Witness Name: Matthew Style
Statement No.: 2
Exhibits: MS2/1 – MS2/197
Dated: 19 April 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 and Social Care (the Department), 39 Victoria Street, 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 to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3. This statement will focus on the NHS's preparedness for and response to the pandemic, including issues of capacity and resilience. In particular, this statement will address the following sections:

a. Section 1, the Department's role in planning the healthcare system's response to a pandemic, and how such plans changed and/or developed during the course of the COVID-19 pandemic at the same time addressing the Department's role in shaping the healthcare system's response throughout the COVID-19 pandemic (questions 3 - 14 of the Inquiry's request);

b. Section 2, additional funding provided to the healthcare system throughout the COVID-19 pandemic (questions 15 and 16 of the Inquiry's request);

c. Section 3, the NHS's hospital bed capacity (questions 27 to 29, 48 to 50, 64 and 65 of the Inquiry's request);

d. Section 4, the NHS's workforce capacity (questions 51 to 55 of the Inquiry's request); and

e. Section 5, support for healthcare staff (questions 56 to 57 of the Inquiry's request).

3. 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 and belief 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 needed.

4. 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 the Deputy Chief Financial Officer at NHS England (NHSE).

Section 1: The department's involvement in planning and shaping the healthcare system's response to COVID-19

Overview of the Department's roles and responsibilities in planning and shaping the healthcare system's response to COVID-19

5. This Section covers evidence about emergency response, international engagement, engagement with the Devolved Governments and central planning activities, including the evolution of the Department's COVID-19 Battle Plan, which was and remains an area outside of my responsibility. These matters were the responsibility of the Director General for Global Health, a position that was held over the relevant period and is still held by Clara Swinson. I have relied on Departmental records and briefing, and my understanding of the overall approach to the pandemic response in providing this information.

6. I am asked about the extent of the Department's powers or responsibilities in relation to operational decision-making within the NHS in England during the relevant period.

7. The Department is, and was during the relevant period, responsible for setting strategy, securing funding, and taking forward legislative and other changes necessary to support the healthcare system in delivery. The Department also plays a role in 'troubleshooting', i.e., dealing with issues of a cross-cutting, complex and/or highly concerning nature, such as leading the response to the COVID-19 pandemic, as set out in the Department's annual report 2020/2021 and, in particular, in the Permanent Secretary's performance report **(MS2/1 - INQ000235008)**.

8. In practice, this often involves coordinating engagement between different partner organisations, and/or Arm's Length Bodies (ALBs), such as NHSE and Public Health England (PHE), later replaced by the UK Health Security Agency (UKHSA). ALBs are accountable to the Secretary of State and both indirectly (through the Secretary of State) and at times directly to Parliament. The Secretary of State sets their strategic direction, holds them to account for the delivery of agreed objectives of their statutory functions and duties, and provides them with their funding. A more detailed summary of the Department's relationship with ALBs and their functions is set out at paragraphs 40 to 86 of Sir Christopher Wormald's Tenth Witness Statement to

the Inquiry dated 27 October 2023 (referred to in this statement as "the first witness statement in this Module").

9. As part of NHSE's responsibilities, they provided operational guidance to NHS organisations. As explained in the first witness statement in this Module, NHSE operationally merged with NHS Improvement (NHSI) in 2018. Throughout the relevant period, the two bodies functioned as one integrated organisation, although they retained their individual legal and financial responsibilities. They were referred to jointly as "NHSEI", though for the purposes of this statement I refer to them as NHSE.

10. Strategic direction for NHSE (and for the NHS, via NHSE) was set in the Government's annual statutory mandate to NHSE **(MS2/2 - INQ000327536; MS2/3 - INQ000327522; MS2/4 - INQ000327521)**, alongside its capital and resource spending limits. A more detailed summary of the Department's role in relation to NHSE performance, through the statutory mandate and other formal and informal means, is set out at paragraphs 121 to 127 of the first witness statement for this Module.

11. In summary, NHSE is responsible for seeking to achieve the objectives in the mandate, which include specific performance targets. The mandate is not a complete articulation of all the things the Government expects the NHS to do in a given period, as such an articulation would be both vast and unhelpful. Nor is it a full articulation of how the Government expects either the NHS or NHSE to achieve their objectives and/or discharge their functions. Both the NHS and NHSE have significant operational autonomy, and this has been designed into the system to align operational decision making with operational accountability. The mandate is designed to set direction, priorities and key expectations of performance within the context of continued delivery of a wide-ranging health service by the NHS.

12. The mandate for 2020-21, published on 25 March 2021 was set out in high level, focused terms, given the centrality of the COVID-19 response **(MS2/3 - INQ000327522)**. Previous and subsequent mandates included more specific

expectations such as, from 2021-22, a set of metrics by which progress on delivering the Government's 13 priorities for the NHS would be monitored. These included metrics on, e.g., performance against targets for elective and A&E waiting times, and for increasing the number of general practice appointments. The expectations set in the mandate for NHSE, including delivery targets, reflected the funding envelope available to NHSE in the relevant year. The total funding envelope (i.e., its capital and resource limits) was given statutory effect in the mandate document. Annual financial directions were published alongside each mandate **(MS2/5 - INQ000391364)** that provided additional information, including on any ring-fences within the overall funding figures that had been set by HM Treasury (HMT). In practice, NHSE discusses many of its plans with the Department and Ministers regardless of where formal authority lies, as set out in the remainder of this statement.

