Witness Name: Matthew Style
Statement No.: 1
Exhibits: MS/1-MS/116
Dated: 22 March 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MATTHEW STYLE

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1. I, Matthew Style, Director General for Secondary Care and Integration, at the Department of Health & Social Care, 39 Victoria St, Westminster, London, SW1H 0EU will say as follows:

2. I make this statement in response to the request from the UK COVID-19 Public Inquiry (the Inquiry) dated 16 March 2023, under Rule 9 of The Inquiry Rules 2006 (SI 2006/1838), requiring the Department of Health & Social Care (the Department) to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3. The Inquiry's request focuses on the period 1 March 2020 to 28 June 2022 (the relevant period). This statement builds on the first three statements provided by the Department to the Inquiry in relation to Module 3. In broad terms, this statement addresses the impacts of the pandemic on, and the steps taken by the Department to address issues relating to, the performance of non-COVID-19 services, including elective and cancer care.

3. In this statement, I address the Inquiry's questions relating to the following issues:

    a. general practice;
    b. urgent & emergency care – ambulances;
    c. urgent & emergency care – NHS 111;
    d. COVID-19 impacts on non-COVID-19 healthcare services;
    e. cancer care;
    f. the use of technology to maintain services; and
    g. the impact of the pandemic on patient behaviour.

4. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. As a corporate statement involving many different areas of policy within the Department, information has been gathered from a number of sources. This statement is to the best of my knowledge accurate and complete at the time of signing, in line with responding as far as possible within the Inquiry's deadlines. Notwithstanding this, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

5. As set out above, I am the Director General for Secondary Care and Integration at the Department. I first became a civil servant in 2001 and first joined the Senior Civil Service in 2008. I have been a Director General since I joined the Department in November 2021. I have previously been Deputy Chief Financial Officer at NHS England (NHSE).

6. The second witness statement in this Module dated 3 November 2023, which I co-signed with Jonathan Marron and Professor Lucy Chappell, sets out role of NHSE in relation to the NHS at paragraph 15. It will naturally be the case that where further detail regarding NHSE's actions and role is required, that detail is best sought from NHSE.

7. Where relevant, steps taken by the Department are set out with reference to the three-phased approach taken by the NHS in 2020 which concentrated on responding to the initial outbreak and first COVID-19 peak; restarting urgent non-COVID-19 services where applicable; and restoring non-COVID-19 services to pre-pandemic levels where possible whilst preparing for the demands of winter 2020. The phases were communicated in letters from NHSE to healthcare providers.

8. On 30 January 2020, the first phase of the NHS's preparation and response to COVID-19 was triggered with the declaration of a Level 4 National Incident. The phase one letter dated 17 March 2020 **(MS/1 - INQ000087317)** set out measures for the repurposing of NHS services, staffing and capacity to look after the growing numbers of COVID-19 patients in need of care.

9. In the letter dated 29 April 2020 **(MS/2 - INQ000087412** the second phase of the NHS response was set out, urging all NHS systems and organisations to fully step up non-

COVID-19 urgent services while still retaining the ability to redirect / increase capacity to respond to the impact of COVID-19 should it be needed again.

10. The focus of the third phase of the NHS's response to COVID-19, as set out in the letter dated 31 July 2020 **(MS/3 - INQ000051407)**, was to accelerate the return of non-COVID-19 services to pre-pandemic levels and prepare for winter, while taking into account lessons learned from earlier phases.

11. The statement covers a range of non-COVID-19 healthcare areas, including general practice, elective care, cancer, and urgent and emergency care, and details how the Department worked with NHSE, health sector organisations and voluntary, community and social enterprises (VCSE) to maintain delivery of non-COVID-19 services through the waves of the pandemic, including the value technology had in supporting people to access services. The statement also details the analyses the Department undertook or commissioned to understand the total impact of COVID-19 on the population.

12. NHSE is, and was during the relevant period, responsible for the operational delivery of NHS healthcare, whilst the Department holds NHSE to account. For example, collection of data on operational delivery and performance of healthcare services is the responsibility of NHSE. Ministers were regularly provided with updates on these data throughout the relevant period. However, the Department's level of involvement in troubleshooting and/or collaborating with NHSE when issues arose differed depending on the scale and type of issue. In some cases, the Department required further assurance from NHSE (as outlined at paragraph 120), and in other cases the Department collaborated with NHSE to develop detailed plans (as outlined at paragraph 115).

General Practice

13. I am asked about the number of GP appointments available across the NHS in England as at 1 March 2020 and the levels of utilisation of those appointments at that time. I am further asked about whether and how the number of GP appointments changed in England during the relevant period and the reasons for those changes, if known.

14. NHSE publishes online data monthly relating to appointments in general practice (this was published by NHS Digital (NHSD) until it merged with NHSE on 1 February 2023). Each publication contains information about GP appointments for the previous 30 months. The Department had access to these data releases during the relevant period.

15. The data were and are collected from GP systems, which are designed for practices and Primary Care Networks (PCNs) to use in everyday work and not for the purpose of data analysis. This means that there are variations in data quality. These quality issues limit what can be inferred from this data and as such they are considered experimental statistics. For each publication, NHSE indicates the coverage for the data provided.

16. For the purposes of this statement, I will refer to data in NHSD's publication of 'Appointments in General Practice' for June 2022' **(MS/4 - INQ000391385)**. This provides information which spans the relevant period. This includes scheduled practice appointments, scheduled telephone consultations, and other activity such as home visits, online consultations, and immunisations if they were recorded in a practice's appointment system for an individual patient. No information on demand (the volume of people attempting to book appointments) or capacity (the total number of appointments notionally available) is recorded as part of this data set.

17. I outline below the total number of appointments in general practice for each of the months within the relevant period, excluding Covid-19 vaccination appointments. There is seasonal variation in general practice, with more appointments typically taking place during autumn and winter than spring and summer. This is due in part to the higher incidence of respiratory diseases during colder months, as well as seasonal vaccination campaigns, such as for flu, that take place in the autumn.

Month	**Total Count of GP Appointments (excluding Covid-19 vaccination appointments)**
February 2019	24,329,279
March 2019	25,575,060
April 2019	23,865,779
May 2019	24,691,679
June 2019	23,197,410
July 2019	26,308,333
August 2019	22,846,393
September 2019	25,788,437

October 2019	30,054,362
November 2019	26,809,584
December 2019	23,606,506
January 2020	27,199,296
February 2020	24,104,621
March 2020	24,053,468
April 2020	16,007,881
May 2020	16,417,212
June 2020	20,690,805
July 2020	22,491,437
August 2020	20,150,520
September 2020	26,714,255
October 2020	28,301,932
November 2020	25,061,602
December 2020	23,535,936
January 2021	22,492,069
February 2021	22,399,569
March 2021	27,225,424
April 2021	23,879,932
May 2021	23,508,395
June 2021	26,784,182
July 2021	25,739,219
August 2021	23,852,171
September 2021	28,522,501
October 2021	30,303,834

November 2021	30,405,070
December 2021	25,140,776
January 2022	25,635,474
February 2022	25,355,260
March 2022	29,595,038
April 2022	23,913,060
May 2022	27,495,508
June 2022	25,828,078

18. I outline below the total count of face-to-face appointments; home visit appointments; video/online appointments; and the number of appointments for which the mode of appointment is unknown. This data covers the mode of appointment for each of the months within the relevant period[1].

19. The pandemic led to unprecedented changes in the work and behaviour of GP practices which were subsequently reflected in the GP appointments data publication. The variation in approaches to appointment management between practices was likely greater than usual during the COVID-19 outbreak, affecting data quality. Appointments conducted online or by video may not have been routinely captured in appointment books, so a move to these types of appointments could explain some of the observed decrease in appointment numbers. Reported appointments in general practice steadily recovered during the summer and in early autumn 2021.

Month	**Face to Face Appointment**	**Home Visit**	**Telephone**	**Video/online**	**Unknown**
February 2020	19,230,573	227,935	3,322,242	172,638	1,151,233
March 2020	15,921,794	172,773	6,637,656	127,230	1,194,015
April 2020	7,480,941	100,673	7,652,390	44,213	729,664

[1] The mode of appointment as reported in the GP Appointments Data Dashboard (GPAD) is set locally by general practices so may not represent the actual care setting of the appointment. For example, some video conference appointments may be logged by the practice as face-to-face. In addition, certain system suppliers have technical limitations that mean the mode of appointment cannot be accurately reported in GPAD.

May 2020	7,729,597	112,018	7,813,734	41,650	720,213
June 2020	9,763,381	133,805	9,849,385	59,057	885,177
July 2020	11,184,673	140,787	10,114,285	80,764	970,928
August 2020	10,388,825	119,250	8,742,071	77,183	823,191
September 2020	15,092,880	148,978	10,262,198	124,282	1,085,917
October 2020	16,870,816	161,721	9,950,370	137,466	1,181,559
November 2020	13,886,990	150,187	9,954,012	108,583	961,830
December 2020	13,133,882	137,310	9,278,556	107,719	878,469
January 2021	11,887,083	129,033	9,571,141	106,564	798,248
February 2021	11,850,255	130,396	9,546,051	103,245	769,622
March 2021	14,593,975	154,148	11,383,424	127,147	966,730
April 2021	13,058,306	148,827	9,704,359	111,032	857,408
May 2021	13,032,902	142,291	9,436,985	108,085	788,132
June 2021	15,030,018	161,666	10,606,719	125,564	860,215
July 2021	14,607,857	157,992	10,060,423	120,833	792,114
August 2021	13,717,325	151,619	9,149,072	110,029	724,126
September 2021	17,266,602	171,829	10,068,770	155,354	859,946
October 2021	19,471,561	178,593	9,449,544	174,465	1,029,671
November 2021	19,031,327	203,352	9,993,842	160,580	1,015,969
December 2021	15,312,340	181,264	8,723,325	125,798	798,049
January 2022	15,414,102	171,669	9,212,553	130,798	706,352
February 2022	15,531,971	170,435	8,820,538	127,697	704,619
March 2022	18,333,743	200,945	10,088,419	152,018	819,913
April 2022	15,049,567	172,936	7,893,805	126,453	670,299
May 2022	17,630,858	200,862	8,792,743	144,188	726,857
June 2022	16,744,191	187,640	8,082,270	136,117	677,860

Changes in GP appointment numbers

20. The Inquiry asks about the reasons for the changes in GP appointment numbers over the relevant period. Whilst public messaging during this time sought to reinforce the message that individuals who had health concerns should not delay seeking help from the relevant health practitioner, appointment numbers did drop. GP appointment numbers reached a low point in mid-April 2020, with approximately 0.83 million average appointments per working day (compared to 1.23 million appointments per working day in April 2019) **(MS/5 - INQ000372796)**.

