control of Bulk Oxygen Infrastructure Projects was put in place across the industry oxygen suppliers (BOC, Air Products & Air Liquide) by DHSC, cognisant of devolved administrations use of these suppliers. This was to ensure that engineering capacity, bulk oxygen equipment, bottled oxygen and liquid oxygen distribution were focussed on the delivery of projects and services that most effectively met the needs of the Level 4 incident, including for Nightingale Hospitals and the emergency response more broadly.
736. The National Oxygen Infrastructure Programme ("**NOIP**") was established in March 2020 as a sub-cell of the Oxygen and Ventilation National Covid-19 Cell (operated by DHSC and described below). The NOIP team was a multi-agency forum that worked 'virtually' and collaboratively – working across organisational and commercial boundaries - to assess system impact, intelligence and determine national, regional and local Trust medical oxygen requirements. Further detail regarding the NOIP's terms of scope can be found in its project initiation document. A key role was to support allocation of funding for works improvements (**[AP196 INQ000270013]**).
737. In early March 2020, a national data collection across all acute Trusts in England was initiated, to understand their oxygen infrastructure and bed capacity that was capable

of delivering bed-head piped medical oxygen supply. Oxygen capability was constrained by a number of factors:

- a. vessel size;
- b. evaporator capacity;
- c. controls capacity; and
- d. distribution pipework within a hospital (pipe diameter and configuration).

738. NHS England also made arrangements for all Trusts to be fitted with gauges which monitored their oxygen consumption, which provided real-time feedback on how they were tracking against overall oxygen capacity. Where capacity was identified as a concern for a particular Trust then this informed decisions to prioritise funding through the capital works programme described below.
739. With this information, multi-disciplinary regional teams (estates, emergency planners and clinicians) undertook surge planning exercises to explore how bed capacity could be increased. Where critical resilience issues were identified, these were collaboratively addressed as urgent priorities.
740. The NOIP team carried out further analysis which detailed all Trust proposed oxygen infrastructure projects, and the beds that could be created by them. This data was presented back to regions who prioritised the schemes based on their surge capacity modelling exercises.
741. Following prioritisation into 'waves', the NOIP team worked across the health system and the works supply chain to establish the scope of the required projects and the specific work that would be required. This initial work identified 59 projects in four prioritised sequential waves, for example:
- a. the oxygenation of existing beds;
  - b. the refurbishment/recommissioning of existing capacity; and
  - c. the fit out of new beds introduced specifically in response to the pandemic.
742. The prioritised project list was shared with supply chain partners with the intention of establishing the efficacy of the proposals with Trusts and what alternative schemes could be developed to provide the same outcomes, without using limited and scarce

oxygen resources whilst working within the allocated budget. The shortlist of initial urgent projects included the Nightingale hospitals.

743. The first phase of these projects delivered oxygen to over 3,000 additional beds at acute hospitals in just over four weeks (compared with a 'normal' 16 weeks) with a further 1,547 in various stages of completion.
744. NHS England issued several communications early in the pandemic in relation to oxygen. In particular:
- a. a letter and guidance to CEOs, Medical Directors, Critical Care Directors and respiratory/acute medicine directors on 31 March 2020 outlining urgent actions which should be taken to mitigate risks posed by increased demand for oxygen. The distribution was also effected through a number of other methods, including existing online platforms which bring together NHS estates professionals and also through circulation to engineering professionals;
  - b. a systemwide alert on 6 April 2020 via the CAS. This provided guidance on safely managing oxygen systems to achieve maximum sustainable flow, and the process for responding to, and escalating, concerns or defects in equipment. This was issued in light of the incident at Watford General Hospital, as described in further detail below; and
  - c. a further systemwide letter on 12 April 2020 issued jointly by NHS England's Strategic Incident Director and Chief Commercial Officer. This also outlined the steps which Trusts should implement to avoid placing unnecessary demand or pressure on the supply chain. Queries or escalations were to be addressed through regional delivery teams, who in turn would prioritise requests with regional and national estates teams ([INQ000226892]).
745. Following the completion of the planning phase of the first wave oxygen projects, preparations commenced for a second wave of projects. Each regional team was asked to reconfirm its priorities for the second Wave 2 schemes. Final submissions were received from those teams by 24 April 2020.
746. The NOIP team then considered the newly identified second wave Trusts that had been given priority status by the regional teams, which then proceeded as Wave 2a. The remaining second wave Trusts were then planned in as Wave 2b subject to supplier resources (albeit Wave 2b was subsequently redefined as Waves 3 and 4).

747. By May 2021 NHS England had concluded most of the Wave 1, Wave 2, Wave 3 and Wave 4 projects (seven projects remained, that were programmed to complete prior to the end of July 2021). The Wave 5 pipeline projects were reconfirmed with regions, and handed over to the suppliers to assist in their work planning and prioritisation for the future.
748. In addition to the NOIP, which provided national oversight and coordination, regions developed their own cells to respond to incidents reported to them by local Trusts. NOIP supported these cells and other frequent queries.
749. Broadly speaking the NOIP was effective in mitigating oxygen supply incidents throughout its existence, the most notable of which are described further below.
750. The NOIP identified a number of lessons learned when reflecting on its work which can be summarised as follows:
- a. Trusts which had fully followed the DHSC guidance referenced above, to include implementation of a local and effective multidisciplinary medical gases safety committee, did not suffer issues during the pandemic;
  - b. there was a need to review and more broadly reinforce that guidance to ensure that Trusts were aware of its requirements;
  - c. further evaluation of, and investment in, Trust pipework systems was, and is, required;
  - d. business continuity plans related to oxygen supply should be updated to include surge planning;
  - e. a need to expand the medical gas specialist workforce;
  - f. similarly a need to invest in the most oxygen efficient medical equipment as well as systemwide deployment of new flow monitoring technology;
  - g. efficient ward-level management makes a huge difference to the efficacy of oxygen supply; and
  - h. a need for improved governance and assurance, to include building on the identified benefits of multi-disciplinary working between technical/engineering and clinical experts (particularly through medical gases safety committees).

751. The Healthcare Safety Investigation Branch ("**HSIB**")<sup>57</sup> also conducted two investigations and issued reports relating to oxygen supply, which noted several safety-related recommendations. Those investigations were carried out in response to specific incidents, which are described in further detail below.

#### Oxygen incidents

752. There were several incidents relating to oxygen supply which arose during the pandemic; illustrative examples are set out below:

#### Watford General Hospital (West Hertfordshire Teaching Hospitals NHS Trust)

753. On the morning of 1 April 2020 all of Watford General Hospital's alarm panels were triggered to indicate that there was high pressure within the oxygen delivery system. An initial review by their engineering team suggested that this was because the VIE system regulator panel had frozen in an open position. Later that evening, at around 21:50, ICU staff noticed that high and low-pressure alarms were sounding and flashing on one of the local area alarm panels, but no other panels were experiencing the same issue. This was due to an electrical fault with the one panel.
754. On the afternoon of 3 April 2020, a low pressure alarm sounded in ICU, which was reported to the estates management team. The Director of Environment then discussed the issues which had been experienced with the oxygen supply system with clinical teams on 4 April 2020. He informed them that the system was running at capacity and also experiencing significant issues with icing. The Trust's chief operating officer and executive team declared a critical incident at 10:50 hours the same day, which resulted in ambulances diverting as well as seven patients being transferred to local hospitals and four patients being transferred internally to ICU so as to make use of equipment which was more efficient at using oxygen.
755. In addition, an acute physician at the hospital assessed all patients who had been prescribed oxygen, with a view to identifying those whose supply could be reduced while at the same time maintaining sufficient oxygen saturation levels.
756. Those measures were successful in reducing the load on the system to below the maximum safe operating level. Engineers also attended the site and increased the

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<sup>57</sup> HSIB was formed in 2017 to improve patient safety through independent investigations into NHS-funded care across England. For the purposes of the Relevant Period HSIB was funded by DHSC and hosted by NHS England.



pressure output of the system which was able to deliver a higher maximum flow rate, and which allowed the Trust a greater ability to cope with temporary surges in demand for oxygen.

757. The incident was stood down at 22:30, having run for 11 hours and 40 minutes, during which time around 60 ambulances were diverted. No patients were harmed.
758. NHS England conducted a rapid review into the incident and commissioned the HSIB to assist with the same. That HSIB report produced several safety observations, which were followed up and implemented. NHS England also issued, as detailed above, the CAS alert on 6 April 2020 to remind providers of the steps they should take to maintain the functionality of their oxygen systems ([AP044 INQ000371235 AP045 INQ000269927, AP046 INQ000269928, AP047 INQ000269929 and AP197 INQ000270026]).

Diana, Princess of Wales Hospital, Grimsby (Northern Lincolnshire and Goole NHS Foundation Trust)

759. In November 2020, the Trust had experienced isolated instances of oxygen pressure alarms and subsequently identified that two patients in HDU receiving oxygen therapy had desaturated without obvious explanation (although to note that they recovered without any adverse effects). Measures to mitigate risk were taken by moving patients to other areas of the hospital where sufficient oxygen supply was understood to be fully available. A test indicated that pressure dropped in the HDU, and shortly thereafter it declared an incident which included a request to divert incoming patients to other hospital sites. It also redistributed patients across the site to level out oxygen demand. A combination of its remedial actions and the reduction in patient numbers due to the diversionary arrangements meant that it was able to stand down its incident after seven days.
760. This incident was also the subject of an HSIB investigation which summarises the factual background and learning identified in detail.
761. One of the findings raised by HSIB was that there had been a delay in the Trust receiving and acting upon the guidance issued by NHS England on 31 March 2020 because it had not been circulated through the CAS and the individuals to whom it had been sent had both been absent from the Trust.
762. Following the incident, and as set out above, NHS England issued a further alert on oxygen supply via the CAS on 19 November 2020 which emphasised the need for

Trusts to be aware of the risks as set out in its initial letter and guidance issued on 31 March 2020. The NHS England guidance had not initially been issued via CAS, for reasons of speed, and so this subsequent alert identified a number of mitigating actions which Trusts should take, particularly in light of the likely demand for oxygen therapy over the Winter. Those measures included the establishment of local leadership teams imbued with the right expertise, including key clinical leaders and hospital oxygen engineering teams, to ensure that demand did not outstrip supply

**AP/044** **INQ000371235**

#### Epsom and St Helier NHS Trust ("ESH")

763. On 16 December 2020 ESH reported concerns related to its oxygen supply to the London regional NHS England team, who convened a call for 13:30 the same day. The call was attended by, amongst others, the Chief Executive and Medical Director of ESH, as well as regional and central NHS England oxygen colleagues and engineers. Their oxygen capacity had reached 100% earlier that day, although they had managed to reduce this to 95% as a result of transferring a small number of patients to St George's Hospital. A number of immediate actions were agreed on the call, to include ESH speaking with engineers and its oxygen supplier on potential technical solutions, and for a further update to be provided later the same day. ESH also agreed to continue monitoring and assessing oxygen-dependant patients that could be transferred to other hospitals, albeit it was acknowledged that this was only a short-term solution.
764. A further call took place at 17:15 on the same day, at which ESH reported that their oxygen usage had been 91% in the last hour. This noted that a new piece of equipment, a 'manifold' which is used to decompress oxygen cylinders, would be installed by 18 December 2020 and also that new cylinders would be installed over the weekend of 19/20 December 2020. As a result of this remedial work the oxygen capacity at St Helier hospital increased (**[AP199 INQ000270054 and AP200 INQ000270053]**).

#### Royal Lancaster Infirmary (University Hospitals of Morecambe Bay NHS Foundation Trust)

765. On 13 January 2021 the NHS England regional and national EPRR teams were alerted about a potential risk to the oxygen supply at the Royal Lancaster Infirmary. The Trust was concerned that a crumbling concrete roof could cause damage to the oxygen pipe supplying their main clinical building. They had implemented a remedial plan but this would take around one week to complete, and so in the meantime

requested temporary installation of a bulk tanker or tank to provide resilience in the event of damage to the pipe. NHS England's Regional Delivery Director for Estates and Facilities Delivery Team spoke to the Trust the same day, contacted BOC (an oxygen supplier) about any possible mitigations they could implement on an urgent basis, and also requested further information from the Trust regarding the potential incident.

766. Discussions took place between the Trust and NHS England on 14 January 2021, as well as a site visit, to include consideration of risk mitigation plans as well as the potential need for the Trust to declare a major incident. By the afternoon of 15 January 2021 the Trust confirmed that it had sufficiently mitigated the issue to the stage where there was no need to transfer any patients. This was through a combination of mass oxygen ration kits, cylinders, regulators and hose kits having been delivered to the Trust meaning that oxygen could be delivered to those patients who needed it. Equipment had also been ordered to repair the concrete roof which presented the risk in the first place.
767. Further concerns were raised by the Trust in an update to NHS England on 20 January 2021, considering particular equipment not having been delivered and also part of the concrete roof having fallen (albeit fortunately not in a position which caused damage to the oxygen pipework). NHS England sought urgent clarifications on the measures which had been implemented and sought to expedite delivery of cylinder trolleys from BOC to provide further mitigation to the Trust's risk. NHS England also sought to convene an urgent meeting that day to discuss the situation. BOC responded later that same day to provide some technical advice to the Trust, and later again that same day the Trust's chief operating officer confirmed that a considerable amount of work had been implemented to mitigate the risk and which had put them in a much better position as a result.
768. NHS England subsequently requested that the Trust commission an independent risk management review in relation to the incident, due to concerns that it had not been appropriately escalated to the Trust's senior management team. This review was finalised and issued on 18 February 2021.

#### Extortion threat

769. NHS England was made aware of damage to an oxygen store at a Sheffield hospital, which resulted in a piece of estates work being undertaken nationally to ensure adequate secure fencing was in place around vulnerable and/or critical infrastructure.

770. The work was undertaken in the context of NHS England being made aware of an extortion attempt whereby there had been a threat to detonate a bomb at an unspecified hospital if demands were not met.
771. Although there was no evidence that the damage to the oxygen store and the extortion threat were linked, in the face of the increase in threat level of terrorist intent to target the health sector in the UK during Covid-19 outbreak, NHS England considered that it had no choice but to respond on a national basis given the risk to patient survival for the large numbers who were dependent on oxygen.
772. The recommendation that NHS England made was to erect high-security fencing around all hospital medical gas and VIE units. In addition, surveillance CCTV and security patrols were increased. It was not widely known that these measures were implemented due to a possible bomb threat, rather these measures were implemented under the guise of other concerns including broader threats to staff that NHS England was aware of and the fence cutting 'vandalism' at the Sheffield hospital.
773. The work was co-ordinated by the National EPRR team with the assistance of the seven regional EPRR leads in England and the National Estates Team. It was completed on a confidential basis. In total there were 178 hospital sites with VIE protection that received increased daily inspections. 23 hospitals had completely new fencing, 19 received nighttime inspections and 106 had CCTV and wider patrols put in place.
774. Over the same period that the estates teams were working hard to find local suppliers (who had not been furloughed) to conduct the necessary fencing work, they were also contending with a multitude of other very challenging estates issues such as delivering sufficient oxygen flow rates in hospital buildings to treat patients. The latter was very difficult due to equipment freezing with increased oxygen vapour release and limited piping capacity in older hospital buildings. The NHS England and hospital estates teams were concurrently also responsible for procurement of considerable additional equipment for Covid-19 care, engineering modifications to create new critical care areas, repairing faulty equipment that had been placed under high demand etc.
775. At a time of unprecedented demand, a critical part of the NHS's emergency planning and estates resources had to be redirected onto work to mitigate a malicious threat made when the NHS was at its most vulnerable.

## Ventilators

776. The following paragraphs set out the number of ventilators available to patients across the NHS in England for the Relevant Period. This also includes an explanation of the number of clinical staff required per ventilated patient, the level of training required, details of steps taken to increase the number of ventilators and the availability of other equipment such as CPAP, ECMO and haemodialysis.

777. Ventilators are machines that assist or replace a patient's breathing by moving pressurised air with adjustable concentrations of oxygen in and out of the lungs. Patients with Covid-19 who are admitted to hospital often have problems breathing. If their blood oxygen level is low, the hospital may provide:

- a. standard oxygen therapy using a loose-fitting face mask - the patient is awake and is breathing on their own;
- b. non-invasive ventilation ("**NIV**") - the patient is awake and breathing on their own with either:
  - i. a Continuous Positive Airway Pressure ("**CPAP**") machine, i.e., the patient wears a tight-fitting face mask, hood or helmet which increases the amount of oxygen in the air the patient breathes and the ventilator positive pressure helps keep the patient's lungs inflated;
  - ii. a Bilevel Positive Airway Pressure ("**BiPAP**") machine - similar to a CPAP machine but a more sophisticated ventilator allowing for different air pressures when breathing in and out – sometimes used for patients with existing lung problems; or
  - iii. an Intermittent Positive Pressure Ventilator ("**IPPV**") machine – the patient wears a tight-fitting face mask, hood or helmet which increases the amount of oxygen in the air and the machine normally has both CPAP and BiPAP functions.
- c. mechanical ventilation ("**MV**") – the term invasive positive pressure ventilators is often used interchangeably here. MVs are used for patient who are unable to breath properly on their own. MVs use an IPPV machine with a tube that is inserted into a patient's windpipe and breathes for the patient. The patient's own breathing efforts, and cough reflexes, are usually stopped using drugs. The patient is sedated and not conscious. MVs are used in different forms –

for example, anaesthetic MV machines are used to keep patients asleep in the operating theatre. These are usually used where a patient has healthy lungs and only requires ventilation for a maximum of 12 hours. They are not as sophisticated as other MVs. Transport ventilators, which are usually quite limited in function, are designed to be portable and used for transporting patients around or between hospitals.

778. Ventilators require a supply of oxygen. Ventilators also require specific consumable products such as filters and tubes as well as connectors to power outlets and oxygen supply outlets. Reference is made to these within the following paragraphs.
779. The paragraphs below set out details of ventilator availability, including modelling carried out to assess ventilator demand and steps taken to increase the availability of ventilators. Further paragraphs:
- a. describe any incidents notified to NHS England in which there were concerns regarding the availability of ventilators;
  - b. consider the availability of other equipment used to provide care for Covid-19 patients such as continuous positive airway pressure (“CPAP”), extracorporeal membrane oxygenation (“ECMO”) and haemodialysis machines; and
  - c. consider the number of staff required per ventilated patient and the level of training required.

#### Ventilator availability

780. As set out in Section 4, over the course of February and March 2020 a series of meetings refined the projected demand for ventilators. At various times, planning was carried out against changing estimates.
781. Prior to the pandemic, individual Trusts were responsible for purchasing ventilators as and when required and so there was no central inventory of ventilators in England.<sup>58</sup>
782. NHS England undertook collection of new categories of data and introduced new processes to confirm both current stock and new demand, by:
- a. Launching a survey of Trust ventilator availability on 27 February 2020.

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<sup>58</sup> At the date of this Statement there is still a ventilator reserve but NHS England understands that this will close by March 2024.

- b. Establishing on 2 April 2020, the National Ventilation Advisory Group (“**NVAP**”) with regional representation. Calls usually involved NHS England’s Strategic Incident Director or deputy to provide clinical input into decision-making and were held daily (seven days per week) to challenge, review and allocate equipment where required, based on urgent clinical need. A system of gathering and recording data was put in place, which by mid-April led to a complete map of institutions using oxygen across the country, which assisted with the allocation of ventilators to Trusts. The allocation process included an assessment at regional and Trust level of existing patients, Covid-19 infection growth rates, and the equipment already in place. Representation from all regions had a positive effect – there were examples of regions whose Trusts had less urgent need for ventilators agreeing that the available equipment should go to Trusts in other regions instead.<sup>59</sup> Frequency of calls and meetings of the NVAP changed over the next 18 months based on Covid-19 prevalence rates. An example of the forward looking data that was sent to the NVAP tracking included separate spreadsheets for ventilators, and other critical equipment is provided.

783. The returns developed the following picture:

- a. the 27 February 2020 survey reported back in the first week of March. The total number of adult acute Trust mechanical ventilators available was reported as 4,954 and a further 1,362 could be repurposed – these were mainly in theatres and recovery rooms. An additional 878 paediatric ventilators were available with an additional 163 that could be brought online. The total number was 7,357. This included transport ventilators and anaesthetic ventilators;
- b. on 11 March 2020, the Oxygen and Ventilation team indicated that information gathered to that date suggested that for ventilators that could be used in critical care environments, there were 5,300 ventilators with a further 1,050 paediatric ventilators that could be brought online. It was noted that further ventilator capacity was expected outside critical care.

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<sup>59</sup> Ventilators could be despatched from the central warehouse and received by the relevant region within 24 hours. In other cases, moving to another region ventilators that were embedded in a hospital setting and connected to the relevant infrastructure and systems could take longer.

- c. on 17 March 2020, before the Health and Social Care Select Committee, NHS England's Chief Executive Officer stated that as of that date, there were 6,699 adult mechanical ventilators operational in the NHS, together with 750 paediatric mechanical ventilators, an estimated 691 in the private sector and 35 in the MoD. By 21 March the number of available ventilators available from independent sector organisations with whom NHS England was making arrangements to utilise capacity had risen to approximately 1,200. A week later, the military was asked to assist with the transfer of ventilators to NHS premises and proceeded to move 100 ventilators in London alone within the first four days;
  - d. on 25 March an update on national ventilator capacity was provided to the NIRB meeting [INQ000087537]. A total of 8,752 ventilators were stated to be available, with 7,357 in NHS hospitals, 1,208 in independent sector organisations and 187 veterinary and newly purchased ventilators;
  - e. on 5 April 2020, it was stated that 9,000 mechanical ventilators were available in England;
  - f. as of 6 April 2020, there were 9,865 mechanical ventilators available to the NHS across the UK, with approximately 600 of those being in the devolved administrations [INQ000087380 and INQ000087381]; and
  - g. by the end of June 2020 there were 21,200 mechanical ventilators, 14,900 BiPAP and 11,800 CPAP. By September these figures rose to (and remained relatively stable into 2022 at) 31,400 mechanical ventilators, 15,200 BiPAP and 16,500 CPAP.
784. From 3 March 2020, DHSC had been seeking to secure as many ventilators as possible through existing routes [INQ000087456]. The Government decided from 13 March 2020 to pursue all available options, with its strategy being to buy as many ventilators as possible from both UK and global suppliers as part of a wider 'oxygen, ventilation, medical devices and clinical consumables' programme (with contracts let by DHSC as part of a joined-up programme with NHS England).
785. To ensure best purchasing power, the DHSC took responsibility for sourcing and procuring ventilators (and associated consumables) and for the management of commercial relationships with suppliers and manufacturers, except in relation to the Cabinet Office's 'ventilator challenge' which the Cabinet Office oversaw. NHS England was responsible for the allocation of ventilators within England.



786. On 6 March 2020, SSHSC asked NHS England's Chief Commercial Officer to look at the supply position with ventilators to ensure NHS needs were being communicated effectively to DHSC. From 6 March 2020, NHS England's Chief Commercial Officer had daily progress calls, which included discussions on ventilators, with DHSC officials. The latest demand modelling was discussed along with timings of deliveries of additional ventilators into the country.
787. There were also discussions on payment for and utilisation of ventilators ordered by individual Trusts, which were to be held in central stock warehouses, to be allocated to regions that were evidencing high demand. The approach during the Relevant Period was to create a centralised supply of ventilators to be delivered to specific regions and/or Trusts as part of a ventilator allocation process. The centralised supply was for new ventilators being procured by DHSC and any new ventilators that individual Trusts had ordered and which were delivered during the Relevant Period.
788. Also on 6 March 2020, NHS England's Strategic Incident Director sent a note for the attention of all Trust Chief Executives and Medical Directors, indicating that they now needed to prepare to maximise their capacity to provide IPPV and non-invasive ventilation for patients who require respiratory support because of Covid-19. The letter indicated that steps should be taken to ensure that all machines which were able to provide IPPV were serviced and ready for use - this included anaesthetic machines used in operating theatres and anaesthetic rooms and ventilators used in critical care, radiology, emergency departments and other remote sites in the hospital **[INQ000087275 and INQ000087276]**. It should also include returning to safe service any stood down and reserved machines.
789. On 15 March 2020, the Prime Minister asked leading manufacturers to build medical ventilators to deal with the anticipated demand during the pandemic. NHS England did not manage this programme. NHS England's focus as at this date was on the number of ventilators physically in the country, whether sourced from other countries or from within England from the programme or otherwise.
790. Also on 15 March 2020, NHS England's Chief Commercial Officer had a call with the Prime Minister about ventilators as the appeal was launched. Weekly meetings were then arranged with the Prime Minister and a process was created to track ventilators coming into the country.
791. On 16 March 2020, NHS England entered into formal discussions with a number of independent sector healthcare providers in England that collectively represented 80%

of the acute overnight capacity within the private hospital sector in England. The discussions were about enabling the NHS to utilise the providers' premises, staff and equipment for the provision of healthcare services to NHS patients. Processes were approved for transferring equipment, including ventilators, from these premises.

792. From 17 March 2020 onwards, DHSC circulated the Oxygen and Ventilation Situation Report **[INQ000087358 and INQ000087359]** - a spreadsheet updated daily setting out updates on various workstreams relating to ventilator procurement, including conventional procurement (new deals with suppliers, manufacturers and intermediaries), the Cabinet Office's ventilator challenge, ventilator consumables and the "PO to Ward" process (how to distribute procured ventilators and manage Trust engagement processes). Recipients of these SitReps included NHS England officials, as well as NHS colleagues in the regions and people within Government departments.
793. On 20 March 2020, NHS England considered at its NIRB meeting the potential additional ventilator capacity that could be provided from the independent sector **[INQ000087347]**. Utilisation of premises, equipment and staff commenced around 21 March 2020. Also at that meeting, NHS England emphasised the importance of clear guidance and criteria on the process for allocating ventilators being made available as soon as possible.
794. A briefing to NHS England's Chief Executive Officer as preparation for a meeting with the Prime Minister on 23 March 2020 (**[INQ000087334, INQ000087335 and INQ000087336]**) included the estimated number of patients in London requiring mechanical ventilation against the NHS surge capacity, with the former increasingly rising above the latter from that date.
795. Through April various updates were provided on oxygen and ventilation which showed that efforts to increase supply had been successful (See **[INQ000087376]** as an example).
796. On 8 April 2020:
- a. an update was provided to NHS England's NIRB meeting noting that sufficient oxygen supply was in place to meet current demand across the regions. The potential to establish a mutual aid arrangement between the seven regions to support the distribution of oxygen and ventilator supply was considered.

- b. a communication from NHS England's Chief Operating Officer to Regional Directors stated "*The numbers also suggest that we will also have enough physical ventilators and associated equipment and supplies in the country*".  
**[INQ000087383, INQ000087384, INQ000087385 and INQ000087386]**

797. In London, the worst affected region at the time, 22% of beds offering invasive ventilation were unoccupied.
798. As part of a focus on the Birmingham and Manchester Nightingale field hospitals, the 10 April 2020 NIRB meeting considered the ongoing work on oxygen and ventilator capacity across the region to manage supply for the new and existing NHS facilities **[INQ000087539]**.
799. On 15 April 2020, NIRB members considered the need to review the ventilator and oxygen capacity that could be deployed over the next six to twelve months at a regional and national level, the phasing of this and the potential risks to implementation **[INQ000087404]**.
800. By the end of June 2020, around 24,000 ventilators were available. The successful ventilator challenge was producing high numbers of new ventilators.
801. On 29 July 2020, NIRB members considered a report on the proposed approach to strategic allocation of ventilators and associated equipment to regions **[INQ000087448]**.
802. By 3 August 2020, around 30,000 ventilators were available.
803. By Autumn 2020 ventilation was still being used where it was clinically necessary but other treatments had been identified that prevented many infected patients from becoming ill enough to need a ventilator. In December 2020, the NHS's "*Getting It Right First Time*" programme published "*Clinical practice guide for improving the management of adult COVID-19 patients in secondary care*" which shared learning from Trusts during the first wave **[AP201 INQ000269984]**. This stated that increased use of CPAP and other NIV such as high flow nasal oxygen ("**HFNO**") may reduce the need for invasive ventilation and that timely recognition of failure and escalation to intubation was key.

*Incidents notified to NHS England in which there were concerns regarding the availability of ventilators or ventilator-trained staff*

804. DHSC was procuring ventilators, particularly from abroad where a large number were being bought and flown in from China. NHS England would have approximately 3-4 days lead time knowing how much new ventilator stock would arrive (particularly when the ventilators were being flown in from Shanghai). Once the stock arrived in the country it was transported to a warehouse in the Midlands, MoD Donnington, that had been rented by DHSC from the Army. Large scale distributions of ventilators began from the start of April with the military assisting with the transportation from the warehouse to hospitals around the country once decisions were made on allocation.
805. The intention was that ventilators newly arrived at the warehouse would be opened, inspected and consumables would be added so that a full package of machine, tubes, masks and anything else needed could be distributed to hospitals. Due to the way the warehouse worked, consumables were not stored in the same place as the ventilators and recipients of ventilators received the consumables separately.
806. NHS England was having conversations with Trusts who were seeking to buy additional ventilators with the aim of ensuring that ventilators were bought on a national basis to ensure those hospitals that needed them were prioritised. This resulted by early May in a letter from NHS England's Chief Commercial Officer and the Director General for PPE and Public Health (DHSC SRO for PPE policy) which was sent to Trust chief financial officers and Regional Directors explaining the efforts being undertaken to procure new supplies, including ventilators, and highlighted that it was vital that the Government procured certain items, including mechanical ventilators, BiPAP/NIV ventilators, CPAP devices and oxygen concentrators, nationally rather than individual NHS organisations competing with each other for the same supplies [INQ000226899].
807. Before this letter was sent, by the third week in March 2020, the data was showing a doubling of Covid-19 cases every three days in London meaning the NHS would have been overwhelmed by the start of April 2020. London Trusts were raising increased concerns about the potential shortage of ventilators. Those Trusts had been managing the situation locally up to then by moving ventilators between their premises.
808. There were reports that some of the newly obtained ventilators sourced directly from China had issues with connections to other equipment used in English hospitals e.g., the ventilator tubing was not compatible with the wall sockets [INQ000087462]. A number of newly arrived ventilators from China that had this problem were sent to Birmingham in mid-April. The issue was solved within 24 hours.

809. On 31 March 2020, two Trusts reported that they had run out of CPAP machines [INQ000087372]. NHS England, after confirming that non-invasive ventilator equipment was acceptable, liaised with the Cabinet Office to arrange for a delivery from the central stock held at the warehouse at MoD Donnington.
810. On 1 April 2020, NIRB was provided with an update on ventilator capacity and the ongoing work to address concerns and requests that had been raised by regional teams [INQ000087376]. Over the following days, more NIVs were delivered with 253 mechanical ventilators being delivered to five Trusts in the Midlands area on or around 4 April 2020 [INQ000087375].

Availability of other equipment including CPAP, ECMO, haemodialysis machines and others and any steps to increase availability

811. DHSC was not only buying mechanical ventilators. DHSC also bought oxygen concentrators. If piped oxygen is not available at the bedside, an oxygen concentrator sucks in air, removes nitrogen and provides air with higher concentrations of oxygen than room air to the patient or ventilator. Procurement of additional oxygen concentrators was underway in early March with a 9 March 2020 report indicating that progress was good with stock already bought. By 27 March 2020, significant volumes of oxygen concentrators had been procured.
812. DHSC also bought non-invasive ventilator machines. There was not a shortage of this type of equipment in the NHS compared to mechanical ventilators but given the pressure to procure ventilator related equipment, anything available was bought. By late March 2020, this had reduced and as the Ventilator Challenge got underway, the buying of non-invasive ventilators stopped. The non-invasive ventilators and oxygen concentrators were helpful to care homes, some mental health facilities and hospices - these premises did not have piped oxygen.
813. There was much less independent procurement of consumables. As consumables needed for ventilator use were often produced by the same manufacturers as the ventilators, it made sense to bulk buy and ensure there was stock. This proved useful for the second wave as there was enough stock to meet the demand.
814. In early April 2020, critical care data was starting to show a much higher rate of acute kidney injury ("AKI") necessitating renal replacement therapy ("RRT") than first envisaged – approximately 24% of ventilated patients admitted to intensive care. A paper was presented at the 10 April NIRB meeting showing that modelling was

indicating that the demand for RRT at peak surge would be 1,200 patients **[AP202 INQ000269930]**. With 950 machines capable of the standard of care (known as "CVVH" - Continuous Veno-Venous Haemofiltration which is a temporary treatment for patients with acute renal failure who are unable to tolerate haemodialysis and are unstable), there would be a shortfall. CVVH also requires specific consumables in the form of plastic disposables, dialyser and filtrate replacement fluid. Procurement of additional machines for CVVH was difficult and there was substantial concern over the supply of consumables. The paper noted that NHS Supply Chain was confident of being able to supply for the next two weeks. It also noted that there was much greater consumable capacity to deliver haemodialysis. NIRB approved sending a letter to intensive care leads and NHS regional leads on RRT and regional mapping of equipment access and supplies shortfall **[INQ000087539]**.

815. NHS England's letter to regions **[AP203 INQ000269931]** indicated that in hospitals with high levels of Covid-19 admissions to intensive care, demand for RRT (and therefore machines capable of CVVH and associated consumables) was outstripping supply. The letter indicated that critical care networks and Trusts with critical care units should mitigate this by preventing AKI (as per the published clinical guidance on avoiding AKI **[AP204 INQ000269932]**), using CVVH machines intermittently (three patients per machine per each 48 hour period), moving to intermittent haemodialysis within critical care units where there was access to a reverse osmosis water supply, establishing critical care units with co-located renal dialysis units that can install reverse osmosis support and drainage, by taking these steps identify CVVH machines that are not required to meet demand, having regional teams running an asset mutual aid function to distribute CVVH machines to critical care units reaching capacity and encouraging clinicians to follow best available techniques to preserve consumables.
816. The National Equipment Allocation Panel determined the distribution of centrally procured reverse osmosis machines and haemodialysis machines. The supply of consumables remained between the NHS hospital and the manufacturer of the machines used. A letter was issued to Regional Directors and critical care networks on 21 April 2020 on access to RRT consumables **[AP205 INQ000269935]**. It noted that supply and distribution of consumables was being managed nationally and that deliveries of orders for the following two days would be met but that Trusts that had less than four days' supply should place orders for four days only. The Trusts themselves were to place the orders with their suppliers. The national renal incident team were to support the suppliers to determine how the orders would be fulfilled.

Subsequent four days orders were to be placed at specific times by Trusts. After a week, the supply constraints would be reviewed to define further ordering frequency. The letter also stated that supply issues may affect initiation of haemofiltration and that published clinical advice on alternatives should be followed and mutual aid should be sought via the critical care and renal networks.

817. In preparation for Wave 2, the Oxygen and Ventilation Programme undertook stockpiling of renal consumables including CVVH consumables over a period of months prior to the expected Wave 2 peak. DHSC was responsible for buying the stock through contracts with four suppliers on the NHS Supply Chain framework.
818. Following Wave 2, a weekly renal stock take was initiated with Trusts to inform the overall supply picture and inform the product allocation model.
819. ECMO is used for treatment of acute heart failure. It can be used after heart surgery to assist in the transition from cardiopulmonary bypass to ventilation. ECMO is only recommended by NICE for short term support and before starting treating, health professionals need to have in place a plan for how to support the patient afterwards. ECMO should only be used for patients whose condition would not get better with other treatments, and whose acute heart failure is likely to recover, or if there was a clear plan for what would happen afterwards – for example, a heart transplant. NICE was also told that ECMO may need to be withdrawn from patients whose heart failure is not likely to recover or who cannot have more treatment. ECMO should only be performed by a team of health professionals with special expertise and training in carrying out ECMO for acute heart failure in adults. The critical issue in ECMO use is the staff training in clinical decision making to determine which patients are most likely to benefit from treatment. The Service Specification published by NHS England explains that ECMO can be commissioned from highly specialist adult ECMO centres for adults with severe potentially reversible respiratory failure **[AP206 INQ000269889]**.
820. The National ECMO Service in England supports adults with severe respiratory failure and is commissioned from five centres. During winter 2018/19, the service supported around 30 patients at any one time for a sustained period of over eight weeks, with a peak of 36 patients. With a review of clinical priorities within the established ECMO centres it was anticipated that in the region of 40-50 patients could safely be supported on ECMO at any one time.

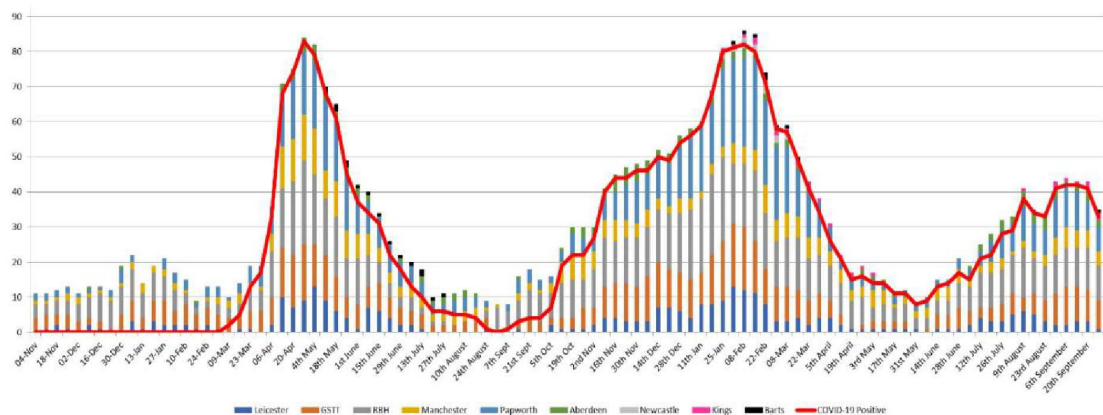
821. There was initially no formally reported international data on the use of ECMO in the Covid-19 population but intelligence had been shared within the international ECMO clinical community which suggested that the demand for ECMO in this patient cohort was likely to be limited. A report prepared by the Covid 19 Specialised Services Emergency Planning Team on surge planning for adult respiratory ECMO for the 1 April NIRB meeting [AP207 INQ000269918] indicated that a report from the Intensive Care National Audit and Research Centre suggested that the likely reason for low ECMO use was that those who had become the most unwell as a result of Covid-19 were often not suitable for ECMO due to underlying health problems and co-morbidities and that WHO guidance recommended that ECMO should only be offered in expert centres with sufficient ECMO case volume, expertise and infection control provisions to manage Covid-19 patients.
822. The report also indicated that 17 Covid-19 patients out of 2,464 in critical care on 26 March 2020 met the then criteria for ECMO and suggested that with peak demand for Level 2 and 3 critical care expected in mid-April of 22,000 up to 152 ECMO beds would be required. Revised inclusion criteria were proposed to include potentially reversible severe respiratory failure, a Lung Injury Score (LIS)  $\geq 3$ , failed trial of ventilation in prone positioning  $\geq 6$  hrs (unless contraindicated) and certain other assessed factors.
823. The report set out two options:
- a. option A was to close the ECMO service and re-deploy the staff to critical care surge on the basis that it appeared inevitable that demand for ECMO would outstrip capacity so ethically capacity should not be filled on a first come first serve basis; and
  - b. option B was to surge capacity to 100 beds at a rate of 20 beds per unit over two weeks. There were stated to be sufficient ECMO machines for this capacity but deliverability of this option depended on staffing,
- NIRB approved Option B.
824. Use of ECMO approached but remained under the limit of capacity of the ECMO service at the peak of Wave 1. The maximum utilisation was 87 on 22 April 2020.
825. Updated clinical guidance on ECMO for respiratory failure was published in June 2020 containing minor changes to the inclusion criteria in light of experience which would potentially support a small increase in the number of patients accessing the



ECMO service. It was anticipated that this increase could be accommodated in the existing service provision.

826. As Wave 2 approached, a paper on an ECMO surge plan was presented to the 14 October 2020 NIRB meeting [AP/110 INQ000269972]. The plan indicated that two additional surge centres at Newcastle and Barts, London would be commissioned to support the service once bed occupancy had exceeded 80, to create an additional 20-25 beds. Subject to capital investment, a pooled additional resource of equipment and consumables was proposed to be established to reduce need for mutual aid and impact on protected services (e.g., cardiac surgery and paediatric ECMO). NIRB approved the surge plan [AP209 INQ000269976].

827. Use of ECMO remained under the limit of capacity at the peak of Wave 2. The graph below shows adult ECMO beds occupied from November 2019 to September 2021 and was taken from the weekly snapshot that was produced to track ECMO service usage.



### Staffing required for ventilated patients and levels of training required

828. The different levels of care are described in paragraphs 196 to 210 above; staffing ratios recommended by the GPICS [AP210 INQ000269890] are discussed in paragraphs 223 to 231 above.

829. By mid-March 2020, there were increasing concerns that, based on the projected number of intensive care beds that would be required for Covid-19 patients, there would not be sufficient appropriate nurses. It was then understood that Covid patients in ITU would in the main be Level 3.