13. Collection of data on operational delivery and performance is the responsibility of NHSE. The focus of this statement, therefore, is on explaining how the Department received and used data in decision making and in holding the health system to account. Some published statistical collections were paused during the pandemic to release capacity to support the COVID-19 response. Those data collections affected are listed on the NHSE website and include some collections relevant to issues within this Module **(MS2/6 - INQ000391379; MS2/7 - INQ000391380)**. The decision to pause some collections was informed by guidance from the Office for Statistics Regulation **(MS2/8 - INQ000391315)**.

14. NHSE is, and was during the relevant period, responsible for the operational delivery of NHS healthcare, and as such, the Department holds NHSE to account for this delivery. However, the Department's level of involvement in supporting and collaborating with NHSE when issues arose differed during the relevant period, depending on the scale and type of issue. The Department collaborated with NHSE to enable military support for healthcare services (see paragraphs 41 and 210 for more detail). During the relevant period, the Department also took a more operational role

in relation to the supply and distribution of Personal Protective Equipment (PPE) to support the healthcare response to the pandemic. As set out in paragraphs 181 to 219 in the second witness statement for this Module, the Department was part of the Supply Chain Cell, convened by NHSE to manage product supply issues, including the supply of PPE. The Department activated the National Supply Distribution Response (NSDR) to support delivery of emergency PPE for health and care providers. The Department also worked with the Cabinet Office (CO), NHSE, Ministry of Defence (MoD) and the NHS Supply Chain to establish the Parallel Supply Chain to procure PPE for the health and care sector.

15. I am asked to provide an overview of the Department's plans in place for healthcare systems to respond to a pandemic such as COVID-19 as of 1 March 2020. I am asked to include information on various operational matters including the adjustment of service levels to meet demand and the management of resources. I am further asked how these plans changed and/or developed between 1 March 2020 and 28 June 2022 and the reasons for those changes.

16. Following a request from the Secretary of State on 10 February 2020 (**MS2/9 - INQ000106107)**, the Department led on developing the COVID-19 Action Plan, which was published on 3 March 2020 **(MS2/10 - INQ000057508)** and set out what the health and social care system across the UK had done to tackle the COVID-19 outbreak, and plans going forward. The Action Plan was jointly agreed between the UK Government and the Devolved Governments.

17. The Action Plan set out:

a. What the Government knew about the virus and the disease it caused;
b. How the Government had planned for an infectious disease outbreak such as that caused by COVID-19;

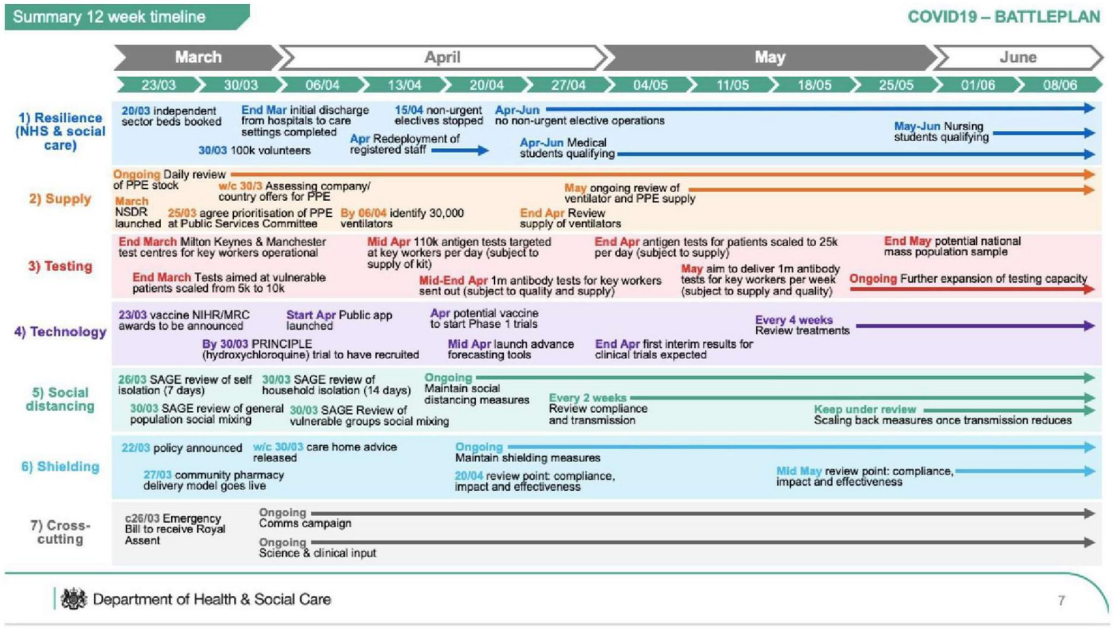
c. The actions that the Government had taken in response to the COVID-19 outbreak so far;
d. What the Government was planning to do next, depending on the course of the outbreak; and
e. The role of the public in supporting the Government's response, both in the immediate term and the future.