21. The move to increase the number of remote appointments benefited patients who sought increased flexibility and convenience and helped to both maximise the amount of care general practice could provide and manage the risk of COVID-19 infection for staff and patients.

22. However, findings from the 2021 GP patient survey illustrated that 42% of respondents had avoided making a GP appointment at any time in the last 12 months **(MS/6 - INQ000391392)**. The two main reasons cited were because people were worried about the burden on the NHS (20%), and because people were worried about the risk of catching COVID-19 (17%).

23. This was reflected in a March 2021 Healthwatch report, which found that people were worried about "overloading" health services and not speaking to their GP unless they felt their health issue was of extreme importance **(MS/7 - INQ000366256)**.

Actions taken to expand GP appointment capacity

24. I am also asked about any actions taken to expand GP appointment capacity during the relevant period and whether such efforts were successful. During the relevant period, numerous measures were introduced to alleviate pressure on general practice and the Department sought clinical and operational advice from NHSE on which GP services could be deprioritised in order to prioritise the COVID-19 response. The aim of these measures was to allow general practices to prioritise pandemic response activity and support their patients and communities, including those most clinically vulnerable on their patient lists.

25. The following sections set out changes that were implemented, including suspending activities using powers in the Pandemic Regulations (this suspension was extended several times and is explained fully in the following sections), introducing the isolation note to remove the increase in demand for fit notes requiring GP appointments, measures taken

with the Royal College of General Practitioners (RCGP) to support students on whom the rescheduling of exams had an impact, changes to the Quality and Outcomes Framework and Investment and Impact Fund, as well as other financial measures.

Suspension of terms under the Pandemic Regulations

26. On 19 March 2020, in response to the first wave of the pandemic, NHSE (with Secretary of State agreement) allowed GP practices to suspend the following activities, if necessary, to free up capacity to support the COVID-19 response **(MS/8 - INQ000087325):**

    a. New patient (including alcohol dependency) reviews;
    b. Over-75 health checks;
    c. Routine medication reviews (except where a patient was being regularly monitored);
    d. Clinical reviews of frailty;
    e. The requirement to report to commissioners about Friends and Family Test (FFT) returns (in line with the suspension of this requirement across wider NHS services);
    f. The requirement to engage with and/or review feedback from Patient Participation Groups (PPGs);
    g. The requirement on dispensing practices to cleanse (quality check) their dispensing lists.

27. These changes were given statutory force via the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020, or 'Pandemic Regulations', which came into effect shortly afterwards on 27 March 2020. A key objective of these regulations was to give statutory footing to enable primary care contractors to deviate from their contractual requirements and prioritise the COVID-19 response. The regulations also contained the legal underpinning for the medicine delivery service for vulnerable people who were shielding.

28. These regulations enabled NHSE, with the Secretary of State's agreement, to make the following changes:

    a. Suspend contract terms or the enforcement of particular terms of service for primary care contractors (GPs, community pharmacy and dentistry) in order to prioritise the delivery of particular services. Announcements made under this power are detailed in paragraphs 29-34.

b. Introduce variations of core hours for services. For primary medical (i.e., GP) contractors, these terms of service were intended to support patient access to GPs **(MS/9 - INQ000109194; MS/10 - INQ000109187; MS/11 - INQ000109188; MS/12 - INQ000109189; MS/13 - INQ000109191; MS/14 - INQ000109192; MS/8 - INQ000087325; MS/16 - INQ000109193)**. This power was used to announce a variation to core hours to require practices to open for four bank holidays at Easter and in May.

c. Modify the minimum number of GP appointments bookable via NHS111. This power was used to announce an increase from 1 appointment per 3000 registered patients per day to 1 appointment per 500 registered patients per day **(MS/17 - INQ000372798)**.

29. Following on from these initial changes, in June 2020 NHSE announced, with Secretary of State agreement under the 'Pandemic Regulations', a suspension of the requirement to obtain patient consent when transferring clinically suitable patients onto electronic repeat dispensing (eRD). The eRD system enables prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. In response to the increasing pressure placed on primary care, practices were asked by NHSE to consider using eRD for all clinically appropriate patients, to ensure safe prescribing whilst maintaining patients' access to medications.

30. The suspension of new patient reviews, over-75s checks, routine medical reviews, reviews of clinical frailty, engagement in PPGs and cleansing of dispensing lists came to an end on 30 June 2020. The suspensions were reintroduced in November 2021 until March 2022 in response to the Omicron variant.

31. The following changes were retained at this point in order to support the continued primary care response to the pandemic:

    a. Suspension of the requirement to report FFT result was extended until 31 March 2022. The suspension was reviewed by the Secretary of State and extended on 30 June 2020, 30 Sept 2020, 31 March 2021, 30 June 2021, 30 September 2021, 30 November 2021 and 31 December until 31 March 2022, when the suspension ended.

    b. The uplift to the number of directly bookable appointments into NHS 111 remained in place until 30 September 2021 and was reviewed by the Secretary of State and

extended on 30 June 2020, 30 Sept 2020, 31 March 2021 and 30 June 2021 until 30 September 2021 when the uplift ended.

32. The suspension of the requirement to obtain consent for moving clinically suitable patients to eRD was extended until 30 September 2021.During this time, the suspension was reviewed by the Secretary of State and extended on 30 June 2020, 20 September 2020, 31 March 2021 and 30 June 2021 until 30 September 2021 when it was made permanent on 1 October 2021.

33. The extension of the uplift to the number of directly bookable appointments from NHS 111 was intended to support the effective triage of COVID-19 patients. Patients with COVID-19 symptoms were directed to use NHS111 online or call NHS111 rather than call or visit their GP.

34. Patients were clinically assessed by NHS 111 Covid Clinical Assessment Service and those deemed unwell enough to need to see a clinician were directed to the appropriate clinical service, including to general practice via directly bookable appointments. Additional directly bookable appointments were therefore required to support this pathway. This reduced the volume of patients who approached their practice with symptoms and helped keep NHS staff and patients safe.

35. The GP Contract Regulations (the National Health Services (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015) and Directions (Alternative Provider Medical Services Directions) were amended in October 2021 to remove the need for patients to consent to their eRD being issued in a format appropriate for eRD (explained at paragraph 32). The inclusion of eRD dispensing as part of a practice's repeat prescribing protocols, was intended to have some or all of the following benefits:

    a. a reduction in footfall to the GP practice and to the community pharmacy, thus supporting social distancing
    b. a reduced workload for prescribers allowing better prioritisation of resources

The Isolation Note

36. Prior to the pandemic, GPs issued around 10 million fit notes a year in England. On 20 March 2020, a new 'isolation note' was introduced by Government to protect GP services from a surge in demand for fit notes for COVID-19 related absence **(MS/18 -**

INQ000399080). Its purpose was to cover situations when individuals were required to self-isolate and needed to provide formal notification of their absence from work and the reason for that absence without needing to contact a doctor.

37. Isolation notes could be generated directly through the NHS website and NHS 111 online and were available across all nations. This kept patients with COVID-19 symptoms, or those sharing a household with someone with symptoms, away from surgeries and removed unnecessary additional pressures on GPs.

38. The isolation note service continued until the legal requirement for self-isolation was revoked on 24 February 2022. The service remained open for those employers who chose to accept the isolation note as a form of evidence.

39. On 1 May 2023, the isolation note service was closed.

Exam Rescheduling

40. On 19 March 2020, due to social distancing measures and travel restrictions, the RCGP cancelled two of the three core assessment components required for trainees to be awarded a Certificate of Completion of Training (CCT) and qualify as a GP over the summer of 2020 **(MS/19 - INQ000409753)**. Approximately 1,500 final year (ST3) GP trainees were affected by the cancellation. The Department was not consulted prior to this decision being made.

41. The Department worked closely with the RCGP, NHSE, Health Education England, the General Medical Council (GMC) and GP trainee representatives to develop and implement alternative assessment solutions, which enabled the majority of affected trainees to gain their CCT to their previously anticipated schedule.

42. With appropriate social distancing safeguards in place, and additional protections for trainees who were shielding, the RCGP was able to resume the Applied Knowledge Test (AKT) at test centres from July 2020.

43. The RCGP introduced a Recorded Consultation Assessment (RCA) to enable submission of video or audio recordings of consultations as a temporary alternative to the Clinical Skills Assessment (CSA). Competence demonstrated by trainees through the RCA was required to be at the same standard as covered by the CSA in order to gain CCT.

Quality and Outcomes Framework (QOF) Income Protection

44. The QOF was introduced in 2004 and is a voluntary reward scheme for general practices which incentivises activity related to the management of long-term conditions (e.g. diabetes, asthma, cardiovascular diseases) and prevention activities (e.g. vaccination and cervical screening). General practices are awarded points, each attracting a payment, for doing specific activities or achieving outcomes described in a set of indicators. The number of points earnable varies by indicator. Some indicators reward practice-level activity (e.g. keeping a register of patients with specific conditions) and others reward the practice for the proportion of patients who have received the clinical care specified (e.g. the percentage of patients diagnosed with diabetes and a history of cardiovascular disease who are treated with a statin) or who have achieved a particular outcome (for example the percentage of patients with a diagnosis of hypertension in whom their last blood pressure reading was within a particular range). QOF indicators and points values for each financial year are published in the General Medical Services (Statements of Financial Entitlements) Directions ('SFE Directions') and come into force on 1 April every year and in NHSE guidance. In 2020/21 there were a total of 567 points available **(MS/20 - INQ000330884**

45. On 9 July 2020, NHSE wrote to GP practices, announcing their intention to make changes to the QOF **(MS/21 - INQ000051183)**. To help release GP capacity to focus on higher clinical priorities while ensuring practices remained financially viable, NHSE (with the agreement of the Secretary of State and the General Practice Committee (GPC), a committee of the British Medical Association), planned to income-protect elements of the 2020/21 QOF. These plans were confirmed in guidance by NHSE on 7 September 2020 **(MS/22 - INQ000372783)**. Specifically:

    a. Some performance against indicators (worth 139 out of 567 points) continued to be paid on the basis of practice performance. These related to flu vaccination, cervical screening, maintaining disease registers and prescribing medication for long-term conditions.
    b. Performance against indicators worth 354 points were subject to income protection based upon historical practice performance. It was expected that some of the activity that was income protected would continue and to be eligible for income protection practices were required to agree an approach to QOF with their commissioner that included the identification and prioritisation of the highest risk patients for proactive review.