830. On 17 March 2020, NHS England issued the Phase 1 Letter, which stated “A far wider range of staff than usual will be involved in directly supporting patients with

*respiratory needs. Refresher training for all clinical and patient-facing staff must therefore be provided within the next fortnight.” [INQ000087317]*

831. On 25 March 2020, a joint statement was issued on developing immediate critical care nursing capacity by nursing leaders (including the Chief Nursing Officers of the Four Nations, the Chief Executive of the NMC, the Chief Executive Officer of the RCN) [AP211 INQ000227427].
832. The statement stated:
- “Critical care nurses will be required to take a team working approach rather than a ratio approach to patient care in order to deal with a surge in patients requiring critical care support. Other nurses, doctors and Allied Health Professions will be required to support the critical care workforce which will be challenging in terms of both their skills, knowledge and welfare. Critical care nurses will need to be supported to manage increased numbers of patients while supervising non intensive care colleagues.”*
833. In December 2020, the NHS's Getting it Right First Time programme published *“Clinical practice guide for improving the management of adult COVID-19 patients in secondary care”* which shared learning from Trusts during Wave 1 [AP201 INQ000269984].
834. It included recommendations on development of respiratory support units which stated:
- “For respiratory support units a minimum of one qualified nurse, competent in managing patients requiring respiratory support (including set-up and mask fitting), to four patients is advised. To allow for adequate staff numbers additional staff may need to be trained.”*
835. On 10 December 2020, NHS England published *“Advice on acute sector workforce models during Covid-19”* which was developed with HEE to provide an advisory framework to help support Trusts to organise their workforce in a way best suited to deliver their plans for Phase 3 [AP212 INQ000269986]. The document expressly stated that it was for individual employing organisations and Trusts to make appropriate decisions about staff models and care. The document included the following staffing ratios and stated that they should not be exceeded unless local and regional mutual aid options have been explored and exhausted and escalated appropriately:

- a. bedside trained critical care nurses to level 3 patients – 1:2;
- b. bedside registered nurses – 1:1 (including both core critical care staff and surge capacity staff);
- c. senior clinician: patient ratio – 1:15 (including both core critical care consultants and surge capacity staff);
- d. middle-grade staff to patients – 1:8 (including both core critical care and surge capacity staff);
- e. in addition to bedside nurses, on each shift there should be at least one co-ordinating nurse (or more, depending on the level of surge) and staff allocated to support data capture; healthcare assistants or medical support workers will also be required to act as runners and support bedside nurses;
- f. in surge conditions, in addition to senior medical staff providing direct patient care, there may need to be at least one co-ordinating consultant on each shift (or more, depending on the level of surge); they will be required to co-ordinate admissions and discharges across all units within the hospital and support decision-making about transfers and mutual aid with systems and/or regional colleagues.

## SECTION 11: WORKFORCE

836. Staff are the NHS' most important assets. Without them, patients could not be cared for.
837. This Section covers what steps NHS England took through the pandemic to maximise or support staff availability. Specifically, it covers:
- a. Maximisation of staff resources.
  - b. The Workforce Cell.
  - c. Data and modelling.
  - d. Staff sickness absence and testing.
  - e. Measures to increase capacity.
  - f. Immigration Health Surcharge.
838. NHS England's Third Module 3 Statement will cover:
- a. the role of NHS England with respect to supporting the health and wellbeing of the NHS workforce prior to the pandemic;
  - b. how NHS England monitored the health and wellbeing of the workforce, before and during the pandemic;
  - c. steps NHS England took to support the health and wellbeing of the workforce during the pandemic;
  - d. supporting the Black, Asian and Ethnic Minority workforce, including risk assessments and targeted support for other specific staff groups; and
  - e. staff deaths in service.
839. We understand that vaccines and therapeutics will be considered as part of Module 4.
840. Having enough staff is central to NHS resilience and capacity (and to staff resilience and capacity), as set out in NHS England's First Module 3 Statement. Section 2 of this Statement expands this further, including the headcount and vacancy picture as the NHS entered the pandemic and throughout the Relevant Period.
841. Maximising staff to create more capacity can entail any or all of the following:

- a. changes to staff ratios, such as for critical care - this is covered in Section 10 above;
- b. redeployment of staff from their core training area to another – as covered throughout this Statement;
- c. early deployment of those in training, as was the case with student nurses and doctors – this is covered further below;
- d. 'bringing back Staff', by encouraging those who have recently left to return – this is covered further below;
- e. recruitment of additional staff, such as from the international clinical workforce and using volunteers to free up clinical resources – this is covered further below; and
- f. removing friction and obstacles to deployment and recruitment, such as 'digital staff passporting' to transfer staff more swiftly between organisations, and removing costs such as the Immigration Health Surcharge – these are covered further below.

842. As articulated in the NHS People Plan, maximising staff availability is about more than numbers. A key element of staff capacity is retaining staff, ensuring their health and wellbeing are looked after and that barriers to coming to work are identified, and where possible, removed or mitigated.
843. Strictly speaking, prior to the pandemic responsibility for many of these issues did not rest with NHS England. NHS England's First Module 3 Statement (at Section 2) explains the different organisations responsible for elements of workforce prior to the pandemic.
844. However, early in the pandemic, NHS England recognised there was a need to take a lead role in supporting the expansion, redeployment and health and wellbeing of the entire workforce at pace and scale. Almost from a standing start in some cases, it responded to emerging issues by building insight mechanisms and recommending national solutions.
845. A series of workstreams were set up through the Workforce Cell (set out below) and in the People Directorate to implement these proposed steps.

846. As noted above, NHS England's Third Module 3 Statement covers several of these connected initiatives, including risk assessments for vulnerable staff and psychological support services.

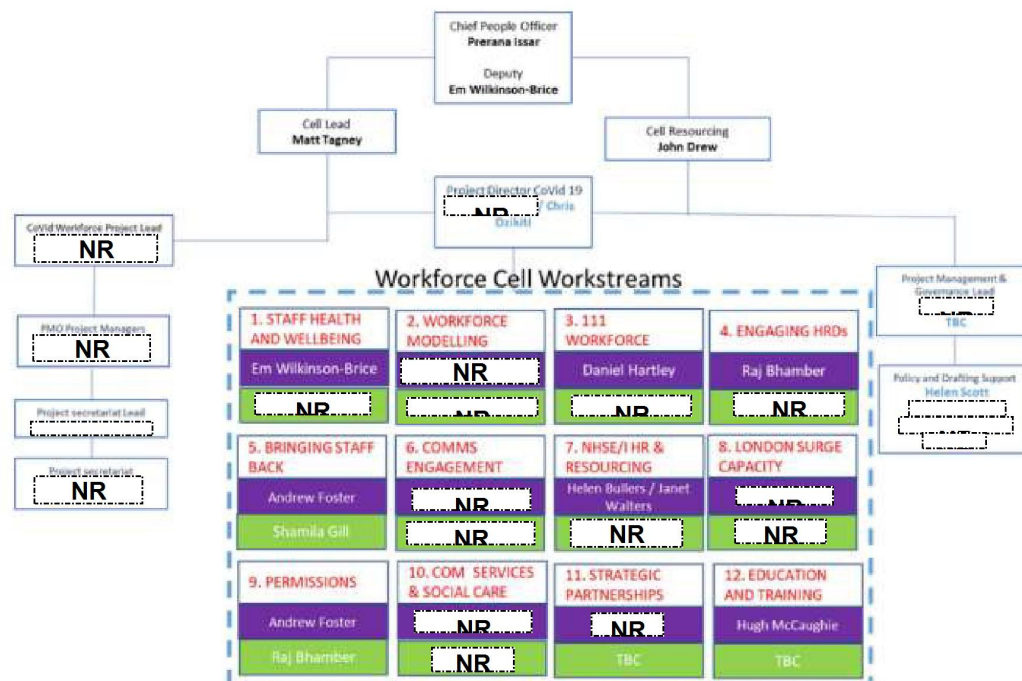
## Workforce Cell

847. 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). At the start of the pandemic the new People Directorate was in its infancy.

848. The Workforce Cell was established in March 2020 as part of the national incident response structure; however, a Covid-19 workforce planning group had started meeting from 28 February 2020. One of the key objectives of the national workforce response was supporting and mitigating a potential 20-30% absentee rate.

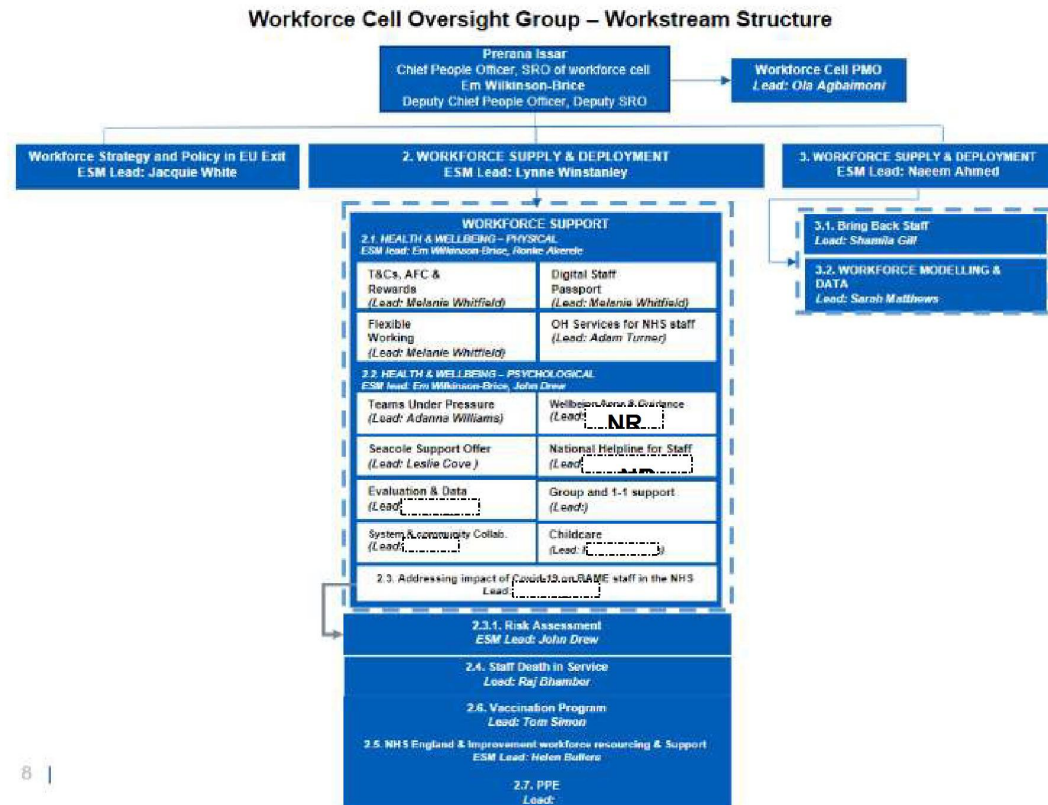
849. The Chief People Officer was appointed SRO for the Workforce Cell, reporting into NIRB.

850. An example of the early Cell structure is as follows:



851. In March 2020, the Workforce Planning daily SitRep meeting was established as the governance mechanism for the Workforce Cell. The group was led by two Directors of Workforce and Organisational Development (South West & North West regions) and had representation from Human Resources and Organisation Development, the Nursing and Clinical Directorates, Communications, Estates, Workforce Policy, and HEE. The role of this meeting as set out in the exhibited terms of reference (**[AP213 INQ000269982]**) included providing workstreams with up-to-date information from key governance groups including NIRB, Tactical Fusion and Strategic Fusion.
852. Workstreams were formed within the Workforce Cell in March 2020 with the responsibility of delivering elements of the original Workforce Project Initiation Document, reacting to emerging issues and managing additional commissioned work. The daily Workforce Planning SitRep meeting continued as a decision-making group where required, decisions often taking the form of recommendations to the SRO or Deputy Chief People Officer ("**DCPO**"), which could be escalated as appropriate. The frequency of the SitRep meeting reduced to weekly in Summer 2020, but the group retained decision making powers within the Cell and maintained cross-organisational representation.
853. Following a review in October 2020, the Workforce Cell entered the second phase of governance in November 2020 when the Workforce Cell Oversight Group ("**WCOG**") was established. The WCOG was a weekly decision-making forum, chaired by the DCPO, with senior representation from the professional leads, the regional teams, and teams within the People Directorate. The workstreams were reorganised across three pillars: Policy; Safety & Support (discussed as part of NHS England's Third Module 3 Statement); and Supply, to reflect the approaching challenges of Wave 2. An illustration of this is as follows:



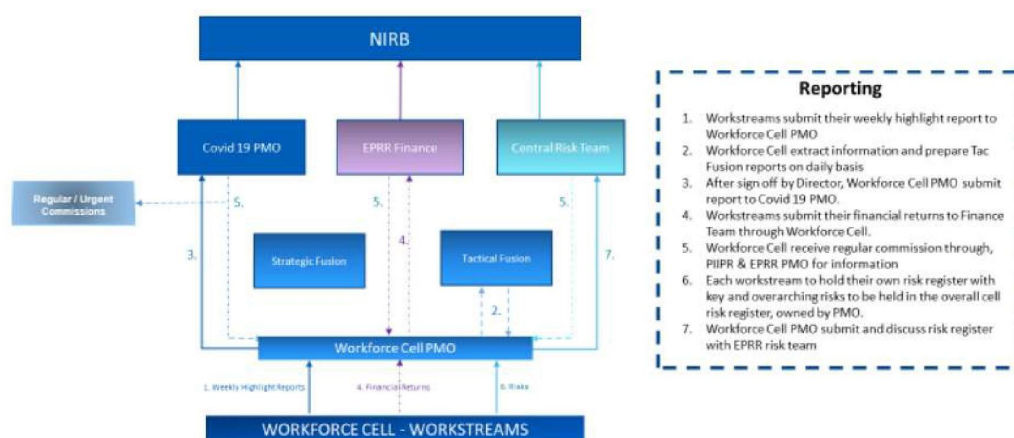


854. Bring Back Staff, Reserve and Medical Support Worker programmes (discussed later in this Section) were governed within the Workforce Cell, working with internal and external stakeholders, regions and systems to maximise the recruitment and employment of retired returners back into the NHS workforce. This work was directed by NIRB, the Chief People Officer and the Regional Directors of Workforce & Organisational Development. The programmes became part of the Workforce Supply and Safety Pillar of the Workforce Cell on 16 March 2021, when the cell governance structure was revised. The supply workstreams held a weekly programme specific oversight group, led by the programme SRO, which fed and reported into the WCOG.
855. The modelling workstream sat within the Workforce Cell, carrying out supply and demand modelling as directed by the NIRB, the Chief People Officer, the Regional Directors of Workforce & Organisational Development, and other workstreams within the Workforce Cell. The workstream reported in line with the Workforce Cell requirements and via the established reporting mechanisms administered by PIIPR PMO and EPRR PMO.
856. There was a direct relationship in place with HEE, through the Director of Workforce Planning and Information, who was also (i) a joint lead for the modelling workstream



within the Workforce Cell and (ii) a member of the Workforce Cell Daily SitRep meetings which were established as the governance mechanism for the Workforce Cell.

857. An illustration of the flow of information in relation to the Workforce Cell is set out below:



## Data and modelling

858. As the NHS does not use a single staffing computer system across all settings, gathering consistent and reliable data required a bespoke SitRep to be established. SitRep data from all parts of the service created a dashboard that, for the first time, revealed how many staff were absent on the previous day across all settings.
859. Workforce supply and demand modelling had previously never been needed at a national level to understand the daily operational demands on the NHS. Modelling was achieved by applying staff ratios to specific bed types in order to forecast the workforce requirements for Covid-19 beds on a daily basis.
860. At the start of the pandemic, NHS England ran its own models that estimated demand due to Covid-19 for PPE, workforce, pharmaceuticals and consumables. The models were based on simple consumption per admission or consumption per bed day assumptions, providing context for decision making to a varying extent.
861. This workstream was part of the People Directorate and the Workforce Cell, sitting independently of the NHS England Covid-19 Modelling Cell but contributing to this

national modelling work. The goal of the Workforce Modelling workstream was to investigate and provide available workforce information to:

- a. forecast the impact of Covid-19 on the NHS workforce;
- b. triangulate and model the effect of mitigating workforce actions (i.e., those initiatives discussed in this section to maximise workforce capacity); and
- c. assist regional systems designing and implementing their EPPR work.

862. The workstream was also tasked with considering how both supply and demand were changing and where staff with limited training/volunteers (as an example) could best be deployed. Initial development of a workforce model that combined data on staff in post from Electronic Staff Records and the epidemiological modelling by Imperial began on 16 March 2020. At this point, it was unclear what interventions the Government might introduce to delay the spread of Covid-19 within the population, and therefore, high level modelling was required to understand the possible effects of different scenarios on workforce availability, to inform decision making around activity.<sup>60</sup>

863. On 19 March 2020, the Workforce Modelling Team was tasked with developing a high level Covid-19 Workforce Dashboard. This workstream was linked with DHSC to avoid duplication of work. A single dashboard would replace the need to cascade manually produced dashboards, releasing analyst time and ensuring everyone with access could always see the most current information. The decision to use Allocate HealthRoster C-Cloud daily data to report staff absence nationally was approved. The initial release of staff absences data onto the Covid-19 Situation Operational Dashboard took place on 30 March 2020 and covered services provided by Trusts.

864. Additional support (both capacity and capability) was needed to develop absence models and dashboards while the substantive workforce analytics team was formed. Bed modelling data from the NHS England Covid-19 Modelling Cell was used directly within this workforce supply and demand model. Additional modelling support was secured from partners on 24 March 2020.

865. Modelling of different scenarios was undertaken to estimate the demand and supply gap at different points throughout Wave 1. These included modelling the Covid-19

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<sup>60</sup> As set out in Section 4, modelling only considers what might happen based on a number of assumptions.

critical care staffing ratios to understand the impact on supply. The outputs of this were presented at Workforce Cell oversight meetings, helping to inform where action on the workforce was required.

866. The model was rolled out in May 2020 to regional teams to enable local analysts to use the modelling without the need for central team input.
867. The modelling tool was deployed into the summer of 2020 to support elective care recovery by modelling various scenarios to estimate the workforce requirements for increased elective and non-elective activity. The model was further utilised as social distancing measures evolved, particularly in care settings to show what activity was possible within the continuing NPI constraints.

### Impact of Covid-19 on Sickness Absence

868. Overall sickness absence amongst staff based in HCHS<sup>61</sup> <sup>62</sup> has been higher during the NHS response to the pandemic than during the equivalent period in the previous year. However the sickness absence rate had been steadily rising before the pandemic.
869. The table below<sup>63</sup> provides an overview of sickness absence rates based on regions between 2019/20 and 2020/21, including data on the FTE days lost due to sickness absence.<sup>64</sup>

|     |   | 2018-19  |   |                       | 2019-20  |   |                       | 2020-21  |   |                       |
|-----|---|--|---|-----------------------|--|---|-----------------------|--|---|-----------------------|
|     |   | Full Time Equivalent Days Lost to Sickness Absence (includes non-working days) | Full Time Equivalent Days Available (includes non-working days) | Sickness Absence Rate | Full Time Equivalent Days Lost to Sickness Absence (includes non-working days) | Full Time Equivalent Days Available (includes non-working days) | Sickness Absence Rate | Full Time Equivalent Days Lost to Sickness Absence (includes non-working days) | Full Time Equivalent Days Available (includes non-working days) | Sickness Absence Rate |
|     | England   | 17,730,992   | 421,649,129   | 4.21%                 | 19,568,889   | 436,884,468   | 4.48%                 | 21,182,524   | 454,869,841   | 4.66%                 |
| Y56 | London  | 2,464,597  | 69,719,140  | 3.54%                 | 2,812,414  | 72,753,780  | 3.87%                 | 3,187,140  | 75,924,854  | 4.20%                 |
| Y58 | South West  | 1,678,870  | 40,157,098  | 4.18%                 | 1,858,512  | 42,158,972  | 4.41%                 | 1,795,094  | 43,302,314  | 4.15%                 |
| Y59 | South East  | 2,122,811  | 54,826,137  | 3.87%                 | 2,379,085  | 57,127,680  | 4.16%                 | 2,626,216  | 59,651,244  | 4.40%                 |
| Y60 | Midlands  | 3,334,738  | 73,712,380  | 4.52%                 | 3,656,790  | 76,262,071  | 4.80%                 | 3,901,398  | 79,710,626  | 4.89%                 |
| Y61 | East of England                                       | 1,576,123  | 38,390,422  | 4.11%                 | 1,708,151  | 39,925,535  | 4.27%                 | 1,908,684  | 41,733,136  | 4.57%                 |
| Y62 | North West  | 3,098,194  | 63,665,328  | 4.87%                 | 3,424,429  | 65,885,885  | 5.20%                 | 3,807,522  | 68,906,318  | 5.53%                 |
| Y63 | North East and Yorkshire                              | 3,132,308  | 69,501,505  | 4.51%                 | 3,393,176  | 71,298,031  | 4.76%                 | 3,691,485  | 73,536,048  | 5.01%                 |
| QZZ | Special Health Authorities and other statutory bodies | 323,350  | 11,577,121  | 2.77%                 | 338,332  | 11,471,514  | 2.95%                 | 274,986  | 12,105,300  | 2.27%                 |

<sup>61</sup> Hospital and Community Health Service.

<sup>62</sup> HCHS workforce data related to staff directly employed in Trusts and other core organisations who are paid.

<sup>63</sup> Sourced from NHS Sickness Absence Rates NHS Sickness Absence Rates January to March 2021, and Annual Summary 2009 to 2021, Provisional Statistics.

<sup>64</sup> Note: 1. Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff; and 2. While lower sickness absence rates, in general, indicate lower levels of sickness absence it should be noted that lower rates can also indicate under reporting of sickness absence.

870. Prior to the pandemic, anxiety/stress/depression/other psychiatric illness accounted for the highest proportion of sickness absence, and this is still the case.<sup>65</sup>
871. Between May 2019 and February 2020, anxiety/stress/depression/other psychiatric illness accounted for over 25% of sickness absence **[AP214 INQ000270136]**.
872. In April 2020, the percentage of staff absence caused by anxiety/stress/depression/other psychiatric illness dropped to 20.9% **[AP215 INQ000270137]**. However, this reached a new high of 32.4% in July 2020 **[AP216 INQ000270138]**. It has since dropped back to around 23% in 2022/23.
873. Data relating to staff absence was reported by NHS Digital during the Relevant Period. Data is reported monthly, quarterly and annually with varying degrees of detail. From May 2020, additional Covid-19 absence data began to be published, initially in the quarterly report. Absence was reported using a range of metrics including FTE days lost to Covid-19, a sickness absence rate for sickness absence related to Covid-19, and sickness absence due to Covid-19 as a percentage of the FTE days lost due to sickness for all reasons. Data was reported at an organisation level, staff group level, and regional level.
874. In March 2020, sickness absence due to Covid-19 as a percentage of FTE days lost due to all reasons was 15.9%, growing to 30.6% in April 2020 before falling to 9.8% in June 2020. The rate stayed below 10% until November 2020 when it rose to 15.6% increasing further as Wave 2 progressed to a peak of 28.6% in January 2021 before falling once more **[AP217 INQ000270144]**. In April 2021, the Covid-19 sickness absence rate was 7.5%.
875. The available data only shows how much of the sickness absence was accounted for by Covid-19. In early 2020, sickness absence rates increased generally, meaning the total number of staff absent from work was higher. It was not the case that Covid-19 merely replaced other illness as the cause of sickness absence.
876. For example (and as set out in **[AP217 INQ000270144]**):
- a. In March 2020, the sickness absence rate was 5.3%:
    - i. 2,003,457 FTE days were lost; and

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<sup>65</sup> Aside from the annual waves of respiratory infections, such as coughs, colds, and flu, musculoskeletal problems (other than back problems) and gastrointestinal issues were the other primary causes of sickness absence.

- ii. 318,140 of those days were lost to Covid-19.
  - b. In April 2020, the month with the highest absence rate of 6.2%:
    - i. 2,259,640 FTE days were lost; and
    - ii. 690,569 of those days were lost to Covid-19.
  - c. Even in months where absence was generally lower, both generally and due to Covid-19, such as August 2020:
    - i. 1,487,744 FTE days were lost to sickness absence
    - ii. 60,877 of those days were lost due to Covid-19.
- 877. Over the period March 2020 to March 2021:
  - a. sickness absence peaked in April 2020 at 6.2%;
  - b. in March 2021 the sickness absence rate was 4.0%; and
  - c. instances of absence using the Covid-19 related reason sickness absence code were highest in April 2020, accounting for 30.6% of all FTE days lost through absence.
- 878. Different roles and regions were affected at different times during the pandemic, as set out in exhibit **[AP217 INQ000270144]**.
- 879. For example, at a regional level:
  - a. In March 2021, the London region and the South East region had the highest Covid-19 related sickness absence rate at 13.2% each.
  - b. The South West region reported the lowest rates of Covid-19 related sickness absence in March 2021 at 9.1%.
- 880. At a staff group level **[AP217 INQ000270144]**:
  - a. In April 2020 49.5% of the FTE days lost of HCHS doctors was due to Covid-19. Covid-19 remained a key reason for absence in this group throughout Wave 1 and then again in Wave 2.
  - b. Covid-19 also accounted for a high proportion of the sickness absence for nursing staff. In Wave 1, this was across the board with all roles impacted significantly.

- c. In January 2021, Covid-19 accounted for over 40% of the sickness absence of ambulance staff and their support staff.

## Testing

- 881. Testing was led by PHE and DHSC. In support of that effort, NHS England stood up its NHS Testing Cell, which in collaboration with PHE contributed to part of Pillar 1 of the DHSC national testing programme. This involved scaling up swab testing for those with a medical need and, where possible, the most critical key workers as identified by DHSC.
- 882. During the pandemic, the NHS Testing Cell was tasked by DHSC with coordinating:
  - a. the NHS RT-PCR1 testing programme, which included high throughput and rapid turnaround testing;
  - b. the serology testing programme for NHS patients, as clinically required, and serology testing for social care;
  - c. testing of known variants of concern initially in collaboration with PHE and subsequently by NHS laboratories; and
  - d. lateral flow device testing programme for asymptomatic staff and other NHS uses.
- 883. Whilst the most vulnerable patients were prioritised for testing, all additional capacity was to be used for testing of Trusts' own staff, neighbouring acute and ambulance Trusts and, as extra capacity became available, community, mental health and primary care services, along with social care. Trusts were asked to prioritise staff in 14 day household isolation (testing the index case only), those working in critical care, emergency departments and ambulance services, and any other high priority groups determined locally.
- 884. By 12 April 2020 with laboratory testing capacity at 15,000 per day, testing eligibility, determined by DHSC, was expanded to all symptomatic staff and their household members across the NHS, including individuals working in the NHS outside of acute care. A key aspect of this decision making was to enable non-symptomatic staff members who were isolating, because a household member was symptomatic, to return to work if a test proved negative. Staff were tested from this point onwards at either NHS swabbing sites or the regional testing centres, the latter using the capacity

outside of the high volume testing labs that were part of the network of diagnostic testing facilities (the so-called NHS Lighthouse Labs). .

885. On 28 April 2020, the Government's expansion of armed forces-led mobile testing units saw the start of a roll-out programme of testing including symptomatic workers who are unable to work from home. This meant that all NHS staff were now eligible for testing whether or not they were symptomatic.
886. By the beginning of May, when NHS testing capacity reached 25,000 per day, all patients who required testing to enable treatment could be tested and where asymptomatic staff testing was required, it was undertaken. There were on-going calls for regular asymptomatic testing from professional bodies and patient groups.
887. On 24 June 2020, when NHS capacity had been further increased to 43,500 tests per day, the available NHS testing capacity was to be used for testing non-symptomatic staff working in situations where there was an untoward incident, outbreak or high prevalence rate. The CMO advised that periodic staff testing could be accessed as part of PHE's 'SARS-CoV-2 immunity and reinfection evaluation' ("**SIREN**") study. Trusts were encouraged to support a minimum 10% enrolment of staff into the SIREN study.
888. From 9 November 2020, following Test and Trace's introduction of new lateral flow antigen tests, plans were also put in place to make asymptomatic testing available to all NHS patient facing staff, with 34 Trusts being early adopters of lateral flow antigen tests before a wider rollout to all Trusts.
889. From 24 November 2020, in addition to lateral flow devices, field testing of Loop-mediated isothermal amplification (LAMP) testing technology was undertaken to test asymptomatic staff using saliva.
890. NHS England has been unable to draw a correlation between testing and its impact on staff availability. The data is inconclusive; this is because data relating to home testing was contingent on the individual uploading data.

### **Workforce Capacity Initiatives**

891. The following sections provide examples of how capacity was increased throughout the pandemic by increasing the numbers of NHS staff available by the use of volunteers.
892. As set out previously and within NHS England's First Module 3 Statement, workforce

capacity is a longstanding issue in the NHS. As of March 2020, there were over 100,000 vacancies, although the majority of these were being covered by Bank and agency staff. The pandemic increased these challenges. At the 13 March 2020 NIRB meeting, a paper was presented by the Chief People Officer based on the impact of a 20-30% absentee rate.

893. Work undertaken by professional group leads on increasing the workforce had previously been set out at the NIRB meeting on 10 March 2020. At that point, four main categories of staff had been identified:
- a. those in non-clinical roles with registration;
  - b. those working in non-clinical roles with lapsed registration;
  - c. retirees; and
  - d. students.
894. An important element of this work was engagement with professional regulators to ensure that staff were able to return to frontline practice safely. For example, nursing engagement with the NMC led to a joint letter from UK CNOs, the NMC and RCN on 12 March outlining that nurses might need to change the way in which they work during the pandemic and that the NMC would enable them to do this.
895. At that same meeting on 10 March, NIRB was updated on the workforce absence forecasting model. The model would provide forecasts for two mitigating policy options to bring staff back:
- a. bringing back retired staff (no more than one and no more than two-years since retiring); and
  - b. bringing back staff who had resigned voluntarily for reasons that did not constitute a risk,
- and the following scenarios being introduced for the general public:
- c. social distancing (now called protecting the vulnerable);
  - d. household isolation (sometimes called case isolation);
  - e. home isolation + quarantine;
  - f. home isolation + quarantine + social distancing; and



- g. no mitigation.
896. Nationwide and across Nursing & Midwifery, Medical & Dental and Allied Health Professional (such as nutritionists, physiotherapists, occupational therapists) staff groups (excluding primary care staff), it was projected by the workforce absence forecasting model that the NHS would have to deal with an absence rate of between 20.6% and 37.6% at the peak depending on scenario. Due to staff age profiles:
- a. East of England was forecast to be the worst affected region (21.2% to 38.7%); and
  - b. Nursing and Midwifery staff were forecast to be the worst affected group (21.0% to 38.4%).
897. The next version of the workforce absence forecasting model was expected by 18 March 2020 and would include the next iteration of the infection spread model informed by SAGE, further mitigating policy options (such as volunteering or use of military staff), and Primary Care Data.
898. On 17 March 2020, proposals were submitted to NIRB for freeing up resources in Trusts and General Practice. The objective of these proposals was to give guidance to acute, community, mental health and ambulance Trusts on what they should do to create capacity and free-up resources to focus on the pandemic.
899. The proposals included:
- a. Review of internal clinical roles – maintaining the resource necessary to carry out essential functions and redeploy the remainder to frontline support at primary/secondary providers as appropriate. Clinical chairs were to be asked to take more active roles within primary care.
  - b. Suspension of non-urgent activities including non-urgent training and conferences.
  - c. Consideration of how CCG back-office staff could support primary and secondary care.
  - d. Simplification and, where appropriate, suspension of certain planning and governance arrangements.
900. Planning prior to the pandemic had already identified some actions that could be taken, such as legislative levers in the Coronavirus Act 2020 to allow temporary

registrations of staff by regulatory bodies (General Medical Council, NMC and the Health and Care Professions Council).

901. The Coronavirus Act 2020 (as further discussed in Section 8) enabled people who had recently left the permanent register and overseas qualified professionals who had started their application but not yet joined the permanent register to be placed at any Trust during the pandemic period. Initially the temporary registers were limited to those who had practised recently. This was later extended, and for nursing this resulted in an expansion of eligible individuals from those who had practised within the last 3 years to the last 5 years.

### **Bring Back Staff**

902. The Bring Back Staff ("**BBS**") programme aimed to coordinate the urgent response to the NHS' ability to cope with the anticipated sharp rise in Covid-19 cases. The rise in cases was expected to lead to a shortage of staff resulting from increased workforce pressures, levels of staff sickness and self-isolation. It was a large-scale and multifaceted programme, led by NHS England and overseen by the Chief People Officer with support from multiple organisations.<sup>66</sup>
903. A paper on workforce updates and initiatives was presented at NIRB on the 13 March 2020, with the BBS programme being a vehicle to coordinate work on enhancing workforce supply. A central programme team was established to design and support a local redeployment approach to priority areas. The following categories of potential returners had been identified:
- a. Medical – c.15,000 (including approximately 2,773 GPs) who had either taken voluntary erasure from the Medical Register or who were registered without a licence to practice.
  - b. Nurses – c.51,000 registrants who had left the register within the 3 previous years. This excluded voluntary removals, those removed from the register and those who did not have a UK address.
  - c. AHPs – c.18,700 AHPs who had left the register over the 3 years previous, across the UK.

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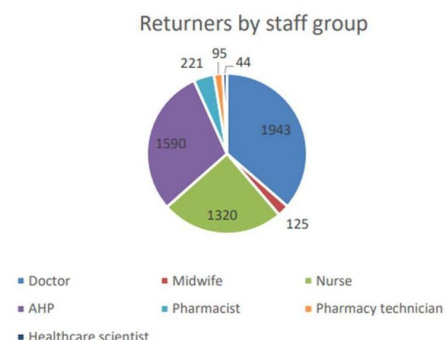
<sup>66</sup> The Leadership Academy, HEE, DHSC, Department for Work and Pensions, GMC, NMC, Health and Care Professions Council, General Pharmaceutical Council, Skills for Care, Capita, NHS Employers, NHS Business Services Authority, NHS Professionals and Indeed

- d. Midwifery – work commenced to establish plans to respond to insufficient staff to support clinical activity considering 10%, 20% and 30% staff absence. Work was also undertaken to review minimal staffing numbers required to support clinical activity.
904. The raw data represented the potential numbers available to re-join the workforce, but it did not consider the availability of those individuals.<sup>67</sup>
905. The BBS Programme delivery was in 2 phases. The BBS Programme was not initially intended to be a multi-phase programme, but it evolved to address the continued workforce capacity challenges. The phases were:
- a. Phase 1 (March 2020 – August 2020): Established a process for the recruitment and deployment of registered and employment checked workforce. To expedite this process, given the scale of the workload and the timescales, Capita were commissioned to support the process.
  - b. Phase 2 (September 2020 – June 2021): Moved towards a regional delivery model, which was underpinned by the national framework established in Phase 1. Specific focus was shifted towards providing a workforce to support national programmes, for example, the Covid-19 vaccination programme.
906. A key element of the BBS programme's work was to link up work being led by professional leads in NHS England. For example, as part of their professional leadership role, the CNO wrote to senior nurse leaders in Trusts on 19 March outlining the actions being coordinated with the other UK CNOs and the NMC to increase nursing capacity in the face of the pandemic.
907. A "Call to Arms" process started on 20 March 2020 with a 20-day window for returners to log an expression of interest.
908. By 23 March 2020, there were over 5,000 expressions of interest:

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<sup>67</sup> The information held for these individuals was also only accurate at the time of them leaving the NMC register (the NMC has no powers to keep contact information up to date for previous registrants).

|                      |             |
|----------------------|-------------|
| Doctor               | 1943        |
| Midwife              | 125         |
| Nurse                | 1320*       |
| AHP                  | 1590        |
| Pharmacist           | 221         |
| Pharmacy technician  | 95          |
| Healthcare scientist | 44          |
| <b>Total</b>         | <b>5338</b> |



909. The first aim of the BBS programme was to identify suitably experienced individuals who were interested in registering on the programme to support the NHS. During this initial period, NHS England provided regular updates to DHSC, sometimes multiple times per day, on the number of individuals registering their interest.
910. In April 2020, the GMC wrote to approximately 12,000 doctors, those who were registered but did not hold a licence to practice. The NMC reached out to members whose licence had lapsed by between 4 and 5 years and offered them an opportunity to enrol on the temporary register. This decision to further open the temporary registers followed discussions between regulators and professional leads to manage the potential clinical risk. The NMC offered the opportunity to internationally registered nurses who were not registered in the UK to join the temporary register.
911. In a parallel process, regional teams were quickly established in the form of BBS Regional Hubs, with staff being redeployed from within NHS England and other ALBs to support the programme. Expressions of interest had been submitted to NHS England; however, the roles those individuals could potentially fill would be determined at a local level, and therefore, regional influence was key to converting interests into appropriate employment offers.<sup>68</sup>
912. By the end of June 2020, there had been 47,000 expressions of interest and, following vetting of the applications and removal of duplicate applications, over 34,000 expressions of interest were passed to the BBS regional hubs.
913. Converting expressions of interest into substantive roles came with challenges. The initial "Call to Arms" took place when the modelling and evidence from other countries

<sup>68</sup> Due to the extent of the response, Capita was engaged to support the processing of the pre-employment checks as there was not sufficient capacity at a regional level to complete the checks at pace.

(such as Italy) suggested that there would be demand for additional staff, and that having a pool of skilled individuals who could be called upon was a priority. Beyond the modelling which indicated that additional critical care staff would be needed and projected absence rates, NHS England was not in a position to forecast shortages in particular roles or locations. The scheme was created as a "push" scheme rather than a "pull" scheme, focussing on increasing potential capacity rather than being demand based.

914. Once expressions of interest were received by NHS England, initial vetting and application processing was conducted nationally. Applications were then passed to the Regional Hubs to determine whether they would draw from this cohort to fill vacancies, although it would be for Trusts to employ individuals (as is normal). As this process was underway:
- a. the Wave 1 peak had started to pass;
  - b. more was understood about the treatment and transmission of Covid-19; and
  - c. Trusts had evolved their approaches to staffing. Largely, acute Trusts had been able to manage their staffing requirements locally by redeploying staff within systems.
915. A further constraint faced by NHS England in converting these expressions of interest into substantive roles was the limited potential to offer returners a role comparable to the roles they had held previously (provided they were suitably qualified). Personal and often health-related reasons were also sometimes a barrier. Barriers included:
- a. concerns about age-related vulnerability to Covid-19;
  - b. caring responsibilities; and
  - c. supporting home-schooling for family members.
916. Despite their willingness to help, many potential returners could offer only limited availability, or could only work flexible hours. These constraints would have been difficult for healthcare providers to accommodate, given the need for most clinical staff to work and coordinate across shifts. Returning staff were also required to undergo training before placements could commence, regardless of their previous qualifications, to ensure they were competent to treat patients in their new proposed role.

917. Taking note of learning from Phase 1 of the programme and following an options review at NIRB on 15 June 2020 [AP218 INQ000270145]. Phase 2 moved to a local and professional ownership model through the Regional Hubs, with national support and oversight. This was a demand focussed approach to reflect the needs of systems.
918. During Phase 2, Regional Hubs maximised employment of the returners by expanding the employment hubs out into the local systems. The local systems identified demand and matched returners to roles.
919. Phase 2 was aligned to national programmes, including NIHR, Plasma Harvesting, Continuing Healthcare, Test and Trace and the National Flu and Covid-19 Vaccination programmes, prioritising returners into roles. In the development of Phase 2, a variety of returner profiles were considered alongside examples from Trusts, ICSs and Regions to understand how needs could be met most effectively. Many returning staff who had been deployed in Phase 1 had been placed on flexible Bank contracts, allowing Trusts to draw on the resource when needed and providing the flexibility returning staff favoured. These national programmes worked well with this flexible demand-led working pattern.
920. The Covid-19 Vaccination deployment programme demonstrates the evolution of the BBS programme and successes can be attributed to the lessons learned during the BBS campaign. During the vaccination deployment programme, regional teams were supplied with infrastructure models and IT systems along with the ability to decide what was required locally. This programme allowed more flexibility in hours and location, and, for those who wished to help but were more vulnerable, an opportunity to undertake roles which did not bring the same level of risk as frontline services.
921. Over the course of both Phases of the BBS programme:
- a. 2,557 processed applications were passed to the NHS 111 telephone service and other remote working opportunities (where returning staff had expressed an interest in remote working or were unable to work face-to-face);
  - b. the Regional Hubs' BBS teams processed 33,533 applications. Of this number:
    - i. 14,311 pre-employment checks were completed;
    - ii. 4,098 were employed to frontline settings with 1,256 of these employed within the vaccination programme,

- c. approximately 250,000 care hours were delivered by returners; and
  - d. 47,000 individuals who had not only retired, but they had also let their professional registration lapse, offered to help the NHS.
922. Although the contribution of returners was significant, the conversion rate from expression of interest to being employed was relatively low as was the demand for returners (at least relative to initial expectations) as the pandemic developed. However, a lot of the learning has informed ways of attracting and recruiting people to the NHS and social care since.

### **The Health and Care Reserve Programme**

923. The Health and Care Reserve was established as a follow-on from the BBS Programme to provide a dependable, competent, trained, emergency contingent workforce that can support the health and care system at times of increased pressure.
924. Views on longer-term alternatives to the BBS programme were collected in August 2020 including the establishment of a Staff Reserve. Following consultation of those staff already engaged through the BBS programme, a pilot was approved by NIRB in October 2020. The Health and Care Reserve Programme grouped likely reservists into two categories: the Professional Reserve; and the Support Reserve. The Professional Reserve would be built of professionally qualified individuals who could serve alongside NHS staff on an occasional basis or to support surge capacity, and include both volunteers and returning staff. The Support Reserve would consist of trained individuals with discrete, highly focussed skillsets who could be employed in carefully defined settings, potentially freeing up professionally qualified staff for more demanding roles. The Support Reserve would include 3 roles: Support Reservists (previously qualified, happy in supporting role); Step Up Reservists (unqualified, want to give back through a meaningful role that requires some training; and Health First Reservists (students/young people looking for work experience). and commenced at 10 pilot sites in selected regions in March 2021.
925. Following evaluation, the Reserve programme was funded through the BBS funding allocation underspend and was established in September 2021. 4,000 reservists were recruited to support frontline winter pressures and the vaccination roll out of 2020/21. The programme addressed the lessons from the BBS campaign and reflected the need for a system led programme.