18. During this period, the Department was also developing the more detailed COVID-19 Battle Plan (agreed by the Prime Minister on 22 March 2020). The COVID-19 Battle Plan was intended to organise the work of the Department to lead the health and social care response to COVID-19, drawing on work already underway in the Department to identify and organise key workstreams.

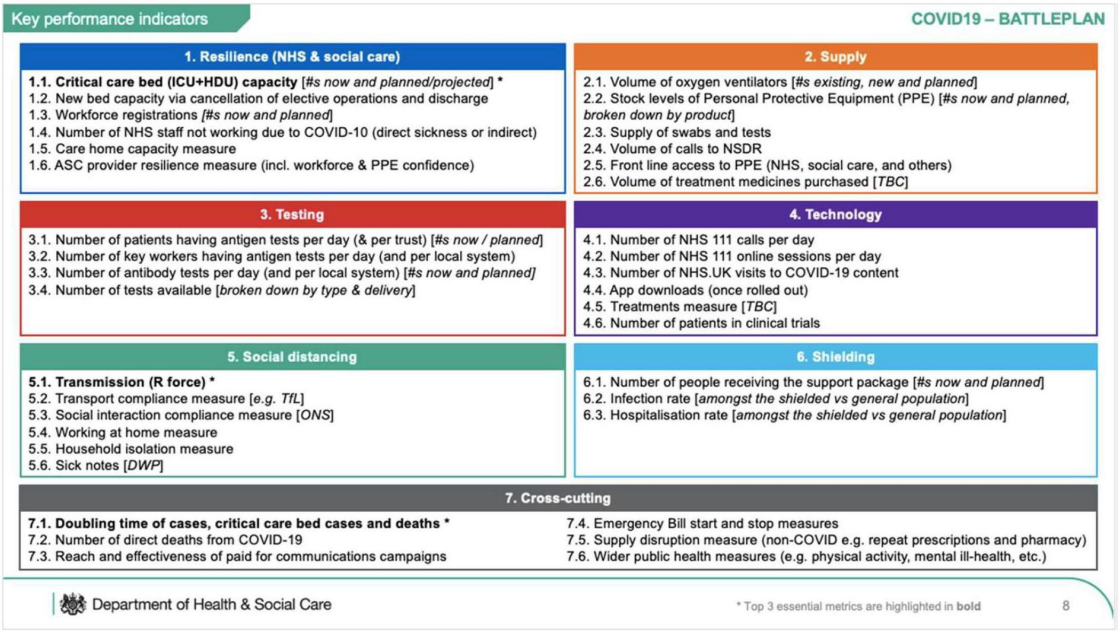
19. The Battle Plan set out the broad phases of the proposed response to COVID-19, reflecting those in the Action Plan: (1) Contain, (2) Delay, (3) Research, (4) Mitigate and (5) Recovery **(MS2/11 - INQ000056110)**.

20. Work under the Battle Plan was initially split into six workstreams, to which each was assigned a Senior Responsible Owner (SRO). The SROs were drawn variously

from the Department, ALBs and Ministry of Housing, Communities & Local Government (MHCLG), reflecting their organisations' respective responsibilities, and the Department worked closely with all of them to ensure a coherent approach to delivery of the Battle Plan. Resilience of the NHS and social care was a key workstream and the responsibility for its delivery fell to both the Department and NHSE. The aims of each of the workstreams for the initial three-month period are set out in the image below **(MS2/11 - INQ000056110):**



21. Each Battle Plan workstream was underpinned by a number of key performance indicators (KPIs) **(MS2/11 - INQ000056110)**:



22. The Battle Plan continued to be developed to reflect changing priorities and an evolving understanding of the virus. However, it remained broadly consistent, covering similar areas and encompassing work by the Department's policy teams and some of the ALBs, particularly NHSE and PHE. Two further versions were produced over the Summer of 2020, on 11 May 2020 (version 2.0) **(MS2/12- INQ000107087; MS2/13 - INQ000106504; MS2/14 - INQ000106505; MS2/15 - INQ000106506)** and on 21 July 2020 (version 3.0) **(MS2/16 - INQ000106542; MS2/17 - INQ000106543; MS2/18 - INQ000106544)**.

23. Progress on the workstreams was reported to the Department's Oversight Board by SROs or their deputies on a weekly basis. The Oversight Board was later renamed the COVID-19 Oversight Board and met weekly until the end of June 2021, after which the frequency of meetings varied to reflect the level of assurance needed during phases of the pandemic.

24. During this period, the NHSE had responsibility for the operation of the healthcare system in England, and therefore would have been responsible for holding

and developing more detailed plans in relation to ensuring those services were maintained. Questions relating to the detail of these, or any changes or amendments that may have been made to operational plans for the healthcare system during the relevant period, should be directed to NHSE.