46. On 3 December 2021, as part of a wider package of easements (further details at paragraph 73) announced following the emergence of the Omicron variant, NHSE (with the agreement of the Secretary of State and the GPC) announced that QOF would also be part income-protected for 2021/22, in a similar manner to 2020/21. Further detail was announced on 7 December 2021. 389 points (just over half) had conditions removed. The remaining indicators (e.g. cervical screening, immunisations) retained their conditionality.

47. To be eligible for this income protection, practices were required to agree with their commissioner a plan setting out how QOF care would be delivered wherever possible, with priority according to clinical risk and accounting for inequalities.

Investment and Impact Fund (IIF)

48. The IIF which was due to commence from 2020 with £40.5 million funding was repurposed. The incentive scheme forms part of Network Contracts Direct Enhanced Service (DES) and supports PCNs to deliver high quality care to their population, as well as the delivery of priority objectives from the NHS Long Term Plan **(MS/23 -** **INQ000113233** . To release capacity for PCNs to focus on the highest clinical priorities from 1 April 2020 £16.25 million was made available to PCNs without conditions. From October 2020 to March 2021, the remaining £24.25 million of funding was made available with conditions focusing on incentivising prevention activity for cohorts of patients at risk of poor health outcomes and for tackling health inequalities proactively.

Additional Funding for General Practice during the First Wave

49. General practice had a key role in supporting people with COVID-19 in their communities and identifying and supporting clinical extremely vulnerable (CEV) people on their patient lists. This role, alongside managing staff illness and self-isolation, created additional costs. Further costs were incurred by practices for providing additional capacity on bank holidays, extra requirements with regard to care homes and locum pay for increased absence cover. To meet these additional costs the Government made COVID-19 specific support funding available to general practice at different stages.

50. In July 2020, HM Treasury (HMT) approved a total of £197.5 million of non-recurrent funding for the Support Fund. This total was agreed to cover the funding for the bank holiday provision of additional services, the early introduction of the Enhanced Health in Care Homes service specification, and absence cover. NHSE were required to provide a report detailing how the funds were spent. NHSE provided an initial report in February

2021 and a final report for the financial year 2020/21 in June 2021 **(MS/24 - INQ000409880; MS/25 - INQ000111299)**.

51. On 4 August 2020, NHSE wrote to practices outlining that they would be able to submit claims to their Clinical Commissioning Group (CCG) for the additional costs incurred for the provision of core services during the bank holiday at Easter and on 8 May 2020 **(MS/26 - INQ000058034)**. Practices were also invited to claim for the additional costs incurred in delivering additional services to care homes, which continued to be claimable until the end of September 2020.

52. The letter also noted previous advice that practices should offer full pay to staff for COVID-19 related absences, including those who were shielding or those who had completed a risk assessment and been advised not to deliver face-to-face care and were unable to work remotely. This applied from 23 March to 31 July 2020. From 1 August 2020, the usual contractual and legal position applied.

53. This Support Fund was designed as a temporary response to cover additional COVID-19 related costs incurred at this point. Although the fund was designed to recognise additional work undertaken by practices at the time, there were also overlaps with recovery ambitions. The design of the fund assumed GP practices may require additional capacity to deal with a surge in demand, and that there would be a level of pent-up demand from individuals choosing not to access GP services early in the lockdown.

Additional funding for General Practice during the Second Wave

54. In November 2020, £150 million of non-recurrent revenue funding was secured from HMT. This General Practice Covid Capacity Expansion funding was made available to support expanding GP capacity up to the end of March 2021, to stimulate the creation of salaried posts. The fund was subsequently extended by 6 months, from April to September 2021.

55. The funding was not delivered through the national GP contract; it was apportioned through Integrated Care Systems (ICSs) to CCGs, ringfenced for use in general practice. NHSE made clear to commissioners that it was for ICSs and CCGs to determine how best to spend this non-recurrent funding within the financial year, within general practice **(MS/27 - INQ000058907)**.

56. NHSE stated that accessing the fund was conditional on practices recording activity broadly back at their own pre-COVID-19 levels, and CCGs were asked to seek to

understand and support the relatively small number of practices that were finding restoration of their activity most difficult **MS/27 - INQ000058907**

57. NHSE also made available the following, to support systems to increase GP capacity:

    a. financial support (up to £120k) in addition to the £150 million to each Sustainability and Transformation Partnership (STP)/ICS to support the process of recruiting and deploying employed GPs on the basis set out (in NHSE's funding announcement letter of 9 November **MS/27 - INQ000058907**
    b. an optional flexible GP employment contract template; and
    c. a digital suppliers framework to assist GP workforce deployment by matching sessional capacity to local demand.

58. In addition, NHSX (discussed more fully at paragraphs 175 -190) supported GP practices with remote working by rolling out hardware, software, setting standards and providing 40,000 laptops and over 21,000 headsets which were delivered to local IT service providers for local deployment to general practices to assist with remote working.

59. NHSE apportioned £120 million of the budget to ICSs which was, in turn, allocated to CCGs, to cover the period from 1 April 2021 to 30 September 2021.

60. NHSE confirmed this 6-month extension of the Covid Support Fund, the monthly phasing, and the similar clinical priorities it should support, in a letter to the system in March 2021 **(MS/29 - INQ000193391)**.

Winter Access Fund

61. In Autumn 2021 there was growing public concern around the challenges felt by patients seeking access to GP services. In response to this concern, the Winter Access Fund (WAF) was developed.

62. On 14 October 2021, NHSE published 'Our plan for improving access for patients and supporting general practice', including a £250 million WAF **(MS/30 - INQ000391358)**. ICSs were initially asked to submit spending plans for the WAF by 28 October 2021. The emergence of Omicron and subsequent acceleration of the COVID-19 vaccination booster programme from early December led to delays in implementation. Revised plans were submitted by 11 February 2022 and led to a concerted effort to distribute funds ahead of the 31 March deadline.

Measures in the plan included the following:

a. Expanding the Community Pharmacist Consultation Service, which refers patients to community pharmacists, for a same-day appointment in a community pharmacy.
b. Additional funding to help NHSE drive full adoption of cloud-based telephony technology across all practices as rapidly as possible.
c. Establishing a £5 million fund to facilitate essential upgrades to practice security measures.
d. Expanding the Access Improvement Programme, a scheme that worked with hundreds of practices experiencing the greatest access challenges, by providing tailored support to make changes and improvement to how they work.

63. Examples of how the WAF was used included additional hubs and helplines, expanding home visiting capacity, and funding additional sessions from staff.

64. The NHSE letter to general practice on 7 December 2021 set out actions to support general practice teams to progress the expanded COVID-19 vaccination programme **(MS/31 - INQ000067603)**. This included further details of the short-term cloud-based telephony offer available to general practice. The solution was deployed to practices which showed an interest in the offer and allowed them to use Microsoft Teams telephone functionality for outbound calls, freeing up existing telephone lines and so increasing incoming call capacity.

Response to the Omicron Wave

65. In November 2021, the emergence of the Omicron Variant meant that the Government committed to significantly ramping up the COVID-19 booster vaccination programme. This meant that over the winter period 2021/22, general practices were asked to prioritise vaccinations and urgent care until the end of the booster campaign.

66. Communications to the public set out that during this period some GP appointments may be delayed, but practices remained open and continued to offer services to their patients. Public messaging highlighted the importance of coming forward with health concerns (expanded at paragraph 234).

67. On 3 December 2021, the following additional measures were announced following the agreement of the Secretary of State and would run until 31 March 2022. These changes

were made to release GP capacity to ensure delivery of the expanded COVID-19 vaccine programme:

a. Part-suspending the QOF.
b. Part-suspending and repurposing the IIF to incentivise practice sign-up to the vaccine programme. Indicators introduced in April 2021 covering flu immunisation and appointment recording and categorisation were paid as normal. The remaining indicators were suspended and the funding repurposed. The majority of the funding allocated to these suspended indicators was instead allocated to PCNs via a PCN Support Payment, on a weighted patient basis, subject to confirmation from the PCN that it was reinvested into services or workforce. The remaining funding was allocated to a new IIF incentive to support PCNs whose practices fully participated in the vaccination programme.
c. Deferring routine health checks for new patients and patients aged 75 and over under powers of the Pandemic Regulations.
d. Income protecting the minor surgery Directed Enhanced Service (DES) and suspending contractual enforcement of the minor surgery additional service. Performing minor surgical procedures in general practice is an additional source of income and includes injections for muscles, tendons and joints, and invasive procedures such as incisions and excisions. It was anticipated there would be a reduction in non-urgent procedures during the pandemic period and income protection prevented a loss of anticipated income from delivering these additional services.
e. Reducing the percentage of dispensing patients whose medication needs to be reviewed from 10% to 7.5% under the Dispensary Services Quality Scheme (DSQS).
f. Increased "item of service fees" (i.e., a fixed fee paid per vaccine administered) for COVID-19 vaccination.

68. On 17 December 2021, further time-limited measures to release capacity were developed with other Government Departments (OGDs):

a. DWP made legislative changes that extended self-certification for sickness from 7 to 28 days for statutory sick pay (until 26 January 2022) and removed the requirement for fit notes to access benefits.

b. A temporary auto renewal of prescription charge exemptions was introduced by the Department. This covered existing prescription charge exemption certificates that were due for renewal up to 26 January 2022. The certificates were extended for six months.
c. The Home Office wrote to shooting organisations to request that firearms certificate applicants who were about to submit a request wait until January 2022.
d. The Department for Transport/Driver and Vehicle Licensing Authority suspended requests for medical information for the provision of drivers' licenses until 12 January 2022 (excluding essential workers e.g., bus and lorry drivers).

69. On 20 December 2021, the temporary suspension of the requirement that practices report to commissioners about the FFT returns was extended until 31 March 2022 via the powers of the Pandemic Regulations.

Urgent & emergency care – ambulances

Emergency ambulances

70. I am asked about the number of emergency ambulances available across the NHS in England as at 1 March 2020 including the number of emergency ambulances operated by the independent ambulance sector available to the NHS. I am further asked about details of whether and how the number of emergency ambulances available to the NHS changed in England during the relevant period, the reasons for that change (if any), and any steps taken to increase the number of emergency ambulances and whether such efforts were successful.