## **Medical Support Worker Programme**

926. A new 'Medical Support Worker role' was conceived and proposed by the NHS England Medical Director for Clinical Effectiveness in March 2020. It was designed for staff with medical experience.
927. Following the conception of this role, a job description was developed in conjunction with NHS Employers in April 2020 and funding approved in October 2020. The role was designed to augment existing clinical teams and provide relief to clinical teams who were very stretched.
928. In December 2020, the BBS Programme wrote to its engaged medical workforce regarding the Medical Support Worker role. In total 422 responded, of which 387 were interested in the role. After clinical vetting, 274 were identified as suitable for the role, with 114 employed from December 2020 – June 2021.
929. The Medical Support Worker programme initially sat as part of the BBS Programme and used the established regional infrastructure. As the need for the staff evolved from Covid-19 relief into a broader purpose, the responsibility for the programme transitioned into the Medical Directorate.

## **Students**

930. Students were a key source of additional capacity for the workforce during the pandemic.
931. Various groups of students were identified early in 2020 and discussions about how students could best support the NHS were led based on how each profession could be mobilised rather than on a regional basis. For example, the CNO, supported by HEE's Chief Nurse, led discussions across the Four Nations with the NMC, relevant higher education institutions and other stakeholders. Emergency powers were dealt with separately for each profession.
932. Use of students was on an opt-in basis and those that did not wish to opt-in were supported to complete their training programme. The information provided as part of the student opt-in process highlighted the potential risks of opting into the workforce, including the disruption to their studies and the personal risk they were taking by putting themselves on the frontline of the fight against a novel virus.

## **Nurses**



933. The nursing profession reacted innovatively to meet demands placed on the NHS during the pandemic. Temporary changes to professional regulation enabled final-year nursing students to voluntarily undertake paid placements in the NHS. Neither full-time employees nor full-time students, these individuals undertook a hybrid role strengthening the frontline workforce.
934. Following conversations with NHS England's Chief Executive Officer, in January 2020 the CNO commenced discussions with regional Directors of Nursing about the increasing demand for nursing staff. As part of these discussions, it was considered that the student population was likely to be part of a cohort of additional, available workforce.
935. Initially, final year nursing students within the last 3 months of their degree programmes were considered. However, early feedback from the regions and devolved administrations suggested that this would not be a large enough cohort and those in the last 6 months of their degree programmes should be considered. The potential cohort of student nurses was around 18,000 individuals (including 4,500 mental health specialists). More than 12,000 second and final year nursing and midwifery students enrolled to provide additional support.
936. Utilising nursing students in the workforce required appropriate registration status to be granted by the NMC. Special powers to do this were granted via the Coronavirus Act 2020 and a consistent deployment process was adopted across the UK. This consistent process ensured the approach for registration and support packages was the same for all students. In being placed on the temporary register, these students were deemed to have undertaken adequate training to become registered nurses.
937. As students, these individuals were not employed by Trusts, the NHS, or their universities, and therefore, did not hold employment contracts. They held contracts with their universities who, in turn had agreements with Trusts for students to undertake placements. In order for students to undertake these additional paid placements, a suitable contract of employment was drawn up by NHS Employers.
938. On the 19 March 2020, a joint statement was issued by the NMC, the 4 UK CNOs, the Council of the Deans of Health, the RCN, Unison, and Unite **[AP219 INQ000232032]**. This statement explained how the undergraduate nursing programme would be changed to enable students to opt to undertake the final six months of their programmes as clinical placements. Additionally, initial details were provided regarding the opportunity for students in the last six months of their

programmes to join a specific student part of the emergency register. This part of the emergency register included specific conditions of practice to ensure appropriate safeguards were in place. These students would undertake a transitional period of 4-8 weeks as an Agenda for Change Band 4, progressing to Band 5 in line with the changing duties.

939. Due to the significant pressures on the system and the need to ensure that frontline services were fully supported, those students in Years 2 and 3 of their degree programmes were asked to opt-in to a revised programme structure where they would undertake no more than 80% of their time in clinical practice and 20% in academic study. Ordinarily, students work in a supernumerary capacity (i.e. non-contracted and so not counted as part of the workforce) in addition to the required staff. However, under this model, the students would not be supernumerary but would be supervised and work within an appropriate delegation framework.
940. In addition to the early qualification route for final year students, an offer was made to first year students to move into a practice-based role on a temporary basis. Clinical placements were paused and programmes of study adapted. NHS England and HEE were more reluctant to rely on first year students because these students would be delaying their eventual qualification and progression into the workforce by taking "time out" from their studies to work in hospital settings. Despite this risk, the opportunity was made available for these students to take up paid or unpaid roles within NHS settings but this time would not count towards practice hours or experience.
941. 31,000 students opted into paid placements, of which 23,000 ultimately took up paid placements. The majority were final year students, but 60% of second year students also opted into paid placements. The deployment data for Wave 1 is set out below:

# Wave 1 Deployment Data

| NURSING & MIDWIFERY STUDENTS                   |                          |        |          |                            |            |            |              |       |                     | INFO                 |
|--|--------------------------|--------|----------|----------------------------|------------|------------|--------------|-------|---------------------|----------------------|
| Overall Total Students                         | Total Students Available |        |          | Total Students Unavailable |            |            | %Unavailable |       | Latest refresh date |                      |
| 31,603   | 27,292                   |        |          | 4,311                      |            |            | 13.6%        |       | 19/06/2020 09:32:19 |                      |
| HEIs Status by Region                          |                          |        |          |                            |            |            |              |       |                     |                      |
|  | East of England          | London | Midlands | North East and Yorkshire   | North West | South East | South West   | Wales | Grand Total         |                      |
| Total HEIs                                     | 6                        | 10     | 14       | 11                         | 10         | 7          | 4            | 2     | 64                  |                      |
| Active HEIs                                    | 6                        | 10     | 14       | 11                         | 10         | 7          | 4            | 2     | 64                  |                      |
| Total Students by Field of Nursing & Midwifery |                          |        |          |                            |            |            |              |       |                     |                      |
| Field of Nursing & Midwifery                   | East of England          | London | Midlands | North East and Yorkshire   | North West | South East | South West   | Wales | Grand Total         | Response rates (co.. |
| Adult Nursing                                  | 1,633                    | 2,985  | 3,380    | 3,272                      | 4,224      | 1,553      | 1,599        | 57    | 18,703              | 73%                  |
| Child Nursing                                  | 296                      | 733    | 503      | 654                        | 908        | 310        | 241          |       | 3,645               | 87%                  |
| Learning Disability                            | 78                       | 82     | 116      | 191                        | 141        |            | 24           |       | 632                 | 58%                  |
| Mental Health                                  | 567                      | 1,141  | 950      | 847                        | 1,083      | 257        | 394          |       | 5,239               | 89%                  |
| Midwifery                                      | 483                      | 723    | 457      | 541                        | 539        | 312        | 323          |       | 3,378               | 77%                  |
| Not Specified                                  |                          |        | 3        |                            | 1          |            | 2            |       | 6                   |                      |
| Grand Total                                    | 3,057                    | 5,664  | 5,409    | 5,505                      | 6,896      | 2,432      | 2,583        | 57    | 31,603              | 77%                  |

942. As the clinical need altered, further paid placements were withdrawn on 31 July 2020 and all running placements were brought to a close ahead of the new academic year. The emergency standards were also withdrawn by the NMC.
943. An options model for re-engaging the student nursing workforce was requested by NIRB in October 2020 and, in December 2020, as Wave 2 progressed, consideration was given to further redeployment of student nurses into the NHS workforce. The options model suggested the reinstatement of the same changes to training as were utilised in Wave 1. However, the timing of Wave 2 in relation to the academic year presented challenges, as many students would not be within their last six months of training. It was considered unlikely that the scheme would see as many students join the workforce as was seen during Wave 1.
944. In January 2021, NIRB considered enlisting final year students into the workforce as well as encouraging and incentivising student nurses to join the NHS Professionals Staff Bank. The Staff Bank is the largest pool of healthcare professionals who can be contracted to undertake temporary shifts in hospitals Those students registered with the Staff Bank were able to take on additional paid work as Band 2 health care assistants. At the time only 40% of students were registered with the Staff Bank.
945. Following conversations between NHS England, HEE and DHSC, and taking into

consideration the perspectives of stakeholders including the NMC and staffing unions, DHSC wrote to the NMC on 13 January 2021 requesting the NMC put in place the NMC emergency standards as quickly as possible to enable those nursing students who wish to contribute to tackling the pandemic to opt-in to paid clinical placements.

946. Unlike Wave 1, the DHSC directions [AP220 INQ000299755] to the NMC included a request from NHS England for the emergency standards to enable all final year students to enter paid placements in the NHS on a full-time basis, and envisaged that students in their first and second years remain in their education programmes in clinical placements and undertaking academic learning as planned. The decision would be reviewed after 12 weeks. The rationale for the request was that the greatest need was within nursing.
947. The timing of this relaunch meant that students were at a different place in their programme of study. Fewer students had the requisite skills to enter the workforce, and therefore, the uptake of this scheme was much lower than in Wave 1 with approximately 5,000 students entering the workforce and undertaking paid placements. The period to induct student nurses into paid placement roles took between 6-8 weeks and, as Wave 2 was already well established by January 2021, the demand curve was different and therefore the impact made by these students was potentially lower than in Wave 1.

### Doctors

948. In March 2020, approximately 5,500 medical students were in their final year and due to qualify as doctors between April and June 2020. As with nurses, this group was seen as the most capable of safely entering the workforce, having undertaken the most training and therefore able to join the workforce directly rather than in a supernumerary (i.e. non-contracted and so not counted as part of the workforce) capacity.
949. After completing their medical studies, medical graduates must undertake and complete a two-year postgraduate training programme to be able to practice as a doctor in the UK. This is known as the UK Foundation Programme and these individuals gain the title of Foundation Year 1 ("FY1"). The usual start date for the programme is August each year.
950. Unlike the NMC, the GMC already held powers under section 18 of the Medical Act 1983 to register individuals in an emergency scenario. Once an emergency has been

declared, the powers are effectively enabled and the GMC can register individuals, applying such restrictions to practice as it deems appropriate. The GMC held established plans to operationalise this power which included transferring all provisionally registered doctors to be fully registered to undertake work outside of foundation placements and to register final year medical students with conditions. It was decided that emergency powers would be used if a time arose when registration was needed to allow these individuals to undertake specific tasks (i.e. prescribing, death certification). FY1 doctors were already provisionally registered and therefore already able to provide frontline services.

951. In March 2020, the Medical Schools Council ("**MSC**") issued advice to UK medical schools to expedite qualification and prioritise final year exams where they had not yet been taken. Many medical schools graduated their final year medical students early, the date of which varied by institution. Some schools brought forward final examinations to allow earlier graduation, whilst others retained their normal schedule or decided not to graduate their students early.
952. By April 2020, the position had changed, and GMC invoked the option to register medical students and invited those in their final year to apply early for provisional registration. This meant that those students who had graduated from their medical school were able to work as doctors ahead of the usual August admission timeline. As with nurses, this was an option provided to medical students and there was no compulsory opt-in requirement. In addition to the offer made to final year students, work was undertaken to optimise the impact of doctors in training by cancelling imminent rotations so junior doctors could stay in a work environment with which they were familiar and effective. Additional practical steps such as the cancellation of study leave and examination (other than those essential for patient care) were also implemented.
953. HEE played a fundamental role, working collaboratively with partners to increase medical workforce capacity safely. This included creating a new hybrid post – Foundation Interim Year 1 ("**FiY1**") which gave those final year medical students the opportunity to join the NHS workforce early. The specific title 'FiY1' was created to denote the separation in roles and responsibilities between this post and FY1 doctors already working in the Foundation Programme.
954. The UK Foundation Programme Offices, jointly funded and governed by HEE and the four UK Health Departments, managed the application and allocation process, and liaised with the four UK Health Departments and Foundation Schools to support the

deployment of medical students. Ordinarily its assessment process would have been undertaken in person, with graduates wishing to enter the Foundation Programme assessed by clinicians, however, to ensure those clinicians were kept in hospital settings, the process was moved online. The MSC's operating guidance set out that the roles and responsibilities of FiY1s were limited to undertaking supervised tasks as part of a recognised clinical team, including note taking, ordering investigations and completing discharge documentation. FiY1s would need to be under direct supervision to see acutely unwell patients.

955. In Wave 1, 3,800 medical students were deployed to Trusts in England in FY1 roles.
956. The safety of FiY1 doctors was paramount to the deployment of final year medical students. Employers were required to give FiY1 doctors an induction and provide appropriate supervision. They were also not to be asked to work beyond their competence. HEE opened access to relevant e-learning materials to all FiY1 doctors and published a guide for Trusts to offer Wellness Inductions
957. In addition to the FiY1 initiative, medical students from all years could volunteer to undertake other supportive roles in the NHS. It is estimated that around 2,200 students volunteered in this way in England (2,800 across the UK). It was challenging to obtain precise data on the numbers due to the fluid nature of developments and the pressures on medical schools' time to undertake data collection.
958. In Wave 2, as with nursing students, the timing resulted in fewer students at a position in their studies to step into FiY1 roles. There was effectively a competency gap; moving the students into the workforce would have had a lower impact on the workforce (as the students would not be able to offer the same services as during Wave 1) and would have likely had a higher impact on the students. There was also the continuing impact on progression of the medical student population. Many elements of postgraduate training were postponed, ultimately delaying the career progression of those individuals. Internationally, some countries opted to take a "fallow year" to allow students to catch up on time missed but the nature of the training/workforce pipeline in the UK ruled out this approach.
959. In October 2020, medical students were again offered the opportunity to join the workforce as part of the vaccination effort. Vaccination roles were designated using the NHS staff banding structure and medical students were able to undertake 12 hours paid work a week as a Band 4 vaccinator delivering the injections. This role was not made available to nursing students.

## Redeployment

960. Meeting the workforce demands of the pandemic meant both using existing staff differently as well as 'making more'. Redeployment is the process of arranging for staff to perform in a different setting or role.
961. Learning from EU Exit supported redeployment. 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 (as discussed further below).
962. Guidance for expanding the workforce for critical care is covered in Section 10. NHS England also produced (and updated) two further pieces of guidance:
- a. "Redeploying your secondary care medical workforce safely", initially published on 26 March 2020 and updated on 9 July 2020 **[AP221 INQ000269959]**; and
  - b. "Redeploying our people safely" published on 4 April 2020 **[AP222 INQ000269941]**.
963. In parallel with the development of this guidance, employers asked for clarity regarding the application of the Clinical Negligence Scheme for Trusts ("CNST")<sup>69</sup> during the redeployment of clinical staff to other departments, roles and clinical duties as a result of COVID-19. Confirmation was obtained by NHS England from NHR that clinical staff at Trusts would still be protected by the CNST if they were deployed to a new area of work at a Trust, including one which was outside their normal speciality, or at a different Trust, during the pandemic.
964. Under section 11 of the Coronavirus Act 2020, the Government was to provide an indemnity for clinical negligence liabilities associated with Covid-19 which were not covered by indemnity arrangements such as those provided by the CNST, insurance companies or medical defence organisations (see paragraph 624 above).
965. The guidance in "Redeploying your secondary care medical workforce safely" was stated to be applicable only in exceptional circumstances. It set out the level of supervision staff might need if they were redeployed, to ensure they still worked

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<sup>69</sup> CNST handles all clinical negligence claims against member NHS bodies where the incident took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Membership of the scheme is voluntary but all Trusts currently belong to the scheme.

within their competency. It was to be read in conjunction with guidance issued by HEE on trainees. The guidance explained how, unlike the national capacity building schemes, redeployment should be locally determined, as local discretion was needed when deciding which of the measures should be enacted and the timing of their implementation. Local variation in staff skill mix, staff availability, services available on site, patient population and impact of Covid-19 were all factors as to why the NHS England guidance was positioned and designed to support local decision making. At the point of publication, many Trusts were already working on detailed plans for redeployment and this document was informed by their experience.

966. Several principles were outlined for medical staff redeployment, summarised below:

- a. Supervision: All redeployed doctors were to be appropriately supervised when delivering clinical care by senior doctors who routinely worked in this service, recognising that through necessity there was likely to be a higher number of junior doctors per supervising senior doctor.
- b. Competency: It could be considered likely that staff within two years of completing foundation training retained their foundation competencies and were suitable to work across all specialties with the appropriate level of supervision. Confidence, experience and site familiarity were all to be considered and support provided as required.
- c. Induction: All doctors redeployed to a new clinical area were to receive a focused induction. This induction would concentrate on clinical considerations to deliver safe patient care, life support and personal protective equipment (PPE) training. If departments already had standard induction packs aimed at FY1/2 or CT1 (Core Trainee) level, these could be used for this purpose. Induction should occur as a priority so that staff were prepared for redeployment.
- d. Rosters: Working patterns with an increased presence of staff at night and out of hours were potentially required and therefore all staff, in all specialties and at all grades might be needed to contribute to on-site, on-call rotas. Senior grades might be needed to cover their junior colleagues as their skills were redeployed.
- e. Staff wellbeing: It was considered likely that there would be high sickness rates and staff would be stretched beyond their usual working practices. It was also recognised that working outside usual systems is stressful and,



sometimes, extreme circumstances would additionally impact on wellbeing and staff morale. Local support mechanisms for doctors were to be developed as a priority and rosters designed with the assumption that a proportion of staff would be unavailable due to sickness. Staff Wellbeing is covered in NHS England's Third Module 3 Statement.

- f. Prioritisation: Organisations would have their own local prioritisation processes which should be followed. The following was a suggested order of priority:
  - i. admitting team (based in the emergency department or similar clinical area)
  - ii. inpatient team and emergency surgery/procedure team (joint or separate as appropriate)
  - iii. staff delivering ongoing, time-critical elective care such as cancer treatment
  - iv. staff delivering ongoing elective care such as virtual clinics.
- g. Further escalation: Further redeployment of clinical staff might be needed and the process for this should consider individual staff circumstances, including their previous experience and, in some cases, their own health and current medical history.

967. The publication of the second guidance document, "COVID-19: Deploying our people safely", published 13 April 2020 (and updated 30 April 2020) built on the first publication. It recognised the impact on staff and used learning to address what was now a broader group of staff and the deployment of those joining the NHS in temporary support of the existing workforce.

968. The document covered:

- a. principles to consider when deploying staff into settings and roles which are unfamiliar to them;
- b. consideration of the issues facing each professional group;
- c. consideration of issues relating to additional capacity from returners, students and volunteers;

- d. position of the professional regulators;
- e. advice on inductions;
- f. training resources; and
- g. indemnity arrangements.

969. The document provided practical and operational advice to Trusts regarding inductions and training of staff and the principles section provided a framework. The framework was future facing due to the evolving nature of the NHS response. Some of the key principles are detailed below:

- a. Action all areas: Whereas the initial focus of the NHS response to Covid-19 was on establishing critical care capacity, robust pathways were now needed to support people to leave hospital and continue their care, assessment and rehabilitation in community settings (including end of life care). Trusts were to mobilise a wide range of staff groups to ensure that capacity could meet significantly increased demand.
- b. Early Deployment: Deployment of staff into clinical areas with which they were unfamiliar was ideally to occur early, prior to any surge in demand to ensure that staff could receive the right training, induction and familiarisation with a new work environment and set of processes.
- c. Building competence and confidence: Staff brought many transferable skills with them into new clinical areas but would usually require some training, often in some quite basic aspects of delivery. Staff were to be encouraged to undertake a competency self-assessment relevant to their profession (see links to profession-specific resources below) with clinical competence noted as context-specific, not the same as confidence, or necessarily related to seniority.
- d. Supervision: All staff working in a new clinical setting or organisation were to be appropriately supervised when delivering clinical care with access to a clearly identified supervisor who was competent to act in that role. The intensity of supervision (e.g., direct, remote etc.) needed to be tailored to individual needs, but assuming that more rather than less would be required.
- e. Prioritisation: It was vitally important that all staff felt their knowledge and skills were being used to maximum patient benefit. Organisations would have their

own local processes which should be followed but flexibility was needed to ensure key services were covered when in demand and the rate of sickness absence among staff taken into account.

970. The publication further detailed the various groups of professionals and how they might be best utilised to support patient care. For example, the AHPs group consists of 14 distinct professions including paramedics, dieticians, osteopaths and podiatrists, and as they often work as autonomous practitioners, they would be best deployed to lead and deliver crucial therapy, clinical or technical services. AHPs were to be divided into two categories: therapy/rehabilitation; and science/technical, with those in the first category best suited to leading and delivering crucial cross sector rehabilitation services, and the latter category best suited to maximising imaging capacity, building critical care and ambulance service capacity.
971. Subsequently, there were additional profession-specific guidance documents issued by NHS England. These provided a similar level of detail about the transferability of skills as the “Redeploying your secondary care medical workforce safely” document. The development and publication of additional profession specific guidance addressed the potential need for acute Trusts to further engage a broader range of individuals to support demand.

### **International Nurse Recruitment**

972. International recruitment has always been vital to the NHS. Led by the CNO and the deputy CNO, the international nurse recruitment programme was established as part of the Governments 50,000 nurse commitment. Since September 2019, approximately 70,000 Internationally Educated Nurses ("**IENs**") have joined the NHS.<sup>70</sup> Around 2,000 IENs continue to be recruited monthly, supporting the pandemic recovery.
973. Throughout 2020/21 and 2021/22 the NHS recruited around 32,102 IENs throughout the pandemic restrictions. In 2020/21, 11,232 IENs registered with the NMC and joined the NHS in England. In 2021/22, 20,870 registered with the NMC and joined the NHS in England.

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<sup>70</sup> This includes only those recorded as part of the Electronic Staff Record.

974. In November 2020 funding was made available for the recruitment of around 300 IENs into critical care settings to support with operational pressures. This support was awarded across 25 Trusts.<sup>71</sup>

975. This level of recruitment was supported by several measures, including:

- a. Hotel quarantine exemption and funding support: In 2021 NHS England was successful in working with DHSC to obtain an exemption for internationally recruited nurses using hotel quarantine. Trusts were required to ensure accommodation met strict quarantine guidance that had been developed jointly by PHE, DHSC, NHS England and NHS Employers. This was one of the few exemptions made available for entry into the UK. For Trusts that were unable to meet the strict quarantine guidance, NHS England provided up to £1,750 per IEN using hotel quarantine to support the continuation of international nurse recruitment throughout the pandemic.
- b. NMC Temporary Register: The Coronavirus Act 2020 allowed the NMC to introduce a temporary register. This introduced flexibility to allow IENs who has passed all elements of the NMC registration process except the Objective Structured Clinical Examination to register temporarily. The table below shows the number of candidates who joined the temporary register, the majority of whom then joined the permanent nursing register:

| Wave   | Number of temporary register |
|--------|------------------------------|
| Wave 1 | 2628                         |
| Wave 2 | 1732                         |
| Wave 3 | 602                          |

- c. Exam validity extension: NHS England worked with the NMC to automatically extend the validity of computer-based test results due to expire between 1 March and 31 August 2021 by six months, to allow IENs to continue with their NMC registration without delays.
- d. Objective Structured Clinical Examination ("OSCE") capacity – NHS England worked with the NMC and DHSC to increase UK wide OSCE capacity to

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<sup>71</sup> The total funding which the programme was able to provide to support NHS organisations with international nurse recruitment and the costs of internationally recruiting in each year was: 2020/21 - £95 million; 2021/22 - £56 million; and 2022/23 - £69 million.

address OSCE requirements following the lifting of Wave 1 test centre closures and to support increased IEN recruitment.

- e. Visa extensions: The validity of visa vignettes<sup>72</sup> were extended from a one month to a three-month period, allowing the pipeline of IENs to continue without delays.
976. To support IENs, NHS England developed a best practice guidance for IENs travelling to England during the pandemic. This included information on risk assessments, vaccinations and pastoral support **[AP223 INQ000270023]**.
977. NHS England and DHSC were, and are, committed to ensuring that IEN recruitment is ethical. For example, in May 2021, due to significant Covid-19 pressures in India, a decision was made to pause travel and employment of nurses from India to the UK, to ensure these nurses could support their country and their families. All Trusts were expected to fulfil the offer of employment when this temporary pause was lifted.

#### Pastoral Care Support

978. Funding was provided to all Trusts to increase pastoral care. This included the release of £50,000 per Trust undertaking international recruitment to support the additional pastoral care costs associated with Covid-19 in March 2021. Costs included:
- a. onboarding – including access to technology and accommodation;
  - b. quarantine and testing requirements of new arrivals;
  - c. costs associated with joining the NMC Temporary Register;
  - d. induction – including access to specific training for international staff, welcome initiatives and pastoral lead resource;
  - e. education – access to career development support and skills gap analysis activities;
  - f. health and wellbeing;
  - g. objective structured clinical examination training – strengthening infrastructure, including practice educator resource.

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<sup>72</sup> A visa vignette is the physical visa that is assed to an individual's passport.

### *Covid-19 grants to International Nursing and Midwifery Associations*

979. Throughout the programme NHS England has funded grants of up to £10,000 to International Nursing and Midwifery Associations ("INMAs") to ensure that they are able to provide additional pastoral, professional and health and wellbeing support to international nurses and midwives working in the NHS. The first round of grants in June 2021 was provided to 12 INMAs.
980. In December 2021 NHS England provided emergency grants to 15 INMAs to increase support in response to the risk posed by the Omicron variant. Grants ranged from £2,500 up to £5,000; the total amount distributed was £70,000. Project initiatives included:
- a. delivering sessions to address vaccine hesitancy and myth-busting;
  - b. "You are not alone" wellbeing webinar;
  - c. purchasing of groceries for nurses who tested positive in isolation;
  - d. befriending scheme;
  - e. virtual meditation classes; and
  - f. virtual multi-faith groups.
981. To date, four rounds of grants have been provided to INMAs (including the December 2021 emergency grant). The programme supported the development of 30 INMAs supporting 25 different nationalities.

### **Healthcare Support Worker Programme**

982. In September 2020, NHS England established a dedicated programme to support Trusts to rapidly accelerate the recruitment of healthcare support workers ("HCSWs") to meet increased service demand under the leadership of the CNO.
983. HCSWs cover roles at Bands 2 and 3 and include healthcare assistants, nursing assistants and theatre support workers. These roles are often a gateway into the service, potentially leading to long term careers with the NHS. They are also relied upon as a supply route into Trainee Nurse Associates and pre-registration nursing.
984. There are several known factors impacting the growth of this workforce including changes to the labour market and HCSW pay, all of which have impacted the pipeline of those taking up new roles as well as those leaving the NHS.

985. The programme sought to:

- a. raise awareness and understanding of the role;
- b. accelerate recruitment through sustainable and efficient processes;
- c. bolster capacity to welcome individuals who were new to healthcare through effective induction and onboarding; and
- d. mitigate attrition through enhanced pastoral support and career progression opportunities.

986. To support providers, NHS England did a number of things including:

- a. launching a national recruitment campaign to highlight HCSW roles to individuals outside of the NHS and social care whilst partnering with industries impacted by the pandemic, e.g., travel and retail;
- b. investing £60 million to create supernumerary capacity for induction, pastoral and development support and additional HR capacity 2020/21 and 2021/22;
- c. commissioning a review of the Care Certificate to accelerate the delivery of the programme safely during a HCSWs induction programme;
- d. offering bespoke support including virtual platforms to maintain local recruitment pipelines; and
- e. publishing the learning and development roadmap to enhance competency development and retention.

987. The programme continues post pandemic to support areas such as the non-elective backlog. There are now more than 12,000 HCSWs employed in the NHS (+8.4% growth as of April 2023), totalling over 157,800 FTE staff in post – the highest ever recorded. This compares to the previous workforce peak in March 2021 of 155,649 FTE staff.







### **Covid-19 Digital Staff Passport**

988. Redeployment within systems was supported by digital staff passporting that was piloted during the pandemic.<sup>73</sup>

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<sup>73</sup> The Covid-19 Digital Staff Passport will be decommissioned in early September 2023 ahead of the implementation of the developing NHS Digital Staff Passport.

989. Within the NHS there are several ways in which staff can be shared across systems:

| Solution                               |   | When to use  |
|--|---|--|
| Workforce Sharing Agreement (aka MOU)  |  | Should be used for transferring staff from outside the NHS (e.g. Primary and Social Care) as it provides a legal agreement between parties.                                |
| NHS Smart Card                         |  | Provides some evidence of identity and where somebody works and enables access to some systems.  |
| ESR Inter Authority Transfer (IAT)     |  | If an application has been created on ESR then the IAT can be used to pull across information, if entered, from current NHS employer.                                      |
| ESR Self service record                |  | If staff member has access to ESR self service, provides evidence of training record. Employment checks are implied, without specific information being available.         |
| Collaborative Bank Apps                |  | Enables bank workers to work in neighbouring providers in scope of the collaborative bank and relies on quality of identity and employment checks process for each system. |
| Digital Staff Passport (COVID version) |  | Available to all NHS providers and all staff. Provides legal agreement between parties. Employers verify quality of identity and employment checks.                        |

990. The Covid-19 Digital Staff Passport established a clear national framework, with clarity over legal obligations and indemnities as well as a consistent approach to the data that is passported between organisations.

991. The 'passport' contains all relevant information about a member of staff, including:

- a. basic details relating to employment checks – including DBS and right to work information;
- b. professional registration details as applicable;
- c. details relating to current employment – including the employing Trust, role, staff group, department and pay band; and
- d. Occupational Health clearance confirmation and any restrictions or reasonable adjustments required for the staff member.

992. Having all of this information as part of a digital passport removes barriers by removing the need for repeating important but time consuming checks which have already been carried out by the staff member's employing Trust. The passport cannot be used as a tool for onboarding new staff – passports can only be issued once all required employment checks have been completed.

993. The system was beta tested, with improvements made following this to ensure the process was streamlined:



## Key Improvements from Beta phase



| Improvements                                  | Benefits  | Impact   |
|---|---|--|
| Simplified registration process               | Reduced average time taken to register from 4-6 weeks to c. 1 wk<br><b>Saves HR teams time and faster to register</b> | <b>Faster registration</b><br>- takes only 1-2 hrs for each of HR teams and IG leads to register |
| Regional IG agreements with national guidance | Reduced time for IG leads to c. 1 wk<br><b>Saves IG leads time and faster to register</b>                             |  |
| Saving draft credential                       | HR teams now able to <b>prepare information prior to appointment with staff</b>                                       | <b>Reduce time to issue</b><br>- takes HR and Staff to issue to c. 5 mins per passport           |
| Interface with ESR                            | HR teams now pull data directly from ESR, <b>saving time and reducing errors</b>                                      |  |
| Vaccinator credential added                   | As well as basic ID and employment record, a vaccinator role credential <b>evidences completion of training</b>       | <b>Evidences vaccinator role &amp; competencies</b>  |
| Trust comms pack                              | Helping to <b>embed use of passports</b> into standard processes  | <b>Growing awareness and demand</b>  |

**Growing demand** supported by frequent webinars with:

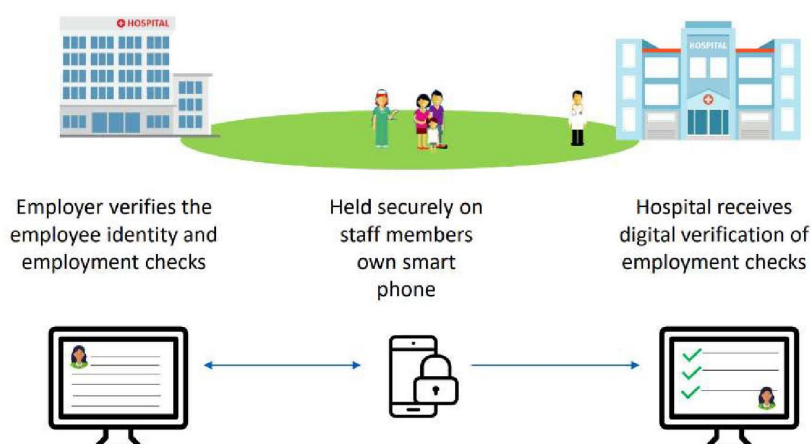
- HRDs
- ICS/Regional Workforce Leads
- IG leads
- HR User training

994. How the system works can be illustrated by the following diagram:

## How COVID Digital Staff Passport works



Staff will hold and share a verified record of their digital identity and employment checks on their own smart phone in a tamper-proof format that they can present to any other NHS organisation they are deployed to.



995. The passport was used as part the vaccination programme, with the benefits of:

- a. Secured and verified digital identity of all staff member on shift;

- b. Confirmation of:
  - i. Job Role in vaccination centre;
  - ii. Training and competence achieved; and
  - iii. Vaccine(s) that the staff member can administer.

## **Volunteers and Charities**

996. On 17 March 2020, the National Director of Strategy presented a proposal to establish an online volunteering platform with geo-location technology. As many offers of support were already incoming at this point, the proposed platform would coordinate and manage requests from NHS organisations for assistance during Covid-19, ensuring that support was, where possible, matched to need in real-time and in the immediate geographical locality.
997. On 26 March 2020, a proposal for how volunteers might support the NHS was presented to NIRB [INQ000087355]. It was conceived that volunteers might help to: reduce pressure on health and care staff and services; support timely discharge from hospital; enable the approximately 1.4m people in the clinically highest risk group to 'shield' for 12 weeks; and support people who were (socially) vulnerable to keep safe and well during lockdown (and to self-isolate as appropriate).
998. The volunteer workstream had a number of components, including:
- a. NHS Volunteer Responders: A single online volunteering platform for the NHS to match vetted local volunteers with clinically high risk and vulnerable people in their community, and support hospital transport and discharge. The platform was intended to be a back-up, local authority-led programmes which would complement and not replace informal community schemes or the national 'help your neighbour' campaign; it was aimed specifically at helping the most clinically at-risk and socially vulnerable people, in a safe and sustainable way, and also enabling coordination with GPs and other clinicians.
  - b. NHS Volunteers: To advise Volunteer Service Managers in Trusts on appropriate risk management and supporting Trusts to consider where additional volunteer capacity might safely help to reduce pressure on services.
  - c. Auxiliary Ambulance and Emergency Department volunteering in partnership with St John Ambulance: To provide:

- i. additional capacity to the ambulance service for both emergency and non-emergency calls, as well as higher acuity patient transport.
  - ii. additional capacity in Trusts through supply of clinically trained volunteers. This included support to monitoring of patients and support reducing hospital handover delays.
- d. 'Home from hospital': Working with Age UK and the British Red Cross to enable prompt and safe discharge. This was later extended to also include the Royal Voluntary Service ("**RVS**").
  - e. Project Nightingale: Identifying people for non-clinical roles, working with third party organisations to potentially redeploy their staff such as flight attendants who had first aid training.
  - f. Vaccination programme: volunteers provided additional support to the Covid-19 vaccine roll-out by delivery of vaccinations themselves, logistics and in stewarding.

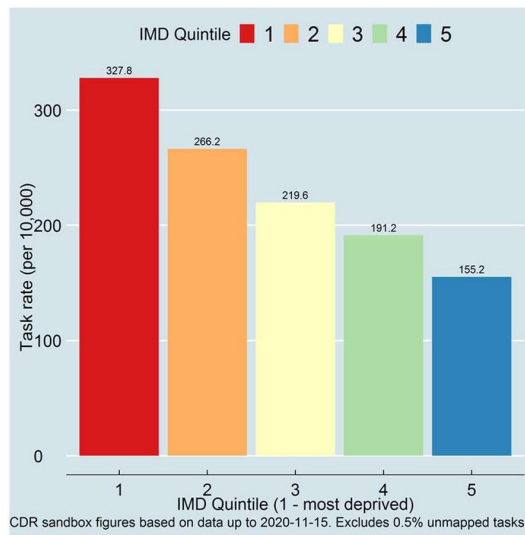
999. Several of these initiatives are described further below to illustrate the use of volunteers throughout the Relevant Period.

#### NHS Volunteer Responders

1000. Seven days after the proposal to develop the service was approved, NHS Volunteer Responders was launched on 24 March 2020 in partnership with the RVS and the GoodSam app. It enabled individuals to register to support the NHS and the clinically highest risk and socially most vulnerable members of their community in four different roles: Community Response Volunteer; Patient Transport Volunteer; NHS Transport Volunteer; and Check-in and Chat Volunteer.
1001. The programme originally asked for 250,000 people to step forward to volunteer their time to support the NHS and in the first 24 hours over 270,000 people registered to volunteer. 750,000 came forward within 6 days of the launch and recruitment was paused. Of the 750,000 who volunteered, 590,633 were approved following appropriate ID and DBS checks. By the end of September 2020, 384,896 had made themselves available through the app. Referrals started to be made from 30 March 2020 with the first tasks completed from 7 April 2020.
1002. Whilst the programme had been set up by the NHS to support healthcare professionals, the programme was swiftly adapted to be sector agnostic, enabling

anyone who might be in contact with a vulnerable person the ability to request support, including social care, MPs, police and fire services and voluntary sector groups.

1003. From 23 April 2020 the programme was expanded to enable self-referral from anyone who needed support whilst either shielding or self-isolating. Both of these changes meant that the programme was accessible by people who needed support who might not otherwise be known to statutory services already.
1004. Safeguarding was a significant component of the programme, with volunteers encouraged to report any concerns about those they were assisting to a national call centre run by the RVS. By 13 December 2021, the safeguarding team had managed 18,030 safeguarding concerns. Many of these were previously unknown to statutory services and the RVS worked with services in each case to ensure people received the support needed. 63% of all safeguarding cases related to either food poverty or psychological wellbeing.
1005. The app's functionality enabled volunteers to be matched with those needing support geographically. Tasks were sent out in real time and could be responded to swiftly by volunteers based within the vicinity of the person needing support.
1006. The GoodSam app was already in use by NHS111 and Ambulance Trusts for other forms of volunteer support and so the NHS were already familiar with its functionality. It was also extensively stress tested by NHSX to ensure it was sufficiently robust to withstand the volume of volunteers and tasks that might be required.
1007. Over 2.2 million tasks were completed by volunteers between April 2020 and June 2021. As a programme that was designed as a 'back-up' to existing local authority programmes, the number of referrals from different parts of the country varied, with significantly higher rates of referral in areas of deprivation. Analysis by NHSX in December 2020 showed that task rates were 337.8 per 10,000 population in Indices of Multiple Deprivation ("IMD") quintile 1 (most deprived), compared to 105.2 in IMD quintile 5 (least deprived) as shown in the graph below.



1008. A survey of volunteers undertaken by the RVS in July 2020 – some three months after its launch - included both positive and negative experiences of the NHS Volunteer Responders programme. Many shared frustrations with wanting to help but not being able to either through lack of demand or challenges with the application process and app. More than half surveyed felt the programme could have been better organised **[AP224 INQ000269983]**. There was initially a mismatch between supply for volunteers and requests for support, especially in areas of less deprivation. However, over time this became more balanced.
1009. A survey was also undertaken by those that had received support through the programme and of professionals who had requested support. An August 2020 survey found that the programme had met its core aims, with 92% reporting that they felt the programme allowed them to stay home and 93% that it helped them stay safe **[AP225 INQ000269978]**. Meanwhile the referrer survey found that 80% agreed that without the programme some of their patients would have struggled to shield / self-isolate, and 83% agreed that the programme helped to reduce pressure on the NHS / social care / other services **[AP226 INQ000269997]**.
1010. Research conducted through a NHS survey in March and April 2022 – two years into the programme found that, amongst other things:
- people from ethnic minority communities reported significantly greater benefits from volunteering than those with a white background;
  - the overwhelming majority of over 11,000 respondents were proud to have taken part, felt valued and that they were fulfilling a genuine need; and

- c. people who were new to volunteering said they were now keen to continue.
1011. The programme was designed to provide a flexible volunteer resource that could be deployed in different ways as need developed. This included innovative uses of the programme that had not been anticipated such as volunteers dropping off and picking up clinical samples for use in research trials and dropping off equipment such as blood pressure monitors to enable remote monitoring. The most significant development to the programme, however, enabled volunteers to support the vaccination programme (as will be examined in Module 4).

#### NHS Volunteers

1012. At the start of the pandemic, many Trusts stood down their volunteers to reduce footfall and to reduce risk to individual volunteers. However, there were many volunteers who wanted to continue and several areas where the support of volunteers made a significant difference to:
- a. the experience of patients, for example, volunteers supporting remote visiting;
  - b. staff experience, for example, volunteers delivering refreshments to the ward;  
or
  - c. services, for example, volunteer corridor runners between different areas of a hospital,
1013. To support continued volunteering, NHS England produced updated guidance to Volunteer Service Managers at regular intervals, in addition to developing a number of revised volunteer roles with input from IPC colleagues and developing an NHS Futures platform where Volunteer Managers could share good practice.

#### Ambulance Auxiliary and Support in Emergency Departments

1014. During the winter of 2019/20 NHS England had commissioned St John Ambulance to provide additional ambulance support for both emergency and non-emergency calls during the winter months. This contract was due to finish on 31 March 2020.
1015. Recognising the need for this support to continue during the pandemic, NIRB approved an extension to this contract, initially until October 2020. This was subsequently extended from November 2020 to March 2022 and again from April 2022 to June 2022. At this point a multi-year contract was agreed in recognition that an auxiliary service which can provide additional surge capacity to the ambulance

service at times of increased pressure would be beneficial year-round.

1016. Initially contracted to deliver support to the ambulance service, St John Ambulance also recognised that their clinically trained volunteers could provide support to emergency departments as well. This additional resource was provided through the centrally commissioned service between April 2020 and March 2021. Beyond March 2021 the emergency department support remained available to Trusts, but this was locally commissioned following feedback received.