25. I am asked, in relation to national, regional and NHS Trust level, for details of:

a. the emergency preparedness, resilience and response ("EPRR") framework that applied within the healthcare system, identifying the individual or body with responsibility for declaring the level of emergency;
b. the extent to which the Department directed that any national body, regional body or individual NHS Trust should use the EPRR framework as part of its response to the COVID-19 pandemic; and
c. any changes made to the EPRR framework during the relevant period.

26. Paragraphs 138 to 150 of the first witness statement in this Module include an explanation of the Secretary of State's designation as a Category 1 responder under the Civil Contingencies Act 2004 (CCA), the Department's Emergency Preparedness, Resilience and Response (EPRR) function, for which the Department's Operational Response Centre (ORC) has responsibility, and its role as the Lead Government Department (LGD) for pandemic preparedness, response and recovery.

27. The first witness statement in this Module also explains that NHSE plays a lead role in NHS emergency planning. NHSE's responsibilities include ensuring that both itself and NHS Integrated Care Boards (ICBs) (previously Clinical Commissioning Groups) are properly prepared for dealing with emergencies (including pandemics). The NHS EPRR Framework explains how NHSE should go about this duty **(MS2/19 - INQ000194005)**. Developing and updating the NHS EPRR Framework is the

responsibility of NHSE. NHSE is therefore best placed to provide information on the development and changes to that Framework.

28. In addition to the NHS EPPR Framework, NHSE is also responsible for developing NHSE's Incident Response Plan. This explains the processes involved in managing incidents depending on the level of emergency. NHSE is best placed to provide further information on the content and development of this.

Engagement with Other Bodies

29. I am asked for an outline of the relevant UK Government Ministries, Departments, Non-Departmental Public Bodies and Arm's Length Bodies, devolved administrations, regional and local governmental bodies that the Department worked with, in respect of the response of healthcare systems to the COVID-19 pandemic. I am further asked for an overview of the Department's relationship with these organisations in fulfilling its role as part of healthcare systems' response to the COVID-19 pandemic, in terms of their respective roles, functions, responsibilities and accountability, and details of any structures and processes in place to support such engagement.

30. The Department works through a number of ALBs to deliver its strategic objectives. The ALBs whose functions are of greatest relevance to the core issues in this Module are NHSE, NHSI (which was operationally merged with NHSE throughout the relevant period), PHE and later the UK Health Security Agency (UKSHA) as set out in paragraph 35 below, the National Institute for Health and Care Excellence (NICE) and the Care Quality Commission (CQC).

31. Day-to-day relationships between the ALBs and the Department are, and were during the relevant period, underpinned by framework agreements setting out their respective roles, responsibilities, accountabilities and expectations on ways of working together. The framework agreements in place between the Department and NHSE

and the Department and NHSI were published in 2014 and 2018 respectively **(MS2/20 - INQ000113155; MS2/21 - INQ000409910)**.

32. The first witness statement in this Module explains the formal and informal relationships that existed between the Department and NHSE throughout the relevant period. One method by which the Department worked with EPRR representatives across the health and social care system and the Devolved Governments during the relevant period included daily national calls.

33. These daily national calls were set up in January 2020 to provide leadership and coordination across the health and social care system. These calls continued until June 2020. They were chaired by the Department and attended by representatives from both NHSE and PHE who would provide updates on their respective plans.

34. Furthermore, the Department worked with NHSE by holding a coordinating role. During the period 1 January 2020 to 31 July 2020, NHSE led on measures to manage hospital capacity and staffing under co-ordination from the Department and later wider Government.

35. PHE provided technical leadership and input in assessing the public health risk to the UK during the pandemic. PHE was later replaced by the UK Health Security Agency (UKHSA), which was established on 1 April 2021 and became operational on 1 October 2021, as detailed in paragraphs 45 to 47 of the first witness statement in this Module.

36. The Department also worked with its ALBs through monthly meetings. From 6 October 2020, the Department's COVID-19 programme director convened and chaired a monthly COVID-19 ALB Battle Plan meeting to which representatives of the ALBs were invited. The main purpose of these meetings was to ensure that ALBs were

kept up to date on key aspects of the Government's response to COVID-19 and to give them the opportunity to ask questions and raise issues.

37. Throughout the relevant period, the Department also worked with a range of other government departments (OGDs) on the response to the pandemic. The Department established direct working relationships with counterparts in relevant organisations to progress workplans. The Department's engagement with OGDs on matters relevant to the scope of this Module is outlined below.

38. Oversight of COVID-19 response work was conducted through the UK Government's cabinet committee structure established in response to the pandemic. These included Cabinet Office Briefing Room Meetings (COBR), Ministerial Implementation Groups (MIGs) and COVID Operations Committees (COVID-O). As explained in Sir Christopher Wormald's Third Witness Statement to the Inquiry dated 29 March 2023: *following the Government's activation of the COBR system, the response centred around its meetings, first chaired by the Secretary of State and then by the Prime Minister and where necessary the Secretary of State. Alongside the establishment of COBR, the Government's response to COVID-19 shifted the whole of Government decision making process owing to the scale of the incident, with CO/No.10 COBR function assuming responsibility for major Government decisions including where the meetings were chaired by the Department's Secretary of State. From the point that the Prime Minister chaired COBR on 2 March 2020, it would be accurate to characterise all major decisions made as part of the Government's response to COVID-19 as having been taken on a whole Government basis.*

39. *As* further explained in Sir Christopher Wormald's Third Witness Statement, *from 17 March 2020, COBR meetings were supplemented by regular, often daily, COVID-19 meetings chaired by the Prime Minister, with the Deputy Prime Minister deputising when the Prime Minister was unavailable. Four new Ministerial Implementation Groups (MIGs) were established to support COBR, including: a*

healthcare committee, HMIG, chaired by the Secretary of State focusing on the preparedness of the NHS. The CO provided the secretariat for the MIGs.