71. In short, questions about the number of emergency ambulances available at different times, and therefore whether there were changes in numbers occurred during the relevant period, are operational questions best directed towards NHSE. Information about the number of emergency ambulances is not routinely provided to the Department and numbers will fluctuate as vehicles are decommissioned and new or refurbished vehicles replace them.

72. In broad terms, throughout the relevant period, the role of the Department in relation to emergency ambulances was to facilitate performance and accountability discussions between NHSE and the Secretary of State. Any steps taken to increase the number of emergency ambulances would have been carried out by NHSE as this is an operational decision.

The National Ambulance Coordination Centre

73. I am asked about the role of the National Ambulance Coordination Centre (NACC) and the relationship between individual trusts and the NACC.

74. Typically operating during winter pressures, the NACC was put into operation throughout the pandemic and became the single point of oversight for assessing, determining and communicating the national level of escalation within ambulance services. The NACC is an NHS-led function, and the Department is not involved in decisions about its deployment or operation.

75. Hosted by West Midlands Ambulance Service, the NACC's functions include continuously monitoring ambulance demand and pressures, coordinating mutual aid arrangements between ambulance trusts, national liaison with other emergency services, and the coordination of Military Aid to Civilian Agency requests.

76. The NACC also has a role in the collection of information for NHSE and the subsequent dissemination of that information to providers around the country (including the Devolved Governments) to ensure that they have the best possible situational awareness on major incidents and emerging issues elsewhere in the UK.

999 calls

77. I am asked about the number of 999 calls made to ambulance services across the NHS in England in the week up to 1 March 2020 and the extent to which response time targets for those calls were met. I am also asked for details of the changes in numbers of 999 calls made to ambulance services in England during the relevant period and the reasons for those changes. Finally, I am asked whether 999 ambulance response time targets were met during the relevant period and, if not, the extent to which targets were not met and the reasons, if known.

78. NHSE regularly publishes data concerning Ambulance Quality Indicators online. Throughout the relevant period, there are data capturing the number of 999 calls answered by ambulance services in England per day, which I exhibit alongside my statement for the benefit of the Inquiry (**MS/32 - INQ000216427**). I provide the following comments by way of overview.

Numbers of 999 calls

79. In March 2020, average numbers of 999 calls answered per day rose to 27,900, which was their highest level since the collation of data in the current format began in 2017, 17% higher than 23,800 in March 2019. The number of calls then fell to a low of 18,556 in April 2020, which was 22% lower than the same month pre-pandemic. The number of 999 calls answered then generally rose between May 2020 and January 2021 but remained below pre-pandemic levels until May 2021.

80. It is important to note that ambulance response times can have an impact on numbers of 999 calls, with more patients calling back for an update on their response when waiting times are longer. The number of total ambulance incidents is an alternative measure of ambulance demand and is not affected by the number of repeat callers. While the total number of incidents followed a similar pattern to 999 calls in the spring of 2020, the fluctuations were much smaller. There were 22,000 incidents per day in May 2020, which was 6% lower than the same month pre-pandemic.

81. The fall in both 999 calls answered and incidents in the early stages of the pandemic suggest that there was some reduction in ambulance demand over this period.

82. Between May 2021 and June 2022, 999 calls answered remained above pre-pandemic levels, peaking at 32,700 per day in October 2021. This is likely to have been driven in part by response times increasing above pre-pandemic levels over this period causing a rise in repeat callers.

Response times

83. The NHS Constitution **(MS/33 - INQ000421414; MS/34 - INQ000421419; MS/35 - INQ000391375)** includes a pledge on waiting times. In particular, within the Constitution, the NHS pledges to:

    a. Provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution;
    b. Make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered; and
    c. Make the transition as smooth as possible when patients are referred between services and to put patients, their families and carers at the centre of decisions that affect them.

84. In the Handbook to the NHS Constitution **(MS/36 - INQ000391374; MS/37 - INQ000421415; MS/38 - INQ000421418; MS/39 - INQ000421420; MS/40 - INQ000421422; MS/41 - INQ000421423)**, there is a pledge that all ambulance trusts will:

    a. Respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes;
    b. Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes;
    c. Respond to 90% of Category 3 calls in 120 minutes; and
    d. Respond to 90% of Category 4 calls in 180 minutes.

85. These response time categories were adopted in 2017 on the recommendations of the Ambulance Response Programme. The programme led an extensive evaluation including over 14 million 999 calls, developing a framework for ambulance trusts to more efficiently allocate resources to the most urgent calls, while still providing clinically appropriate responses to all patients. I exhibit the national framework which describes the four categories of ambulance calls (**MS/42 - INQ000421421**)

86. I summarise below the way in which 999 calls are categorised and who is responsible for this.

87. 999 calls to ambulance are first answered by BT, who determine the appropriate regional ambulance trust for the call to be transferred to. Ambulance call handlers then ask the caller scripted questions about the symptoms being experienced, assisted by triage software. From this evaluation patients are assigned to a response time category, and ambulance resources are matched to these incidents by dispatchers according to their categorisation. Incidents may subsequently be subject to clinical validation from clinicians based in the control room to determine if a different response is more appropriate.

88. I summarise below the way in which response times changed throughout the relevant period (**MS/36 INQ000391374**).

89. Response times initially rose in March 2020, with Category 1 (C1) Mean Response Time (MRT) increasing to 8 minutes (m) 7 seconds (s) from 7m 18s in February 2020, and Category 2 (C2) MRT increasing to 32m 6s, compared to 22m 7s in February 2020. Response times then fell sharply in May 2020, with C1 MRT falling to 6m 34s and C2 MRT falling to 13m 28s.

90. Between May and July 2020, the C2 MRT standard of 18 minutes was met for 3 consecutive months. Response times then rose steadily, with C2 MRT hitting a peak of 29m 39s in January 2021 during the second wave of the pandemic, before initially improving between February and April 2021, but then again beginning to rise from May 2021. From July 2021, response times were above pre-pandemic levels, with the following C2 MRT performance: July 2021 (41m 4s), September 2021 (45m 30s), October 2021 (53m 55s), and March 2022 (1h 1m 5s). C1 MRT increased to 9m 35s in March 2022.

Urgent & emergency care – NHS 111

Numbers of NHS 111 call assessors and healthcare advisers

91. I am asked about the number of 111 call assessors and healthcare advisers available across the NHS in England as at 1 March 2020. I am also asked about details of any changes in the number of 111 call assessors and healthcare advisers in England during the pandemic and the reasons for those changes.

92. The question of the number of 111 call assessors and healthcare advisers is best directed towards NHSE, which was the body responsible. NHSE does not publish routine statistics about the number of 111 call assessors and healthcare advisers. As such, the Department cannot provide the number of 111 call assessors and health advisers available across the NHS in England as 1 at March 2020.

93. However, in order to assist the Inquiry with the approximate numbers of those working in NHS 111, the Department understands that there were approximately 4,600 FTE call handlers and almost 900 clinicians working as part of the NHS 111 service at December 2023 (**MS/43 - INQ000391393**).

NHS 111 calls

94. I am asked about the number of 111 calls made across the NHS in England in the full week up to March 2020 and the extent to which response time targets for those calls were met. I am also asked about how the number of 111 calls in England changed during the relevant period and for the reasons for that change.

Numbers of 111 calls

95. NHSE produces regular statistical notes online setting out the number of NHS 111 calls, amongst other information (**MS/44 - INQ000409757**).

96. There was a 71% increase in NHS 111 calls received per day from February 2020 to March 2020. 95,600 calls per day were received in March 2020 as compared to 56,000 calls per day in February 2020. Whilst the percentage of calls answered decreased over this period (in March 2020, less than half of received calls were answered (47%), as compared with 84% in February 2020 and 88% in January 2020) the absolute number of calls answered remained the same (1.4 million calls were answered in March 2020 as compared to 1.36 million in February 2020). This is due to the onset of the COVID-19 pandemic in March 2020 which caused a stark increase in 111 calls while the supply of 111 calls handlers remained broadly the same in the short term.

97. The number of calls received per day fell after March 2020 from 95,600 calls per day to 55,200 in April 2020. The number of calls received began to rise again from March 2021 and stayed above pre-pandemic levels each month for the remainder of the relevant period.

98. The number of calls answered remained between 42,000 and 50,000 per day across 2020. As inferred from the data, the higher levels of 111 calls received may have been driven in part by longer call answer times, with more callers abandoning their initial call and calling again.

Response targets

99. I am asked whether 111 targets were met during the relevant period and, if not, the extent to which targets were not met, whether this varied by region and time period, and the reasons for failing to meet targets, if known.

100. NHSE has responsibility for the operational oversight of NHS 111. It has developed key performance indicators (KPIs) for the integrated urgent care service and these are exhibited in full **(MS/45 - INQ000409853; MS/46 - INQ000409899; MS/47 - INQ000409897)**. These indicators are operational in nature as opposed to a commitment to the public on service standards. As such, they do not appear in the Handbook to the NHS Constitution, nor do they appear in legislation.

101. The response targets during the relevant period are outlined below. As set out at paragraph 103, there were a number of additional KPIs in place, but I focus here on the KPIs that are more relevant to the question of response times.

102. From April 2019 to March 2021, there was a target for the proportion of calls abandoned after 30 seconds to be less than or equal to 5%. From April 2021 to March 2023, the target was for the proportion of calls abandoned to be less than or equal to 3%.

103. Prior to April 2021, there was a target for 95% of calls to be answered within 60 seconds. From April 2021 onwards, the target is for the average speed of answering calls to be less than or equal to 20 seconds.

104. As a summary, in relation to the proportion of abandoned calls, the target proportion of less than or equal to 3% of calls abandoned was met in England in June 2020 (2.5%), July 2020 (2.4%) and February 2021 (2.6%) **MS/43 INQ000391393)**.

105. As to the extent to which the targets for answering time were met, neither the percentage of calls answered within 60 seconds nor the average time to answer calls targets were met for England throughout the relevant period.

106. As to the question of regional variation in meeting targets:

a. In relation to the target concerning the proportion of calls abandoned, the Midlands recorded the lowest percentage of abandoned calls across all regions during the relevant period and met the target of 3% most often (11 of the 28 months in the relevant period). By contrast, the North East and Yorkshire and the North West did not meet the target of 3% during the relevant period. During May and August 2020, most regions met their 3% target, except the North East and Yorkshire, the North West and the South West, which did not meet the target.

b. In relation to the target concerning response times, a similar trend can be observed. The North West and the North East and Yorkshire region performed below the national average during the relevant period. The Midlands and London generally performed better than the national average across the relevant period and met the target of 95% of calls answered within 60 seconds in June 2020. Although London had the lowest proportion of calls answered within 60 seconds in March 2020 (13.4%), it recovered quickly in the following months and continued to perform consistently very highly throughout the time period. During October 2021, when the lowest proportion of calls were answered within 60 seconds across England (29.1%), London performed highest across the regions, with 48.9%, whereas the

North East and Yorkshire had the lowest performance, with only 14.8% of calls answered within 60 seconds.