1017. Between April 2020 and March 2021:

- a. 119,783 hours of support was provided to emergency departments / hospitals by St John Ambulance; and
- b. 121,945 hours of ambulance support.

1018. Between April 2021 and March 2022, 82,192 hours of support was provided to ambulance services.

#### Home from Hospital support

1019. In addition to the auxiliary ambulance contract, NHS England commissioned British Red Cross and Age UK to provide home from hospital discharge support during the winter of 2019/20. This was also due to end on 31 March 2020.

1020. NHS England therefore also extended these contracts over the same time periods as noted above for St John Ambulance.

1021. During Wave 1, British Red Cross and Age UK provided support to 165 schemes, supporting 21,000 patients with assisted discharge services.

1022. During Wave 2 (which was the most severe), the RVS were also added into the commission and the total number of services supported increased to 182 services across 107 Trusts.

#### Other forms of volunteer support

1023. Additional ways in which volunteers could support the NHS continued to be considered throughout the Relevant Period. During Wave 2, through working with the Voluntary and Community Sector Emergencies Partnership, other forms of volunteer support, such as Re:Act, were identified.

1024. Prior to the pandemic, Re:Act volunteers, who are typically veterans or ex-blue light

volunteers, provided support in emergencies overseas.

1025. NHS England worked with Re:Act to extend support offers to different parts of the NHS. During the pandemic they pivoted their operations, providing support to:
- a. Test & Trace;
  - b. the vaccination programme; and
  - c. hospitals with surge requirements such as portering, help in mortuaries, or in Intensive Care Units.

### **Immigration Health Surcharge**

1026. The NHS Surcharge (Immigration health surcharge) is a charge levied on anyone not ordinarily resident in the UK coming to the UK on a temporary stay of more than 6 months.
1027. Once paid, and once a visa is granted, the immigrant can use NHS services. The surcharge must be paid at the time of making a visa application and must be paid to cover the full duration of the visa.
1028. At the end of April 2020, the Government announced that frontline workers with visas due to expire before 1 October 2020 would receive an automatic one-year extension and be exempt from the NHS surcharge for the duration of the exemption.
1029. Around April/May 2020, the removal of the surcharge was included in a list of potential areas for discussion with DHSC in terms of removing barriers for nursing retention and recruitment but the impact of this was not assessed other than including an estimated cost of introducing the policy (estimated at c.£85 million) in the points for discussion. This was fed into DHSC who took this forward with the Home Office / HMT (as we noted that their agreement was needed for the idea to be feasible). On 21 May 2020, the Government announced that overseas NHS staff and care workers would no longer have to pay the surcharge.
1030. NHS England has not been involved in any work that analyses the impact of the removal of the surcharge. If any analysis of this sort has been carried out, it is more likely to have been carried out by DHSC, but NHS England has no knowledge of any such analysis being carried out.



## SECTION 12: NIGHTINGALE HOSPITALS

1032. This Section sets out NHS England's role in the creation, commissioning, operation and decommissioning of the Nightingale Hospitals ("**Nightingales**") and the Nightingale Surge Hubs and includes information on funding, activity and challenges.

### Overview of Nightingales

1033. Historically, a Nightingale ward is a large open-plan ward that provides dormitory-style accommodation for hospital inpatients, rather than the individual or shared rooms which are now favoured in modern hospitals. It allows for easier observation of patients as there is no subdivision of the ward. It is also a term used by the military for field hospitals.

1034. The following table indicates the seven Nightingales that were established in England in 2020 in response to the pandemic the date on which they were approved and the date they became operational:

| <b>Nightingale</b> | <b>Approval date</b> | <b>Operational date</b> |
|--------------------|----------------------|-------------------------|
| London             | 23 March 2020        | 3 April 2020            |
| Birmingham         | 10 April 2020        | 16 April 2020           |
| Manchester         | 10 April 2020        | 13 April 2020           |
| Harrogate          | 15 April 2020        | 21 April 2020           |
| Bristol            | 17 April 2020        | 27 April 2020           |
| Sunderland         | 29 April 2020        | 5 May 2020              |
| Exeter             | 1 July 2020          | 6 July 2020             |

### Decisions to create, commission and operate the Nightingales

1035. Considering the modelling of expected numbers of Covid-19 patients based on the RWCS, preparations to manage a surge in Covid-19 infections and the impact on NHS resources had been discussed by NIRB during March 2020.

1036. By mid-March 2020, news reports were emerging from Italy of high death rates and the inability of Italian hospitals to treat the increasing number of seriously ill Covid

patients. Similarly, there were images and reports of the field hospitals established at speed in the province of Wuhan, China, to care for the rising numbers of infected patients.

1037. NIRB noted at its 20 March 2020 meeting [**INQ000087329, INQ000087330, INQ000087331 and INQ000087347**] the continued overarching risk that even with continued mitigations the NHS might be overwhelmed by Covid-19 with potential adverse health and public consequences. High absence rates among the healthcare workforce were likely due to staff sickness from Covid-19, self-isolation and caring responsibility (e.g., school closures). Redeployment of staff to high-priority areas was also expected.
1038. At that time, modelling indicated that London would be the first area within England to experience a surge of cases. The peak had previously been expected to occur in mid-June, but was now expected sooner. Imperial College modelling deduced 455 ITU beds per million population which translates to 4,000 critical care beds in London. The London capacity at that time was circa 800 critical care beds. The NHS was seeking to expand critical care capacity at pace including via ventilator procurement and other equipment procurement, medical gases and oxygen supplies, medicines supply and arrangements for use of independent sector capacity. The independent sector could theoretically provide an additional 316 ventilated beds and the London STPs estimated that they could make an additional 1,355 ventilated beds available before 10 April. Further iterations of availability of additional beds were ongoing, with later STP estimates suggesting a current planned surge of critical care capacity of 2,769 ventilated beds across the five London NHS systems.
1039. A three-phase approach was being considered by NIRB focusing on surging capacity, super-surging capacity and "external capacity". This included discussion of a proposal to commission a 1,000-2,000 bedded Covid-19 facility for London. The potential benefits and risks associated with this and the next steps to develop the feasibility plan for the proposal were considered.
1040. The vision of what became the concept of the Nightingale was largely conceived over the course of the weekend of 21 and 22 March 2020. This followed models that had already been deployed in other countries (e.g., China), and reflected the fact that at the point of conception, the scientific understanding and the experience of other countries indicated that there was likely to be a greatly increased need for ventilated

beds and critical care; the projections at this point suggested that the NHS in England would quickly run out of suitable facilities to treat patients. The Nightingales were therefore created, on the basis it was better to have them in place, as a contingency in extreme circumstances, but one which NHS England hoped never to use. Inherent in the Nightingale assumption was that they would need to be "right-sized", to enable flexibility regarding staffing models, and able to be built at speed.

1041. Once the idea of the Nightingale had been formed, NHS England needed to assess three key factors - costs, authority to proceed, and who practically would be able to make this happen. Rough costings were initially produced to give the Government a general indication, following their steer that funding should not be the limiting factor at this point.
1042. On 23 March 2020, NHS England officials, including the London Regional Director, the London Regional Medical Director, the Chief Executive Officer and the Chief Operating Officer, attended a meeting with the Prime Minister, SSHSC and a number of other Government ministers and officials [INQ000087337 and INQ000087338]. At the meeting, the NHS attendees briefed the Prime Minister that, based on the current trend, expected demand over the next two weeks for critical care beds in London would be 7,488. It was explained how the NHS would be able to surge its capacity in London, within its existing footprint, to a total of 1,555 staffed and equipped beds (Surge 1) over the next two weeks, and a further 1,955 (Surge 2). This would give a total capacity in London of 3,642 beds factoring in utilisation of 132 independent sector beds. Despite these measures the demand for critical care beds might still be overwhelmed by Monday 30 March 2020.
1043. The group was advised that a further option to meet the projected demand was to progress "Project Nightingale" which was the rapid creation of an additional 4,000 critical care beds in the ExCeL Centre in Newham. A workable deliverable solution could provide 500 beds within 4/5 days but to do so would require military support. Oxygen for 500 beds could be delivered within that timeframe. An additional 3,500 beds could be in place by 3 April. It was suggested the facility could become a national resource as the surge spread to other regions. It was assumed that enough ventilators would be secured and that staff for the facility would be provided from outside London depending on the pattern of outbreaks across England. The Prime Minister confirmed approval for the creation of the London Nightingale. The intention with the facility was to only treat Covid-19 patients that needed mechanical ventilation. Each bed would have a ventilator which required oxygen to be piped to

the bedside. An oxygen supply tank needed to be procured and associated piping needed to be constructed. Healthcare staff experienced in critical care would manage patients. The open plan setting and rows of beds meant that fewer senior staff would be needed to oversee junior staff than compared to a usual hospital setting with bays and side rooms for individual patients. All patients would be unconscious (as is the usual situation when using a mechanical ventilator). This implied that the design and build of the facility would be easier and quicker; for example, there would be need for far fewer patient bathrooms than would be the case in a general hospital setting.

1044. This clinical model for the London Nightingale became the starting point for consideration of subsequent facilities. However, the understanding of Covid-19 as a disease and its impact on the human body progressed rapidly and impacted on consideration and determination of the appropriate clinical mode for subsequent Nightingale and later uses of the facilities.
1045. Following consideration at NIRB, NHS England publicly announced on 24 March 2020 [INQ000087578] that a new facility, referred to as the NHS Nightingale Hospital, London, would be ready for use from the following week. It was stated that the London Nightingale would be based at the ExCeL conference centre and initially provide up to 500 beds equipped with ventilators and oxygen with capacity increasing, potentially up to several thousand beds, should it be required.
1046. On staffing, work was progressing at pace to deliver a workforce. Volunteer non-clinical staff were being recruited and staff at the London Nightingale were offered accommodation and transport.
1047. NIRB decided on 25 March 2020 [INQ000087356] that the London Nightingale should be managed as part of Barts Health NHS Trust. Under this approach, the clinical staff working at the Nightingale would be seconded into Barts Health NHS Trust and the Nightingale would be managed in accordance with the Trust's routine management processes and under the Trust's CQC registration. This "host Trust" arrangement set the model of accountability of operation of all Nightingales across England. It is akin to a hospital opening a facility at a new site – most Trusts operate more than one location.
1048. The contractual arrangements and the physical construction of the site, only made possible by a team of sub-contractors, the military, volunteers and NHS workers, continued at pace over the next few days. On 3 April, NHS England announced that the London Nightingale was to officially open that day.

## Expansion of the Nightingales

1049. On 23 March 2020, NIRB considered the approach to surge capacity planning across the other six regions in England **[INQ000087339, INQ000087340 and INQ000087357]**. This included the timeframe for implementation in London and other regions, taking into account the anticipated increase in Covid-19 cases in the coming weeks. NIRB requested that the London region develop modelling and plans to clarify and provide assurance on the approach at two, four, six and twelve weeks. NIRB members also requested that, drawing from the London region's approach, surge capacity plans should be developed by the other 6 regions.
1050. Feasibility assessments on further potential sites as part of NHS England's Nightingale Expansion Programme begun 24 March 2020, with support from the MoD who undertook population and resources plotting and mapping work **[INQ000087346]**. This focused on factors to take into account when determining the location of further Nightingale facilities such as population densities, age of population, population deprivation, travel times (patients bound for the Nightingale were to be transferred from a local NHS hospital while mechanically ventilated or otherwise intensively supported) and locations of Trusts with critical care capabilities. The latter point ensured there was a locally based supply of appropriately trained and experienced staff to operate the Nightingale and also provide local treatment facilities to any Nightingale patient suffering complications.
1051. Consideration was given to sites similar to ExCel, as well as smaller facilities. Ultimately, sites were chosen on the basis of their ability to create a geographical "spine" of resilience through England, after considering the outputs of the mapping exercises.
1052. A national assurance process was followed with the National Nightingale Assurance Panel. This process was used with all Nightingales although the process was not formally ratified until the NIRB meeting on 17 April 2020. The scale and co-ordination needed for the Nightingale Expansion Programme meant that it would be efficient and appropriate for this to be done centrally by NHS England – meaning Trusts could focus as much as possible on operational matters.
1053. The National Nightingale Assurance Panel was chaired by the Chief Operating Officer and included a range of persons including NHS England representatives and, for specific Nightingales, NHS England's Regional Director, the Chief Executive of the host Trust and the relevant Nightingale's Chief Executive and Medical Director.

1054. The national assurance process contained four key domains:

- a. Estates – review of the many options for Nightingale sites and management of relaxation of planning matters;
- b. Supplies – a checklist of the critical items needed for patient care and enough stock to provide patients for five days. An asset management system needed to be in place and there needed to be security of supply (in terms of physical security of stocks and supply chains) to ensure stock was not depleted;
- c. Clinical – the clinical model needed to be submitted to a national clinical panel with modelling assumptions, proposed model of care and key clinical and mobilisation risks indicated. There would also be an in-situ clinical walkthrough of the Nightingale prior to it being deemed operational which was undertaken by members of the national clinical panel, reviewing at a high level the systems and processes in place to provide safe care; and
- d. Legal – securing the site (usually involving a licence to occupy with the landlord) and commissioning the clinical services. The latter included Heads of Terms between NHS England and the host Trust and the adapted NHS Standard Contract with a side letter containing relevant indemnities. The Exercise of Functions by the National Health Service Commissioning Board (Coronavirus) Directions 2020 came into force on 28 March 2020. These Directions (**[AP227 INQ000269934]**) empowered NHS England to commission the host Trusts to provide health services from Nightingales (e.g., Barts in London). Without these Directions, that commissioning role would have fallen to CCGs under section 3 of the 2006 Act. NHS England advisors would work with project leads with supportive visits being undertaken to gain assurance.

1055. Once the assurance process against the four domains (as above) was complete, final national review and sign-off was the responsibility of the National Nightingale Assurance Panel (acting on behalf of NIRB). In all cases, this also involved a 'walk through' by certain members of the Panel. Once the national assurance process had been completed, the host Trust undertook their own assurance and notified the national team when this was complete before the first patient could be received.

1056. A new Critical Care Staffing Model was proposed for all London Trusts to allocate all staff groups into NHS hospitals and Nightingales. This was to be implemented immediately, along with the creation of the Greater London Workforce Hub, and co-

ordinated by HEE. Those volunteers and staff seconded into the Nightingale were offered free accommodation, meals and transport between their accommodation and the Nightingale.

1057. From late March 2020, the Nightingale Expansion Programme kept under consideration a range of different sites across England. These included the six locations outside London where Nightingales were actually established – Manchester, Birmingham, Bristol, Harrogate, Exeter and Sunderland along with others including:

- a. a university site in Hatfield;
- b. a conference centre in Bournemouth;
- c. a conference centre in Farnborough;
- d. a field hospital deployment in Cumbria;
- e. Terminal 4 at Heathrow;
- f. a private leisure centre in Basildon;
- g. an airport facility at Stanstead;
- h. a sports village in Nottingham; and
- i. the Arena in Leeds.

1058. There were a range of reasons why these sites did not progress, including that the spatial analysis carried out with the military indicated certain sites within a region were more appropriately located than others, the proposed facility was too small or too large for the modelled demand in that region, the transport links for ambulance were less favourable, the layout of the proposed facility was not as appropriate as other sites, the site landlord raising concerns about how quickly they could take back control of the site once lockdown ended and events or use of facilities could restart, or complex contractual arrangements associated with use of a site, such as PFI arrangements.

1059. From the end of March 2020 to May 2020 a daily call was established by the Nightingale Expansion Programme with regional Nightingale leads to understand the situations with potential sites for new Nightingales. The six regions outside London were represented – Midlands, North West, South West, North East, East of England and South East. The national Nightingale Expansion Programme provided updates

on specific matters with each region commenting. The call was a forum to test planning in real time, and the many things needed to run in parallel if anything could be opened rapidly. Dual running of site and model might be required. On the call on 31 March 2020 the national Nightingale Expansion Programme stated that decisions on the next round of sites (excluding London, Manchester and Birmingham with the clinical models for the last two being discussed at that time by the national clinical panel) would focus on four aspects – latest updates on national data and assumptions, population mapping work by the army on behalf of ambulance services, estates matters and clinical models [AP228 INQ000269917].

1060. To assist the Nightingale Expansion Programme and ensure that robust decisions were made on development of potential Nightingale sites, the Office of the Chief Operating Officer shared a document setting out the key priorities for scaling out Nightingales with a wide range of persons at NHS England involved in the Nightingales. . The document [AP229 INQ000270072] was a collation of the lessons learned to date and insights from the leadership on the London site and how that played into Regional Leadership. This working document considered a broad range of matters including:

- a. governance of the entities involved in Nightingale development, including the host Trust, local government, military, subcontractors, etc, the frequency and content of meetings, reporting requirements;
- b. the cell and workstream structure covering a number of areas such as estates, procurement, communications, staff support, clinical protocols, finance, IT, pharmacy, etc.;
- c. questions on the rationale for the site – need, capacity gap, population characteristics, clinical models and understanding of Covid-19 at that point, staffing model fitting in with the local area's staffing plan, logistics of transfer of patients;
- d. planning for long lead time actions – oxygen situation at the site, identifying partners, staffing model;
- e. principles for how to work together at pace;

1061. At its 1 April 2020 meeting, NIRB approved four additional sites – the Midlands, North West, North East and South West regions [AP230 INQ000087376] NIRB specifically noted that these sites might not be required in the current wave but it was considered



appropriate that they be prepared in the event that increased capacity was needed. It was noted that the next phase of work to consider additional facilities in other regions was being considered alongside the most up to date data on utilisation and the national position on Covid-19 capacity. NIRB discussed the clinical models to be considered throughout the Nightingale Expansion programme and also the next steps to ensure the resilience of services, strengthen staffing models and assure plans for patient transport and accessibility of services, particularly for vulnerable individuals and rural communities, across the country. NIRB noted generic risks including the availability of ventilators and other key equipment, the timing of delivery of oxygen infrastructure, the staffing strategy and the planning of transport to support patient flows.

#### Financial Overview

1062. In 2020/21, the Financial Directions ringfenced funding of £466 million for the Nightingales.
1063. NHS Improvement responded to a request under the Freedom of Information Act 2000 on 10 July 2020 which stated that the total set up costs for all seven Nightingale sites, was at that date, around £220 million. The set-up cost of each Nightingale was given in a response to a Parliamentary Question on 11 January 2021:

| <b>Nightingale</b> | <b>Set up costs (£)</b> |
|--------------------|-------------------------|
| London             | 57,411,000              |
| Birmingham         | 66,408,000              |
| Manchester         | 23,471,000              |
| Harrogate          | 27,314,000              |
| Bristol            | 14,209,000              |
| Exeter             | 11,163,000              |
| Sunderland         | 20,102,000              |
| <b>Total</b>       | <b>220,078,000</b>      |

1064. Following the end of the first wave, discussions then commenced regarding their future use. Indicative costs had been calculated for each site on standby and a range of stand-up scenarios based on utilisation of beds. The total standby costs monthly were approximately £8.86m, and stand-up costs ranged from £96.58m to £290m depending on the bed capacity utilised. As a result of the Nightingales already having been established, Regional Directors requested that their capacity should be maintained through a potential second peak, winter pressures and recovery of other services. The Nightingales would, in these scenarios, provide valuable back up capacity which could be needed to manage Covid-19 and non-Covid-19 spaces, whilst longer term, more permanent capacity was developed within the healthcare system.
1065. The 11 January 2021 Parliamentary Question response forecast that the total costs including set-up, running costs, stand-by costs, and costs of decommissioning across all Nightingales would reach around £532 million.

#### **Details of each Nightingale**

1066. This section provides further details for each Nightingale relating to the location, the host Trust, the NIRB approvals, and the clinical model including expected types of treatments in the first wave. It also sets out activity levels in Wave 1, how each Nightingale was used in Wave 2 and any other uses of the Nightingales.

#### **London**

1067. The considerations and rationale for the establishment of the first Nightingale at Excel in London and NIRB approvals are set out above.
1068. The process of a patient being admitted within a Nightingale hospital starts with a referral. A Standard Operating Procedure ("**SOP**") was produced for the London Nightingale which supported the admission of patients and ensured that they were admitted to the Nightingale in an efficient and safe fashion [**AP231 INQ000270021**]. It was stated to be made under the governance arrangements of the host Trust. The SOP highlighted that no triage would be carried out in the Nightingale itself. For all patients admitted, the inclusion/exclusion criteria for the Nightingale must have been met prior to acceptance and transfer of patients. Patients with Covid-19 would arrive by ambulance with a dedicated transfer team. The Nightingale Operations Centre would pre-admit the patient on receipt of the patient's relevant information. After arriving in the admissions area, the patient would be identified and the transfer team would wheel the patient to the bed. Patient handover from the transfer team to the

Nightingale team would occur at the bedside within the Nightingale with any equipment such as ventilators being swapped over. The SOP also contained many scenarios that might be encountered and the appropriate action to be taken.

1069. The London Nightingale was open for admittance of patients from 3 April 2020 until 4 May 2020 when the Chief Executive of the London Nightingale announced that no more patients were likely to be admitted and the site would be placed on standby. During that period 57 patients had been admitted, all with Covid-19.
1070. For Wave 2, the London Nightingale was not used to admit patients but from 11 January 2021, the site was used as a mass Covid-19 vaccination centre until late June 2021.

### Birmingham

1071. Following input from the Nightingale Expansion Programme NHS England announced on 27 March 2020 that the Birmingham Nightingale would be established. It was to be hosted by University Hospitals Birmingham NHS Foundation Trust.
1072. The clinical model for Birmingham Nightingale was a “decant LO/O+ model for those with a L2 or L3 treatment level”. The aim was to move as much O/O+ activity at Level 2 treatment level to the Nightingale site and include intensive rehabilitation to allow Trusts to fully surge for Level 3 treatment. It was able to initially provide 62 beds with a potential quick expansion to 600-800 total beds and then to 2,000 total beds within a month with a potential capacity of 4,000 total beds in time. This model was different to the London Nightingale because the existing Trust estate in the Midlands region was able to surge up to 1,545 ventilated beds meeting nearly all of the modelled peak surge demand. The clinical model for the Nightingale was therefore to decompress as much as possible O/O+ activity and include intensive rehabilitation. It was not intended that there would be transfers from Trust premises to the Nightingale for patients on ventilators.
1073. On 10 April 2020, NIRB approved the opening of the Birmingham Nightingale subject to the clinical panel's agreement of the clinical and staffing models for the facility [AP232 INQ000087539] The Midlands' Regional Director provided an overview of its development and operationalisation. The capacity of the Birmingham Nightingale in surge and super surge scenarios was discussed. There was a discussion on the clinical and staffing models that would be implemented. NIRB discussed the proposed organisational structure and leadership team for the new facility and

considered the ongoing work on oxygen and ventilator capacity across the region to manage supply.

1074. The Birmingham Nightingale opened on standby on 16 April 2020, so it was not intended to admit patients immediately, but it had the ability to be stood up at 72 hours' notice and therefore be in a state of readiness to receive patients. No patients were admitted during Wave 1 due to the reducing level of Covid-19 infections and because hospitals in the region had not reached full capacity. In November 2020, in preparation for Wave 2, the Birmingham Nightingale was made ready to accept patients on 48 to 72 hours' notice; but ultimately no patients needed to be admitted.

#### Manchester

1075. The Manchester Nightingale was hosted by Manchester University NHS Foundation Trust.
1076. The clinical model for Manchester Nightingale was a "decant and step-down LO/O+ model". The aim was to take further O+ patients from the date it opened from Level 2 treatment in Trusts. The model focused on ensuring out-flow from intensive care was optimised by step-down and the decant of ward patients. It had a Level 2 treatment level with an estimate of 30% receiving CPAP. It was able to initially ramp up 56 beds with a potential quick expansion to 236 total beds, and a potential capacity of 503 total beds in time. This model was different to both London and Birmingham Nightingales because modelling for the North West region predicted a need for around 2,200 ICU beds and planning exercises in the North West indicated this could be achieved within the NHS hospitals. The predicted early need was to decompress ICU across the region by focusing on removing single organ failure patients from critical care when stable, but still requiring oxygen supplementation, either via face mask, high flow alone or CPAP, and transferring them to the step-down Nightingale facility.
1077. Staffing was to be made up of medical and nursing roles and allied healthcare workers such as physiotherapists and a range of non-qualified support workers. Staff were to be sourced from a variety of sources - by recruitment of non-active NHS staff, including NHS Provider led recruitment and from the independent sector, retired persons, persons drawn by national initiatives (e.g., graduating year 5 medical students) and the non-healthcare professional workforce. If these sources would not be sufficient to enable operations, a workforce plan would be agreed with local Trusts, community care providers and primary care.

1078. On 10 April 2020, NIRB approved the opening of the Manchester Nightingale, subject to the outcome of the upcoming clinical walkthrough and clinical panel meeting. The Manchester Nightingale opened on 13 April 2020 with the first patients admitted a few days later. It was put on standby in mid-June 2020 as the acute hospitals in the North West were considered to have enough capacity to admit Covid-19 patients. During that time, it had admitted 84 patients all with Covid-19.
1079. In preparation for Wave 2 the Manchester Nightingale was stood-up on 29 October 2020. The clinical model was different to the original model: for Wave 2 the site was intended to offer a step-down facility for patients without Covid-19. While it was able to admit patients, none were. From October 2020 until the end of March 2021, the Manchester Nightingale site was used to provide a range of NHS services to non-Covid-19 patients.

#### Harrogate

1080. The Harrogate Nightingale was hosted by Leeds Teaching Hospitals NHS Trust and was based at the Harrogate Convention Centre.
1081. At its meeting on 15 April 2020, NIRB approved the opening of the Harrogate Nightingale subject to no material issues being identified in the upcoming clinical walkthrough. NIRB discussed its capacity and the potential for it to be used for both Covid-19 and non-Covid-19 services in surge and super surge scenarios. Consideration was given to the clinical model that would be implemented at the facility. Members also considered the proposed staffing model for the facility and the training that had been provided to staff to date. NHS clinical and non-clinical staff would be seconded to the Nightingale via an MoU with the host Trust. Support would also be provided from other sources including independent healthcare organisations and direct recruitment. A request via MACA for military support for a variety of roles was also approved. The staffing model balanced the minimum requirements to provide the services safely within the overall context and the pressure on acute NHS providers across the Yorkshire and Humber region. NIRB also considered the need to review the ventilator and oxygen capacity that could be deployed over the next six to 12 months at a regional and national level, the phasing of this and the potential risks to implementation.
1082. The clinical model for Harrogate Nightingale was a “a step-across L3(V) or L2(O+) model used as provider level 3 / level 2 capacity reached, with a period of feeder Trust stabilisation”. The aim was that patients who deteriorated in their local hospital

would be stabilised on ventilation or NIV (CPAP) and then transferred after a 24 hour period to the Nightingale and its step across-model providing level 2 and 3 care. Infrastructure and staffing did not support step-down to ward care so there was reliance on transfer back to local Trusts' premises. The model envisaged that any patient needing more than two organ-failure support would need to be transferred back to Trust premises. Patients would be transferred back to the Trust hospital within 24 hours of extubation. It was able to initially ramp up 60 staffed beds with a potential quick expansion to 236 total beds, and a potential capacity of 496 total beds in time. A clinical and operating model handbook was developed by 1 May setting out how the Nightingale would operate.

1083. The Harrogate Nightingale opened on standby (so not intended to admit patients immediately) on 21 April 2020. No patients were admitted during Wave 1 as the region managed within its existing intensive care capacity. It was able to be reactivated to admit patients within seven days. The site was equipped with clinical imaging equipment and from 4 June 2020 it was used to provide clinical CT scans and diagnostic tests to patients from across the region. By the end of 2020, more than 3,000 patients had received a CT scan or a diagnostic test.
1084. In preparation for Wave 2, NHS England confirmed that the Harrogate Nightingale had been asked to mobilise over the subsequent few weeks to be ready to accept patients if necessary. Ultimately no patients were admitted during Wave 2.

### Bristol

1085. The Bristol Nightingale was hosted by North Bristol NHS Trust and was located at the University of West of England Bristol Exhibition and Conference Centre.
1086. At its meeting on 17 April 2020, NIRB approved the opening of the Bristol Nightingale subject to no material issues being identified in the upcoming clinical walkthrough. The South West Regional Director provided an update on the demand and capacity position across the region and progress to increase bed capacity. Consideration was given to development and proposed operationalisation of the Bristol Nightingale, clinical model, staffing model and management structure, site testing and training, timeline for mobilisations and potential redistribution of PPE.
1087. The clinical model for Bristol Nightingale was similar to the Harrogate Nightingale clinical model - a *"step-across level 3 model to be used once the NHS Trusts' Level 3 capacity had been reached"*. Patients who deteriorate in their local hospital would be intubated and stabilised and then transferred to the Nightingale's step across model

providing Level 3 care. It was able to initially provide 60 beds with a potential quick expansion to 120 total beds, then in time to 180 total beds and a potential maximum capacity of 300 total beds.

1088. Bristol was therefore intended to treat mechanically ventilated patients only. This was because despite maximising ventilated bed capacity in existing NHS providers and use of the arrangements with the independent sector, demand and capacity modelling indicated that maximised capacity would not meet the modelled demand for ventilated beds. Where complications arose, the patient would need to be transferred to a specialist provider. Patients would all be ITU Level 3 and once stabilised post extubation would be repatriated to their local hospital.
1089. The Bristol Nightingale opened on standby (so not intended to admit patients immediately) on 27 April 2020. No patients were admitted during Wave 1 as the relevant circumstance that would trigger activation had not been reached. It was capable of being reactivated to admit patients within 72 hours. The Chief Executive of the Bristol Nightingale announced in June 2020 that the site would be stood down by the end of the month. This meant reactivation would take longer (approximately 7 days) as staff and resources were returned back to other services and hospitals.
1090. For Wave 2, its ability to be reactivated to treat Covid patients was retained. On 25 November 2020 the Chief Medical Office of the Bristol Nightingale stated that it would shortly begin hosting outpatient clinics and day case services so that the NHS in the region had additional capacity to provide routine care and treat those with Covid-19. The site was to offer a paediatric day case service for patients from Bristol Royal Hospital for Children as well as a new high-volume eye assessment hub for patients at Bristol Eye Hospital. Ultimately no Covid-19 patients needed to be admitted.

#### Sunderland

1091. The Sunderland Nightingale was hosted by Newcastle upon Tyne NHS Foundation Trust and was located at Sunderland Innovation Centre.
1092. Following several weeks of preparations, Sunderland Nightingale satisfied the assurance process and at its meeting on 29 April 2020, NIRB approved its opening. An update was provided to NIRB on the phasing of the preparations to open, the clinical model and the design.
1093. The clinical model for Sunderland Nightingale was a Level 1 step-down care to relieve pressure on existing acute hospitals but it could be stepped up to a more

intensive model if required. It was intended that all patients admitted would be Covid-19 positive who would have been stabilised in an existing NHS acute hospital for at least 24 hours before being transferred to the Nightingale. It was able to initially provide 28 ward beds with a potential quick expansion to 14 ITU and 112 ward beds and a potential maximum capacity of 130 ITU beds and 330 ward beds although the infrastructure was present to enable all 460 total beds to be Level 1 (ward care), Level 2 (HDU) or Level 3 (ventilated critical care).

1094. The intention was that the Sunderland Nightingale was not exclusively for mechanically ventilated patients. It was flexible enough to treat Covid patients at different points on their treatment pathway. Patients were expected to be discharged from Sunderland Nightingale to their own home or community step-down care.
1095. The Sunderland Nightingale was put on standby (so not intended to admit patients immediately) on 5 May 2020. No patients were admitted during Wave 1 as there had been a reduction of people with Covid in hospital across the region. It was able to be opened to admit patients with less than two weeks' notice.
1096. On 12 October 2020, in preparation for Wave 2, NHS England confirmed that the Sunderland Nightingale would be mobilising over the subsequent few weeks to be ready to accept patients if necessary. No patients were admitted during Wave 2 and on 25 January 2021 it was opened as a mass Covid-19 vaccination centre. The site continued in this role until 31 March 2022.

#### Exeter

1097. The Exeter Nightingale was hosted by Royal Devon and Exeter NHS Foundation Trust (now Royal Devon University Healthcare NHS Foundation Trust) and was located at the Homebase Site in the Sowton Industrial Estate in Exeter.
1098. The Exeter Nightingale opened on standby (so not intended to admit patients immediately) on 6 July 2020 following an update provided to the 1 July NIRB meeting [AP233 INQ000269954]. An update was provided on the phasing of the preparations for opening, the clinical pathway, and the site design.
1099. While on standby for dealing with Covid-19 patients, the Exeter Nightingale was used to address the CT scan backlog caused by loss of activity and productivity due to Covid-19. This would be for outpatient CT for any of the local providers, with longest waiting patients to be seen first.



1100. The purpose of the Exeter Nightingale was to provide resilience to the South West Peninsula acute providers and critical care network. The clinical model for Exeter Nightingale was to provide a regional resource through a flexible clinical offer that would provide potentially life-saving capacity for mechanical ventilation, non-invasive ventilation and ward-based oxygen treatment for patients with Covid-19 over and above what could safely be provided in the local Trusts. Once the threshold or system triggers were reached within the Trusts, patients would be clinically selected for transfer to Exeter Nightingale according to admission / exclusion criteria. It was able to initially ramp up 24 beds with a potential maximum capacity of 116 beds.
1101. Patients were not admitted until Wave 2 due to the reduction in Covid-19 numbers nationally but from its opening date to mid-November 2020, the facility was used to deliver alternative services including approximately 3,000 diagnostic tests, training of hundreds of overseas nurses and hosting the delivery of a Covid vaccine study.
1102. In preparation for Wave 2, the Exeter Nightingale was opened to admit patients from mid-November 2020. By March 2021, it had admitted 125 patients, all of which were admitted with Covid-19.
1103. Following Wave 2, the site was purchased by the Royal Devon University Healthcare NHS Foundation Trust on behalf of NHS organisations across Devon and the South West region. The site was used to offer a range of orthopaedic, ophthalmology, diagnostic and rheumatology services to local people.

#### **Evolution of the Nightingales after Wave 1**

1104. This section provides more detail on the decision-making following the first wave and the consideration of whether Nightingales should remain in place, as a contingency against further waves. Discussions regarding the longer-term use of the capacity created by the Nightingale sites began in early April 2020 [INQ000087379 and INQ000087393], leading to a paper which was presented to NIRB on 15 May 2020 [INQ000087431] entitled "*Future Use of Nightingales*". This explained how the National Nightingale team had been working with each of the regions to progress and finalise details around future use of Nightingales.
1105. In general, regions were considering:
- a. continuing to use their Nightingale capacity for either the approved clinical model or a different clinical model;
  - b. putting their Nightingale into standby to re-open if required; or

- c. de-commissioning the Nightingale in part or in full (currently only considered because of licence negotiation issues).
1106. An example of the discussions that were ongoing at this time was on the potential to repurpose Harrogate Nightingale to provide outpatient CT scanning **[AP234 INQ000269947]**.
1107. Other discussions took place including a workshop at the London Nightingale convened by the London Regional Director in April 2020 on how the London region could make best use of the Nightingale. Housing operating theatres for 'high volume low complexity' (HVLC) surgery in the conference halls to take advantage of an operating environment separate to Covid-19 positive environments was discussed although not pursued as it became evident that the premises' infrastructure would not support it. The discussion contributed to the London region's HVLC programme (which led the recovery efforts across London in reducing the backlog of elective waiting lists) which in turn led to the roll out of a national HVLC programme.
1108. On 8 June 2020, NIRB members considered a paper on the use of Nightingales from June 2020 to April 2021 **[INQ000087435 and INQ000087436]**. The paper outlined the current status of each Nightingale and indicative costs for each on standby and a range of stand-up scenarios based on utilisation of beds. The paper explained that as a result of successful interventions to manage demand and lower the Covid-19 curve as well as discharging long-stay patients, none of the Nightingales had been required to function to their initial planned capacity. In addition, the decreasing Covid-19 infection rate meant that the Nightingales were not currently required and had therefore (except for Exeter which was yet to open) gone into standby.
1109. Regional Directors had requested that the capacity of the Nightingales should be maintained through a potential second peak, winter pressures and recovery of other services. NIRB approved proposals to maintain physical Nightingale capacity as below:
- a. London Nightingale: Reduce capacity to 425 beds;
  - b. Birmingham Nightingale: Reduce capacity from 1,200 to 850 beds;
  - c. Manchester Nightingale: Maintain capacity of 633 beds;
  - d. Harrogate Nightingale: Maintain capacity of 495 beds;
  - e. Sunderland Nightingale: Maintain capacity of 460 beds;

- f. Bristol Nightingale: Maintain capacity of 301 beds; and
  - g. Exeter Nightingale: Maintain capacity of 116 beds.
1110. The paper also set out the approach to standby and stand-up plans. Detailed execution plans for standing up each Nightingale were to be developed to provide a specified number of beds within five days, rising to the required levels thereafter. Nightingales were expected to retain a week's worth of appropriate supplies (PPE, ICU consumables and equipment) when on standby. The paper provided an indication for each Nightingale of how quickly each Nightingale could re-open, the number of beds initially, the staff requirements and the plan to re-engage staff and plans for ramping up bed numbers.
1111. The paper also contained a change of use assurance process which NIRB had approved. It required the host Trust and the relevant region to submit to NIRB than approved business case, setting out outline finances, any estates implications including agreement with the site's landlord, whether there were any supplies constraints, an approved clinical model and any legal implications such as contractual implications, CQC registration and updated equality and inequality health impact assessments.
1112. The approach to decommissioning Nightingales was also set out in the paper. This was a four-stage approach – pre-decommissioning planning, formal approval of the plan and business case, mobilisation of the decommissioning works and hand back of the site. Indicative high level decommissioning costs were provided for each Nightingale.
1113. The final subject in the paper was the establishment of NHS England's Nightingale Steering Group to take over Nightingale related activity from July 2020 and which would be accountable to NIRB. This group would identify risks and mitigations to Nightingales and provide a governance platform for any stand-up requirements, changes of use, decommissioning and end of contract closing.
1114. The paper also contained a number of annexes that provided more detailed comments and information on the matters above.
1115. On 30 July 2020, HMT decided that Nightingale sites should remain until 31 March 2021.

## **Wave 2 and decommissioning**

1116. Over August and September 2020, the Nightingale Oversight Cell had requested from each Nightingale information on the activation assurance process. This required information on the status of bed numbers, the estate, supplies, clinical matters, workforce, IM&T, finance, legal leadership, activation plans and legal matters. An example **[AP235 INQ000270146]** relates to the Bristol Nightingale. This enabled the Nightingale Oversight Cell to update NIRB on the readiness or any specific issues with the activation of any of the Nightingales.
1117. In early October the Chief Operating Officer sent an email to a team of senior people within NHS England with the subject line "*Planning to stand up the Nightingales in NW, NEY and Midlands*" **[AP236 INQ000269970]**. The email indicated that after multiple discussions these Nightingales were to be brought to a state of readiness that would enable them to be opened within a couple of weeks. The email acknowledged a briefing the week before on the Nightingales by the Nightingale Oversight cell and stated that the data was showing that, on current trends, the Manchester Nightingale would be needed before the impact of additional government actions were felt. It highlighted that although the Harrogate and Birmingham Nightingales might not be needed, it was necessary to plan to take a series of steps over the following days to make it possible to use them. On 12 October 2020, the Prime Minister held a press conference indicating that the country was entering a new and crucial phase in respect of Covid as cases had increased by a factor of four in the previous four weeks. The Prime Minister stated that Nightingales in the north of England were being prepared for service.
1118. An updated briefing entitled "Nightingales - supporting the Wave 2 pandemic response" was provided by the Nightingale Oversight Cell to NIRB's 16 October 2020 meeting **[AP237 INQ000269974]**. The briefing outlined the approach being taken to support stand-up of Nightingales including associated issues. It provided an overview of the activation process and described emerging options on additional use of Nightingales although it noted that further work was required on this.
1119. It included the following table as an overview on each Nightingale:

| Region & Nightingale                                   | Clinical model and bed capacity to stand-up   | Key dates  |
|--|---|--|
| North West: Manchester Central Convention Complex      | <ul style="list-style-type: none"> <li>Step down care: acute beds with 30% CPAP. Nurse led</li> <li>36 beds proposed for reactivation. The clinical model will help promote flow from MFT hospitals to help manage winter and COVID-19 pressures</li> </ul> | <ul style="list-style-type: none"> <li>Proposed stand up date: 26/10/20. Can stand up in 7 days once triggered</li> <li>Site to be vacated for dilapidations by: 29/01/21</li> <li>Lease expiry: 19/03/21</li> </ul> |
| North East and Yorkshire: Harrogate Convention Centre  | <ul style="list-style-type: none"> <li>Level two and three critical care (ventilated and NIV (O+)) for Covid-19 patients</li> <li>Decompression site for other trusts</li> <li>30 beds to start off with could go to 60</li> </ul>                          | <ul style="list-style-type: none"> <li>Proposed stand-up date: TBA. Can stand up in 5 days once triggered</li> <li>Site to be vacated for dilapidations by: 07/02/21</li> <li>Lease expiry: 31/03/21</li> </ul>      |
| North East and Yorkshire: Sunderland Innovation Centre | <ul style="list-style-type: none"> <li>Level 1 ITU1 acute care with ITU back up. COVID-19 positive acute inpatient decompression for hospitals.</li> <li>28 beds to be stood up</li> </ul>  | <ul style="list-style-type: none"> <li>Proposed stand-up date: TBA. Can stand up in 10 days once triggered</li> <li>Site to be vacated for dilapidations by: 07/02/21</li> <li>Lease expiry: 31/03/21</li> </ul>     |
| Midlands: Birmingham NEC                               | <ul style="list-style-type: none"> <li>Mixture of step down and ventilated beds</li> <li>Surge capacity for 23 referring acute sites across 14 trusts</li> <li>360 beds can be stood up and can be increased to 382</li> </ul>                              | <ul style="list-style-type: none"> <li>Proposed stand-up date: TBA. Can stand up in 5 days once triggered</li> <li>Site to be vacated for dilapidations by: 07/02/21</li> <li>Lease expiry: 31/03/21</li> </ul>      |
| South West: Exeter                                     | <ul style="list-style-type: none"> <li>Mixture of step down and ventilated beds and regional centre for COVID-19 patients across the area</li> <li>116 over 5 wards (3 general, 2 ITU)</li> </ul>   | <ul style="list-style-type: none"> <li>Proposed stand-up date: TBA. Can stand up in 3 days once triggered</li> <li>Site to be vacated for dilapidations by: 07/02/21</li> <li>Lease expiry: 06/05/21</li> </ul>      |
| South West: Bristol                                    | <ul style="list-style-type: none"> <li>ITU beds as relief for local area</li> <li>6 ventilated beds ramping up to 30 on activation.</li> </ul>  | <ul style="list-style-type: none"> <li>Proposed stand-up date: TBA. Can stand up in 7 days once triggered</li> <li>Site to be vacated for dilapidations by: 07/02/21</li> <li>Lease expiry: 31/03/21</li> </ul>      |
| London: Excel  | <ul style="list-style-type: none"> <li>Critical care: single-organ failure, ventilated COVID-19 patients.</li> <li>To operate in a surge ++ environment and to relieve pressure on NHS sites</li> </ul>   | <ul style="list-style-type: none"> <li>Proposed stand-up date: NA. Alternative use being considered</li> <li>Site to be vacated for dilapidations by: 06/11/20</li> <li>Lease expiry: 31/12/20</li> </ul>            |

1120. The activation process was that the Nightingale Oversight Cell would provide a recommendation to the Nightingale regional meeting which would form a view of the recommendation, with NIRB ultimately considering and if appropriate approving the recommendation.