40. *The MIG system continued until 29 May 2020 when it was replaced with two Cabinet Committees, COVID-Operations (COVID-O) and COVID-Strategy (COVID-S). The COVID-O and COVID-S model of collective decision making remained in place until March 2022 and February 2021 respectively. In May 2020, CO created a COVID-19 Taskforce to oversee matters. Throughout the pandemic the Department remained the principal department on health and social care issues arising from the pandemic.* The MIG system and later COVID-O were the formal means by which decisions were taken and through which the Government engaged with OGDs to oversee the progress of workplans.

41. As explained above, the Department worked closely with the MoD, including on requests for Military Aid to Civil Authorities (MACA). Departmental officials would work to ensure any requests were coordinated in line with national health priorities, met the MACA principles and were approved by the Secretary of State or an appropriate Minister.

42. The Department also worked closely with the Home Office in relation to the Immigration Health Surcharge (IHS). Further details on the IHS can be found at paragraphs 280 – 281 of this statement.

43. As set out in Sir Christopher Wormald's Third Witness Statement, dated 29 March 2023, on 11 June 2020 the Department implemented a Gold structure to *provide oversight of the local containment aspects of the Test and Trace programme, and escalated issues requiring national decisions* **(MS2/22 - INQ000106468)**. *Weekly Gold meetings (also known as Local Action Committee meetings) were chaired by the Secretary of State and covered the latest epidemiological briefing and assessment; assurance for containment action underway; discussed the implications of any trends identified; and proposed issues to raise with the Cabinet Office and Prime Minister on*

a weekly basis **(MS2/23 - INQ000106471**; **MS2/24 - INQ000106469)**. *Final decisions were taken by Ministers following recommendations to COVID-O and COVID-S*. The Gold meetings enabled the Department to engage with regional and local government representatives from across the country.

Devolved Governments

44. Paragraphs 14 to 18 of Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, provide an overview of the Department's engagement with the Devolved Governments in fulfilling its role as part of the healthcare systems' response to the COVID-19 pandemic.

45. As explained in that statement, *whilst health and social care policy is largely devolved to the Welsh and Scottish Governments and the Northern Ireland Executive, the Department has some reserved policy areas with UK-wide responsibility, including our international relations. Public health is a devolved matter and this meant that certain arrangements to respond to the pandemic could be made separately by the Devolved Governments.*

46. *There had been official level engagement in place with Devolved Governments on health and social care issues, including a number of existing fora across areas such as supply of medicines and medical goods; EU and trade policy; Adult Social Care; and EPRR teams. The need to work together to respond to the pandemic precipitated considerable cross-UK, collaborative working between the UK Government and the Devolved Governments. Numerous existing structures were utilised and additional structures were put in place throughout the pandemic to support policy co-ordination and decision making between the UK Government and the Devolved Governments at official and ministerial level, including formal UK Government Cabinet Committee structures like Cabinet Office Briefing Room (COBR) meetings, Ministerial Implementation Groups (MIGs) and Covid Operations Committees. Regular*

discussions also took place between the UK Government, Health and First Ministers of Scotland and Wales and the Northern Ireland Executive.

47. *UK Health Ministers established regular, dedicated conversations on the health and social care Covid-19 response from 10 March 2020. These provided an important forum for the discussion of key issues and coordination on responses and communications in areas of devolved competence.*

48. *Each of the Devolved Governments has its own CMO, CSA and Deputy Chief Medical Officers (DCMOs). The UK CMOs meet regularly and there is collaboration and coordination between the CMOs and CSAs across the UK Government and the Devolved Governments, which supports coordinated scientific advice to the UK Government and the Devolved Governments.*

49. *The Department, the Devolved Governments and the UK's national public health organisations had also agreed to set a common framework on health protection* **(MS2/25 - INQ000106904)** *to ensure there continued to be a robust UK-wide regime on public health protection and health security. This framework was established in response to the UK's exit from the EU. An operating model and governance arrangements have since been implemented to strengthen strategic and operational cooperation between the UK Government, the Devolved Governments and the national public health organisations of the UK.*

Engagement with the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser and other government medical advisers

50. I am asked about the ways in which the Department worked with the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Scientific Adviser (CSA) and other government medical advisers in so far as it is relevant to the Provisional Outline of Scope for Module 3.

51. The respective functions of the CMO and the CSA are explained in paragraphs 97 to 101 of the first witness statement in this Module.

52. The CMO for England is the UK Government's chief medical adviser, and the professional head of all directors of public health (DPH) in local government and the medical profession in Government. The CMO provides public health and clinical advice to Ministers in the Department and across Government.