The expansion of NHS 111 capacity

107. I am asked for details of any steps taken to expand 111 capacity during the relevant period and whether such efforts were successful.

108. NHSE were the body responsible for NHS 111 capacity and for establishing additional services alongside NHS 111 in the course of the pandemic, including COVID-19 response services, which were set up to triage calls from patients who were experiencing symptoms relating to the COVID-19 outbreak. Where NHSE were expanding NHS 111 capacity, regular updates were provided to the Secretary of State as part of winter preparation meetings (**MS/48 - INQ000399104; MS/49 - INQ000399103)**

109. On 17 September 2020 the Secretary of State announced new 'front door' measures for urgent care so patients could access the right service and avoid unnecessary visits to emergency departments. As part of this, the Secretary of State announced investing £24 million to increase call handling capacity in NHS 111 to make sure there were more clinicians on hand to provide expert advice and guidance **(MS/50 - INQ000409754)**.

COVID-19 impacts on non-COVID healthcare services

The Department's role in formulating response plans for non-COVID-19 healthcare services

110. I am asked about the involvement of the Department in formulating an Incident Response Plan or any other plans or framework by which the NHS would ensure services for conditions other than COVID-19 were maintained during the relevant period.

111. The Department did not publish an Incident Response Plan as such but, following sign-off by the Secretary of State, NHSE published operational guidance to all NHS Trusts and Foundation Trusts, Clinical Commissioning Groups (CCGs), GP practices and Primary Care Networks, and Providers of Community Health Services on 17 March 2020 **(MS/1 - INQ000087317**. This asked trusts to "postpone all non-urgent operations" to maximise inpatient and critical care capacity but stated that "emergency admissions, cancer treatment and other clinically urgent care should continue unaffected."

112. As set out at paragraphs 8 to 10, NHSE was responsible for publishing subsequent operational letters to guide specific healthcare services in the early stages of the pandemic.

113. As an example, on 25 March 2020 and following sign-off by the Secretary of State, NHSE wrote to NHS dental practices setting out immediate changes to services due to the overriding need to limit transmission of COVID-19 **(MS/51 - INQ000391355)**. These included deferring routine, non-urgent dental care including orthodontics; establishing remote urgent care services; providing telephone triage for patients with urgent needs; and setting up networks of urgent dental care (UDC) sites for face-to-face care where clinically necessary.

114. Following the NHSE letter of 17 March 2020, non-urgent services were reprioritised to maximise inpatient and critical care capacity. To ensure services for conditions other than COVID-19 could be stepped back up as quickly as was safe to do so, NHSE published a further letter on 29 April, following review by the Secretary of State. The letter asked, "all NHS local systems and organisations working with regional colleagues to fully step up non-COVID-19 urgent services as soon as possible over the next six weeks" (**MS/2 - INQ000050226)**.

115. Following this, with Secretary of State review and Department collaboration on developing associated financial incentive schemes, NHSE published a letter on 31 July 2020 advising local systems of their new shared focus (**MS/3 - INQ000051407**). This included:

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.
b. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally.
c. Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

116. I am asked to provide details of any steps taken by the Department to maintain care and treatment for conditions other than COVID-19. I am further asked whether the

Department identified any specific aspects of healthcare for non-COVID-19 conditions which were most impacted by the pandemic. I am also asked to provide a summary of any contingency plans or other steps taken by the Department in order to mitigate the negative impact of the pandemic on healthcare for conditions other than COVID-19.

117. NHSE is responsible for the collection of data on operational delivery and performance. NHSE was also responsible for making the operational decisions to re-prioritise non-urgent healthcare services at the beginning of the pandemic. However, the Department facilitated performance and accountability discussions between NHSE and the Secretary of State. These provided an opportunity for the Secretary of State to challenge NHSE and commission internal analysis where appropriate to inform decision-making.

118. These discussions took the form of regular meetings of the Secretary of State, senior officials, senior NHSE executives and officials from Cabinet Office/No10. Each meeting broadly covered:

a. Data availability and gaps in services (including those services that had stopped);
b. The guidance that had been issued or any planned guidance in relation to scaling back services;
c. Any live issues being reported by the system, CQC or the media;
d. The exit strategy from current restrictions; and
e. Where possible, what we might have wanted to keep in place e.g., digital service provision.

119. I exhibit minutes from a selection of meetings from the relevant time period to demonstrate the varying focus of these meetings (**MS/52 - INQ000409861 [temporary service changes] ; MS/53 - INQ000409864 [A&E/111 transformation] INQ; MS/54 - INQ000409860 [cancer and emergency dentistry]**).

120. Furthermore, the Secretary of State and Departmental officials would also ask NHSE for more detailed information to support them in discharging their functions. As an example, on 8 April 2020, the Secretary of State requested a higher level of detail on cancer referral data and the impact of COVID-19 on cancer patients **(MS/55 - INQ000421416)**. Following this request, a meeting took place on 9 April with Dame Cally Palmer (National Cancer Director) and Professor Peter Johnston (National Clinical Director for Cancer) in attendance. Dame Cally Palmer provided an update on cancer

services, and the rationale for prioritising certain treatments was discussed (**MS/54 - INQ000409860**).

121. In addition to facilitating accountability discussions between the Secretary of State and NHSE, the Department also had a role in supporting the charity sector to mitigate the impacts of COVID-19.

122. On 8 April 2020, the Chancellor of the Exchequer announced that the charity sector would receive a £750 million package of support will be delivered through 3 different workstreams:

a. £370 million for smaller, local charities working with vulnerable people;
b. £20 million minimum pledge for the BBC's Big Night In fundraiser; and
c. £360 million to be allocated by Government Departments to charities providing key services and supporting vulnerable people during the COVID-19 crisis.

123. The allocation of the £360 million referred to above was led by the Department for Digital, Culture, Media and Sport (DCMS) with individual Government Departments supporting bids made by VCSE organisations, which would then be considered by DCMS. The Department supported bids for £200 million which was allocated to hospices and a further £22 million which was allocated to ambulance, mental health and other public health charities. By accessing these funds, the Department supported charities working to mitigate the impacts of COVID-19 on non-COVID-19 services, as referred to below at paragraph 146 within Maternity services.

124. The COVID-19 pandemic will have had an impact on all non-COVID-19 services. I have drawn out several specific areas of healthcare below within which the Department had a more significant role in either:

a. taking steps to maintain care and treatment for conditions; and/or
b. mitigating the negative impact of the pandemic on non-COVID-19 services.

125. At the request of the Inquiry I have restricted my remarks in this statement to the specific services identified by the Inquiry as within scope of this module.

Elective Care

126. As per paragraph 114 above, elective activity was significantly reduced at the start of the pandemic in order to prioritise urgent and COVID-19 care. In preparation for the publication of the 31 July 2020 letter, the Department was involved in the development of the incentive scheme for elective recovery. The intention to move towards a revised financial framework for the latter part of 2020/21 was set out in Annex Two to the letter which indicated additional funding would be available 'to support delivery of a breakeven position' **(MS/3 - INQ000051407)**. As COVID-19 pressures were beginning to reduce at that point, there was a focus on using the 'window of opportunity' before winter to accelerate the return to near-normal levels of non-COVID-19 health services.

127. This letter set out non-COVID-19 recovery priorities for the NHS.

128. The Department's role over the following 6 months was facilitation of Secretary of State/NHSE monitoring and accountability against these ambitions including planning for winter. This was done by a regular (usually weekly) rhythm of meetings looking at both urgent and emergency care and elective care in the wider context. The focus and content of those discussions evolved and varied at different stages as winter and COVID-19 pressures waxed and waned.

129. NHSE developed a Clinical Priority Programme (CPP) for elective patients. The CPP is a review of patients waiting for elective care treatment. It assesses the clinical risk of patients on the waiting list, categorising them in order of clinical urgency by checking their condition and risk factors.

130. In September 2021, the Government published "Build Back Better: Our Plan for Health and Social Care" which covered the high-level investment and associated commitments to recover the COVID-19 backlog in elective and cancer care **(MS/56 - INQ000257025)**. This included £8 billion for additional activity in 2022/23 to 2023/24.

131. The budget/Spending Review 2021 confirmed additional capital investment of: £1.5 billion to expand capacity of surgical hubs supporting improved productivity and higher volumes of treatments – as at December 2023 there were 94 operational elective hubs – and £2.3 billion for diagnostics/Community Diagnostics Hubs (now called "Centres" [CDCs], to increase volume and availability of diagnostic services especially MRI and CTs). 141 CDCs were operational in November 2023 and had delivered over 6 million additional tests **(MS/57 - INQ000253812**. In deciding on these investments, the Government took account of a range of evidence, including NHSE modelling on the

capacity needed to tackle the backlog of patients in need of treatment, to ensure sufficient capacity to treat cancer referrals in a timely manner, and the Independent Review of Diagnostic Services published in November 2020 **(MS/58 - INQ000409873)**.

132. In February 2022, NHSE published it's 'Delivery plan for tackling the COVID-19 backlog of elective care' **(MS/59 - INQ000087534**. The Department worked with NHSE on the development of the delivery plan including by leading negotiations with HMT and No10 on the scale of ambitions and the funding required to deliver them. The Department also worked with NHSE to assure the credibility and deliverability of ambitions and approach set out.

Community Pharmacies

133. Community pharmacies have a critical role in the supply of medicines to patients and measures were taken to enable community pharmacies to stay open so that patients were able to continue to access their medicines.

134. In March 2020, pharmacy legislation in England, (the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013), was changed by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020 to enable temporary suspension of certain activity to support community pharmacies to focus on patients' most urgent needs during the pandemic. NHSE subsequently announced the temporary suspension of a range of routine audits and administrative reporting, the Pharmacy Quality Scheme (PQS), the introduction of the Hepatitis-C testing service and pilot services. A pre-existing provision of the same legislation was also relied on, which allowed pharmacies some flexibility over opening hours during emergencies, including allowing them to instigate a change in opening hours and closures giving only 24 hours' notice to NHSE. The ability to suspend the operation of terms of service that was given to NHSE in March 2020 was also applied in a way that gave pharmacies the ability to close their doors to the public for, in practice, up to 2.5 hours a day to give staff the time to focus on dispensing prescriptions and providing advice over the phone. It also gave them the opportunity to maintain the hygiene of pharmacies, take necessary rest breaks, and ensure dispensing of medicines continued safely.