1121. The paper noted that regions and host Trusts had been exploring the role that Nightingales could play in addition to providing services as per their existing clinical models. Options included the following:

- a. Manchester and Birmingham - not planning any additional use of sites at this point in time;
- b. London - in the process of considering alternative uses at the Excel;
- c. Harrogate: Covid O beds, elective care (outpatients or non-surgical day case e.g., chemotherapy infusions) and mass vaccinations centre;
- d. Sunderland - mass vaccination centre and potential long-term resilience and/or training centre;
- e. Exeter - continued diagnostics services, Covid- 19 vaccination trials, Mobile MRI, 2 endoscopy rooms and infusion and ambulatory services; and
- f. Bristol - regional service for Bristol Eye hospital (diagnostic hub) for paediatric and outpatient, mass vaccination centre and retain as training centre.

1122. At the meeting, NIRB emphasised the importance of decisions to reactivate NHS Nightingale facilities being supported by Covid-19 or non- Covid-19 clinical use cases and understanding of the demand and capacity position within the relevant system to show the necessity of using each individual facility. Members welcomed the proposed approach to reviewing the clinical model for each facility. On workforce, NIRB noted

that the models to support these facilities had been agreed regionally. It highlighted the need for careful consideration of the deployment of workforce to support the operation of all NHS Nightingale facilities, ensuring that decisions on staffing were taken in the context of the wider demands on the NHS workforce and competing priorities across the Covid-19 response.

1123. A week later, at the 23 October 2020 NIRB meeting, members considered the clinical model that would be implemented at the Manchester Nightingale, which would provide non-covid step-down care, with an initial 36 G&A beds **[AP238 INQ000269975]**. NIRB approved the opening of the Manchester Nightingale and requested further work to clarify the proposed model and process for expanding the facility beyond the initial proposed 36 beds and how this will be accessed by systems across the wider North West, including the potential transfer of staff and patients to the facility. Manchester Nightingale opened on 29 October 2020. A second fully staffed ward could be opened as needed. Wards were for step-down purposes.
1124. At the 13 November 2020 NIRB meeting, members were asked to approve activation of the Exeter and Birmingham Nightingales. The report provided to NIRB by the Nightingale Oversight Cell **[AP239 INQ000269981]** detailed information on the proposed clinical models that would be implemented at these sites, bed information, the workforce position, the proposed timescales for activation and the triggers for this based on demand were all discussed. NIRB members discussed the need for engagement with the Government ahead of the opening of the facilities. Subject to completion of assurance checked and relevant approvals from the Government, NIRB members resolved to approve the activation of these two sites **[AP240 INQ000270005]**.
1125. By 26 November 2020 HMT had approved the stand-up of the Exeter Nightingale.
1126. At its 5 March 2021 meeting, NIRB members were asked to approve the decommissioning of all Nightingale sites **[AP241 INQ000270009]**. A paper was submitted to NIRB which indicated that as of 5 March 2021, over 54,000 people had received vaccinations, 12,000 diagnostics had been completed and across three of the Nightingales more than 750 inpatients had been treated. The paper noted that on the information available, the numbers of beds occupied with Covid patients was reducing significantly such that it was appropriate to begin decommissioning by 31 March 2021. The paper provided the current hand back position of each Nightingale and highlighted factors relevant to the decommissioning including staff redeployment, redistribution of assets and financial costs.

## Challenges of Nightingales

1127. It is important to recognise that the hope was that Nightingales would not need to be used at all, as that would indicate that the existing hospital capacity could cope with patient demand. They existed as a contingency – providing capacity for specific treatment only if required.
1128. Nightingale facilities were not hospitals providing care to patients in the same way that Trust hospitals provide care. A Trust hospital has multiple departments dealing with many different aspects of care and treatment that a patient may need. It is designed to enable care to be provided in the most effective way and reflects the breadth of the needs of patients, staff and visitors. The hospital has staff on hand with qualifications and experience across a wide range of healthcare disciplines.
1129. As explained above, the Nightingale facilities were essentially large open spaces that, if the need arose, would be filled with rows of beds of patients needing specific treatment. This reflected the fact that they would only be used as a last resort when the healthcare capacity of the country was stretched as far as possible. The layout of the Nightingales reflected the potential need for staffing ratios to be reduced, if necessary. The approach was approved as an "in extremis" model by the CQC.
1130. A number of the Nightingales were designed only to take intubated Covid-19 patients with no other medical needs (such as dialysis). The initial blueprint was to accommodate patients with a single organ disease only. As indicated earlier, Nightingales were not intended to have the same capability to treat the range of conditions as a non-Nightingale hospital. Clinical models included transfer to non-Nightingale hospitals where a patient developed multi-organ failures.
1131. As time progressed and the clinical understanding of Covid-19 as a disease progressed, it was understood that Covid-19 could potentially be a multi-organ failure disease. The clinical model considered appropriate for later Nightingales in Wave 1 took account of the latest understanding of Covid-19 and the potential resultant needs of the population the Nightingale served.
1132. The peak of cases in Wave 1 was reached in mid-April 2020, with only a very small proportion of the then Nightingale capacity being used. Discussions on future uses of the Nightingales had already started with consideration of the appropriateness of the clinical model. While certain Nightingales were put to other uses when in standby between the waves, there was a need to ensure each could be stood up to undertake

its primary purpose as the "capacity of last resort" if future Covid-19 waves led to existing hospitals being overwhelmed.

1133. As indicated above Nightingales would only be used when existing capacity was stretched as far as possible. The availability of appropriately experienced and qualified staff was a major factor in determining capacity. It was always known that procuring staff for Nightingales would put pressure on the local hospitals as staff for Nightingales were redeployed from other NHS hospitals in the region on a rota basis. Volunteers were often used for non-clinical roles such as porters, but the pressure was on clinical staffing. The clinical staffing at the London Nightingale in Wave 1 caused tensions during times of surge or super-surge when clinical staff were a scarce resource and were needed back at "home" hospitals. Regional workforce cells provided support to mitigate this challenge by identifying appropriate staff to staff for the Nightingale wards without diluting staffing to unacceptable levels. Medics from the military were also used in the Manchester Nightingale for a variety of roles, which reduced to an extent the staffing pressures. Inevitably where Nightingales were used or would have been used for their primary purpose, this would have entailed much reduced clinical staffing ratios.
1134. There were concerns in mid-late March 2020 that Nightingales would not have the number of ventilators needed to treat the numbers of Covid patients that the Nightingales were designed to treat. The clinical models for each Nightingale were based on the assumption that there would be enough ventilators. As indicated elsewhere in this document, procurement of ventilators was progressed at speed and at scale during February and March 2020 by DHSC with an allocation process overseen by NHS England that ensured procured ventilators were directed to areas where demand was highest and supply was lowest. As a result, no patient who needed a ventilator went without.

### **Nightingale Surge Hubs**

1135. In late 2021, NHS England took steps to establish surge capacity, taking into account lessons it had learned from previous set-up and use of Nightingale facilities. New temporary structures were planned as an urgent means of improving NHS resilience. These new structures were generally referred to as 'Nightingale Surge Hubs'.
1136. They were set up in circumstances where high levels of staff absence due to Covid-19 infection, combined with the rapid increase in infections driven by the new Omicron variant and uncertainty over whether hospitalisation rates would be similar to



previous waves, raised the prospect of a surge in hospital admissions exceeding what could be provided within existing capacity.

1137. As part of broader steps to expand capacity, including the use of virtual wards and monitoring technology, on 21 December 2021, a multi-disciplinary team comprising NHS England, DHSC and commercial partners took steps to coordinate the establishment of Nightingale Surge Hubs.
1138. Based on lessons learned, the clinical model used within Nightingale Surge Hubs was different to that used in the original Nightingale hospitals established in the first wave of the pandemic. While the original Nightingale hospitals were located in their own separate site, it was decided that Nightingale Surge Hubs would be co-located with acute hospital sites. This was to enable better and quicker access to NHS resources and personnel as and when required.
1139. The initial Nightingale Surge Hubs were to be located in the grounds of eight hospitals across the country as set out in the table below:

| Region                   | Trust   | Site                           |
|--------------------------|---|--------------------------------|
| North West               | Lancashire Teaching Hospitals NHS Foundation Trust    | Royal Preston Hospital         |
| North East and Yorkshire | Leeds Teaching Hospital NHS Trust                     | St James's University Hospital |
| Midlands                 | University Hospitals Birmingham NHS Foundation Trust  | Solihull Hospital              |
| Midlands                 | University Hospitals of Leicester NHS Trust           | Leicester General Hospital     |
| East of England          | East and North Hertfordshire NHS Trust                | Lister Hospital                |
| London                   | St George's University Hospitals NHS Foundation Trust | St George's Hospital           |
| South East               | East Kent Hospitals NHS Foundation Trust              | William Harvey Hospital        |

|            |                         |                    |
|------------|-------------------------|--------------------|
| South West | North Bristol NHS Trust | Southmead Hospital |
|------------|-------------------------|--------------------|

1140. The majority of Nightingale Surge Hubs provided step-down beds to free up capacity for more acute admissions in the main acute hospital building.
1141. As set out in the Covid Hospital Emergency Capacity Principles and Procedures (developed from those used in NHS Nightingale facilities and in other resource constrained environments such as conflicts and natural disasters), the primary purpose of these hubs was to provide more bed capacity if the record number of Covid-19 infections led to a surge in admissions outstripping existing capacity and for the minimum time needed. There was an option to rapidly expand ward capacity by moving patients who no longer required frequent medical/ nursing input and could be managed by staff with essential care skills working to agreed protocols and under appropriate clinical oversight. The procedure envisaged that essential bedside care would be given by a wider pool of staff, including but not limited to healthcare students, therapists, and healthcare assistants who would supplement existing traditional clinical roles. Trusts were invited to consider local volunteers with a health background, including St John Ambulance volunteers and those willing to come out of retirement.
1142. The initial Nightingale Surge Hubs each had a capacity of approximately 100 patients except Lister Hospital which had a capacity of 55 beds. There was potential to set up further Nightingale Surge Hubs that could provide up to 4,000 “super surge” beds across the country.
1143. Construction expenses incurred by relevant Trusts in the setting up of Nightingale Surge Hubs were directly reimbursed by NHS England using existing Covid-19 monies and mechanisms. As of 12 January 2022, approximately £10.6 million had been incurred for design, enabling works, power, heating, water and waste and other elements to ensure the structures were safe and appropriate for use.
1144. In early February 2022, consideration was given to dismantling the London, Leeds, Hertfordshire and Birmingham hubs as those regions would not require the additional capacity and no alternative uses had been proposed. In relation to the North West hub, the region was noted to be experiencing sustained levels of pressure and the hub had been treating patients from late January. It continued to be used to support the local NHS hospital (and was the only surge hub to ever receive patients).

Proposals for alternative uses were received for the Leicester, Kent, and Bristol hubs, but these did not go ahead. By May 2022, all hubs had been de-commissioned except for the North West.

## SECTION 13: PRIVATE HOSPITALS

1145. This Section covers arrangements during the Relevant Period with private hospitals. It should be noted that the arrangements set out in this Section were with specific private or independent sector organisations that owned and operated private hospitals. The private or independent healthcare sector is often abbreviated to "IS". This Section uses the general term "independent sector organisations" to refer to all private sector entities that own and operate private hospitals and the term "IS Providers" to refer to the specific subset of independent sector organisations that participated in the NHS arrangements during the Relevant Period. Reference to the Independent Healthcare Provider Network ("IHPN") are references to the organisation that represents the interests of IS Providers. Most, but not all, IS Providers are members of IHPN.
1146. Other arrangements existed during the Relevant Period between the NHS and the private or independent sector that did not relate to private hospitals. These included arrangements with mobile diagnostics service providers and hospices. This section does not detail those arrangements but further information can be provided if required. There are also other types of independent sector entities that provide NHS funded healthcare services which do not operate private hospitals and are therefore outside the scope of this section. These include primary care providers (GPs, dentists and pharmacists), private providers of diagnostic services (such as eye health providers), and voluntary organisations or charities (such as hospices) providing NHS services.
1147. There were three distinct types of arrangements during the Relevant Period with IS Providers the "2020 Contracts", the "2021 Contracts" and the "2022 Contracts". This section considers for each type of arrangement the involvement of NHS England in the decision-making process, information on the types of treatment and the number of IS Providers involved and funding arrangements.
1148. The 2020 Contracts were in place for the longest period (March 2020 until 31 December 2020 for the last expiring contracts). They represented a very different and novel way for the NHS to work with independent sector organisations. The 2021 Contracts and 2022 Contracts were in place for all or part of the 1 January to 31 March period of each year (which is often referred to as Quarter 4 (Q4) of the NHS financial year). This Section therefore considers the 2020 Contracts in greater detail than the 2021 Contracts and the 2022 Contracts.

1149. It should also be noted that in late 2020, and continuing during the Relevant Period, NHS England established the Increasing Capacity Framework (“ICF”). This enabled healthcare commissioners and Trusts to enter into call-off contracts with participating independent sector organisations for the provision of a wide range of NHS healthcare services. The framework expires in late 2024. This Section does not provide further information on the ICF, but further information can be provided if required.

### **Pre-pandemic use of independent sector organisations**

1150. Prior to the pandemic Trusts and commissioners of NHS services contracted with independent sector organisations for delivery of a range of NHS services in different ways.

1151. One example was the exercise of patient choice. If a patient is referred by their GP for consultant-led treatment, that patient has the right, under the NHS Constitution, to choose which provider they are referred to from all those who have a contract with any NHS commissioner to provide the required service. Certain services are excluded from the right to choose, such as emergency services, maternity services and certain public health services. A large number of independent sector organisations prior to the pandemic had contracts to provide NHS services which meant patients could often have chosen an independent sector organisation for their treatment at a private hospital, instead of treatment at premises operated by a Trust. The healthcare services provided by the independent sector organisation to the patient were NHS services albeit provided at a private hospital, and the local NHS commissioner would pay for those services.

1152. Another common example was a Trust sub-contracting with an independent sector organisation for additional capacity. The independent sector organisation would provide treatment to the patient on behalf of the Trust which would remain contractually and clinically ultimately responsible for the patient. The Trust that sub-contracted the work (as opposed to the local NHS commissioner) would pay the independent sector organisation.

1153. NHS services delivered by independent sector organisations prior to the pandemic were predominantly episodes of elective care - care that is, planned in advance involving specialist clinical care or surgery and is usually undertaken following a referral from a GP or community health professional.

1154. The arrangements with IS Providers during the Relevant Period, and as explained in more detail in this Section, were very different to the pre-pandemic arrangements. NHS England's Phase 1 Letter emphasised that by 15 April 2020 all non-urgent elective operations were to be postponed, in order to expand acute and critical care capacity to the maximum [AP242 INQ000221477]. Under the 2020 Contracts, private patient care was initially halted save for specifically agreed patients with long term neurological conditions and urgent oncology cases. The letter stated that arrangements with IS Providers were to enable independent sector staff and facilities to be available flexibly to Trusts and commissioners. The intention was to provide the NHS with access to utilise the relevant IS Providers' entire operational capacity and facilities including clinicians, support staff, equipment, expertise, beds and physical healthcare premises including such aspects of inpatient, outpatient and diagnostic capacity. This was very different to how independent sector organisations had been used by the NHS prior to the pandemic.
1155. As a result of the Phase 1 Letter, during the initial months of the Relevant Period, non-urgent elective care activity (NHS or private) was not the priority and the IS Providers were essentially used as if they were operationally part of the local Trust estate with staff able to work across the organisations, equipment being moved around if needed and premises being used in ways not previously seen.
1156. NHS England published "*Revised arrangements for NHS contracting and payment during the COVID-19 pandemic*" on 26 March 2020 which followed on from the Phase 1 Letter and clarified the contractual implications between commissioner and Trusts and non-NHS providers. The 26 March letter stated that focus was on helping Trusts to prepare for and respond to the pandemic and that local reporting requirements (unless required for business-critical purposes) should be relaxed.

## **2020 Contracts**

1157. As explained above, in late February 2020, early modelling data for Covid-19 in England predicted levels of Covid-19 spread which would result in the need for admission of patients for ITU support, bed plus oxygen support and other bed admissions which would significantly exceed NHS capacity and overwhelm the NHS, resulting in insufficient general acute beds, ITU beds and oxygen. NHS England had discussions with the Government and the devolved administrations about options to obtain more capacity, including use of independent sector organisations.

1158. Ongoing work included assessing total available private sector capacity and how it could be mobilised to work effectively in support of the national Covid-19 response (including private hospital buildings, private wards in NHS hospitals and the associated workforce).
1159. On 4 March 2020, exploratory discussions were held between NHS England's Director of NHS Operations and Delivery, representatives from a group of independent sector organisations and IHPN (in a coordinating role) regarding procurement of their capacity. Descriptions of the role these organisations could play in the Covid-19 response were considered along with matters such as critical care capacity within the independent sector estate, workforce arrangements including collaboration with NHS organisations and flexibility to use independent sector staff where needed and the position on private patients who receive treatment at private hospitals via private medical insurance or self-payment. A 'Concept of Operations' document was jointly developed to record these discussions **[AP243 INQ000270104]**. This document refers to the working assumption being that Covid-19 patients needing, or at most risk of needing, critical care would be admitted to NHS facilities, with no use of independent sector critical care. This was based on the assumption that the aim was not to mix Covid-19 patients with non-Covid-19 patients in independent sector facilities.
1160. NHS England was also seeking information, via the IHPN, on independent sector organisations' critical care and oxygen capacity. As of 13 March 2020, 43 organisations had been asked about their critical bed numbers and beds with piped oxygen **[AP244 INQ000269903]**. It was reported to NHS England that six organisations had critical care beds – with 169 beds overall – and that twenty organisations had between them 6,732 beds with piped oxygen. There were additional beds available that did not have piped oxygen.
1161. The discussions culminated in a summit called by NHS England involving IHPN, the largest (in terms of bed capacity) independent sector organisations and the largest diagnostic providers. This took place on 16 March 2020, was chaired by the Chief Executive and included discussion of the NHS's aspirations to “block book all IS capacity”, including how this could be done as soon as possible.
1162. Following the summit, formal negotiations commenced at pace with the chief executive officers of the six independent sector organisations with the largest acute

inpatient capacity (Ramsay, Nuffield Health, Circle / BMI, Spire, Care UK (now Practice Plus Group) and HCA), facilitated by IHPN.

1163. The intention was to utilise independent sector organisations in the delivery of NHS services in a very different way than prior to the pandemic. The NHS wanted access to their staff, equipment, premises and facilities to use in the most appropriate way for each local area to respond to the local Covid-19 situation. The intent was not simply to have access to beds. As indicated in the data collection exercise, the number of critical care beds in independent sector organisations was low. Different ways of working were therefore envisaged, including:

- a. NHS patients being provided with care and treatment within the private hospitals by the independent sector organisation's clinicians, including care on an inpatient or day case basis, as an outpatient or for diagnostic services such as imaging and endoscopy;
- b. Trusts physically relocating equipment, including ventilators, from independent sector organisation's premises for use in the Trust's premises for provision of services to NHS patients. This had the effect of diminishing the independent sector's ability to provide critical care services to Covid-19 patients;
- c. Having clinicians from the independent sector organisations temporarily relocated in local Trust hospitals providing care and treatment to NHS patients of that local Trust;
- d. Hybrid teams of NHS employed staff and independent sector organisations' staff working together to deliver care – for example a surgeon and anaesthetist from the NHS working alongside an independent sector organisation's theatre and recovery teams; and
- e. "Lifting and shifting" a Trust's surgical and other team for a specialty into an independent sector organisation's premises (including but not limited to operating theatre suites) where that team would provide care and treatment to the Trust's NHS patients in an environment that was not also used to treat Covid patients. This was referred to as the independent sector organisation "hosting" NHS teams or services.



1164. Between 16 and 18 March 2020, key principles on the approach to a contract were agreed. Draft Heads of Terms were discussed and agreed in principle between negotiating teams.
1165. On 18 March 2020, the Cabinet Office had published "*Procurement Policy Note 01/20: Responding to COVID-19*" which referred to the ability to directly award contracts in circumstances of extreme urgency [AP245 INQ000048822].
1166. On 20 March 2020, Heads of Terms were agreed and approved by the Chief Financial Officer [AP246 INQ000270070]. Consideration was given to which independent sector organisations should be offered the Heads of Terms. The selection of organisations had emerged in the early discussions with IHPN coordination and was based on which providers had sites with bed-based capacity, preferably with oxygen support for some of the beds. At this point, the focus was on bed capacity because this was the capacity that would potentially be overwhelmed in the NHS. A total of 27 independent sector organisations (which this Section refers to as the IS Providers) signed the Heads of Terms. A total of 194 IS Provider individual premises or sites were included in the arrangements at the outset, although this reduced to 191 after three sites (considered not to be appropriate to provide the required services) were removed in the first month. The NIRB meeting on 20 March 2020 noted the arrangements with IS Providers.
1167. The arrangements included that NHS England would for the first week (week commencing 23 March 2020), pay for NHS activity delivered in IS Providers' hospitals in London on a cost per case basis. This was because activity was being bought in the first week rather than capacity, as IS Providers in London were operating as usual in that week. After this first week, NHS England would pay for each IS Providers' capacity across England for a minimum of 13 weeks from 30 March 2020 under a block payment (mirroring similar block payment arrangements established with Trusts), the principles of which are set out in the Funding section of the Heads of Terms. NHS England published details of the arrangements on its website [AP247 INQ000270077] explaining that it included:
- "provision of 8,000 hospital beds across England, nearly 1200 more ventilators, more than 10,000 nurses, over 700 doctors and over 8,000 other clinical staff" and that in respect of London "it includes over 2000 hospital beds, and over 250 operating theatres and critical beds"*

1168. Following signature of Heads of Terms, a detailed form of contract (based on the NHS Standard Contract with appropriate amendments for the pandemic) was agreed and is referred to in this section as the 2020 Contract.
1169. On 24 March 2020, a letter was sent by NHS England informing Regional Directors, STP/ICS leadership teams, CCGs and acute and community Trusts of the arrangements with IS Providers to *"secure all available inpatient capacity and resource in every area in England as part of the response to COVID-19... from Monday 23rd March for a minimum period of 14 weeks."* **[AP248 INQ000270019]**. The letter explained the expectation that local agreement would lead to delivery of a mix of five main scenarios of care and support for NHS patients by IS Providers. These were:
- a. Intensive care level inpatient respiratory care to Covid-19 patients needing oxygen therapy, non-invasive ventilation (NIV) and mechanical ventilation;
  - b. urgent, time-dependent NHS elective care services, to maintain priority elective and cancer pathways as the pressure builds from Covid-19 related admissions;
  - c. diagnostic capacity, in collaboration with the NHS, to maintain urgent priority elective and cancer pathways;
  - d. inpatient non-elective care to NHS patients to help free up bed capacity in NHS hospitals. It was noted that these beds should not be used for patients who are medically fit for discharge; and
  - e. making clinical and support staff available who could if needed be redeployed to support care in other settings.
1170. The letter also detailed the commissioning model and implications for existing agreements as well as providing the relevant details of the independent sector organisations that had signed up to the arrangements. The letter required NHS England's regional teams to immediately agree with NHS organisations in their area a coordinating link for every IS Provider to a nominated Trust or STP/ICS. It also required the formation of an IS Coordination Network in each area that was intended to immediately put to use the IS Providers' capacity.
1171. NHS England, in parallel, established a mobilisation capability to support both NHS organisations and IS Providers to get arrangements in place quickly. This consisted of a central NHS England national mobilisation team, joint work with NHS England

regions and joint working groups with IS Providers. IS Providers resourced a programme management office coordinating function from across IS Providers to link into NHS England structures. The purpose of the mobilisation structure was:

- a. to provide advice, guidance and interpretation on the 2020 Contract terms and purpose;
- b. collect data on activity taking place in IS Providers, including intelligence on service transfers and models of care;
- c. to do further joint work on issues such as clinical governance, staff transfer processes and training of medical staff; and
- d. escalate, and jointly solve, any issues which arose due to the novelty and complexity of the arrangements (and the novelty of the situation in which they were implemented). This allowed the national team to clarify matters relating to the interpretation of the arrangements, examples including relocating whole NHS services (such as chemotherapy suites or cystic fibrosis services - including the staff, equipment and patients) into IS facilities (which did not ordinarily happen), and which organisations paid staff when they working on other providers' premises. Where necessary, NHS England was able to escalate concerns directly to chief executives of IS facilities, who were well-engaged (for example, in relation to the correct implementation of admissions and data collection processes).

1172. These operational support arrangements represented an unprecedented level of collaboration and cooperation between the NHS and the IS Providers and is another significant difference from pre-pandemic arrangements.

1173. To enable the arrangements with IS Providers, the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) (No.2) Directions 2020 were made by the SSHSC and came into force on 27 March 2020 **[AP249 INQ000270049]**. They directed NHS England to exercise the functions of CCGs under sections 3 and 3A of the 2006 Act for the purposes of commissioning health services from independent providers and to support the provision of services by NHS bodies to address Covid-19. The directions were stated to remain in force until 31 December 2020. In other words, the Directions gave NHS England the power to commission services from independent sector providers which would otherwise have been the function of CCGs to commission.

1174. To address potential concerns as to the anti-competitive nature of aspects of the proposed arrangements between the IS Providers and with NHS bodies, the Competition Act 1998 (Health Services for Patients in England) (Coronavirus) (Public Policy Exclusion) Order 2020 was made by the SSHSC **[AP250 INQ000269916]**. The Order, which came into force on 28 March 2020, permitted five kinds of agreements between independent providers and between independent providers and NHS bodies, for the purpose of responding to coronavirus. The Explanatory note to the Order noted that the nature of co-operation between the NHS and independent sector organisations to respond to Covid-19 had been agreed very quickly in response to the rapidly evolving virus outbreak in the UK. It also noted that the Order needed to come into effect quickly (on the day after it was laid before Parliament) to give IS Providers the certainty that they could immediately undertake activities necessary to support the NHS in responding to Covid-19 and that such an immediate response by IS Providers was in the public interest.
1175. The same form of contract was put in place with each of the IS Providers (the only difference was the insertion of the particular IS Provider's sites in the specification). Of the 27 independent sector organisations that had signed the Heads of Terms, all but one signed the 2020 Contract. The remaining organisation chose not to enter into the 2020 Contract.
1176. The service specification in the 2020 Contracts included a requirement that the IS Provider *"must make available to the Commissioner all facilities, diagnostics, staffing, management and full organisation capability"* necessary for the support of the NHS to the pandemic. The arrangement did not include primary medical care services or community health services, whether or not they were provided from the same IS Providers' facilities.
1177. Up to 15 April 2020, each IS Provider was able to treat NHS and private patients outside of the arrangement (with revenue received for doing so to be offset against the costs recoverable by the IS Provider under its 2020 Contract). From 15 April 2020, until notice of de-escalation (on which see below), an IS Provider was not to treat patients outside of the arrangement save for specifically agreed patients with long term neurological conditions and urgent oncology cases, already receiving treatment from the IS Provider before 15 April 2020.
1178. During the 'peak surge' period (15 April 2020 until service of notice of de-escalation), each IS Provider was expected to provide *"operational flexibility and reasonable*

*efforts to provide what further services may be required*". Each IS Provider was to work with a local NHS organisation to agree local patient workflow, case mix, staffing, and equipment deployment. The manner in which an IS Provider worked with local NHS organisations was not mandated by NHS England. NHS England did provide mobilisation support, operational guidance and shared best practice across the country. However, the 2020 Contract purposefully provided flexibility for IS Providers to be used in the most appropriate way for the local NHS area.

1179. The 2020 Contract specification recognised that equipment located in the IS Provider's premises might be needed for use within local Trust premises. The 2020 Contracts therefore included provisions relating to the loaning out, maintenance and return of such equipment.
1180. The 2020 Contract also contained provisions relating to the sharing by local Trusts and the IS Provider of their respective staff, including acknowledging that Trust and IS clinicians could work side by side on patient care as part of hybrid teams. To assist the parties resolve any issues of liability and responsibility in relation to staff mobilisation and sharing, a staffing MOU and a clinical governance MOU were included in the 2020 Contract, to be used by the relevant IS Provider and local NHS bodies.
1181. The 2020 Contracts were to be for a minimum of 14 weeks, then continuing on a rolling basis, terminable by NHS England on one month's notice.
1182. The payment provisions were detailed and defined "Qualifying Costs" – the costs which NHS England would fund. There were a range of detailed exclusions for each type of Qualifying Costs. The range of Qualifying Costs is set out in the 2020 Contract and more explanation can be provided if required.
1183. Costs were subject to mitigation by the IS Providers. Based on independent analysis of the private healthcare market undertaken by an independent body, the average operating profit of the independent sector was 15%. To reduce the cost to the public purse of capacity not required for NHS patients, it was agreed that IS Providers could retain the 15% margin (providing an incentive to not leave the capacity empty at cost to NHS England), whilst reducing the public costs with the remaining 85%. 85% of net revenue generated by IS Providers in respect of private patients, including long-stay, during periods of the 2020 Contracts when treatment of private patients was allowable, would be set off against the costs to be covered by NHS England. In other words, IS Providers were each to retain 15% of the net revenue

generated by any private patients but 85% of the revenue was deducted from the total running costs of the IS Provider which NHS England was covering. 15% was included in all 2020 Contracts so that each IS Provider had the same terms and conditions; no IS Provider-specific negotiations took place.

1184. KPMG were appointed to support the finalising of the contractual payment mechanisms, provide monthly ongoing financial details and conduct the reconciliation of the actual costs incurred by each IS Provider, on an open book accounting basis covering both the income and expenditure and balance sheets. KPMG were appointed, using Management Consultancy Framework Agreement RM3745, after informal assessment that KPMG had the least involvement in an audit capacity with the larger IS Providers and would therefore have a lower likelihood of encountering material conflicts of interest.
1185. The graphs at the end of this Section indicate, as far as can be confirmed, the amount and type of activity carried out by the IS Providers under the 2020 Contracts.
1186. However, due to the streamlined reporting requirements for all NHS and non-NHS providers during the Relevant Period and the way in which IS Provider's facilities were used, the number and types of treatment provided to patients by IS Providers does not provide a complete picture of the capacity and resources available to the NHS under the 2020 Contracts and utilised by the NHS in its pandemic response. The following types of activity and support might not have been recorded in activity statistics:
- a. IS Providers' staff/clinicians being temporarily re-located during the Relevant Period into local Trusts and assisting in the provision of care and treatment by those NHS bodies to NHS patients, thereby limiting the potential for activity at the IS Provider's premises; and
  - b. Trusts' teams moving into IS Providers' operating theatres where those Trust teams would provide care and treatment to the Trust's patients. Examples of this include Nottingham University Hospitals NHS Trust which moved its cancer surgery teams to Circle's premises in Nottingham, and Norfolk and Norwich University Hospitals NHS Foundation Trust which moved its chemotherapy services to Spire's premises in Norwich. Key NHS activity could be provided to patients in an environment with much lower risk of Covid infection compared to the relevant Trusts' premises accommodating Covid-19 patients.

1187. The use to which IS Providers' resources were put varied locally and regionally, based on availability of certain resources. Some examples are:
- a. the availability of HDU or ICU capacity was a key decision point in whether to utilise IS Providers (as they have less HDU/ICU capacity) and this informed decisions on which patients were most suitable to be treated in IS premises;
  - b. in the South East, IS Providers were generally used solely for elective care although there were a small number of IS Providers that supported the NHS with step-down capacity. The oxygen capacity of IS Providers in the South East was identified as a limitation on treating Covid-19 patients; and
  - c. within the South West, only one IS Provider's premises in Gloucester were used to treat patients with Covid-19.
1188. A paper to the 27 April 2020 NIRB meeting considered the utilisation of the IS Providers to date and proposed an evolution of the then strategy to focus the use of spare capacity of IS Providers on high volume urgent elective and cancer work **[AP251 INQ000269937]**. The paper noted that the most common uses were for cancer services and transfers of acute medical admissions but acknowledged that eight sites out of the 191 contracted (as of the date of the paper) did not have a planned use and were virtually empty. The NHS England IS operational team were working with the relevant regions to ensure plans were agreed as soon as possible. The paper noted that utilisation was high where NHS services were hosted by IS Providers or where an IS Provider's premises had been designated as a dedicated cancer hub or cardiac network. Utilisation was noted to be low where strategies for use were only triggered when surge impacted the NHS, where Trusts had not allocated services transfers due to insufficient staffing, where the capability of an IS Provider's premises had been diminished due to transferring ventilators and other equipment to NHS sites, where (and this applied only to a small number of areas) the local NHS system was unwilling or slow to engage with the IS Providers, where Nightingale deployment was causing the local NHS system to put on hold use of IS Provider premises and where NHS hospitals had sufficient capacity to meet demand.
1189. The proposed shift in strategy was based on several priorities, albeit that local areas would determine appropriate usage. Priorities included:
- a. maintaining high utilisation arrangements;

- b. greater use of low use sites for urgent cancer surgery and chemotherapy, and where there was no clear need for using the whole of a low use site for cancer services than to use it for elective recovery;
- c. beginning the managed return of ventilators to sites; and
- d. considering, from July onward, a variation to the 2020 Contracts to extend targeted sites on advantageous terms,

NIRB approved the proposed strategy subject to confirmation of current levels of utilisation and development of a business case for partial future use of IS Providers working with regional teams and taking account of broader work on demand and capacity [AP252 INQ000269943].

- 1190. On 29 April 2020, NHS England sent the Phase 2 Letter recommending that systems consider retaining extra capacity that had been brought on-line, including access to the IS Providers' premises [AP253 INQ000050226]. NHS systems were advised to make judgements on whether they had capacity to restart routine elective care.
- 1191. Many local systems had developed "Green" (Covid-19 clear) and "Red" (Covid-19) pathways, working with their local IS Providers. IS Providers' premises were often used for green pathways, prioritising protection of critical services, and in many cases hosting entire services.
- 1192. With a potential second wave of Covid-19 infections being anticipated in autumn 2020, combined with the increasing elective waiting lists and the successful continuation of hosted services, consideration was given to continuing the 2020 Contracts to increase elective throughput whilst retaining the flexibility afforded by the 2020 Contracts ahead of the forecast second wave.
- 1193. NIRB considered this approach on 15 May 2020 and it was agreed with the SSHSC.
- 1194. By mid-May 2020 there had been a significant decline of the number of Covid-19 cases in NHS hospitals. De-escalation notices were served on IS Providers on 15 May 2020, effective immediately. The triggering of de-escalation allowed IS Providers to resume routine elective work, including in relation to private patients where capacity was not required by the NHS and subject to prior agreement with the local NHS system. The arrangement whereby 85% of net revenue generated by IS



Providers in respect of private patients continued to be set-off against the costs to be covered by NHS England.

1195. Terms for a variation to ongoing 2020 Contracts were discussed during July and August 2020, to be effective in most respects from 1 July 2020. The variation adjusted the commercial arrangements and included a change to the private revenue offset mechanism (which incentivised IS Providers to use the available/unrequired capacity to carry out private work, generate revenue and thereby reduce the overall costs to NHS England). It also included an agreed minimum capacity percentage of the IS Providers' premises, the inclusion of a defined end date to the 2020 Contract (no later than 31 December 2020 albeit NHS England could still terminate with one months' notice) and the ability for NHS England to reactivate the peak surge regime (allowing access to the full capacity of any affected IS Provider's premises) if and when necessary.
1196. In July 2020, the decision was made to terminate certain 2020 Contracts in whole or part and not enter into the variation with those IS Providers whose entire contracts were to be terminated. Notices to terminate the relevant IS Providers/sites were served, effective 7 September 2020. The remaining IS Providers were all offered and accepted the variation, which provided the adjusted commercial terms described above as an incentive to use the available/unrequired capacity to continue their private work and therefore mitigating costs to NHS England.
1197. Further termination notices were served in relation to four further premises (including a single premises IS Provider) on 30 September 2020, effective 31 October 2020 following a similar review of usage and costs.
1198. After the October terminations, 16 IS Providers remained operating under the 2020 Contract with two expiring on 24 December 2020 (as these two IS Providers were not entering into the 2021 Contract) and the other 14 expiring on 31 December 2020.

## **2021 Contracts**

1199. In early November 2020, discussions began with IS Providers with a view to agreeing new arrangements beyond Christmas 2020 to maintain a "surge" mechanism to allow the NHS to make use of a higher proportion of IS Providers' capacity if required. This was in response to rising Covid-19 rates that had placed additional pressure on NHS services limiting the ability of NHS providers and commissioners to:

- a. plan and/or effect the repatriation of NHS services and teams from IS Providers' facilities to NHS hospitals before the impending expiry of the remaining 2020 Contracts; and
  - b. to engage adequately to put in place local contracts/sub-contracts with IS Providers to replace the 2020 Contracts after expiry (for example by utilising the recently established ICF).
1200. Discussions took place during late November/early December 2020 on the terms for the 2021 Contracts. Once agreed, NHS England issued a letter (dated 17 December 2020) updating Trusts, CCGs and regional teams on the arrangements **[AP254 INQ000269987]**.
1201. Each 2021 Contract was to contain the same terms and conditions; a contract on those terms was offered to each of the 16 IS Providers that held the remaining 2020 Contracts as of December 2020. Fourteen of those IS Providers accepted, which included most of the larger IS Providers (in terms of acute bedded capacity). The table below indicates the IS Providers that entered into the 2021 Contract which accounted for 175 separate IS Provider sites/premises.

|  |   |
|--|---|
| Aspen Healthcare Ltd                                   | Nuffield Health                             |
| Circle Health Holdings Limited<br>(for Circle and BMI) | One Healthcare Partners Limited             |
| Healthcare Management Trust                            | Phoenix Hospital Limited                    |
| Horder Healthcare                                      | Practice Plus (for Care UK)                 |
| KIMS Hospital Limited                                  | Ramsay Health Care UK<br>Operations Limited |
| New Foscote Hospital Limited                           | Spencer Private Hospitals Limited           |
| New Victoria Hospital Limited                          | Spire Healthcare Limited                    |

1202. On 19 December 2020, the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) (No. 3) Directions 2020 came into force **[AP255 INQ000270048]**. Like the earlier directions, these directed NHS England to exercise the functions of CCGs under sections 3 and 3A of the NHS Act for the purposes of commissioning health services from independent providers and to support the provision of services by NHS bodies to address Covid-19. The new directions replaced the previous directions which were to expire on 31 December 2020. The new directions remained in force until 31 March 2021.

1203. HMT wished to approve the terms of the 2021 Contracts and wanted the insertion of a six-week break clause. This led to the 2021 Contracts being signed later than expected. This in turn meant that local NHS organisations did not have certainty on whether the 2021 Contracts would be entered into, and this impacted on their ability to make full use of the IS Providers in early January 2021.