53. Although the CMO is an independent position, the role sits within the Department and as such there is an extremely high volume of interaction between the two. The CMO is a member of the Department's leadership team and attends the Departmental Board and Executive Committee meetings. Prior to and during the pandemic, the CMO provided advice to the Secretary of State, Ministers and officials on public health and clinical matters, along with that of a scientific nature when required. This was carried out through attending various meetings and reviewing advice and submissions that had been put together by officials within the Department.

54. In addition to this, the CMO, Professor Sir Chris Whitty, provides further details in his First Statement to the Inquiry, dated 15 August 2023, *in which he explains how, as well as advising central decision makers (10 Downing Street and the Cabinet Office), the Office of the Chief Medical Officer (OCMO) also provided advice to the Secretary of State for Health and Social Care, Department Ministers and Department officials on public health, science or clinical matters as required. This included advice that was collated by the Department's teams and passed to other departments or to central teams such as the Cabinet Office.*

55. As Professor Sir Chris Whitty explains in that statement, *given that the Department was both the home Department for OCMO and the lead Department for much of the COVID-19 response, there was a very large amount of interaction between the Department and OCMO. Professor Whitty notes at paragraph 5.23 of his First Statement to the Inquiry, dated 15 August 2023, that his calendar indicates that*

he "met formally with the Secretary of State for the Department of Health and Social Care around 233 times in the relevant time period, not including multiple Cabinet Office or 10 Downing Street meetings where we were both present".

56. The functions and responsibilities of the Department's CSA and the CNO are explained in paragraphs 75 to 79 of Sir Christopher Wormald's First Witness Statement to the Inquiry, dated 25 November 2022. I summarise the position below.

57. *The Department has a CSA who acts also as the head/CEO of the National Institute for Health Research (NIHR) and advises on scientific aspects of health. In the period 2016 to 2021 this role was held by Professor Sir Chris Whitty. Prior to that it was held by Professor Dame Sally Davies. Professor Lucy Chappell is the current CSA, taking over from Professor Sir Chris Whitty in August 2021.*

58. In addition to the above, the CSA reports to the CMO (Professor Sir Chris Whitty held both roles between Oct 2019 and April 2021) and sits within the Department, as such there is a high volume of interaction. The CSA attends the Department's ExCo meetings. Prior to and during the pandemic, the CSA provided advice to the Secretary of State, Ministers and officials on scientific and clinical matters. This was carried out through attendance at various meetings and briefing sessions, together with reviewing advice and submissions that had been put together by officials within the Department.

59. *The CNO for England provides clinical and professional leadership for all nurses and midwives in England (with the exception of public health and adult social care nurses), including the 350,000 nurses and midwives who work for the NHS and who make up the largest group of the total NHS workforce.*

60. *The CNO is a member of the joint NHSE/NHSI national leadership team. Prior to the establishment of NHSE in 2013, the CNO was an employee of the Department.*

Previous CNOs were Dame Christine Beasley from 2004 to 2012 and Professor Jane Cummings between 2012 to 2019. The current post holder is Dame Ruth May.

61. The Department engaged regularly with the CNO over the course of the pandemic, most notably on NHS workforce and welfare issues. This included increasing NHS staff capacity at the start of the pandemic and the Department engaged with CNO on returning nursing staff who had recently left the register and the use of student nurses in front line roles. More details on these two issues can be found in paragraphs 250 – 267 of this statement.

62. Further, as recorded in paragraph 6.4 of the Framework Agreement between the Department and NHSE **(MS2/26 - INQ000113155)**, NHSE employs a number of clinical advisers (National Clinical Directors and National Specialty Advisers) **(MS2/27 - INQ000399129)** and has access to other clinical advisers through formal networks. The Department is able to call on these advisers when it has a need for clinical advice (for example, to inform its understanding of NHS frontline delivery and to support high level policy development and support) with the costs of providing such advice being met out of NHSE's overall funding allocation.

Engagement with expert advisory groups and bodies

63. I am asked for a brief overview of how the Department identified and worked with expert advisory groups and bodies (such as New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) and others set out in paragraphs 121 - 176 of Sir Christopher Wormald's First Witness Statement, dated 25 November 2022) in order to inform and shape the response of the healthcare system to the COVID-19 pandemic throughout the relevant period. To remain in scope of this Module, I have not addressed all the expert advisory groups and bodies that the Department engages with, instead, I have explained below how relevant expert groups and bodies engaged with the Department over the relevant period.

64. As stated in Professor Sir Chris Whitty's Fourth Witness Statement to the Inquiry dated 22 August 2023, "*for the great majority of major decisions, SAGE remained the principal conduit by which scientific advice to the Government was channelled*".

65. SAGE was activated in January 2020 to provide expert scientific advice on COVID-19 to the Government. Throughout the pandemic, the frequency of SAGE meetings was determined by the co-chairs: the CMO and the Government's Chief Scientific Advisor (GCSA). SAGE does not have a formal or set membership apart from the GCSA. SAGE drew on expertise from across the scientific spectrum and included experts from within Government and academia. SAGE was supported by several subject specific sub-groups and received evidence and input from additional expert groups and organisations as necessary, with attendees being determined by the co-chairs. The Secretariat for SAGE was provided by officials in GO-Science. Further details on the process of identifying and appointing relevant experts should therefore be directed to that office.