135. The March 2020 legislation also required dispensing contractors (both pharmacies and dispensing doctors), as part of their essential services, to ensure home delivery of dispensed prescription items to eligible patients.

136. At the start of the pandemic Departmental ministers and HMT agreed to provide £370 million in extra advance payments (against which future payments for services, due to community pharmacies, could be offset) to support community pharmacy and ease immediate cashflow pressures arising as a result of the pandemic. These pressures were caused by several issues including increased prescription items, higher drug prices, delayed payments due to the postponement of the Pharmacy Quality Scheme (PQS), and extra COVID-19 costs. The £370 million was paid as an uplift to three advance payments to community pharmacies between April and July 2020.

137. The Department also provided additional funding for Bank Holiday openings to maintain patient access during the pandemic and £300 funding was provided to each pharmacy to support COVID-19 secure working and social distancing. Community pharmacies were also able to access general business support including grants from the Retail, Hospitality and Leisure Grant Fund.

138. In Summer 2021, pharmacies were able to claim for some additional COVID-19 costs incurred between 1 March 2020 and 31 March 2021. They were able to claim for additional staff costs, costs for making premises COVID-19 secure, IT and communication costs to support remote working and virtual patient contacts and notified closures. They claimed a total of £270 million. Following the claims process the Department agreed with Community Pharmacy England that the £370 million uplift to the advance payment would be recovered between October 2021 and March 2022.

Maternity services

139. From the end of March 2020, the Department produced weekly Maternity Situation Reports (SitReps) which included data from the UK Obstetric Surveillance System (UKOSS) on COVID-19 related maternity mortality and morbidity, the risk that COVID-19 posed specifically to BME women who were pregnant and headlines from NHSE on services, workforce, visiting restrictions and antenatal appointments **(MS/60 - INQ000409885; MS/61 - INQ000409877)**. The SitRep would be shared with ministers and the Secretary of State. From March 2022, the SitRep was replaced by the ABCD slide pack, which is described below.

140. The Department led on publishing guidance for pregnant employees entitled 'Occupational Health advice for pregnant women in the workplace' **(MS/62 - INQ000391341)**. The guidance was first published in December 2020 and was developed

in collaboration with the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM), the Health and Safety Executive (HSE) and BEIS. The guidance, which was regularly updated in line with Government policy on COVID-19, was for pregnant employees and provided advice on health and safety in the workplace.

141. Cell Calls were established in April 2020 and would involve NHSE, NHSR, CQC, the Departmental maternity team and other Department teams to discuss Maternity data SitReps and ongoing challenges in maternity units [redacted]

MS/65 - INQ000399101

142. In September 2021, the Department joined a Task and Finish group for maternity to improve vaccination uptake in fertile and pregnant women. Ministers were concerned whether sufficient action was being taken to encourage pregnant women to get vaccinations, and the Government released a video which featured unvaccinated mothers who suffered COVID-19 during their pregnancies, urging pregnant women to get the vaccine.

143. The Department also supported bids to the Government's £360 million fund announced in April 2020, referred to above at paragraph 126. The Department supported a £753,000 bid for funding for Bliss, Tommy's and Sands – three charities which operate in the maternity services sector – which was successful. This funding supported these charities to be able to provide bereavement support for families who had experienced a poor maternal or neonatal outcome and to share COVID-19 messaging to a wide audience.

Community Health Services

144. Community health services (CHS) played a critical role in supporting hospitals to free up beds, providing urgent care, and providing ongoing care and symptom management for patients in the community.

145. The 17 March 2020 letter, signed-off by Secretary of State and sent from NHSE to the NHS (as referred to at paragraphs 8 and 111) set out prioritisation measures which included reprioritising CHS to focus on supporting the discharge of patients from acute settings and rapid response teams working to prevent avoidable admissions to hospitals. CHS were also asked to provide ongoing care and symptom management to patients whose operations were delayed.

146. NHSE with support from the Department and a range of stakeholders, developed a prioritised list of CHS that should be paused, partially paused, or should be maintained. This approach was set out in a letter from NHSE to CHS on 19 March 2020 **MS/1 - INQ000087317**.

147. A submission was sent to Secretary of State on 24 March 2020 setting out the detail of the NHSE approach and confirming there would be no monetary impact on providers as a result of the prioritisation of services, with the expectation that commissioners and providers would reconfigure and deliver their services based on the national prioritisation list for CHS. The Secretary of State noted the submission **(MS/70 - INQ000109180)**.

148. The NHSE letter of 29 April 2020 asked CHS to continue to support discharge, prepare to support the increase in patients in the community with have recovered from COVID 19 and to start to phase back in services, where there is capacity to do so **(MS/2 - INQ000050226)**. The NHSE letter of 31 July 2020 asked CHS to restore service delivery.

149. On 22 May 2020, the Minister for Public Health chaired the first meeting of the CHS Covid Recovery Group, the purpose of which was to pool knowledge and horizon scan risks and opportunities that recovery and renewal pose. The group was set up to ensure professional representatives were able to inform the strategic and policy development of the future of CHS and consisted of representatives from sector organisations, representatives from arms-length bodies and Government officials. A further four meetings were held covering the themes of service and workforce resilience, data and technology The final meeting was held on 27 July 2020 **(MS/71 - INQ000192874; MS/72 - INQ000409870; MS/73 - INQ000409871; MS/74 - INQ000409872; MS/75 - INQ000409868)**.

150. NHSE introduced a SitRep2 data collection in October 2020 to monitor the recovery of CHS. Data focused on those services that had been stopped or partially stopped as a result of service prioritisation in March 2020. The data was used by the Department and NHSE to assess service recovery and identify areas of concern. For example, long waits for adult musculoskeletal services, as identified through the SitRep data, led to a piece of

[2] The Situation Report (SITREP) is an update or report on the status of something, providing a quick understanding of the current situation.

work to develop guidance for the system on reducing waits whilst delivering best outcomes and experience, published in January 2023 **(MS/76 - INQ000409896)**.

Cancer care

151. I am asked to provide a summary of any contingency plans or other steps taken by the Department to ensure that diagnostic screening, care and treatment for cancer was maintained throughout the pandemic. I am also asked whether individual hospital trusts were required to adhere to pre-pandemic targets regarding cancer care during the relevant period.

Care and Treatment for cancer

152. During the relevant period, NHSE issued guidance to all NHS Trusts and Foundation Trusts on maintaining cancer treatment throughout the pandemic. Such guidance was shared and discussed with the Department and its Ministers, but would not have been formally signed off by the Secretary of State.

153. The necessary prioritisation of COVID-19 and emergency patients during the initial phase of the pandemic had a profound impact on the size and length of waiting lists within NHS Trusts. Consequently, it was not credible to expect trusts to meet statutory (or pre-pandemic) waiting times targets and immediate focus was given to restoration of elective activity to minimise the impact of the pandemic. This was set out in Phase 2 and 3 guidance and waiting times expectations were further laid out in the 'Delivery plan for tackling the Covid-19 backlog of elective care' as outlined at paragraph 167.

154. As set out at paragraph 152, NHSE developed and published guidance on maintaining cancer treatment throughout the pandemic. A letter dated 17 March 2020 outlined that to free-up the maximum possible impatient and critical care capacity, all individual hospital trusts were to assume that they would need to postpone all non-urgent elective operations from 15 April 2020 at the latest, for a period of at least three months (**MS/1 - INQ000087317**. However, "emergency admissions, cancer treatment and other clinically urgent care should continue unaffected".

155. On 28 March 2020, NHSE wrote to all NHS trusts and foundation trusts, following on from the 17 March 2020 letter (**MS/77 - INQ000049879**). In relation to cancer, it was stated that "cancer treatment should continue, and that close attention should continue to be paid

to referral and treatment volumes to make sure that cancer cases continue to be identified, diagnosed and treated in a timely manner".

156. On 30 March 2020, NHSE published advice on maintaining cancer treatment during the COVID-19 response (**MS/78 - INQ000000214**) It was made clear that "Essential and urgent cancer treatments must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time". It was also noted that "we have secured the use of almost all independent hospitals across England and their capacity should be used for cancer diagnosis and treatment".

157. The letter dated 29 April 2020 reiterated that "providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the COVID-19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS" (**MS/2 - INQ000050226**). In relation to returning to pre-pandemic levels of treatment, the phase 2 letter stated as follows: "Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments."

158. As set out at paragraphs 10 and 115, NHSE's letter dated 31 July 2020 set out the next phase of the NHS response to the pandemic, effective from 1 August 2020 (**MS/3 - INQ000051407**). One of the NHS priorities outlined in this letter was to accelerate the return of non-COVID-19 health services, making full use of the capacity available in the window of opportunity between August and winter. This included restoring full operation of all cancer services. This work was to be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. This phase of recovering cancer services was to run until March 2021.

159. Furthermore, it was noted in the 31 July 2020 letter that "systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021: to reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels".

160. On 14 December 2020, NHSE published the 'COVID-19 Cancer services recovery plan' (**MS/79 - INQ000399106**). This reiterated the aim of ensuring the right volumes of referrals to identify suspected cancer, including restoring referral levels to at least pre-pandemic levels, and outlined how this aim would be delivered. This included running a major public awareness campaign, ensuring efficient routes into the NHS for people at risk of cancer; and improving referral management practice in primary and secondary care.

161. I am asked how the Department received information during the relevant period regarding the provision and quality of treatment for cancer, and whether this data led to the formulation of any directive, guidance, protocols or other documents from the Department regarding healthcare for cancer patients.

162. The Department continued to monitor the provision of care and treatment for cancer by ensuring that the Secretary of State had detailed and up-to-date data, including for the purpose of holding NHSE to account. NHSE published monthly performance statistics which the Department analysed and presented to ministers. I exhibit six example submissions from the relevant period **(MS/80 - INQ000391325 [March 2020]; MS/81 - INQ000391337 [September 2020]; MS/82 - INQ000391346 [February 2021]; MS/83 - INQ000372786 [August 2021]; MS/84 - INQ000391365 [January 2022]; MS/85 - INQ000372785 [June 2022])**.