1204. The 2021 Contracts differed from the previous 2020 Contracts in the following ways:

- a. payment was based primarily (see below) on activity delivered rather on costs incurred – these were contracts specifically for activity, not (except if peak surge was triggered) for capacity and operational resources;
- b. the 2021 Contracts did not provide for a capacity limit / expectation of capacity to be made available to the NHS but were instead based on a volume of activity to be delivered comparable to the activity of the relevant IS Provider in October and November 2020 (the busiest period);
- c. the services and support expected to be provided were NHS inpatient and outpatient services, urgent and routine elective care and cancer treatment, services that the IS Provider had been appointed to the ICF (see paragraph 1149 above) to deliver. During peak surge 100% of the IS Provider's capacity was to be fully applied to the delivery of the services above and any other services agreed with the local NHS which could be provided to a mutually agreed safe standard of care (but not care for Covid-19 infected patients needing high dependency respiratory support on oxygen therapy, NIV therapy, or mechanical ventilation);
- d. each IS Provider would be paid a minimum guaranteed amount each month. Without the guarantee, the IS Provider would very likely face a sudden drop in income which could only realistically be covered by expanding its private work. The guaranteed amount (which reduced each month) therefore ensured that the IS Provider would not use up capacity on private work which would have severely limited the ability of the NHS to access the capacity for the provision of NHS services. The minimum payment for January 2021 was no less than the average of the relevant IS Provider's October / November 2020 recoverable costs under its 2020 Contract). For March 2021, the minimum payment was the value of the planned activity level for that month as derived from the local NHS activity plans) and for February 2021, the

minimum payment was the mid-point of the January and March 2021 amounts;

- e. actual activity delivered would be valued at NHS Tariff prices and compared to the minimum payments, with only activity value delivered above the month's minimum guaranteed payment attracting any additional payments. This was performed at whole IS Provider level, not by individual premises – the minimum payments and value were an aggregate value for each IS Provider;
- f. if the NHS placed any IS Provider's site into peak surge, the element of the January 2021 payment associated with that site would continue until the peak surge period ended;
- g. when valuing activity (at National Tariff prices), £75 would be added to each inpatient and day case unit of activity to reflect the impact of Covid-19 on throughput and PPE costs. This was not an additional payment but added to the activity total value calculation; and
- h. operationally, there would be enhanced focus on the return of NHS clinical teams from IS facilities to their Trust bases.

1205. The structure of the 2021 Contracts provided a transition back to local commissioning and sub-contracting of services from IS Providers by NHS commissioners and providers. The 2021 Contracts provided additional time for repatriation of services and NHS teams to NHS hospitals, maintained NHS England's flexibility of use and maintained the NHS's ability to take over a whole IS Provider's site if required.

1206. On 13 January 2021, NHS England issued guidance setting out clear expectations that local NHS systems were to make full use of available IS Provider capacity whilst the NHS remained in a Level 4 Incident [AP256 INQ000269994] NHS England regions were subsequently requested to develop an additional "surge plan".

1207. During the period of the 2021 Contracts, a number of the IS Providers' premises were placed into peak surge to address the variable needs of the local NHS providers. These surged premises were reviewed fortnightly by the local teams and NHS England's operational team and were de-surged (access to full capacity given up) where access to the premises' full capacity was no longer required.

1208. Please refer to the graphs at the end of this Section for the number and type of treatments, carried out by the 14 IS Providers under the 2021 Contracts.
1209. As Wave 2 subsided, NHS England held weekly discussions with the local NHS systems exploring the extent to which there was a need to extend the 2021 Contracts. It was decided that the 2021 Contracts should be allowed to expire on 31 March 2021 as planned because additional funding was unlikely to be provided by HM Treasury and at that time there was no prediction of an imminent next wave of Covid.
1210. Additional information was provided to local NHS systems regarding the use of the ICF for future work although this was not mandated. Clear messages were sent to all IS Providers and NHS organisations that the 2021 Contracts would not continue beyond 31 March 2021.

## **2022 Contracts**

1211. The following became evident in December 2021:
- a. rapid rise in infection rates and hospitalisations as a result of the novel Omicron variant to Covid-19;
  - b. the likelihood of a surge in hospitalisations of Covid-19 patients following a Christmas and New Year period with no limitations on social distancing;
  - c. the impact this was predicted to have on the capacity of NHS hospitals to provide elective and other services; and
  - d. the length of time it would take CCGs and Trusts to put in place contracts/sub-contracts for elective services with IS Providers following selection processes whether under the ICF or otherwise.
1212. In December 2021, NHS England activated plans with the aim of creating and freeing up core NHS acute hospital activity to be able to respond to the potential risks of Omicron. The potential risk was very uncertain as evidenced by SPI-M-O analysis on 19 December 2021 **[AP257 INQ000270111]**. The plans included additional surge capacity, use of the Nightingale Surge Hubs and steps to improve discharge.
1213. NHS England was then asked by the SSHSC, as part of NHS England's plans, to identify options to use 100% of the capacity of independent sector organisations in a

similar way to that used under the 2020 Contracts. NHS England considered the options that presented best value to achieve this goal and how much staffed capacity could be made available.

1214. Discussions in mid-December 2021 between NHS England and six of the larger independent sector organisations indicated that around 5,600 physical beds could be made available in peak surge conditions but that only approximately 2,000-3,000 of these beds could be staffed (subject to staff absence levels), although the independent sector organisations could not confirm this figure.
1215. The discussions also indicated that the independent sector organisations would not agree to a contractual mechanism that would enable the NHS to have full access to their facilities, equipment and available staff at short notice if and when the need arose nationally, regionally or locally without a form of minimum guaranteed income.
1216. To persuade the independent sector organisations to agree a mechanism in principle to enter into these arrangements in the very short time available to NHS England, it was necessary for NHS England to offer for the period of the intended arrangements (10 January 2022 to 31 March 2022) a guaranteed minimum income based on 90% of the specific independent sector organisation's best four weeks of NHS activity in the period from October to December 2021. It was also necessary to offer premiums above NHS tariff prices in particular for cancer and more complex specialties to incentivise more urgent cases if that proved necessary. For any peak surge period in which access to 100% of the independent sector organisation's capacity was to be provided to the NHS, an agreed minimum guaranteed payment which reflected the cost recovery approach for payments under the 2020 Contracts would be made.
1217. In considering the appropriateness and value for money of the arrangements, NHS England considered a range of factors including whether the arrangements protected elective work, whether activity performed by the independent sector organisations was paid at an appropriate price to the taxpayer, whether in a peak surge situation - where the cost recovery amounts would need to be paid - there were governance and management arrangements in place to ensure effective use of facilities, and whether the process for agreeing the minimum guaranteed income reflected best practice from the prior year. Given the need to provide minimum guaranteed income, NHS England noted the risk of under-delivery of activity in early

2022 when the NHS was under pressure due to expected high levels of staff sickness.

1218. After liaising with HMT in early January 2022 and receiving appropriate consents and after the proposed arrangements were presented to the 5 January 2022 NIRB meeting **[AP258 INQ000270113]**, the NHS England's Chief Executive Officer considered it necessary to confirm that the SSHSC still wished NHS England to put the arrangements in place in addition to the other measures the NHS was taking. A direction from the SSHSC was therefore requested by NHS England's Chief Executive Officer on 7 January 2022 **[AP259 INQ000279939]**

1219. On 8 January 2022, the SSHSC issued the requested direction, highlighting the need to protect the NHS and prevent a further reduction in NHS capacity **[AP260 INQ000270153]**. The 2022 Contracts took effect from 10 January 2022 for a total of 169 separate IS Provider sites/premises although the contracts were signed later than this date. They expired on 31 March 2022.

1220. The IS Providers that entered into 2022 Contracts were:

|                                |  |
|--------------------------------|--|
| Aspen Healthcare Ltd           | Nuffield Health                          |
| Circle Health Holdings Limited | One Healthcare Partners Limited          |
| The Health Management Trust    | Practice Plus Group Hospitals Ltd        |
| Horder Healthcare              | Ramsay Health Care UK Operations Limited |
| KIMS Hospital Limited          | Spire Healthcare Limited                 |

1221. The services required of the IS Providers under the 2022 Contracts included:

- a. the services which the IS Provider had been appointed to the ICF to deliver at the relevant premises;
- b. any other services delivered or planned to be delivered at the relevant Provider's Premises for NHS patients as of 10 January 2022; and
- c. any other services agreed with NHS England.

1222. As indicated above, during any peak surge period, the IS Provider had to make available all facilities, diagnostics, staffing, management and full organisation capability (the latter to include but not limited to central management and

administrative support services), necessary for the provision of, and for the support of, the response by the NHS to the pandemic.

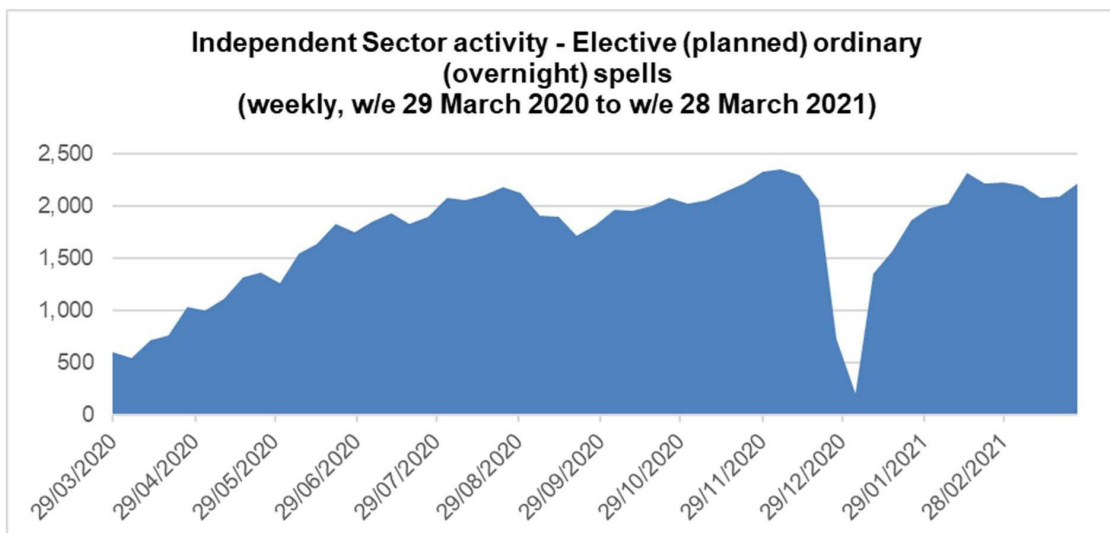
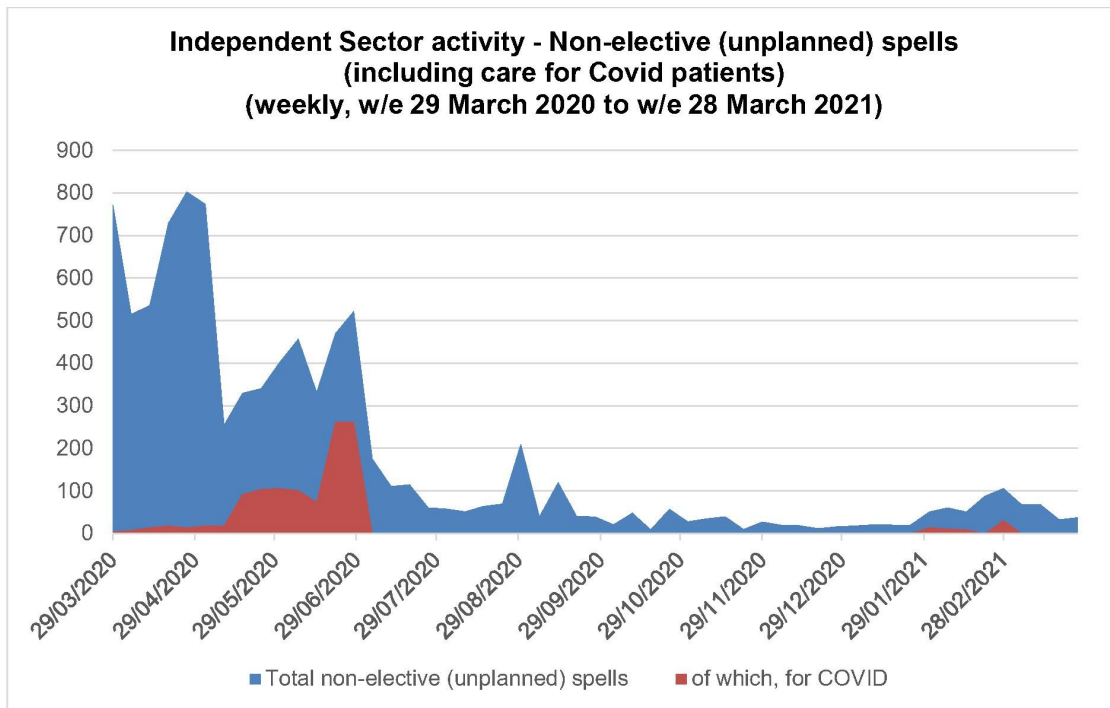
1223. Please refer to the graphs at the end of this Section for the number and type of treatments, carried out by the 14 IS Providers under the 2022 Contracts.

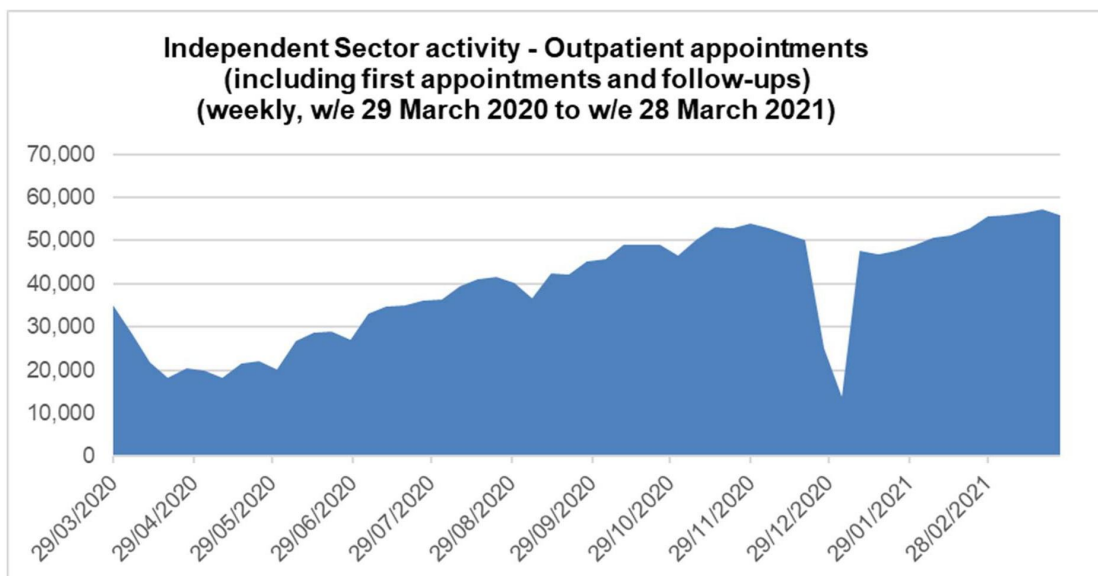
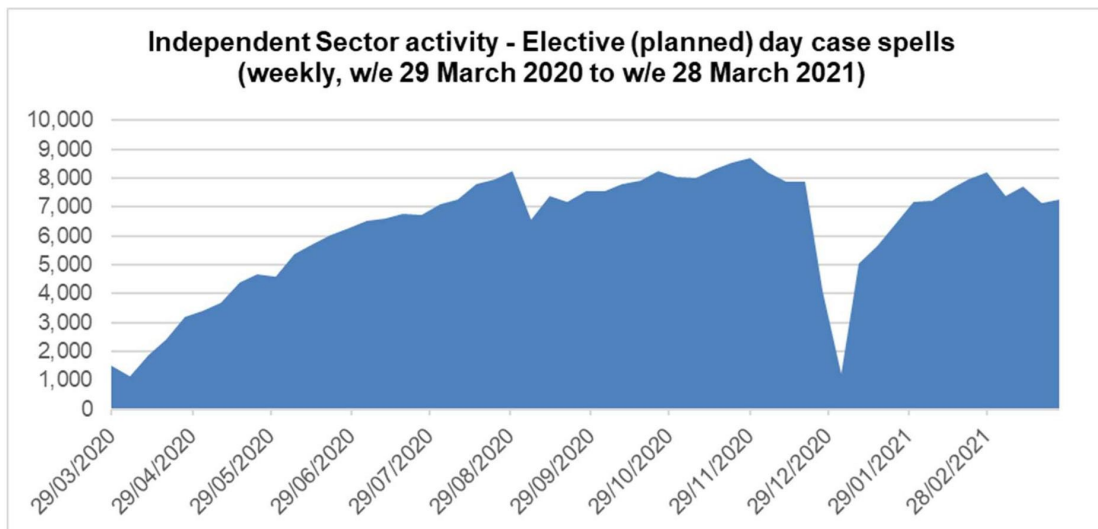
#### **Activity performed under the 2020 and 2021 Contracts**

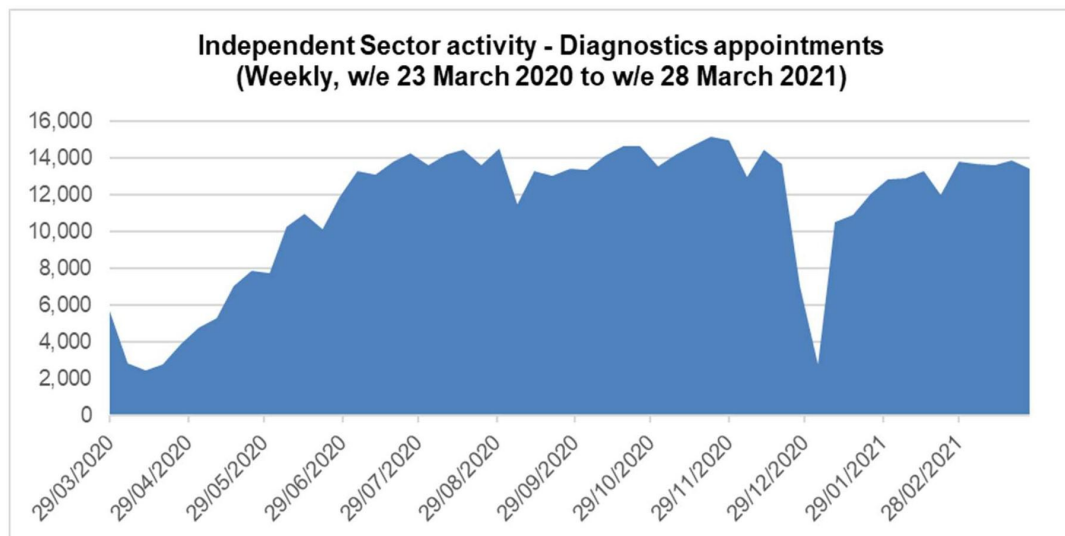
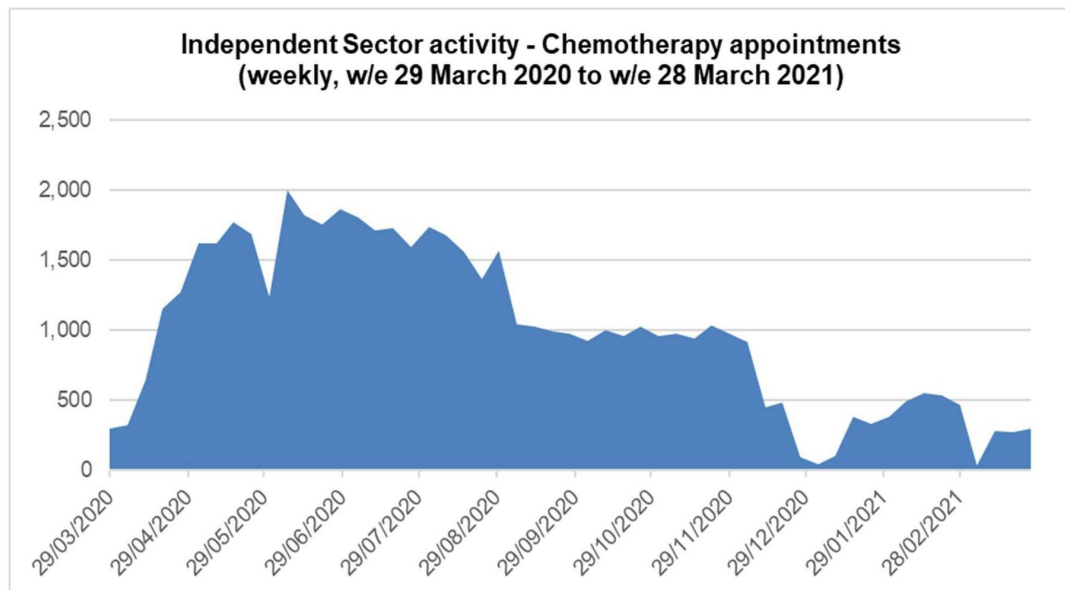
1224. The following graphs indicate activity data collated from IS Providers under the 2020 Contracts and the 2021 Contracts. The data was collected pursuant to the guidance note **[AP261 INQ000270132]**. A high-level explanation of the terms used in the guidance is provided below as a brief explanation to the graphs. The terms are presented in the order they appear in the graphs:

|                   |   |
|-------------------|---|
| Spell             | a spell is a stay by a patient using a hospital bed controlled by a provider where the patient's care is the responsibility of a consultant or the patient is receiving nursing or midwifery care. It differs from outpatient appointments as an outpatient is not using a bed. A spell need not be overnight |
| Non-elective care | care that has not been arranged in advance  |
| Elective care     | care arranged in advance  |
| Ordinary          | a patient admitted for elective care who is expected to remain in the hospital for at least one night   |
| Day case          | a patient admitted for elective care who does not require the use of a hospital bed overnight. Where such a patient does actually stay overnight, they should be counted as an ordinary admission   |
| Outpatient        | attendance by a patient who is not admitted   |
| Chemotherapy      | first or follow-up treatments using anti-cancer drug regimens   |
| Diagnostics       | tests or procedures used to identify and monitor a person's disease or condition (not including tests carried out as part of a national screening programme)  |



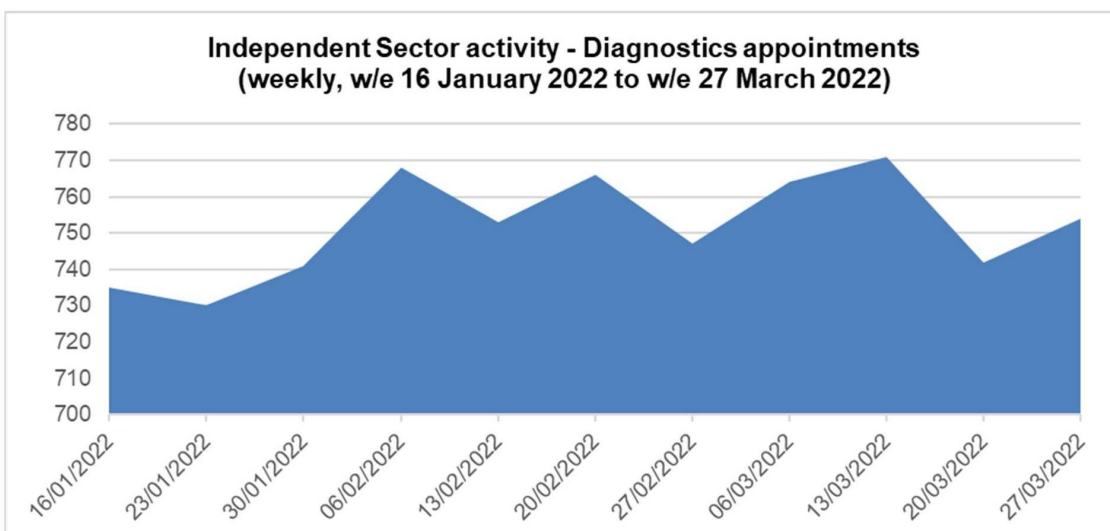
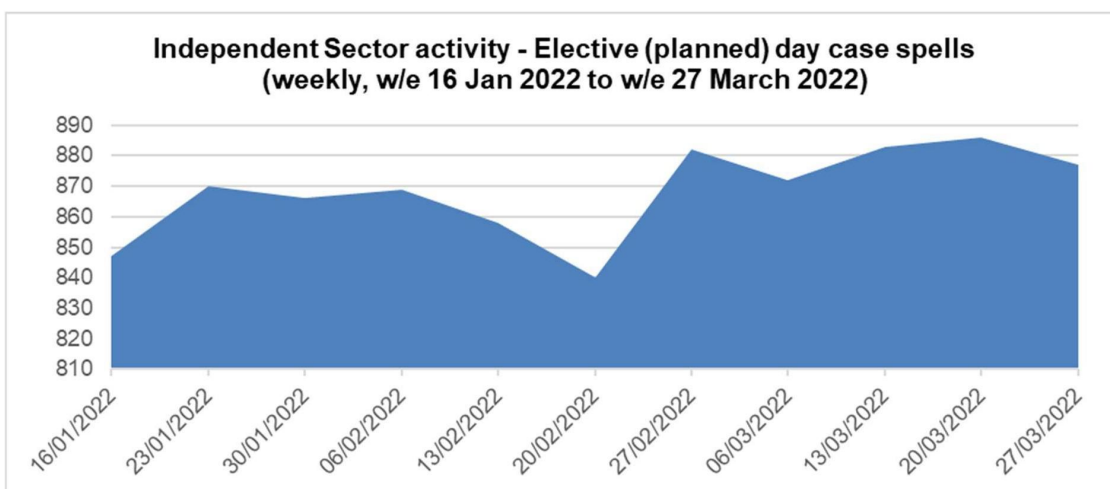
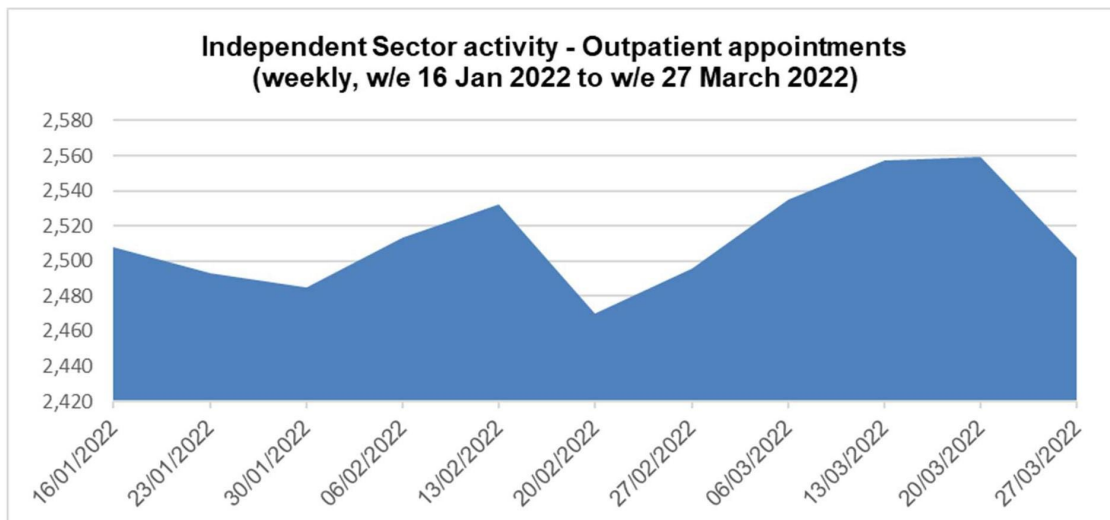


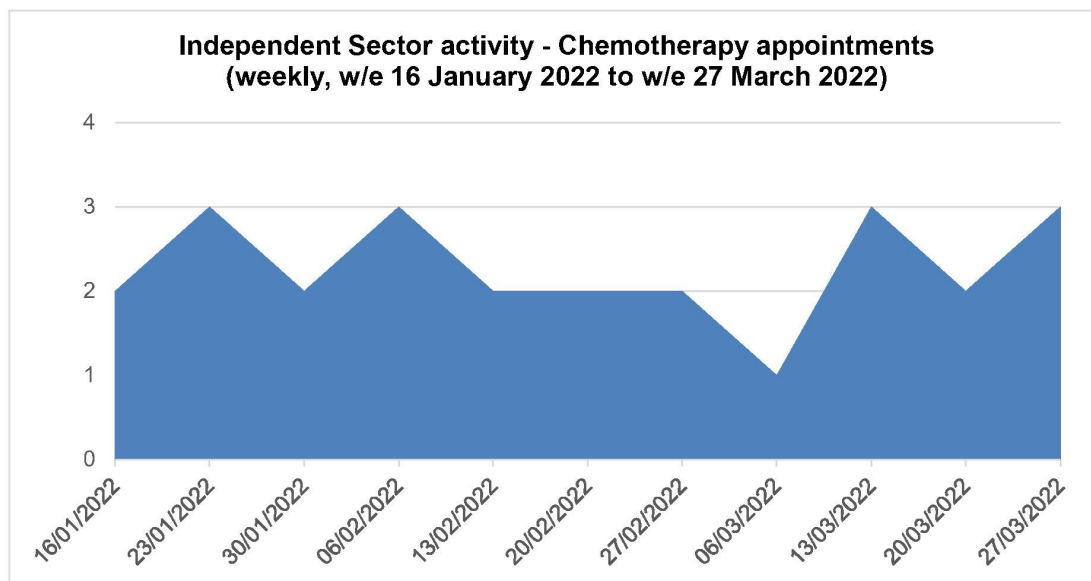




### Activity performed under the 2022 Contracts

1225. The following graphs indicate activity data collated from IS Providers holding 2022 Contracts. The data was collected pursuant to the guidance note **[AP262 INQ000270133]**. This note did not require provision of non-elective activity data.





#### **Funding for 2020, 2021 and 2022 Contracts**

1226. In relation to the 2020 Contracts, there were early discussions with HMT as the Heads of Terms took shape. By 23 March 2020, HMT had agreed the expected financial costs of the Heads of Terms arrangements.
1227. On 15 July 2020, NHS England was copied into a letter from HMT to DHSC indicating that the Chancellor has confirmed additional funding for extended usage of the IS Providers of up to £1.87 billion, in addition to up to £1.12 billion committed prior to that date [AP263 INQ000233886]. The funding was subject to conditions contained in the letter on effective data-sharing and driving value for money.
1228. On 10 August 2020, HMT agreed to continue to fund arrangements with the independent sector organisations to a maximum of £55 million per week until March 2021, subject to conditions set out in a letter to DHSC. HMT agreed to maintain funding in December 2020 for the period January – March 2021 (the 2021 Contracts) provided there was a six-week break clause inserted into the terms.
1229. The 2020/21 Financial Directions ringfenced funding of £2.632 billion for costs associated with independent sector organisations in that financial year.
1230. The cost of the 2020 Contracts and the 2021 Contracts was met from additional funding from HMT. This did not have an impact on the wider NHS England budget or that of Trusts.

1231. The cost of the 2020 Contracts was approximately £1.65 billion. The cost of the 2021 Contracts was approximately £0.46 billion.
1232. For the 2022 Contracts, due to the return to local commissioning arrangements, funding was already included within Trusts' budgets. Trusts were instructed to pay for any activity arranged by them and delivered by the independent sector as they would have done normally (i.e., as if there were no 2022 Contracts in place).
1233. NHS England committed to directly covering the remaining balances with the IS Providers that entered into 2022 Contracts. As there was no activation of the peak surge arrangements, these remaining balances covered centrally were the agreed National Tariff uplifts to certain activity for the period, and payments to ensure minimum income guarantees were met. These totalled c.£10m and were funded from existing NHS reserves and had no significant impact on other budgets for the NHS financial year 2021/22.

#### **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

### Key Figures

Key Figures during the Relevant Period

| Key Leader                   | Role   |
|------------------------------|--|
| <b>NHS England Board</b>     |  |
| Lord Simon Stevens           | <ul style="list-style-type: none"> <li>Former Chief Executive Officer (1 April 2014 until 31 July 2021)</li> </ul>   |
| Amanda Pritchard             | <ul style="list-style-type: none"> <li>Chief Executive Officer NHS England (since 1 August 2021)</li> <li>Former Chief Operating Officer of NHS England (1 August 2019 until 31 July 2021)</li> <li>Chief Executive Officer of NHS Improvement (August 2019 until 31 July 2021)</li> <li>Accountable Officer for Emergency Preparedness, Resilience and Response (August 2019 until 13 December 2021)</li> <li>Chair of National Incident Response Board (NIRB)</li> </ul> |
| Julian Kelly                 | <ul style="list-style-type: none"> <li>Chief Financial Officer and Deputy Chief Executive (since 1 April 2019)</li> </ul>  |
| Professor Sir Stephen Powis  | <ul style="list-style-type: none"> <li>National Medical Director of NHS England (since 30 January 2018)</li> <li>Interim Chief Executive Officer NHS Improvement (1 August 2021 until 30 June 2022 (when NHS Improvement was abolished))</li> </ul>  |
| Dame Ruth May                | <ul style="list-style-type: none"> <li>Chief Nursing Officer (since 7 January 2019)</li> </ul>   |
| Ian Dodge                    | <ul style="list-style-type: none"> <li>National Director Primary Care Community Services and Strategy (retitled directorate in 2020 - until June 2022)</li> </ul>  |
| Prerana Issar                | <ul style="list-style-type: none"> <li>Chief People Officer (1 April 2019 – August 2022)</li> </ul>  |
| Professor Em Wilkinson-Brice | <ul style="list-style-type: none"> <li>Deputy Chief People Officer (September 2019 - March 2022)</li> <li>Acting Chief People Officer (November 2021 – June 2022)</li> <li>National Director for People (since July 2022)</li> </ul>   |

| Key Leader                  | Role   |
|-----------------------------|--|
| Pauline Philip DBE          | <ul style="list-style-type: none"> <li>National Director of Urgent and Emergency Care (December 2015 until December 2022)</li> </ul>   |
| Simon Enright               | <ul style="list-style-type: none"> <li>Director of Communications (October 2013 until 14 May 2021)</li> </ul>  |
| James Lyons                 | <ul style="list-style-type: none"> <li>Director of Communications (Since 17 May 2021)</li> </ul>   |
| <b>EPRR and EU Exit</b>     |  |
| Professor Sir Keith Willett | <ul style="list-style-type: none"> <li>National Director for Emergency Planning and Incident Response (September 2019 until 4 July 2021)</li> <li>Covid-19 Strategic Incident Director (January 2020 until 4 July 2021)</li> <li>Strategic Commander for EU Exit (December 2018 until July 2021)</li> <li>SRO for pandemic flu preparedness programme</li> </ul> |
| Dr Mike Prentice            | <ul style="list-style-type: none"> <li>National Director for Emergency Planning and Incident Response (since April 2022)</li> <li>Deputy National Strategic Incident Director, Covid-19 (February 2020 until April 2022)</li> <li>Regional Medical Director (North) (June 2016 until April 2022)</li> </ul>  |
| Stephen Groves              | <ul style="list-style-type: none"> <li>Director of EPRR (National) (since April 2020)</li> <li>Head of EPRR (National) (since April 2013)</li> <li>National Incident Director</li> </ul>   |
| Professor Chris Moran       | <ul style="list-style-type: none"> <li>Deputy National Strategic Incident Director (March 2020 until April 2022)</li> <li>Chair of Clinical Reference Group</li> </ul>   |
| Dr Chloe Sellwood           | <ul style="list-style-type: none"> <li>London Deputy Head of EPRR (since March 2017)</li> <li>Acting Deputy Head of Emergency Preparedness, Resilience and Response (London) (November 2016 until February 2017)</li> <li>EPRR National Pandemic Flu Lead (since April 2013)</li> </ul>  |



| Key Leader     | Role  |
|----------------|---|
| Kelsay Magowan | <ul style="list-style-type: none"> <li>• Head of Potential Incident Investigation Preparation and Recovery (January 2020 until January 2022)</li> <li>• Chief of Staff to National Director for Emergency Planning and Incident Response (January 2020 until June 2021)</li> <li>• Director of Programme Delivery (June 2021 until January 2022)</li> <li>• EU Exit Programme Lead (December 2018 until June 2021)</li> </ul> |
| Leaf Mobbs     | <ul style="list-style-type: none"> <li>• Director for EU Exit Operational Response (December 2018 until January 2020)</li> </ul>  |
| Neil Permain   | <ul style="list-style-type: none"> <li>• Director of Operations and Delivery (2018 until March 2021)</li> </ul>   |
| Mike Jacobs    | <ul style="list-style-type: none"> <li>• HCID Programme Director</li> </ul>   |

## ANNEX 2

### Summary of regular external meetings

1. A summary of the meetings regularly attended by NHS England representatives is provided below. A broad overview of the intended purpose is provided where possible. In addition to the regular meetings outlined below, NHS England representatives engaged with ministers and Government colleagues at various levels on a daily basis, and illustrations of these interactions are also set out below.
2. From 21 March 2020 there were very regular, often daily, meetings attended by the Prime Minister, senior Cabinet Office officials, the SSHSC and other senior Cabinet Ministers, the Chief Medical Officer, the Government Chief Scientific Adviser and NHS England's Chief Executive Officer to brief the Prime Minister on latest developments. These meetings subsequently became the 'dashboard' meetings (described below).
3. NHS England representatives also attended various meetings as required including Quad meetings (described below), ad-hoc Officials meetings, cross-government Situation update meetings, Covid-19 Healthcare Ministerial Implementation Group ("HCIGs") meetings, Covid-19 meetings with the Prime Minister, COBR(O) and COBR(M) meetings. The focus of these meetings from the perspective of NHS England was generally to relay information about NHS capacity and receive information about Government decisions on next steps. On occasions, work and/or updates were commissioned from NHS England in advance of these meetings around NHS capacity to inform discussions and decision-making.
4. DHSC established a new Covid-19 Oversight Board, which was known as the Reasonable Worst Case Scenario Board and its Terms of Reference related to overseeing the longer-term planning work taking place to ensure that England was ready for a potential pandemic. The meeting was chaired by DHSC with a board comprising of individuals from DHSC, PHE, NHSX and NHS England.
5. Covid 19 Operations Committee - Chaired by the Prime Minister with attendees from cabinet and cross-Government departments. NHS England attendees included the National Medical Director, Chief Operating Officer and the Chief Nursing Officer (when invited to discuss specific issues related to her portfolio).
6. SSHSC Covid-19 meetings - These meetings were held several times per week from 4 February 2020 to 19 March 2020 with the SSHSC. DHSC and PHE officials, and the

NHS England Chief Executive Officer, were invited. This meeting series was superseded by a daily catch up with the Prime Minister and the SSHSC.

7. Prime Minister and SSHSC Covid-19 meetings - Hosted by the Prime Minister, these meetings were held daily from 21 March 2020 to 15 May 2020. The SSHSC was invited, alongside a range of Government departments. The NHS England Chief Executive Officer was invited. This meeting series was superseded by regular meetings to discuss the 'Covid-19 dashboard', which started on 1 June 2020.
8. Prime Minister 'Covid-19 dashboard' meetings - Hosted by the Prime Minister, meeting attendees included SSHSC, HMT and the Chancellor. NHS England attendees included the Chief Executive Officer, Chief Operating Officer and National Medical Director.
9. Daily catch-ups with officials at Number 10 Downing Street - Daily calls were established with NHS England DHSC and others to discuss priority tasks. The meetings started on 17 March 2020 and were held daily Monday to Friday where possible. The meetings ended on 17 April 2020.
10. Test and Trace meetings with SSHSC. NHS England attendees initially included its Chief Nursing Officer and her deputy, who were invited in June/July 2020, and later the National Director for Emergency Planning and Incident Response.
11. UK Senior Clinicians Group - Established in February 2020 as a forum at which senior UK clinicians involved in pandemic management could discuss predominantly clinical issues relating to Covid-19. It was not a decision-making group. Meetings were chaired by the CMO or an appropriate deputy and involved all Deputy CMOs, Chief Medical Officers, Deputy Chief Medical Officers and clinical advisors from all four nations, UK Chief Nursing Officers, and representatives from GCSA, HEE, Scottish Government, Public Health Scotland, NICE, Ministry of Defence, and DHSC as well as NHS England.
12. SAGE - The Scientific Advisory Group for Emergencies ("**SAGE**") meetings were convened in January 2020 by the Government Chief Scientific Advisor ("**GCSA**") and is convened to provide scientific advice to support decision-making in the Cabinet Office Briefing Room ("**COBR**") in the event of a national emergency. It is intended as an advisory group limited to scientific matters and its members vary from meeting to meeting. NHS England did not begin to attend these meetings until 'SAGE 10' (25 February 2020) with NHS England's National Medical Director attending regularly, and

intermittent attendance from other NHS England colleagues. The primary purpose for NHS England attendance was to support in providing NHS specific information as necessary.

13. SPI-M-O Group - This group gave expert advice to DHSC and the wider UK Government on scientific matters relating to an influenza pandemic or other emerging infectious disease threats. NHS England was not a regular attendee but was occasionally invited.
14. Hospital-Onset Covid-19 (HOCl) Working Group - This UK-wide sub-group was commissioned by SAGE on the 3rd April 2020 and (after the first meeting) jointly chaired by NHS England (CNO) and PHE, but by 15 May, joint chairing duties had been passed from PHE to NHS England's National Clinical Director for IPC. This group focused on hospital onset Covid-19 infection / nosocomial infections, and its purpose was to provide thought leadership, direction to analysis and precipitate policy change and interventions that lead to a rapid and sustained reduction in the rate of HOCl. Information from this group fed into groups such as SAGE and supported NHS England's operational response. Members included several NHS England attendees, PHE/UKHSA, NHS National Services Scotland, Public Health Wales, Northern Ireland Executive and several university academics.
15. '4CNO & NMC' meetings - Chaired by the UK CNOs on a rotating basis and with the NMC as secretariat, these meetings were established specifically to respond to the pandemic, building on existing 4 CNO meetings. This forum was focused on the nursing response, returners and student deployment. Some of these meetings also included Unite and Unison when these issues required wider engagement and input. Members included Chief Nursing Officers from all four UK nations, including the Chief Nursing Officer for NHS England and NMC members. During the response, these meetings included discussions around student fees, registration and impact on pension of returning retirees. Regular meetings between the NMC and the 4 CNOs ceased after Wave 1, but the 4 CNOs continued to meet regularly throughout and still meet on a fortnightly basis.
16. Joint Biosecurity Centre Local Action Committee (Gold) meeting with SSHSC (also known as DHSC Gold) - The Joint Biosecurity Centre was established in May 2020 by SSHSC as part of the Test and Trace service to help inform actions on testing, contact tracing and local outbreak management in England, and to advise on Covid-19 alert levels and inbound international health risks. Membership included PHE, ONS,

academic institutions and private industry. Regular NHS England attendees included NHS England's National Medical Director, Chief Nursing Officer and Strategic Incident Director.