66. I am asked for a chronological overview of the advice provided by expert groups and bodies with respect to Module 3. Formal SAGE minutes were circulated within Government, the co-chairs often briefed ministers and the Prime Minister on SAGE's central view. Cabinet Office will be best placed to provide readouts of these discussions. Observers from other government departments, including the Department, Cabinet Office, No10 and HMT joined. The way in which the CMO engaged with the Department, to provide scientific advice, is set out in paragraphs 48 - 55 of this statement.

67. I am asked about how this advice was used in order to inform and shape the response of the healthcare system to the COVID-19 pandemic. Examples within the scope of Module 3 can be found later in this statement at paragraph 102, detailing where SAGE was consulted on the implementation of measures designed to protect

the vulnerable, and paragraph 219, detailing where SAGE planning assumptions informed plans related to ICU beds.

Involvement of the Moral and Ethical Advisory Group

68. I am asked for an outline of the role and function of the Moral and Ethical Advisory Group (MEAG) in respect of decision-making or policy formulation by the Department during the relevant period.

69. The role and details on the MEAG were set out in paragraphs 163 to 165, and 332, of Sir Christopher Wormald's First Witness Statement to the Inquiry, dated 25 November 2022. In summary, the position is as follows:

70. *MEAG was set up in October 2019 as a successor to the Committee for Ethical Aspects of Pandemic Influenza (CEAPI) to provide advice to policy teams. Its establishment followed the recommendations of Exercise Cygnus (2016), which found that the public reaction to a reasonable worst case pandemic influenza scenario needed to be better understood. MEAG is a group of experts and advisers who advise government on moral, ethical and faith considerations to support the development of policies and response plans both in advance of, and during, a pandemic.*

71. *MEAG advises the UK Government. Its secretariat is provided by the Department. The current chairs of MEAG are Professor Sir Jonathan Montgomery and Jasvir Singh.*

72. *The Terms of Reference and minutes of the Group's first meeting are exhibited at* **(MS2/28 - INQ000023076)** *and* **(MS2/29 - INQ000023082**). *This was the only meeting before 21 January 2020, and therefore MEAG did not provide any advice on COVID-19 before this point.*

73. Several MEAG members had previously served on the Committee on Ethical Aspects of Pandemic Influenza, which produced an Ethical Framework for Pandemic Flu (last revised in 2017) that was adopted by MEAG **(MS2/30 - INQ000022847)**. Following MEAG's introductory meeting in October 2019, the group then met on four occasions in March 2020, and on a number of other occasions thereafter until their last meeting on 15 December 2021. Usually the co-chairs would agree the agenda for discussion. On occasion, the MEAG provided advice to teams and officials within the Department. A short summary paper would be presented to the Group at one of its meetings, and then the Group would offer comments and advice for consideration during the development of the policies. The Group was used to inform and shape policy development. The Group did not make final decisions on whether a policy should be taken forward or not. It also wasn't usual practice for the Group to produce a report or paper for officials to consider or reference. The Group finally disbanded in October 2022. The Group discussed and assisted in the development of policies relating to:

a. End of life care **(MS2/31 - INQ000399119, MS2/32 - INQ000421410; MS2/32a – INQ000468606).**
b. Shielding policy and the potential impact on the Clinically Extremely Vulnerable (CEV) **(MS2/33 - INQ000399120)**
c. Implementation of the Coronavirus Bill **(MS2/34 - INQ000399114)**
d. Guidance for healthcare working regarding decisions in relation to care of patients during COVID-19 pandemic **(MS2/35 - INQ000117797)**
e. Refresh of the MEAGs' role in terms of policy development and engagement with Devolved Governments. It also discussed ethical aspects of recent issues faced by the General Medical Counsel **(MS2/36 - INQ000399118)**
f. Ethical principles in dealing with reduction of adult screening backlog due to the pandemic (**MS2/37 - INQ000399125)**.

74. As part of the Inquiry's question involving the Department's engagement with the MEAG, I have also been asked about work in relation to a 'prioritisation tool'. This is a matter for the OCMO and any questions should be directed to that office.

Engagement with other expert partners

75. I am asked for an overview of the role of any other expert partners with whom the Department cooperated, in respect of the response of healthcare systems to the COVID-19 pandemic.

76. Paragraphs 28 to 29 of Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, paragraphs 34 to 36 of Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 25 August 2023, and paragraphs 29 to 32 of Sir Christopher Wormald's Eighth Witness Statement to the Inquiry, dated 30 August 2023, detail the ways in which the Department engaged with international partners in relation to the healthcare system's response to the pandemic. In summary, the position is as set out below.

77. *The UK attended the World Health Organisation (WHO) Executive Board in February 2020* **(MS2/38 - INQ000106099)** *and the virtual Seventy-Third World Health Assembly (WHA) in May 2020* **(MS2/39 - INQ000106866)**, *at which the WHA agreed the COVID19 Response Resolution* **(MS2/40 - INQ000107092)**.