163. As outlined above, the provision of these data was to enable the Secretary of State to hold NHSE to account (as described at paragraph 120) rather than for the purpose of the Department independently formulating any directive, guidance, or protocols regarding healthcare for cancer patients. NHSE was responsible for the development and publication of such guidance.

164. As set out at paragraphs 9 and 114, a letter was published on 29 April 2020, re-emphasising that "Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer Senior Responsible Owners (SROs) must now provide assurance that these arrangements are in place everywhere."

165. Following Secretary of State sign-off, subsequent guidance specifically for cancer was published on 8 June 2020 by NHSE **(MS/86 - INQ000192818).**

166. The Cancer services recovery plan was published 14 December 2020 by NHSE **MS/79 - INQ000399106** This plan was developed by the Cancer Recovery Taskforce and Departmental Officials attended the Taskforce's monthly meetings. As such, the Department had the opportunity to review and comment on the plan as it developed. This plan did not require Secretary of State sign-off as this was part of NHSE's operational responsibilities.

167. As set out at paragraph 132, NHSE published its 'Delivery Plan for tackling the COVID-19 backlog of elective care' in February 2022. This had the following targets for cancer treatment:

a. Local systems were asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.
b. 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days by March 2024.

Screening

168. COVID-19 had a significant impact on the ability of national screening programmes to operate normally, predominantly because staff and facilities were being diverted or used for COVID-19 services. This had a particular impact on radiologists. There were also concerns that the continued operation of services would increase infection risk to patients, e.g., 70% of mammography screening is undertaken in mobile screening vans, which may not have fulfilled the infection prevention and control requirements.

169. On 30 March 2020, advice developed by the Department with input from PHE and NHSE officials and subsequently cleared by the Chief Medical Officer (CMO) was put to Secretary of State **(MS/88 - INQ000391318)**.

170. The submission advised:

a. Invitations for some national NHS adult screening programmes and immunisation services should be rescheduled to help limit social contact and release NHS staff to support the response to COVID-19;

b. Time-sensitive programmes that would quickly result in significant clinical harm if delayed should be continued, including antenatal and newborn screening and routine immunisations for infants; and
c. This approach would be kept under review, so that programmes could be reinstated as soon as was practicable when NHS capacity and Government social distancing advice allowed.

171. The Secretary of State cleared the advice and recommendations on the 4 April 2020, and emphasised that the Chief Executive of NHSE should provide the re-start plan prior to the rescheduling **(MS/89 - INQ000409859).**

172. In the 29 April 2020 letter, NHSE issued its first national direction to national screening providers, covering the recovery of screening services, not the rescheduling of appointments.

173. After the peak of the first wave and the publication of the NHSE letter on 29 April 2020 'Second phase of NHS response to COVID-19', Department activity focused on the recovery of screening services.

174. Official level engagement between staff from the Department, PHE and NHSE focused on understanding the scale of the backlog in the screening programmes, and how recovery could best be achieved. Meetings were also held between Department policy officials, representatives from PHE and NHSE and ministers. These meetings were wide-ranging and looked at the ongoing recovery of screening programmes as well as what could be put in place to prepare for any future waves of the pandemic. These meetings continued through the second and third wave of the pandemic with updates on the current situation of screening services in relation to any backlog in invitations **(MS/90 - INQ000409874; MS/91 - INQ000409878; MS/92 - INQ000409879; MS/93 - INQ000409882; MS/94 - INQ000409883; MS/95 - INQ000409887)**.

The use of technology to maintain services

175. I am asked for details of any advice given by the Department regarding the use of technology within the healthcare system to allow appointments, meetings (including multi-disciplinary and team meetings) and document/diagnostic review to take place remotely. This is an area outside of my responsibility, both during the relevant period and at the time of signing this statement. These matters were the responsibility of Matthew Gould, who

was Chief Executive of NHSX from its establishment in 2019 until it was incorporated into NHSE in February 2022. I have relied on Departmental records and briefing, and my understanding of the overall approach to the pandemic response in providing this information.

176. NHSX, set up on 1 April 2019 with a remit from Sir Christopher Wormald, functioned as a central unit for digital, data, and technology strategy in the UK's health and social care sectors **(MS/96 - INQ000391309)**. The remit set out the lines of accountability and operating authority from the Permanent Secretary to the CEO of NHSX. Its mandate was to drive the digital transformation across the NHS, working in line with the NHS Long Term Plan and the Tech Vision outlined by the Secretary of State. NHSX was operational as a joint unit between NHSE and the Department.

177. I am advised that key focus areas for NHSX included:

a. Improving digital services and data access: enhancing patient access to health services through digital means, including online consultations and electronic health records.
b. Supporting staff with technology: providing NHS staff with the necessary tools and technology to improve care delivery and efficiency.
c. Fostering a health tech ecosystem: Creating a supportive environment for health tech entrepreneurs and innovators, facilitating the development and integration of new technologies in healthcare.
d. Data security and efficiency: ensuring the security of patient data while maximising its value for improving health outcomes.
e. User-centric approach: Prioritising the needs of both the public and staff in the NHS and social care sectors in its digital initiatives.

178. In March 2020, NHSX set up 6 working areas, or 'cells', to address the challenges of COVID-19. These cells and their focus areas were:

a. Clinical Cell: to drive technology solutions to deliver faster lab results; manage demand through online direct care; reduce the burden on NHS staff; predict demand; and generate insights to improve logistics.
b. Scaling Cell: to identify digital solutions to address high-impact area needs and rapidly scale those digital solutions that will have the most impact.

c. Vulnerable, isolated and social care (VISC) cell: to identify and enable delivery of tech solutions to address challenges caused by COVID-19 for the vulnerable, isolated and those dependent on social care.
d. Data Cell: to provide descriptive information related to the spread of COVID-19 and the state of the healthcare system; build models on top of such information to forecast and inform decision making; and use a COVID-19 simulator to model scenarios and predict the impact of interventions.
e. App Cell: A downloadable app for patients to help stop or flatten the epidemic; control the flow of patients who will require hospital treatment in the near future; help return people to their normal life; and gather critical data for NHS and strategic leaders.
f. People Cell: identify and enable the delivery of tech solutions that support the workforce.

179. The following paragraphs focus on the guidance supported by the Department regarding the adoption of technological solutions in the healthcare sector to enhance remote appointments, meetings, and the review of documents and diagnostics. The delivery of these approaches was led by NHSX.

180. There were then several specific approaches to enable remote working. Some were operational and are not covered here as that falls under NHSE's remit. However, there were some initiatives, led by NHSX, which were foundational or used Departmental legal powers which I cover below.

Information Governance Compliance for Video Conferencing

181. NHSX led a collaborative effort with key regulatory bodies on information governance within the healthcare sector, particularly concerning the use of video conferencing. This partnership involved the Information Commissioner's Office (ICO) and the National Data Guardian (NDG) to address the need for data protection and privacy compliance in digital communications.

182. The work resulted in NHSE issuing detailed letters aimed primarily at healthcare providers and professionals **(MS/97 - INQ000399102)**. These letters served to reassure the healthcare sector that the video conferencing solutions complied with existing data protection laws and healthcare specific confidentiality requirements. They outlined the

essential principles and practices for remote consultations and meetings to ensure patient confidentiality and data security.

Telecoms Offers to Support Remote Care

183. NHSX recognised the importance of telecommunications infrastructure in enabling and supporting remote care, especially in the context of the COVID-19 pandemic. This led to a strategic collaboration with various telecoms providers to enhance connectivity and communication capabilities for clinical staff working remotely.

184. This collaboration was targeted at negotiating and securing telecom offers that would meet the specific needs of remote healthcare provision. The primary focus was on ensuring robust and reliable connectivity, which was vital for remote consultations, access to medical records, and communication with other healthcare professionals and patients.

185. Key aspects of this initiative included:

a. Free unlimited data, voice, and text offers: the negotiation of special offers for NHS clinical staff included free unlimited data, voice calls, and text messages on their personal SIM cards. This removed potential barriers to remote working, such as data caps and additional costs.
b. Enhanced accessibility and reliability: the improvement of telecom services ensured that clinical staff had reliable access to the internet and communication tools. This was crucial for delivering patient care, attending virtual meetings and training sessions, and accessing up-to-date information and guidelines.
c. Supporting a shift to telemedicine: the enhanced telecom infrastructure facilitated a broader shift towards telemedicine, enabling virtual consultations and patient interactions. This was particularly important for patients who, for a variety of reasons, are unable to visit healthcare facilities in person.

186. Overall, the telecoms offers and enhancement ensured that healthcare professionals could maintain standards of patient care and communication, irrespective of their physical location. This contributed to the continuity and adaptability of healthcare services during the pandemic.

187. I am asked for an explanation of the factors taken into account when considering increased use of technology within the healthcare system, including whether consideration

was given to potential access issues or other impacts on particular patient groups including but not limited to:

a. The elderly;
b. patients with disabilities, and in particular those with sensory impairments;
c. patients whose first language is not English;
d. patients with literacy issues;
e. patients in areas with poor internet connectivity;
f. the homeless; and
g. patients from lower socio-economic groups.

188. NHSX was responsible for designing digital solutions and, as part of implementing those, was responsible for considering inequalities. This will have included access, or for particular groups or communities, the need for alternative approaches. The original NHSX remit set out to ensure that it supported people to stay well and drive their own care by giving them 'easy access to great digital services and their data' and to 'focus forensically on user needs both of the public and of the staff in the NHS and Social Care'.

189. Six cells were enabled at the beginning of the pandemic to address the challenges of COVID-19 and are described above in paragraph 178. One of these was the VISC Cell which was established to identify and deliver digital solutions to address problems exacerbated by COVID-19 for society's most vulnerable and isolated people (and their carers). Its purpose was to ensure that vulnerable and isolated people had access to essential support, goods and services (including food, medication, communication and healthcare services). It focused on solving the immediate problems at hand as well as embedding positive changes for the future. Taking a user centred approach, I am advised that it worked closely with the care sector to identify and deliver digital solutions that met the needs of target user groups **(MS/98 - INQ000399105)**. Funding was provided to ensure that:

a. care providers had the basic technology infrastructure in place to support them to deliver effective care;
b. care staff could access the information they needed when they needed it;
c. care staff had the skills and confidence to use digital technologies where it could help to deliver care, or improve efficiency;
d. care providers and local authorities could confidently invest in, adopt and scale technologies that were proven to improve care outcome; and

e. commissioners of care had accurate and timely data to make decisions and plan ahead.