17. Joint Biosecurity Centre Silver meetings (also known as DHSC Silver) - Chaired by the Chief Medical Officer, Joint Biosecurity Centre Silver addressed issues of concerns raised at Joint Biosecurity Centre Bronze meetings, to be escalated to Gold as necessary. NHS England's National Medical Director, Chief Nursing Officer and the National Director of EPRR / National Director for Emergency Planning and Incident Response attended on behalf of NHS England. The weekly silver meetings were to discuss the latest Covid issues covering a wide range from epidemiology, projections, outbreaks and modelling. The silver meeting fed into the gold meeting and the papers were usually identical.
18. GCSA, CMO, NHS England CEO and PHE meetings - These weekly meetings pre-dated the pandemic as a healthcare-specific communication and information-sharing tool. Meeting attendees included the GCSA, the CMO and PHE representatives alongside NHS England's Chief Executive Officer. These meetings remained broad in purpose during the pandemic response.
19. Quad meetings (also referred to as "**NHS Weekly**") - These weekly meetings (normally Monday morning) were held between the SSHSC, Minister of State for Health (MSH), Permanent Secretary of DHSC and typically the Chief Executive of NHS England and Chief Operating Officer of NHS England. Following the change in NHS England's Chief Executive Officer in August 2021, the Chief Financial Officer typically attended instead of the Chief Operating Officer. The meetings pre-dated the pandemic and continued throughout. They were discussions covering a broad variety of different topics, rather than a formal decision-making forum. Key points from these meetings were noted by SSHSC's private office and shared with attendees. While some limited opportunity to comment on the notes of the meeting was afforded to NHS England, the notes of the meeting were never formally agreed by the attendees.
20. DHSC tripartite 'Daily Coordination' calls - Established by DHSC on 20 January 2020, the Director and/or Deputy Director of EPRR attended these calls on behalf of NHS England.
21. PHE Strategic Response Group - The PHE Strategic Response Group is a PHE-led group which NHS England attended on at least one occasion. It is NHS England's understanding that the role of the group was to support the SD in their role of cross

Government liaison and communication, including supporting the tripartite arrangements in place with DHSC and NHS England.

22. The New and Emerging Respiratory Virus Threats Advisory Group ("**NERVTAG**") - This is a DHSC expert committee which advises the CMO (and through the CMO, it advises ministers, DHSC and other government departments). Membership includes a range of clinicians and academics. NHS England attended NERVTAG.
23. Daily Finance meetings - The daily finance meetings begun on 16 March 2020 and were a daily check-in between senior finance representatives from NHS England, DHSC and HMT to discuss emerging issues and developing policy. This was not a decision-making group nor did it have a core membership. The meeting series ended in June 2020.
24. Cross-System Efficiency and Finance Board - This is a regular meeting organised by the Finance Directorate in DHSC. The NHS England CFO and Finance staff were invited to the series. The meetings focused on the NHS financial position, financial frameworks as required and the outcomes of the finances (i.e., NHS' performance). The series pre-dated Covid-19 and continued throughout.
25. Capital Delivery Portfolio Board - This is a monthly meeting organised by the Portfolio Directorate in DHSC. The NHS England CFO and finance staff were invited to the series. The meeting focussed on capital projects. The series pre-dated Covid-19 and continued throughout.
26. Monthly Finance meeting - This is a monthly meeting organised by DHSC and including MS(H). The NHS England CFO was invited. The meeting series was requested by MS(H) upon entering his post with the intention of providing an ad hoc brief on the latest financial position and an opportunity for an open discussion on any current pressing issues. These meetings were not formal accountability discussions. The request for the series pre-dated Covid-19.

**ANNEX 3**  
NHS England Pandemic Response Structure

**PART 1: Key NHS England Meetings**

**The NHS England Board and the National Incident Response Board (“NIRB”)**

1. A role of NHS England is to ensure that NHS England and the NHS in England is properly prepared to deal with potential disruptive threats to its operation and to take command of the NHS, as required, during emergency situations. As such the NHS England Board receives update at Board meetings regarding the state of readiness and incidents since the previous update.
2. NHS England and NHS Improvement each established a group known as the Covid-19 National Incident Response Board on 18 February 2020, which met in common (known as the “Covid-19 Board”, “Covid-19 NIRB” or simply “NIRB”) to support the discharge of each organisation’s respective duties and powers and their combined responsibilities by setting the strategic direction and providing oversight of NHS England and NHS Improvement’s response to the Covid-19 incident.
3. The duties of NIRB were (in summary) to:
  - a. set the strategic direction and provide oversight of the NHS England response to the incident;
  - b. work in partnership with other originations (e.g., DHSC & PHE) to protect the public and minimise health impact;
  - c. agree the approach to the implementation of national response measures and related key communications activity;
  - d. determine the redeployment and/or reallocation of NHS England resource to support NHS operational readiness and the response to the incident based on the Government’s cross-departmental strategy and priorities, making recommendations to the NHS England Boards where a proposal has a material impact on staff, the public and/or patients, or where a decision is considered to be contentious and/or repercussive;
  - e. provide oversight and challenge to NHS England operations;
  - f. review key risks and issues escalated to NIRB; and

- g. ensure appropriate arrangements were established at the appropriate time to manage recovery work.
- 4. NIRB approved the evolving iterations of the Covid-19 operating model (as evidenced through the revised iterations of incident governance diagram and cell structures that were presented to NIRB), as well as being the central link between the response and the NHS England executive Group and NHS England Board. Additionally, there were lines of communication through to NIRB via the Chair of each of Tactical Fusion and Strategic Fusion. It is also worth highlighting that the Incident Response Team (National) reported key updates on issues through to Tactical Fusion, and then as required, back to NIRB.
- 5. In November 2020, the duties of the NIRB were amended also to support the implementation of nationally-agreed strategies and programmes and oversee delivery of these. To do this, NIRB would:
  - a. monitor in-year delivery and take action to ensure finance, performance, workforce and quality objectives are achieved;
  - b. consider and agree the approach to implementation for national response measures and related key communications activity, and associated targets;
  - c. for regional and local response, and monitor delivery of these;
  - d. consider the redeployment and/or reallocation of NHS England resource to support NHS operational readiness and the response to Covid-19 based on the Government's cross-departmental strategy and priorities and in the context of delivery of NHS Long Term Plan programmes, the NHS People Plan and EU Exit programme, making recommendations to the NHS Executive Group and NHS England and NHS Improvement if required; and
  - e. review key programme risks and any issues escalated to the Covid-19 Board and, where necessary, determine appropriate action to mitigate these and resolve any barriers to progress.
- 6. NIRB was chaired by NHS England's Chief Operating Officer, and in her absence, the National Medical Director, Chief Finance Officer or Strategic Incident Director.

### **Tactical Fusion**

- 7. Tactical Fusion was responsible for:



- a. Providing daily operational status updates from cells and operational functions covering:
    - i. Current operational assessments;
    - ii. Forward look on operational matters for the next 48 hours - 14 days;
    - iii. Horizon scan to identify issues needing early action 2 weeks+;
    - iv. Support and/or guidance required; and
    - v. Potential risks, issues and mitigations.
  - b. Providing response to regional concerns raised at daily IMT where appropriate;
  - c. Providing situational awareness to attendees of wider strategic focus from Strategic Fusion and National Incident Response Board (NIRB);
  - d. Cohere and co-ordinate cross cell activity at the tactical level;
  - e. Provide a platform for escalation of issues;
  - f. Fuse the national tactical operating picture, collating key points to update at the Strategic Fusion meeting;
  - g. Facilitating information flow across the system to contribute to situational awareness;
  - h. Identifying areas for Contingency Cell support and provide advice and guidance;
  - i. Providing direction, guidance and prioritisation for ongoing work; and
  - j. Feed into the NHS Chief Operating Officer's end of day report with key topics arising.
8. Tactical Fusion was chaired by the Incident Director (National) and, in his absence, the Deputy Incident Director (National).
9. The Joint Situational Awareness Team ("JSAT") was established between PHE and the Joint Biosecurity Centre to bring together all of the data and knowledge on Covid-19 to inform collective efforts to control the spread of the virus. The team was created

in July 2020 and an action was taken during the 21 August 2020 Tactical Fusion meeting to share JSAT information with the Tactical Fusion Group.

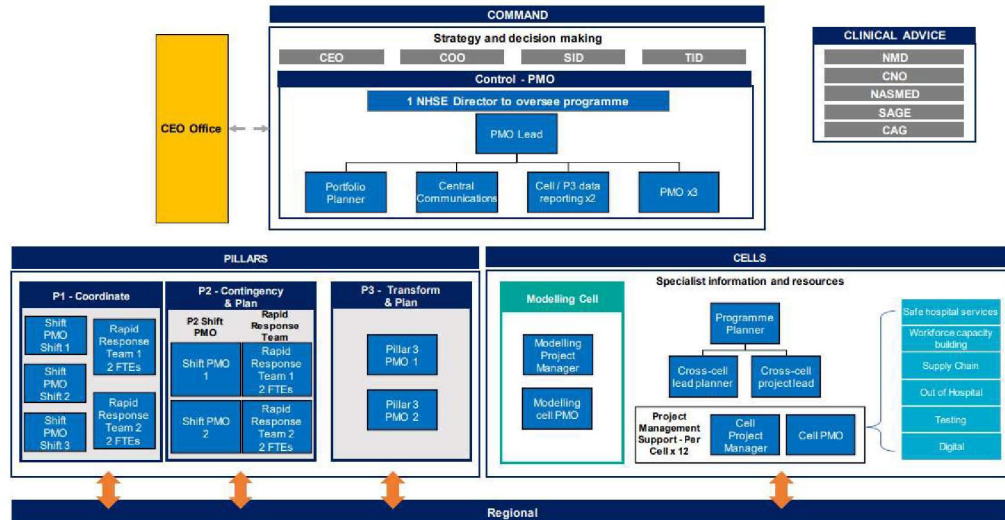
### **Strategic Fusion**

10. The role of Strategic Fusion was to support the cohesive delivery of nationally-agreed strategies and programmes, including NHS England's response to the pandemic and recovery towards the goals set out in the Long Term Plan and other commitments, and the Strategic Fusion Delivery Group by:
  - a. Reviewing and seeking to resolve issues escalated to the Group from the Tactical Fusion Delivery Group or other routes and, where necessary, escalate these to the Operational Response and Delivery Group;
  - b. Sharing information around key areas of interdependency to support alignment in planning and delivery;
  - c. Agreeing national strategic key lines and actions on urgent priorities and issues;
  - d. Receiving regular updates on the latest situation with regard to COVID-19 and NHS recovery from the pandemic to ensure common situational awareness at a strategic / executive level;
  - e. Considering communications prioritisation; and
  - f. Feeding into summary reporting documents with key topics arising as required.
11. Strategic Fusion was chaired by the National Director for Emergency Planning and Incident Response as Strategic Incident Director (or in his absence by the Incident Director (National) or Deputy Strategic Incident Directors). From June 2021 as the incident moved into a recovery phase it was co-chaired by Director for Long Term Plan Delivery and Deputy Chief Operating Officer.

## PART 2: Governance Diagrams

April 2020

### EPRR programme management organisation structure

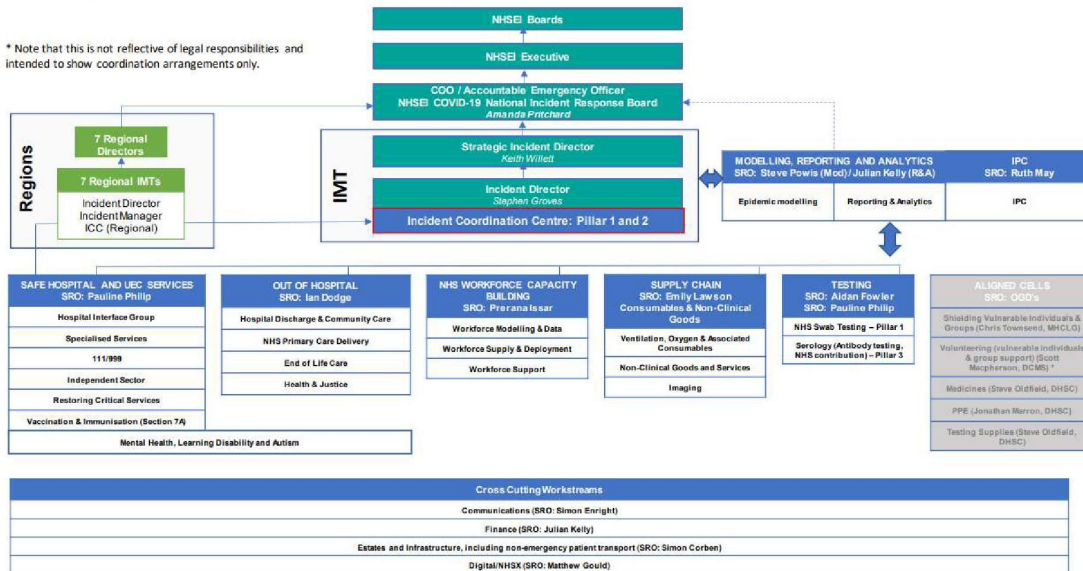


June 2020

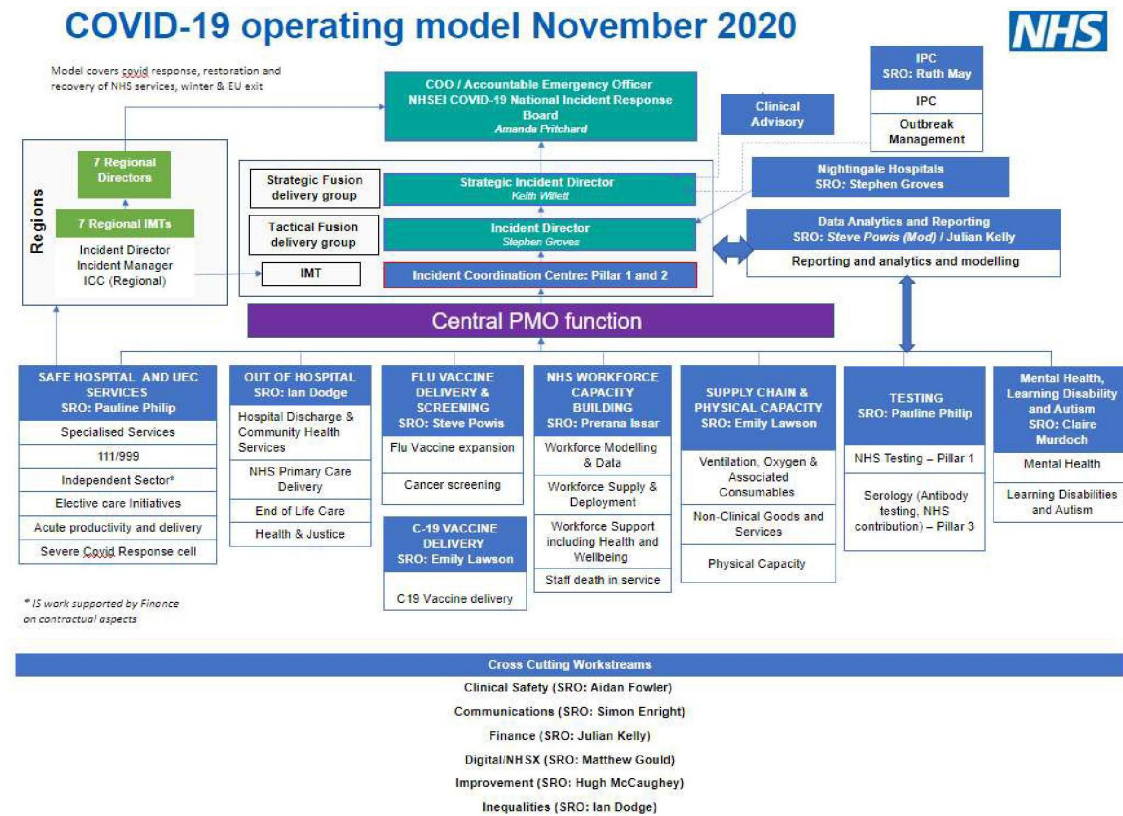
### Current NHSE/ Cell structure and accountabilities\*

NIRB endorsed 3<sup>rd</sup> June 2020

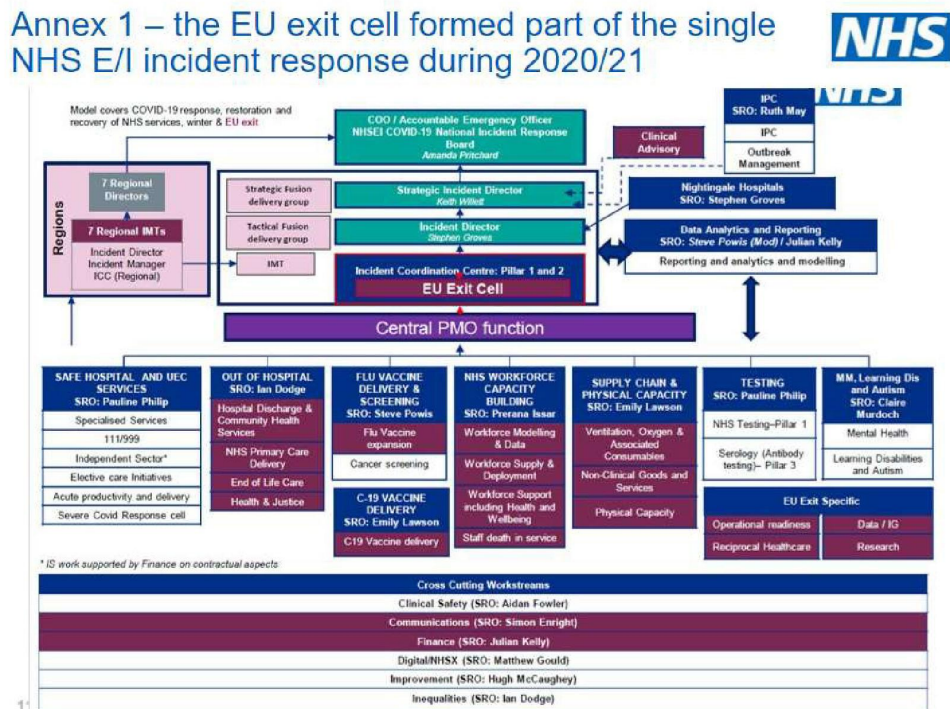
\* Note that this is not reflective of legal responsibilities and intended to show coordination arrangements only.



November 2020



### EU Exit Cell as part of the incident response

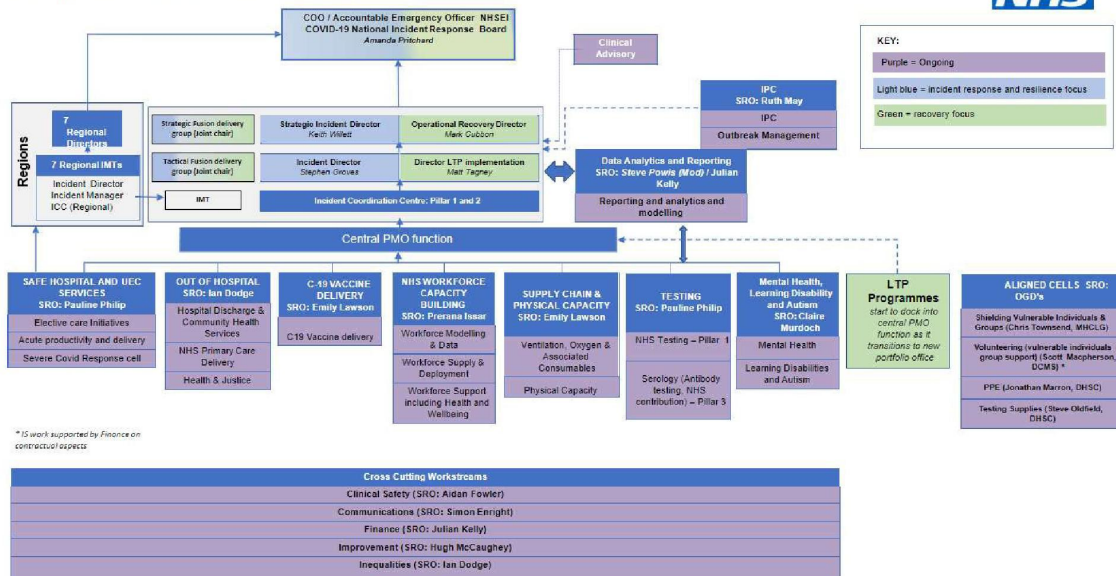


April 2021

## Proposed interim cell status

OFFICIAL/SENSITIVE

Note: Safe Hospital and Workforce sub-cells require reviewing

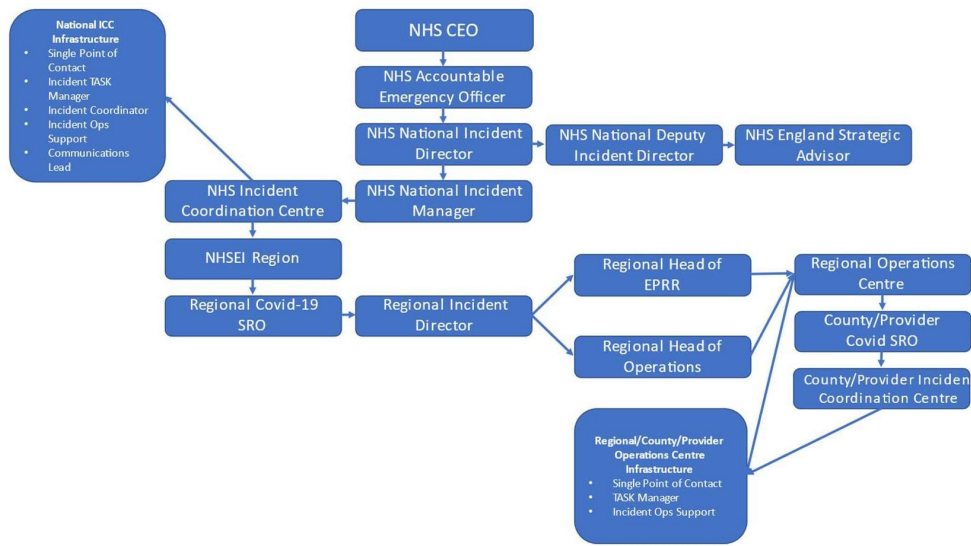




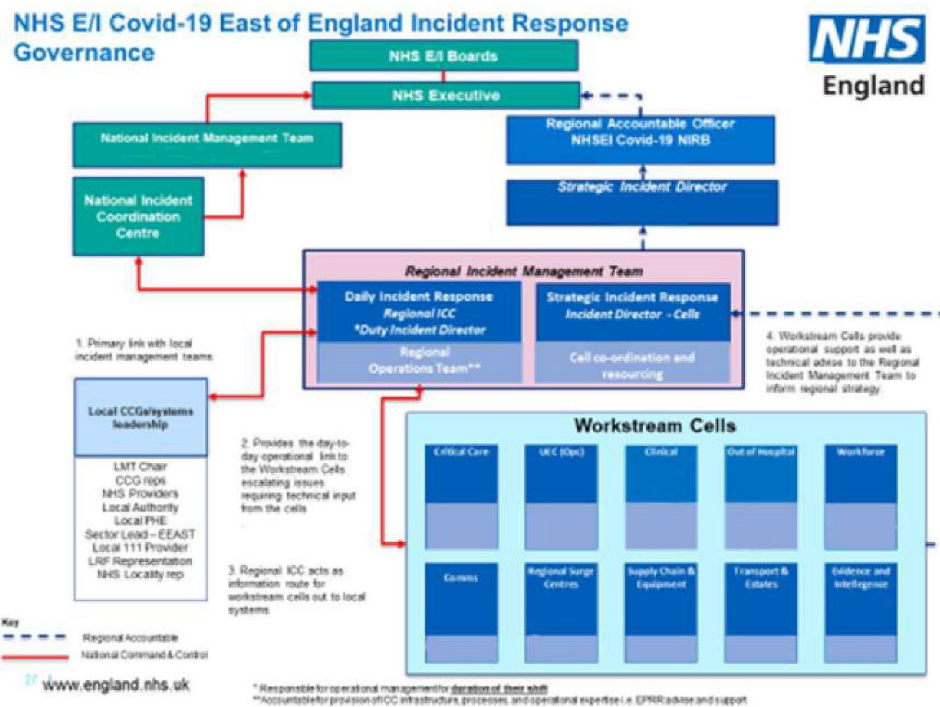
### PART 3: Regional docking

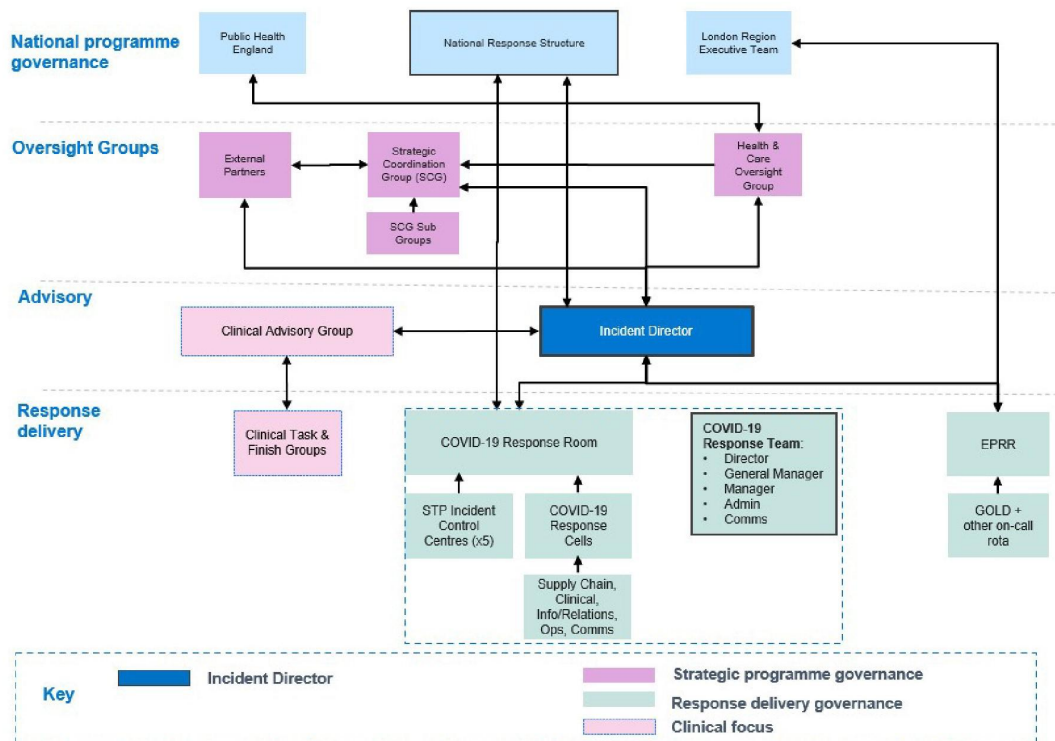
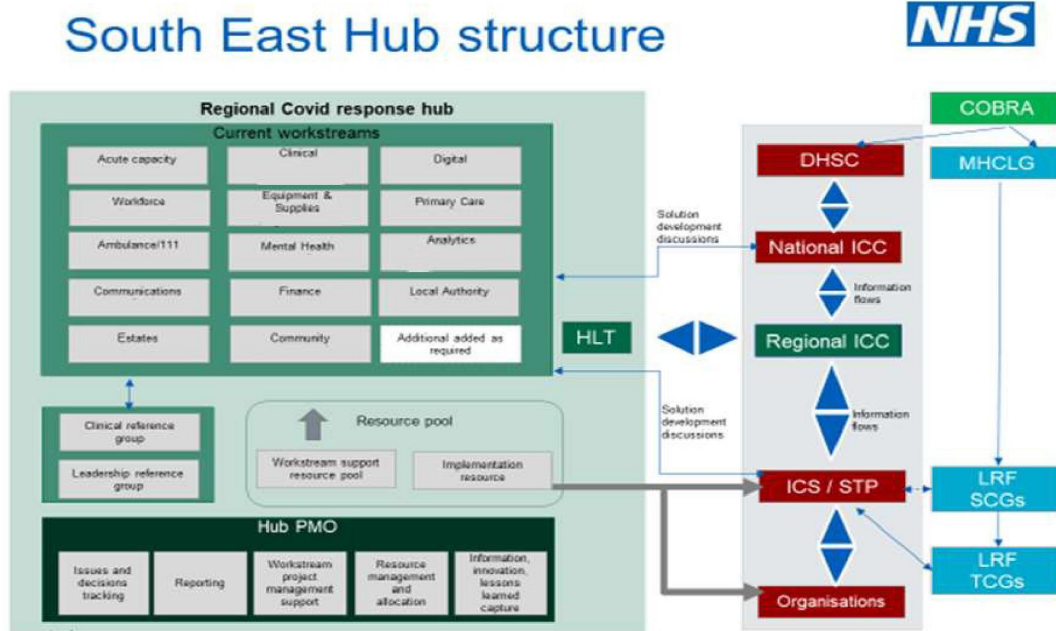
These diagrams represent examples to illustrate how regional arrangements docked into national arrangements. These diagrams do not necessarily represent every governance iteration or the full extent of the governance throughout the Relevant Period.

#### Midlands



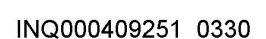
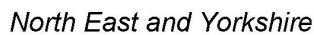
#### East of England





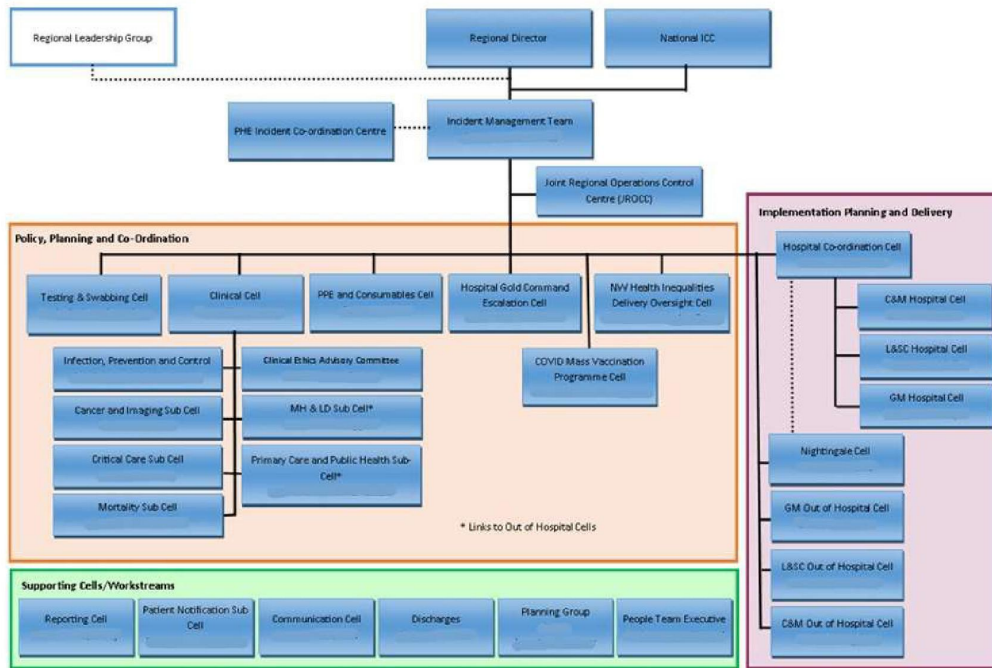
<sup>74</sup> The lower 3 tiers are London-level rather than National

## South West Regional Meeting Structure in response to COVID





## North West



**ANNEX 4**  
NHS Incident Levels During the Pandemic

| Date            | NHS Incident Level    | Supporting Commentary  |
|-----------------|-----------------------|--|
| 30 January 2020 | Level 4 declared      | <p>Not immediately publicised through a system letter - confirmed in a system letter dated 2 March 2020.</p> <p><i>In declaring a level 4 incident, NHS England and NHS Improvement have established an Incident Management Team (National) (IMT- N) with an operational Incident Coordination Centre established 7 days a week, working closely with the Department of Health and Social Care (DHSC), Public Health England (PHE) and other government departments.</i></p> <p><i>All NHS Regions have also been asked to establish an operational COVID-19 Incident Coordination Centre to the same hours working with the national team and their NHS local organisations, CCGs, other health care providers and LRFs.</i></p> <p><b>[AP005 INQ000087445]</b></p> |
| 1 August 2020   | Transition to Level 3 | <p><i>On 19 June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur.</i></p> <p><i>the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR Incident Level will move from Level 4 (national) to Level 3 (regional) with effect from 1 August.</i></p> <p><b>[INQ000113315]</b></p>   |
| 5 November 2020 | Return to Level 4     | <p><i>In response to increasing coronavirus infections the Government and Parliament have today enacted a further set of national Covid measures. The NHS is also seeing increased Covid demand on our hospitals, which is projected to intensify over the coming weeks. The NHS England Chief Executive has therefore today</i></p>   |

| Date             | NHS Incident Level    | Supporting Commentary  |
|------------------|-----------------------|--|
|                  |                       | <p><i>announced that the health service in England will return to its highest level of emergency preparedness, Incident Level 4, from 00.01 tomorrow, 5 November.</i></p> <p><i>This means the NHS will move from a regionally managed but nationally supported incident under Level 3, returning for the time being to one that is co-ordinated nationally.</i></p> <p><b>[INQ000113316]</b></p>  |
| 25 March 2021    | Transition to Level 3 | <p><i>Since the peak of Covid demand in late January, we have seen overall cases of Covid-19 in England steadily decline, with pressures on bed occupancy and critical care reducing accordingly.</i></p> <p><i>At the NHS England public board meeting this afternoon the NHS England Chief Executive therefore announced that the national incident level for the NHS Covid-19 response will now be reduced from Level 4 to Level 3, effective today.</i></p> <p><b>[INQ000113274]</b></p>   |
| 13 December 2021 | Return to Level 4     | <p><i>The UK chief medical officers on 12 December increased their assessment of the Covid-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.</i></p> <p><i>In light of this, we are again declaring a Level 4 National Incident, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in Covid-19 cases.</i></p> <p><b>[INQ000113280]</b></p> |
| 19 May 2022      | Transition to Level 3 | <p><i>With community cases and hospital inpatient numbers now seeing a sustained decline – thanks in part to the success of winter and now spring booster vaccines – and following advice from the National Incident Director, today I will report to the NHS England and NHS Improvement Board my decision to reclassify</i></p>  |

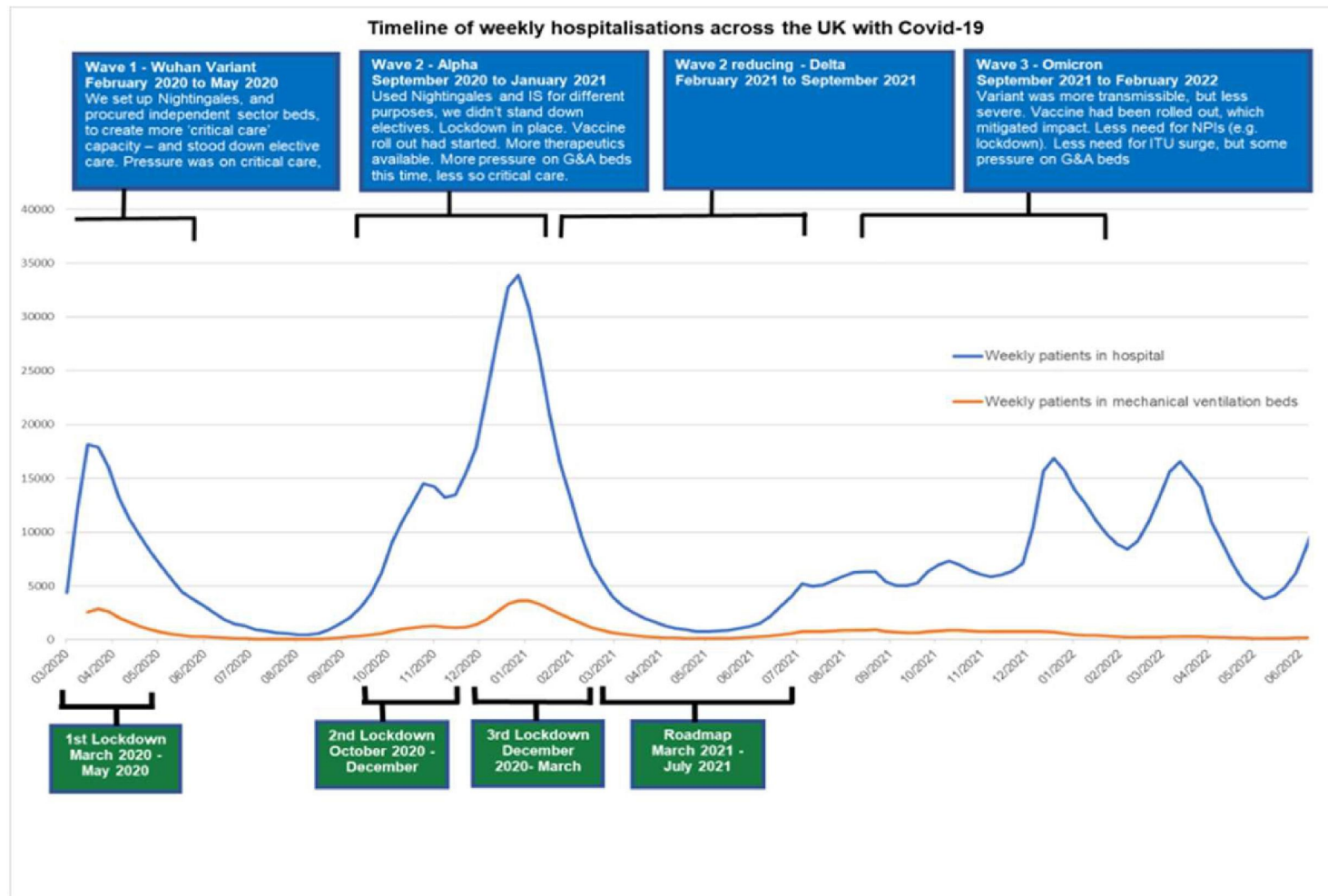
| Date | NHS<br>Incident<br>Level | Supporting Commentary   |
|------|--------------------------|---|
|      |                          | <p><i>the incident from a Level 4 (National) to a Level 3 (Regional) Incident.</i></p> <p><b>[INQ000113284]</b></p> |

## **ANNEX 5**

### **Pandemic Response Timeline**

1. The timeline set out on the following pages is intended to be read alongside NHS England's response to the Tranche 1 Module 3 Rule 9 Request, and specifically, this Statement.
2. It provides a summary of the key events or actions which occurred within the Relevant Period, and which have been described in this Statement but it is not exhaustive.
3. National events have also been provided for context.