190. The approach to ensure that those with protected characteristics were recognised can be evidenced through the NHS COVID Pass, which was primarily used on smartphones, but was adapted for individuals without a mobile phone through the provision of a physical letter. This option was made available to ensure that everyone could access their COVID Pass, regardless of technological capabilities.

191. Individuals who did not have a smartphone or similar device could request an NHS COVID Pass to be sent to them in the post. To be eligible for this service, individuals had to be aged 16 or over, fully vaccinated with a COVID-19 vaccine used in the UK, and either vaccinated in England or the Isle of Man, or registered with a GP in England or the Isle of Man. Even those not registered with a GP could access this service if they had an NHS number. The process for obtaining a COVID Pass letter involved calling the NHS at 119 therefore enabling a non-digital approach. The NHSX App cell supported the development of the COVID pass service.

The impact of the pandemic on patient behaviour

192. I am asked about the extent to which the Department considers that public messaging of "stay at home, protect the NHS, save lives" may have contributed to patients in need of treatment delaying seeking care.

193. Due to the combination of the pandemic itself, the Government's response, and other influences on people's behaviour, it is not possible to isolate the impact of the public messaging of "stay at home, protect the NHS, save lives" on patients delaying seeking care. Instead, work was done to understand the total impact of COVID-19 which is outlined below.

194. Internal analyses were circulated regularly within the Department and across Government, sharing evidence on the health impacts of the pandemic. These brought together data and analysis from multiple sources and included consideration of the direct and indirect health impacts.

Direct and indirect health impacts slides

195. The 'Direct and indirect health impacts of COVID-19' slides, also known as the 'ABCD slides' brought together a wide range of data sources, providing an overview of the direct and indirect impacts of COVID-19 on excess deaths and morbidity **(MS/99 - INQ000372771; MS/100 - INQ000372770; MS/101 - INQ000372772; MS/102 - INQ000372779; MS/103 - INQ000372781; MS/104 - INQ000372769**). The structure was based on categories of harm and excess deaths (categories A, B, C and D), which were identified by the CMO in 2020 and provided the framework for the series of publications with the ONS described below at paragraphs 199-206.

196. The slides included the latest management information on A&E attendance, emergency admissions, GP appointment levels and the proportion of GP appointments that were face to face. They also reported data as it emerged on changes to individual behaviour that would impact on an individual's health.

197. The first slide pack was circulated on 28 April 2020, to the CMO and other colleagues within the Department. Subsequent updates were circulated weekly until 18 March 2021 and fortnightly thereafter. The last update was circulated on 9 December 2022.

198. From May 2021 to October 2022 the slides were sent to ministers with a 'for information' submission.

SAGE papers

199. Additionally, SAGE commissioned work from the Department and the ONS to consider the direct and indirect health impacts of COVID-19. At five points during the pandemic, the Department, working together with ONS, the Government Actuary's Department (GAD), OGDs and think tanks, published papers on the direct and indirect health impacts of COVID-19. The first four papers were reported to and published by SAGE and the fifth, on the impacts of Omicron, was published by the Department.

200. The papers considered impacts of COVID-19 in four categories:

a. Health impacts from contracting COVID-19;
b. Health outcomes from COVID-19 worsened in the event of lack of NHS critical care capacity;
c. Health impacts from changes to health and social care made in response to COVID-19, including changes to emergency care, adult social care, elective care and primary and community care; and

d. Health impacts from factors affecting the wider population, due to the pandemic and from economic impacts, such as increased deprivation.

201. The papers were submitted to SAGE and subsequently published between April 2020 and August 2022 **(MS/105 - INQ000220215; MS/106 - INQ000220222; MS/107 - INQ000220190; MS/108 - INQ000220187; MS/109 - INQ000120639 MS/110 - INQ000220192; MS/111 - INQ000220188; MS/112 - INQ000075019** They were frequently referenced in responses to Freedom of Information requests (FOIs) and Parliamentary Questions (PQs) concerning how the Government was taking into account health impacts, particularly from lockdowns. The papers presented the net impacts of the pandemic due to the uncertainty in seeking to separate out the impacts of infections, interventions and voluntary behaviour changes.

202. The earlier papers used the Reasonable Worst-Case Scenarios (RWCS) to quantify potential worst-case future impacts, emphasising that scenarios were not projections, and that the purpose of the work was to identify the nature and magnitude of risks. The later papers focused on assessing the ongoing impacts on health from COVID-19 infections, behaviour and measures to control the pandemic to that point in time.

203. I am asked whether the Department is aware of any evidence to suggest patients delayed seeking care during the relevant period.

204. Early papers (outlined at paragraphs 207 to 212) identified the risk of people not seeking urgent care as one of a group of factors that could influence mortality and morbidity through changes to emergency hospital activity **(MS/113 - INQ000220213)**.

205. Subsequent papers showed that demand for urgent care reduced significantly in the period March 2020 to mid-2021. The July 2020 paper reported that in April 2020 A&E attendances had been 57% lower than in April 2019 and urgent and emergency admissions had been 37% lower than in April 2019 **(MS/113 - INQ000220213).**

206. By mid-2021 attendances had returned to previous levels. The reports recognised that reduced need for urgent care, fear of catching COVID-19 and not wanting to burden NHS services were contributing factors to the earlier reduction. The reports did not quantify the relative importance of these but presented evidence of the changed need for urgent care, including reduced traffic accidents, reduced non-COVID-19 infections, increased muscular skeletal conditions and increased alcohol related deaths. Evidence was not available on

the extent to which people avoided A&E out of fear of catching COVID-19 or to avoid placing a burden on the NHS.

Fewer patients attempting to access primary care

207. As set out at paragraphs 17 to 19, fewer people were accessing primary care in the early months of the pandemic. The July 2020 paper reported that GP appointments reduced by 30% between the first week and last week in March 2020 **(MS/113 - INQ000220213)**. Appointments returned to previous levels by autumn 2020, though more appointments were held by telephone than had been the case previously **(MS/114 - INQ000220206)**.

208. The September 2021 paper reported that there were an estimated 23 million fewer GP consultations (including both in-person and telephone consultations) in 2020 compared with 2019. The 70 years and older age group had the largest fall in consultations per person per year in 2020 compared with 2019 of around 8.5%, followed by the under 11 age group at around 8%. Some of this may have been due to reductions in childhood infections from fewer contacts **(MS/105 - INQ000220215)**. When looking at the change in consultations by health condition, the largest percentage reduction in consultations was in those without a pre-existing condition (around 16% lower in 2020 compared with the five-year historic average) compared to a fall of zero to around 7% for those with a range of common long term conditions, suggesting that those with already diagnosed conditions largely continued to access GP care **(MS/105 - INQ000220215)**.

209. There was a sharp increase in the proportion of people reporting that they did not need to see their GP (almost 40% of people in 2020, compared to 15% of people in 2019). As set out at paragraphs 22 and 23, findings from the 2021 GP patient survey illustrated that, of those 42% of respondents who avoided making a GP appointment in the last 12 months, 20% cited worries about the burden on the NHS as a key reason behind avoiding making an appointment with their GP. 17% cited worries about the risk of catching COVID-19 as a key reason for avoiding making an appointment **(MS/105 - INQ000220215)**. Younger age groups were most likely not to make an appointment because of concerns about overburdening the NHS (particularly 25 to 34-year-olds), relative to other concerns. A high proportion, particularly of older age groups, did not access primary care due to fear of catching COVID-19 relative to other concerns.

210. Survey evidence indicates that 25% of patients with mental health conditions did not seek care because they were worried about the burden to the NHS, the highest proportion

compared to all other conditions. 20% were worried about the risk of catching COVID-19 and 15% found it too difficult. This change in behaviour may have been a cause of a reduction in new diagnoses and a fall in referrals to mental health services **(MS/105 - INQ000220215)**.

211. One impact of reduced primary care access was identified as a reduction in the diagnosis of long-term conditions. Late or missed diagnosis will have had an adverse impact on health for many people **(MS/105 - INQ000220215)**. Analysis by the Health Foundation's Research and Economic Analysis for the Long-term (REAL) Centre for DHSC compared incidence (new diagnoses) in 2020 and 2021 with 2019. In 2020 the number of new diagnoses of heart failure was 20% lower than may have been expected but by December 2021 the incidence of heart failure per patient seemed largely to have returned to the pre-COVID-19 trend. For other conditions the apparent new diagnoses remained below pre-pandemic trends in December 2021. For respiratory conditions, missing incidence was estimated to be 1.5% for asthma and 8% for COPD **(MS/114 - INQ000220206)**.

212. A second impact of reduced primary care access was possible delays in cancer diagnoses. In the July 2020 paper it was estimated that ongoing service disruptions to cancer screening and GP appointments might potentially result in an additional 1,400 cancer deaths in the long term using a hypothetical scenario. The September 2021 report then looked at the impact retrospectively. It found that screening was below 25% of the 2019 level between March 2020 and May 2020, then recovered throughout 2020, though was still below 2019 rates at the end of 2020. GP referrals for suspected cancers and other pathways were also low between March 2020 and May 2020 (down to 50-70% of 2019 levels) but recovered over the summer. GP referrals were at 80% of 2019 levels at the end of 2020. The report did not quantify the health impacts of these reductions.

213. I am asked whether any steps were taken to ensure patients in need of treatment accessed the healthcare system.

214. Keeping services open for patients was a key step in ensuring patients in need of treatment accessed the healthcare system during the relevant period. As set out at paragraphs 9 and 10 and more fully at paragraphs 111 - 115, NHSE produced operational guidance which required services to remain open.

215. Clear public communications were instrumental in encouraging patients to continue to access the healthcare system. To encourage the public to seek the care and treatment they needed, the Department worked closely with NHSE, who initially launched the "Help us, help you" access campaign on 25 April 2020, **(MS/115 - INQ000205654**

216. The Department understood the importance of ensuring the public knew that they could continue to access the healthcare system. The Secretary of State made this point in a statement to the House of Commons at 22 April 2020. The Secretary of State emphasised that the public should continue to come forward for the non-covid services they needed. This included those who were at risk for strokes or heart attacks and those who were worried they may have cancer **MS/115 - INQ000205654**

217. Just as it is not possible to isolate the impact of the public messaging of "stay at home, protect the NHS, save lives", due to the combination of the pandemic itself, the Government's response, and other influences on people's behaviour (outlined at paragraph 194), it is also not possible to quantify the impact of the public messaging of the "Help us, help you" campaign on increased attempts to access healthcare.

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: 22/03/2024