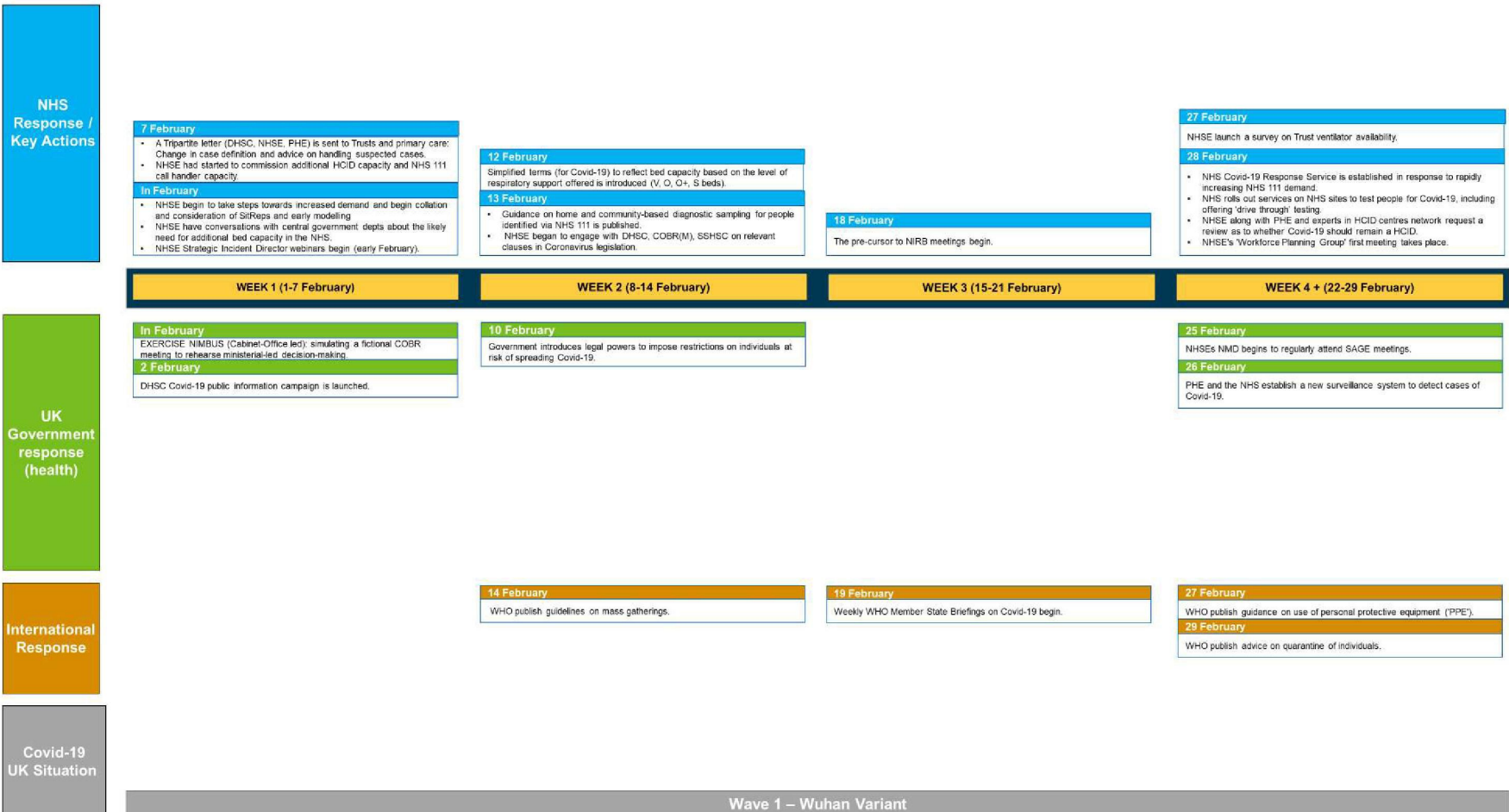
## Summary of weekly hospitalisations across the UK with Covid-19



# January 2020

|                                  |  |   |  |  |
|----------------------------------|--|---|--|--|
| NHS<br>Response /<br>Key Actions | <div>2 January</div> <div>NHSE, PHE and the CMO, become aware of the cluster of cases of a novel virus in Wuhan, China and begin monitoring the situation.</div> <div>7 January</div> <div>NHSE's National Medical Director (NMD) updates the NHS Executive on the outbreak.</div> <div>In January</div> <div>NHSE's Chief Nursing Officer (CNO) commences discussions with regional Directors of Nursing about increasing demand for nursing staff (including student population considerations).</div> | <div>9 January</div> <div>TOTO briefings begin, containing an increasingly detailed description of the latest position with regards to community prevalence, impact on NHS resources and capacity, as well as the international picture(run until 30 March 2022).</div> <div>10 January</div> <div>NHSE stand up its commissioned HCID-A Network in readiness (ahead of Covid-19 being classified as a HCID).</div> | <div>20 January</div> <div>A Tripartite letter (CMO for England, PHE, and NHSE) is sent to the system containing PHE guidance (which included IPC, assessment and investigation of cases and diagnostics).</div> <div>21 January</div> <div>NHSE National IMT and the Incident Co-ordination Centre ("ICC") are formally established, and early cells are initiated.</div> <div>29 January</div> <div>NHSE writes to HCID facility providers asking them to prepare to treat patients and to act as an advice resource to others. NHSE's National Director of EPRR also attends a COBR meeting covering quarantine facilities.</div> <div>30 January</div> <div><ul style="list-style-type: none"><li>NHSE's Strategic Incident Director declares <b>NHSE's first ever level 4 national incident</b>.</li><li>The first two people in the UK who test positive for Covid-19 in Hull are transferred to a HCID Unit in Newcastle.</li></ul></div> |  |
|                                  | WEEK 1 (1-7 January)   | WEEK 2 (8-14 January)   | WEEK 3 (15-21 January)   | WEEK 4 + (22-31 January)   |
|                                  | UK<br>Government<br>response<br>(health)   | <div>In January</div> <div>PHE begin daily SitRep reporting on Covid-19 cases, with assistance from NHSE. (ran to 11 March 2020).</div>   |  | <div>15 January</div> <div>DHSC publish clinical guidance to clinical diagnostic laboratories on the handling and processing of specimens. PHE publish its first Covid-19 IPC guidance.</div> <div>20 January</div> <div>DHSC commence tripartite Daily Coordination calls (NHSE attendees invited).</div> |
|                                  |  |   |  |  |
| International<br>Response        |  | <div>31 December 2019</div> <div>The WHO China Country Office is informed of cases of pneumonia of unknown aetiology detected in Wuhan City, China.</div>   | <div>12 January</div> <div>A WHO press briefing confirms potential human to human transmission.</div>  |  |
|                                  |  |   |  |  |
|                                  |  |   | <div>9 January</div> <div>PHE declares a National Enhanced Incident.</div>   | <div>16 January</div> <div>An interim recommendation by the Four Nations Public Health HCID Group is made to classify Covid-19 as a <b>high consequence infectious disease (HCID)</b> in the UK.</div>   |
| Covid-19<br>UK Situation         |  |   |  |  |

# February 2020





# March 2020

## NHS Response / Key Actions

|   |
|---|
| <b>2 March</b>  |
| NHSE letter is sent to system asking all NHS organisations to establish a Covid-19 IMT.   |
| <b>In March</b>   |
| <ul style="list-style-type: none"> <li>NHSE hold a modelling meeting with the Deputy CMO and lead modellers, aiming to reach a common understanding between SPI-M-O and the NHS on what was known.</li> <li>The GMC considers use of final year medical students as an additional workforce cohort. They and their stakeholders undertake actions to support qualifications and registration for specific groups.</li> </ul>      |
| <b>In March</b>   |
| <ul style="list-style-type: none"> <li>Workforce Planning daily SiRep collection begins.</li> <li>The NHS Covid-19 Data Store is established.</li> <li>National Oxygen Infrastructure (NOIP) is established.</li> <li>An urgent oxygen data collection across all acute Trusts is initiated, to understand oxygen infrastructure and bed capacity that was capable of delivering bed-head piped medical oxygen supply.</li> </ul> |

|   |
|---|
| <b>8 March</b>  |
| NHSE write to regional directors or primary care and public health regarding the Covid Management Service for confirmed Covid-19 patients in the community.   |
| <b>10 March</b>   |
| Initial scoping suggestions for increasing the workforce are heard at NIBB. Workforce forecasting and modelling continue to be a key meeting topic.   |
| <b>11 March</b>   |
| Digital Staff Passport introduced to support staff movement in response of Covid-19 redeployment.   |
| <b>12 March</b>   |
| <ul style="list-style-type: none"> <li>NHSE is asked to prepare plans to 'surge' hospital care.</li> <li>NHSE's Chief Executive and NMD attend a meeting with the Prime Minister to discuss what NHS actions were being taken to increase hospital inpatient and critical care capacity.</li> <li>Testing is expanded to all symptomatic staff and their household members across the NHS.</li> </ul> |
| <b>13 March</b>   |
| <ul style="list-style-type: none"> <li>NIBB agrees the Bring Back Staff programme, beginning 20 March (Phase 1 March – August 2020; Phase 2 September 2020 – June 2021).</li> </ul>   |
| <b>13 March</b>   |
| Covid-19 bed daily SiRep collections begin to come through from Trusts.   |

|  |
|--|
| <b>15 March</b>  |
| Covid-19 Patient Notification System (CPNS) begins (daily reporting on hospital patient and staff deaths).   |
| <b>16 March</b>  |
| Initial development of a workforce model combining ESR data and epidemiological modelling by Imperial begins.  |
| <b>17 March</b>  |
| NHSE sends the "PHASE 1" letter to the system  |
| NEXT STEPS ON NHS RESPONSE TO Covid-19:  |
| <ul style="list-style-type: none"> <li>Postpone all non-urgent elective operations for at least three months</li> <li>Urgently discharge all hospital inpatients who are medically fit to leave</li> <li>Block-buying capacity in independent hospitals, and community health providers and social care providers asked to free up community hospital and intermediate care beds</li> <li>Shift to remote GP appointments and GP pay for performance framework suspended</li> <li>Increase capacity for inpatients requiring respiratory support and dedicated line for local issues with PPE distribution</li> <li>Supporting staff and maximising staff availability</li> <li>Removing routine burdens, including delaying implementation of NHS Long Term Plan</li> </ul> |
| <b>19 March</b>  |
| <ul style="list-style-type: none"> <li>Development of a high level Covid-19 Workforce Dashboard is initiated.</li> <li>Joint statement on expanding the nursing workforce in the Covid-19 outbreak issued by NMC, CNOs of devolved administrations, the Council of the Deans of Health, RCN, Unison and Unite.</li> </ul>  |
| <b>21 March</b>  |
| <ul style="list-style-type: none"> <li>A surge planning request from NHSE is cascaded to the system ("Readiness for increase in hospital admissions for Covid-19").</li> <li>NHSE receive first MACA support request from the system</li> </ul>  |

|   |
|---|
| <b>23 March</b>   |
| <ul style="list-style-type: none"> <li>The Prime Minister and SSHSC hold a COVID-19 update meeting. NHSE's CEO, COO, London Regional Director and London Medical Director attend.</li> <li>NHS agreement with the independent sector to make independent hospitals and staff available to treat NHS patients</li> </ul> |
| <b>24 March</b>   |
| <ul style="list-style-type: none"> <li>NHS Nightingale Hospital announced in London (followed by announcements in following days and weeks, resulting in seven NHS Nightingale Hospitals across England).</li> <li>NHS Volunteer Responders is launched.</li> </ul>   |
| <b>25 March</b>   |
| NHSE issued a "Joint statement on developing immediate critical care nursing capacity" with the Scottish, Welsh, and Northern Ireland governments, Nursing and Midwifery Council, and other stakeholders including unions.  |
| <b>26 March</b>   |
| <ul style="list-style-type: none"> <li>NHSE published "Redeploying your secondary care medical workforce safely" (updated 9 July 2020).</li> <li>A proposal to NIBB on how volunteers might support the NHS is made.</li> </ul>   |
| <b>28 March</b>   |
| Letter to the system: Reducing burden and releasing capacity at NHS providers and commissioners to manage the Covid-19 pandemic: Further guidance to reduce burden and release capacity, focusing on reporting, governance, HR requirements, and other system processes.  |
| <b>30 March</b>   |
| <ul style="list-style-type: none"> <li>Advice on maintaining cancer treatment during the Covid-19 response is published.</li> <li>Initial release of staff absences data onto the Covid-19 Situation Operational Dashboard takes place.</li> </ul>  |
| <b>31 March</b>   |
| NHSE published a letter and guidance outlining urgent actions to be taken to mitigate risks posed by increased demand for oxygen.   |

| WEEK 1 (1-7 March)  | WEEK 2 (8-14 March)   | WEEK 3 (15-21 March)  | WEEK 4 + (22-31 March)  |
|---|---|---|---|
| <b>5 March</b> <ul style="list-style-type: none"> <li>NHSE, PHE and DHSC meet with SSHSC to discuss the logistics of moving from the "Contain" to "Delay" phase.</li> <li>The CMO announces the first death of a patient with coronavirus in the UK.</li> </ul> | <b>11 March</b> <ul style="list-style-type: none"> <li>PHE establish the Covid-19 Hospitalisation in England Surveillance System, "CHESSE" assisted by NHSE.</li> </ul> <b>11 March</b> <ul style="list-style-type: none"> <li>The Chancellor presents his Budget &amp; commits £5bn Covid-19 response fund for pressures on the NHS and other public services.</li> <li>PHE identify a prioritisation list for Covid-19 tests for periods when demand for diagnostic testing may exceed local laboratory capacity and triaging of requests would be required.</li> </ul> <b>12 March</b> <ul style="list-style-type: none"> <li>Government moves from the 'contain' to the 'delay' phase of its response to Covid-19.</li> </ul> | <b>16 March</b> <ul style="list-style-type: none"> <li>Government announces new social distancing measures, including for anyone in a household with symptoms of Covid-19 to stay home for 14 days. Non-essential contact and travel is to stop.</li> </ul> <b>17 March</b> <ul style="list-style-type: none"> <li>EXERCISE NOVUS CORONET: System wide tabletop exercise facilitated by PHE Emergency Response Department stress testing local arrangements for surge and exploring Covid-19 RWCS delivered over 6 working days.</li> </ul> <b>18 March</b> <ul style="list-style-type: none"> <li>PPE to the care sector – facemasks to be distributed to every care home and home care provider.</li> </ul> <b>19 March</b> <ul style="list-style-type: none"> <li>£1.6bn from the Covid-19 fund announced at the budget to be allocated to local authorities, £1.3bn to enhance the NHS discharge process.</li> <li>The 19 March Discharge Guidance letter was published by the Government (co-produced by DHSC, MHCLG and NHS England).</li> <li>The Coronavirus Bill 2020 is introduced as emergency legislation.</li> <li>Joint statement on expanding the nursing workforce in the Covid-19 outbreak made by NMC, CNOs of devolved administrations and others.</li> </ul> <b>20 March</b> <ul style="list-style-type: none"> <li>SSHSC issues a number of directions allowing NHSE to exercise the functions of CCGs and Trusts in respect of the commissioning or provision of healthcare services for any purposes related to the prevention, diagnosis or treatment of Covid-19.</li> </ul> | <b>22 March</b> <ul style="list-style-type: none"> <li>Government announces shielding measures - up to 1.5 million people identified as being at higher risk of severe illness if they contract Covid-19 should stay at home.</li> </ul> <b>23 March</b> <ul style="list-style-type: none"> <li>Meeting with NHSE, PM, SSHSC and other Gov ministers and officials to discuss London pressures, capacity and surge plans. 'Project Nightingale' is discussed.</li> </ul> <b>25 March</b> <ul style="list-style-type: none"> <li>The Coronavirus Act 2020 gets Royal Assent.</li> </ul> <b>26 March</b> <ul style="list-style-type: none"> <li>The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 are made and come into force.</li> </ul> |
| <b>7 March</b> <ul style="list-style-type: none"> <li>WHO publish a statement on cases surpassing 100,000.</li> </ul>   | <b>11 March</b> <ul style="list-style-type: none"> <li>WHO declares Covid-19 can be characterised as a pandemic.</li> </ul>   | <b>19 March</b> <ul style="list-style-type: none"> <li>The Government announces that Covid-19 is no longer considered to be a HCID in the UK, following recommendations made by the Four Nations Public Health HCID Group.</li> </ul>   | <b>26 March</b> <ul style="list-style-type: none"> <li>The first UK lockdown measures legally come into force.</li> </ul>   |

## UK Government response (health)

## International Response

## Covid-19 UK Situation

Wave 1 – Wuhan Variant

# April 2020

## NHS Response / Key Actions

|   |
|---|
| <b>1 April</b>  |
| <ul style="list-style-type: none"> <li>NIRB is formally set up (stands down 31 July 2021, recommences 22 December 2021).</li> <li>The St John Ambulance contract providing additional ambulance support, is extended October 2020 (ultimately extended to June 2022). British Red Cross and Age UK contracts to provide home from hospital discharge support are also extended over the same period.</li> </ul> |
| <b>3 April</b>  |
| NIRB informed that every Trust had been instructed by DHSC / PHE to use its testing capacity.   |
| <b>4 April</b>  |
| NHSE publish 'Redeploying our people safely'.   |
| <b>6 April</b>  |
| <ul style="list-style-type: none"> <li>Nightingale Hospital London admits first patient.</li> <li>A CAS alert providing guidance on safely managing oxygen systems to achieve maximum sustainable flow, and the process for responding to, and escalating, concerns or defects in equipment is released.</li> </ul>   |

|  |
|--|
| <b>8 April</b>   |
| <ul style="list-style-type: none"> <li>Daily Patient Discharge SitRep collection begins. This contains data showing the number and setting into which patients were discharged.</li> <li>TOTO Outbreak SitRep begins (runs to 1 November 2022). This contains a summary of the regional picture (by reference to areas of concern, interventions and mitigations), NHS outbreaks by region and organisation, nosocomial infection data, care home outbreaks, staff absence and forecasted admissions.</li> </ul> |
| <b>6 April</b>   |
| £200m funding to enable the NHS to purchase extra support from hospices to deliver additional inpatient beds and end of life community services is announced.  |
| <b>12 April</b>  |
| Laboratory testing capacity reaches 15,000 per day: testing expanded to all symptomatic staff and household members.   |
| <b>13 April</b>  |
| <ul style="list-style-type: none"> <li>Manchester Nightingale opens (approved 10 April).</li> <li>NHSE publish 'COVID-19: Deploying our people safely'.</li> </ul>   |
| <b>14 April</b>  |
| Tactical Fusion and Strategic Fusion are established.  |

|   |
|---|
| <b>16 April</b>   |
| <ul style="list-style-type: none"> <li>NHSE write to all NHS hospitals and community health providers to cascade the 'DHSC Action Plan'.</li> <li>Birmingham Nightingale opens (approved 10 April 2020).</li> </ul> |
| <b>20 April</b>   |
| Incident End-of-Day reports begin and run until 4 April 2022.   |
| <b>21 April</b>   |
| Harrogate Nightingale opens (approved 15 April).  |

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| <b>24 April</b>   |
| Daily NHS Provider MHLDA SitRep collection begins. Data shows the number of mental health and learning disability beds occupied by Covid-19 and other patients, the number of patients receiving oxygen or ventilation, the number of beds with oxygenation support and non-invasive ventilation available, and staffing absence broken down by reason. |
| <b>25 April</b>   |
| Information campaign to encourage the public to seek care and treatment when they need it begins.   |
| <b>27 April</b>   |
| Nightingale Hospital Bristol opens (approved 17 April).   |
| <b>28 April</b>   |
| Roll-out programme of testing includes symptomatic workers unable to work from home. All staff now eligible for testing whether symptomatic or not.   |
| <b>29 April</b>   |
| NHSE send the 'PHASE 2' letter to the system, setting out the broad operating environment and approach.   |

| WEEK 1 (1-7 April) | WEEK 2 (8-14 April) | WEEK 3 (15-21 April) | WEEK 4 + (22-30 April) |
|--------------------|---------------------|----------------------|------------------------|
|--------------------|---------------------|----------------------|------------------------|

## UK Government response (health)

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|---|
| <b>1 April</b>  |
| <ul style="list-style-type: none"> <li>DHSC Updates on plans to support access to PPE across the health and care system, and development of a Parallel Supply Chain (PSC) for PPE.</li> <li>SSHSC issues COPH notices to healthcare organisations, GPs, local authorities, and national agencies.</li> </ul>  |
| <b>2 April</b>  |
| £13.4bn of NHS Trust debt written off as part of 'major financial reset' for NHS providers.   |
| <b>3 April</b>  |
| <ul style="list-style-type: none"> <li>Nightingale Hospital London opens (approved 23 March 20).</li> <li>The National Ventilation Advisory Group (NVAG) is established.</li> <li>DHSC / PHE had by this time informed every NHS Trust to use its testing capacity (vulnerable patients prioritised, extending to specified NHS staff and others).</li> </ul> |

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| <b>10 April</b>  |
| A cross-government UK-wide plan is published to ensure that critical PPE is delivered to those on the front line responding to Covid-19 (withdrawn Sept 2020). |
| <b>12 April</b>  |
| Laboratory testing capacity reaches 15,000 per day. Testing is expanded to all symptomatic NHS staff and their household members.                              |

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| <b>15 April</b>  |
| The 'DHSC Action Plan' is published, covers policy in respect of the discharge of hospital inpatients into care homes (including testing). |

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| <b>27 April</b>   |
| Matt Hancock announces restoration of non-Covid-19 NHS services.  |
| <b>28 April</b>   |
| Government expands armed-forces led mobile testing, allowing for testing of all NHS staff whether symptomatic or not. |

## International Response

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| <b>2 April</b>                           |
| WHO reports on evidence of transmission. |

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| <b>16 April</b>   |
| WHO issues guidance on considerations in adjusting public health and social measures. |

## Covid-19 UK Situation

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| <b>4 April</b>                                     |
| WHO situation report on 1 million cases worldwide. |

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| <b>16 April</b>                                 |
| Lockdown is extended by 'at least' three weeks. |

Wave 1 – Wuhan Variant

# May 2020

## NHS Response / Key Actions

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| <b>1 May</b>   |
| <ul style="list-style-type: none"> <li>NHSE sets out support measures for BAME NHS staff in response to evidence of disproportionate mortality and morbidity among BAME people with Covid-19.</li> <li>NHSE follow up on the "PHASE 2" letter with a letter to primary care and community health providers setting out expectations to support care homes.</li> <li>Covid-19 related staff absence data begins to be published.</li> </ul> |
| <b>1 May</b>   |
| Weekly Independent Provider SiRep collection begins. Data shows activity by independent sector providers broken down by speciality.  |
| <b>4 May</b>   |
| NHS Seacole Centre opens in Surrey, as the first temporary community hospital for patients recovering from Covid-19.   |
| <b>5 May</b>   |
| <ul style="list-style-type: none"> <li>London Nightingale Hospital is placed on 'stand by' but will act as an insurance policy in case of a second spike.</li> <li>Nightingale Hospital Sunderland opens (approved 29 April).</li> </ul>   |
| <b>6 May</b>   |
| <ul style="list-style-type: none"> <li>Daily Independent Provider MHLDA SiRep collection begins. Data shows Data showing activity by Independent MHLDA sector providers broken down by speciality.</li> </ul>  |

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|---|
| <b>19 May</b>   |
| Weekly NHS Provider SiRep collection begins.                      |
| <b>20 May</b>   |
| Guidance for public on getting NHS help when needed is published. |

| WEEK 1 (1-7 May) | WEEK 2 (8-14 May) | WEEK 3 (15-21 May) | WEEK 4 + (22-31 May) |
|------------------|-------------------|--------------------|----------------------|
|------------------|-------------------|--------------------|----------------------|

## UK Government response (health)

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|---|
| <b>4 May</b>  |
| Government announces that 'test, track and trace' programme will begin with pilot on the Isle of Wight. |

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|---|
| <b>11 May</b>   |
| Government publishes 'Our Plan to Rebuild: The UK government's Covid-19 recovery strategy'. |
| <b>15 May</b>   |
| The Government Office for Science starts to publish the latest R number range for the UK.   |

|   |
|---|
| <b>21 May</b>   |
| Government announces that overseas NHS staff and care workers no longer have to pay the NHS Surcharge (Immigration health surcharge). |
| <b>28 May</b>   |
| NHS Contact tracing system goes live.   |

## International Response

## Covid-19 UK Situation

|  |
|--|
| <b>1 May</b>   |
| Matt Hancock announces that the 100,000 a day testing target has been met. |

Wave 1 – Wuhan Variant

# June 2020

## NHS Response / Key Actions

2 June

Daily Community Discharge SitRep collection begins. Data shows discharge activity for community providers.

3 June

NHSE send 'Restoration of Community Services for Children and Young People' letter to CCGs, Trusts and community providers, superseding the March Prioritisation Letter.

6 June

Nightingale Hospital Exeter opens (approved 1 July).

10 June

Letter on the second phase of NHS response to Covid-19 for cancer services is published.

24 June

- NHSE asks NHS employers to complete risk assessments for at-risk staff groups within the next 4 weeks - first recommended in the 'second phase' letter in April.
- NHSE 'Healthcare associated Covid-19 infections - further action' letter is published after evidence shows that pre-symptomatic and asymptomatic people with Covid-19 can transmit the virus.

WEEK 1 (1-7 June)

WEEK 2 (8-14 June)

WEEK 3 (15-21 June)

WEEK 4 + (22-30 June)

1 June

Government makes third amendments to the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 to reflect the phased easing of the restrictions announced by the Prime Minister on 28 May 2020.

In June

EXERCISE GEMINI: The SSHSC led a pair of exercises to explore, inform and assess the progression of the NHS Test and Trace system (Gemini I and Gemini II).

12 June

- PHE IPC Guidance on new government recommendations for NHS hospital trusts and private hospital providers is published.
- Rescuing the NHS and adult social care in England for Covid-19 is published.

## UK Government response (health)

## International Response

## Covid-19 UK Situation

19 June

Government announces move from Covid-19 alert Level 4 to Level 3.

29 June

The first local lockdown is announced in Leicester (begins 4 July).

# July 2020

NHS  
Response /  
Key Actions

## From July 2020 onwards

NHSE rapidly develop capability to begin to use the Oxford Simulator in its own modelling.

WEEK 1 (1-7 July)

WEEK 2 (8-14 July)

WEEK 3 (15-21 July)

WEEK 4 + (22-31 July)

## 4 July

Third step in easing national restrictions introduced.

## 31 July

- NIRS is stood down. The OpReD went live on 1 August 2021 to support the move to the recovery phase of the pandemic (until 22 December 2021 when NIRS was re-established on return to Level 4).
- NHSE send out the 'PHASE 3' letter to the system, updating on latest alert levels, priorities and outlining financial arrangements.

## 17 July

- Government publishes 'The next chapter in our plan to rebuild: The UK Government's Covid-19 recovery strategy' – includes £3bn funding for the NHS.
- National Framework published for local authorities and local decision-makers setting how to prevent, contain and manage Covid-19 local outbreaks.

UK  
Government  
response  
(health)

International  
Response

Covid-19  
UK Situation



# August 2020

## NHS Response / Key Actions

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| <b>1 August</b>  |
| NHSE moves from a Level 4 incident to a Level 3 incident.  |
| <b>3 August</b>  |
| A planning commission is sent out to national cells and regions to prepare and plan for wave 2, followed by planning workshops.  |
| <b>7 August</b>  |
| <ul style="list-style-type: none"> <li>NHSE publishes guidance to support the implementation of the third phase of the NHS response to Covid-19.</li> <li>NHSE announce Covid-19 revenue business cases will no longer be approved unless they are exceptional, trusts should now identify funds within their own re-prioritised resources.</li> </ul> |
| <b>In August</b>   |
| NHSE issue a National Service Model for Adult Critical Care Transfer Services.   |

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| <b>20 August</b>   |
| NHSE letter setting out further details on new financial arrangements to support the return to near-normal levels of non-Covid-19 services is published. |

WEEK 1 (1-7 August)

WEEK 2 (8-14 August)

WEEK 3 (15-21 August)

WEEK 4 + (22-31 August)

## UK Government response (health)

|   |
|---|
| <b>20 August</b>  |
| Government announces merger of PHE with Test & Trace in new National Institute of Health Protection.  |
| <b>21 August</b>  |
| <ul style="list-style-type: none"> <li>£588m (part of £3bn previously announced for the NHS to prepare for winter) is allocated for care following discharge to support new discharge model and restarting NHS Continuing Healthcare.</li> <li>New 'Hospital Discharge Service: Policy and Operating Model' builds upon the hospital discharge service developed during the Covid-19 response.</li> </ul> |

## International Response

## Covid-19 UK Situation

# September 2020

## NHS Response / Key Actions

### In September

HSE establishes a dedicated programme to support Trusts to rapidly accelerate recruitment of healthcare support workers (HCSWs).

### 23 September

NHSE publishes **Third phase of NHS response to Covid-19** - Clinical prioritisation and validation of elective waiting lists. Webinars with NHS leaders recommence.

### 25 September

- NHSE letter to the system on readiness for increase in hospital admissions for Covid-19.
- Covid-19 Daily Update begins, runs until 31 October 2022.

### WEEK 1 (1-7 September)

#### 1 September

EXERCISE FAIRLIGHT: Cross Government live play exercise run over 3 days, facilitated by MOD exploring national wave 2 and winter preparedness.

### WEEK 2 (8-14 September)

#### 8 September

Government announces new social distancing rules – "the rule of six" – from 14/09.

### WEEK 3 (15-21 September)

#### 17 September

New measures announced to 'improve patient care ahead of winter' – 25 A&Es receive funding to upgrade and NHS 111 piloted as 'front door' for urgent care.

#### 18 September

DHSC publishes its Covid-19 Winter Plan 2020 to 2021 for adult social care.

#### 24 September

UK Government announces the UK Covid-19 alert will be moved from level 3 to level 4. New restrictions are announced the following day.

### WEEK 4 + (22-30 September)

#### 28 September

Government publishes a PPE Strategy setting out 'how government is preparing for a second wave of Covid-19'.

#### 30 September

Parliament votes to renew the Coronavirus Act 2020 for a further six months.

## UK Government response (health)

## International Response

## Covid-19 UK Situation

Wave 2 – Alpha variant

# October 2020

## NHS Response / Key Actions

### In October

- EXERCISE ASCLEPIUS: NHS England and partners conducted a live play field exercise, with an aim to gauge the capabilities of the POD concept for the scalable delivery of mass vaccination, and identify what steps would be needed to mitigate the issues faced by the Mass Vaccinations programme as it stepped up for the SARS-CoV-2 targeted vaccine rounds.
- NIRB approve a pilot programme for the Health and Care Reserve Programme (workforce).

### 9 October

NHSE and PHE 'Help Us, Help You' campaign - 'Accessing NHS Services' launches.

### 12 October

NHSE announces new measures to support hospital services in areas where 'infection is growing the most': reopening Nightingale hospitals and testing asymptomatic staff.

### 28 October

NHS Nightingale Hospital North West (Greater Manchester) reopens and admits first patients.

WEEK 1 (1-7 October)

WEEK 2 (8-14 October)

WEEK 3 (15-21 October)

WEEK 4 + (22-31 October)

### 13 October

DHSC publishes "Winter Discharges: designated settings".

### 14 October

A new three-tier system of COVI-19 restrictions is introduced in England.

### 22 October

SAGE 63: discuss winter modelling and seasonality. SAGE consider that several factors are likely to combine to exacerbate the epidemic during winter.

### 31 October

PM announces new national restrictions from 5/11 to 2/12, including closure of hospitality and non-essential shops. Schools remain open.

## UK Government response (health)

## International Response

## Covid-19 UK Situation

Wave 2 –Alpha variant



# November 2020

## NHS Response / Key Actions

2 November

NHSE start to collect data via the care home capacity tracker as to the number of instances where patients were discharged from hospital to a care home without a Covid-19 test. Runs daily until 22 April 2022.

4 November

NHSE letter announces return to Incident Level 4 from midnight.

10 November

NHSE's Workforce Cell Oversight Group ("WCOG") is established.

9 November

NHSE leaders announce Covid-19 lateral flow antigen testing for asymptomatic patient-facing NHS staff.

17 November

Monthly Community Health Services SiRep collection begins. Data shows the waiting list times for patients and the reasons preventing reductions in waiting lists.

19 November

An oxygen supply CAS Alert is distributed, emphasising the need for Trusts to be aware of the risks as set out in previous letter and guidance issued on 31 March 2020.

24 November

Field testing of Loop-mediated isothermal amplification testing (LAMP) testing technology undertaken to test asymptomatic staff using saliva.

25 November

Daily NHS Staff Lateral Flow Testing SiRep collection begins. Data shows the available stock of LFT testing kits.

26 November

NHS Nightingale Hospital Exeter reopens.

WEEK 1 (1-7 November)

WEEK 2 (8-14 November)

WEEK 3 (15-21 November)

WEEK 4 + (22-30 November)

6 November

NICE announces a new initiative combining NHSE and NICE guidance on the management of Covid-19.

9 November

Following Test and Trace's introduction of new lateral flow antigen tests, plans are put into place to make asymptomatic testing available to all NHS patient facing staff. This is followed by LAMP testing from 24 November.

23 November

"Covid-19 Winter Plan" published – outlines plans for a return to regional tiers after national restrictions are lifted on 2 December.

24 November

Government announces Christmas arrangements easing social restrictions between 23 December and 27 December and publishes guidance on 'Christmas bubbles'.

25 November

Spending Review 2020: £3bn for the NHS pandemic recovery, £3bn to local authorities and 'access to' £1bn for social care.

27 November

PHE publishes guidance on the Covid-19 vaccination programme.

## UK Government response (health)

## International Response

## Covid-19 UK Situation

5 November

Second national lockdown comes into force in England.

Wave 2 – Alpha variant

# December 2020

## NHS Response / Key Actions

**1st December**

- NHS Getting it Right First Time' programme publish 'Clinical practice guide for improving the management of adult COVID-19 patients in secondary care'.
- The Medical Support Worker programme (part of the Bring Back Staff Programme) is initiated.

**8 December**  
NHS delivers the first Covid-19 vaccination.

**9 December**  
NIRB paper 'Lessons ID from Wave 2 and prep for Wave 3 at NIRB' which updates on preparedness for Christmas and January surge.

**10 December**  
NHSE publishes 'Advice on acute sector workforce models during Covid-19'.

**14 December**

- NHSE's 'Cancer Recovery Taskforce' publishes a recovery plan for cancer services.
- The COVID Operations Committee (attended by NHSE COO) discuss a paper on the NHS's capacity over the January to February 2021 period, jointly prepared by DHSC and NHSE (formerly commissioned by the Cabinet Office on 3 December 2020).

**23 December**

- NHSE's COO and CFO jointly issue 'Operational Priorities for winter and 2021/22' letter.
- NHSE circulate 'Discharge into care homes: designated settings' letter to all Trusts.

**24 December**  
NHSE provide an update to No 10 (via the SHSC) on the demand and capacity picture in London as well as data on mortality of patients in hospital with Covid-19 and length of stay.

**WEEK 1 (1-7 December)**      **WEEK 2 (8-14 December)**      **WEEK 3 (15-21 December)**      **WEEK 4 + (22-30 December)**

## UK Government response (health)

**16 December**  
DHSC, PHE, the CQC and NHSE issue new joint guidance for local authorities, CCGs and care providers on discharging hospital patients with a Covid-19 positive test result to designated care.

**20 December**  
Tier 4 'stay at home' restrictions come into place for parts of England (announced the day before by the Prime Minister).

**21 December**  
Tier 4 restrictions come into force in London and South East England.

**26 December**  
More areas of England enter tier 4 restrictions.

## International Response

## Covid-19 UK Situation

**2 December**  
Second lockdown ends and England moves back to a tiered system of local restrictions.

**14 December**  
Government announces discovery of a new Covid-19 'Alpha' variant and confirms that London and parts of the South East will go into Tier 3 restrictions on 16/12.

**21 December**  
PHE begin to publish technical briefings on variants of concern.

**23 December**  
Two cases of a potentially more infectious new Covid-19 variant from South Africa (Beta) are detected in the UK.

**31 December**  
1,050 additional adult critical care beds had been opened but national occupancy for critical care had passed 100% of the standard footprint. 3% of critical care patients across the country were being cared for in surge capacity.

Wave 2 – Alpha variant

# January 2021

## NHS Response / Key Actions

5 January

Weekly Long Covid Assessment Clinic Activity StRep collection begins. Data relates to post-Covid assessment services.

13 January

- NHSE issues operational guidance to regional teams. A webinar is held with the system to talk through next steps.
- NHSE publishes Covid Virtual Ward – Letter and SOP supporting immediate roll out of a COVID 'virtual ward' model.

19 January

NHSE publishes advice on how to manage urgent cancer diagnostics during the pandemic.

20 January

NHSE issues 'For action: Improving discharge patient flow from acute settings' letter

26 January

NHSE publishes 'Reducing burden and releasing capacity to manage the Covid-19 pandemic' (letter reconfirming regulatory and reporting requirements for NHS Trusts / FTs)

WEEK 1 (1-7 January)

WEEK 2 (8-14 January)

WEEK 3 (15-21 January)

WEEK 4 + (22-31 January)

## UK Government response (health)

4 January

Government announces new national lockdown. UK Covid-19 alert level moves from level 4 to level 5

## International Response

## Covid-19 UK Situation

Peak of the pandemic in January 2021

Over 34,000 NHS hospital beds occupied with patients with a Covid-19 diagnosis, with almost 4,000 new Covid-19 positive admissions every day.

6 January

England enters third national lockdown

Wave 2 – Alpha variant

# February - May 2021

## NHS Response / Key Actions

**5 March**  
NIRS discuss decommissioning of Nightingales by 31 March 2021.

**25 March**

- NHSE publishes 2021/22 Priorities and operational planning guidance for systems.
- NHSE announces plan to **step down** to Incident Level 3.

**28 May**  
NHSE publishes letter on antibody testing programme roll out for NHS staff and patients.

February 2021      March 2021      April 2021      May 2021

## UK Government response (health)

**1 February**  
Government announces surge testing to be deployed to monitor and suppress spread of Covid-19 Beta variant.

**2 February**  
DHSC Hospital discharge service guidance is updated.

**22 February**  
PM publishes 'roadmap' for easing restrictions (Step 1 begins in March, Step 2 in April, Step 3 in May, Step 4 in June to July).

**25 February**  
Government change UK alert level from level 5 to 4.

## International Response

## Covid-19 UK Situation

**February**  
NHS admissions are seen to be falling, but still with significant pressure on critical care.

**February to September 2021**  
Wave 2 reducing, emergence of the Delta variant.

**5 March**  
PHE updates on confirmed cases of Covid-19 variants identified in UK

Wave 2 reducing – Delta variant emerging

# June - September 2021

## NHS Response / Key Actions

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|--|
| <b>15 June</b>   |
| NHSE publishes 2021/22 plan for tackling 'Long Covid' with £100million additional support.   |
| <b>30 June</b>   |
| NIRB considered wave 3 planning, in light of SPI-M-O modelling scenarios. Surge plans remained in place, no changes were proposed. |

| June 2021 | July 2021 | August 2021 | September 2021 |
|-----------|-----------|-------------|----------------|
|-----------|-----------|-------------|----------------|

## UK Government response (health)

|   |
|---|
| <b>14 June</b>  |
| Proposed end of all social contact restrictions on 21st June is delayed for up to 4 weeks and vaccination roll-out is accelerated, following concerns over the Delta variant. |

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|---|
| <b>19 July</b>                              |
| All legal limits on social contact removed. |

|   |
|---|
| <b>6 September</b>  |
| Announcement that NHS in England will get an extra £5.4bn over the coming six months to help deal with the backlog caused by COVID, and to help with its pandemic response. |
| <b>14 September</b>   |
| DHSC announces Covid-19 Autumn and Winter plan.   |

## International Response

## Covid-19 UK Situation

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|--|
| <b>14 June</b>                           |
| PHI provides an update on Delta variant. |

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|--|
| <b>September</b>                         |
| Wave 3 emergence of the Omicron variant. |

|                                 |                          |
|---------------------------------|--------------------------|
| Wave 2 reducing – Delta variant | Wave 3 – Omicron variant |
|---------------------------------|--------------------------|

# October 2021- February 2022

## NHS Response / Key Actions

|   |
|---|
| <b>7 December</b>   |
| Concerns about the Omicron variant and implications for NHS capacity, continue to grow. NHSE share 'Covid-19 Omicron planning' document with the SSHSC.   |
| <b>8 December</b>   |
| An update is provided to NIRB on rising numbers and Omicron.  |
| <b>13 December</b>  |
| <ul style="list-style-type: none"> <li>Letter to the system on preparing for the potential impact of the Omicron variant and other winter pressures.</li> <li>NHSE's COO met with the Prime Minister and the Cabinet Office to brief them on planning for Omicron.</li> </ul> |
| <b>17 December</b>  |
| NIRB briefing that there are increasing numbers of Covid-19 infections. Daily calls are set up between the SSHSC and NHSE.  |
| <b>21 December</b>  |
| NHSE provides 'NHS: Preparedness for Omicron' plan to DHSC  |
| <b>31 December</b>  |
| NIRB Briefing reports rising case numbers but highlights a tentative emerging picture that the Omicron variant caused milder symptoms such that critical care capacity remained stable.   |

|   |
|---|
| <b>11 January</b>   |
| Critical care numbers start to fall. A meeting takes place with the Prime Minister providing a situation update and on the impact of Omicron across other NHS services. |
| <b>1 February</b>   |
| NHSE publishes guidelines for supporting our NHS people affected by Long Covid  |
| <b>8 February</b>   |
| Elective Recovery plan blueprint published to address backlogs built up during the COVID pandemic and tackle long waits for care  |

|              |               |               |                         |
|--------------|---------------|---------------|-------------------------|
| October 2021 | November 2021 | December 2021 | January & February 2022 |
|--------------|---------------|---------------|-------------------------|

## UK Government response (health)

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|--|
| <b>9 November</b>  |
| It becomes mandatory for frontline NHS staff in England to have both vaccines. |

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|--|
| <b>8 December</b>  |
| The Prime Minister announces a move to 'Plan B' following the spread of the Omicron variant, which includes compulsory wearing of face masks in public venues and the 'NHS Covid Pass' |
| <b>12 December</b>   |
| UK COVID alert level raised from three to four by the four chief medical officers due to the spread of the Omicron variant.  |

## International Response

## Covid-19 UK Situation

|   |
|---|
| <b>25 October</b>   |
| Critical care demand caused by Covid-19 had risen, now accounting for 27% of critical care cases. |

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| <b>27 November</b>   |
| Reintroduction of some measures for England as a result of the discovery of the Omicron variant. |

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|--|
| <b>3 December</b>  |
| The number of confirmed cases of Omicron in the UK exceeds 100. The Health Security Agency publishes a risk assessment of the new variant. |

|  |
|--|
| <b>24 February</b>                                 |
| The Government ends legal restrictions in England. |

Wave 3 – Omicron variant

# March- June 2022

## NHS Response / Key Actions

**12 April**  
2022/23 priorities and operational planning guidance: Elective recovery planning supporting guidance.

**14 April**  
Publication of revised UK Infection Prevention and Control (IPC) Guidance and an IPC Manual for England.

**19 May 2022**  
NHSE incident level moves from level 4 to level 3 incident, transitioning from Covid-19 response to recovery

**9 June**  
Updated guidance: National infection prevention and control

March 2022      April 2022      May 2022      June 2022

## UK Government response (health)

**15 March**  
Regulations making Covid-19 vaccination a condition of deployment end.

**1 April**  
Living safely with Covid guidance released.

## International Response

## Covid-19 UK Situation