78. *Throughout the relevant period, the Department also bilaterally engaged with other countries to exchange information on their COVID-19 response. In addition to bilateral engagement, there was engagement with the WHO, WHO EURO, the G7, the G20, the Global Health Security Initiative and the European Commission.*

79. *The health track of the 2021 UK G7 Presidency considered actions which G7 countries could take together to manage the COVID-19 pandemic and help ensure better pandemic preparedness and response in the future. In addition to regular*

exchanges on live issues in the COVID-19 pandemic, the UK's G7 agenda focused on four concrete areas: global health security, antimicrobial resistance, clinical trials, and digital health. Commitments were secured across these issues at the G7 Health Ministerial Meeting in Oxford from 3-4 June 2021, including agreement of a Clinical Trials Charter to build on experience during COVID-19 and enable more effective trials for therapeutics and vaccines globally in a pandemic. The declaration was agreed by all G7 members **(MS2/41 - INQ000234916)**, *and the G7 Therapeutics and Vaccines Clinical Trials Charter was published* **(MS2/42 - INQ000234915)**.

80. *The G7 Leaders' Summit on 11-13 June 2021 built on the work of Health Ministers to agree a specific Leaders' Health Declaration in addition to the Carbis Bay Communique* **(MS2/43 - INQ000235009)**, *which shared their agenda for global action to build back better following the COVID-19 pandemic. Leaders committed to take action to prevent, detect, respond, and recover from COVID-19 and future pandemics. They made a commitment to work together to invest in innovation with the aim of making safe and effective vaccines, therapeutics, and diagnostics available within 100 days of a Public Health Emergency of International Concern being declared; and a commitment to make a further one billion COVID-19 vaccines available globally to help end the pandemic.*

81. *The G20 Health Ministers' Meeting, which took place in Rome on 5 and 6 September 2021, focused on building strong cooperation and collaboration to end the COVID-19 pandemic and support recovery around the world, and on better prevention, detection and responses to global health threats and emergencies. The nations agreed to work together to enhance timely global access to safe, affordable and effective COVID-19 vaccines, therapeutics and diagnostics, building on the work led by the PM at the UK-hosted G7 in June 2021. The 2021 G20 Health Declaration was agreed at this meeting* **(MS2/44 - INQ000257326)**.

82. *G7 Health Ministers under the UK G7 Presidency released a joint statement in November 2021 on the Omicron variant and committed to continued close working to monitor and share information on the emerging situation* **(MS2/45 - INQ000257126)**.

83. *The World Health Assembly gathered for a special session from 29 November 2021 to 1 December 2021 and agreed that an Intergovernmental Negotiating Body (INB) would be established to draft and negotiate a WHO convention, agreement or other international instrument on pandemic preparedness and response* **(MS2/46 - INQ000257125; MS2/47 - INQ000257116)**. *The INB met for the first time on 24 February 2022. Negotiations are ongoing and are expected to continue until at least May 2024. Since it was established, the INB has met nine times to date, including four resumed sessions* **(MS2/48 - INQ000257298; MS2/49 - INQ000257299; MS2/50 - INQ000257316)**.

Consideration of the impact of advice, policies and/or guidance on those with existing health inequalities

84. I am asked whether the Department considered how the advice, policies or guidance that it had input into, might impact upon disabled people, clinically vulnerable people, and people from ethnic minority communities or socio-economically disadvantaged backgrounds and/or groups with existing health inequalities. I am asked to provide details of any equality impact assessments, or related assessments, which the Department completed in this respect during the relevant period.

85. Paragraphs 4, 5 and 7 to 26 from Sir Christopher Wormald's Fourth Witness Statement to the Inquiry, dated 10 May 2023, explain the Department's approach to its equalities duties. In summary, the position is as follows:

The Clinical Context to Equalities

86. *Equalities and improving health and wellbeing are at the heart of all the Department's functions. In line with the principles and values that guide the NHS, the Department is committed to ensuring that resources are maximised for the benefit of the whole community, making sure that nobody is excluded, discriminated against or left behind.*

87. *These principles and values, which are reflected in the World Health Organization's August 2008 Commission on Social Determinants of Health report, 'Closing the gap in a generation: health equity through action on the social determinants of health' (the 2008 Report) and the February 2010 Sir Michael Marmot review, 'Fair Society, Healthy Lives' (the Marmot Review), can be seen in the medical practice of clinical prioritisation, i.e., identifying who is most vulnerable and taking the necessary steps to protect them, and are perhaps best illustrated in the context of a pandemic by the prioritisation of the giving of vaccines, assuming a limited supply, to those most in need first* **(MS2/51 - INQ000184077; MS2/52 - INQ000184071)**.

The Department's approach to equalities

88. *The Department's approach to its equalities duties is not just limited to those requirements set out in the Equality Act 2010 (EA 2010) but also includes, for example, the duty in section 1C of the National Health Service Act 2006 (the Act), as inserted by the Health and Care Act 2012, which in part reflects the 2008 Report and the Marmot Review, to reduce inequalities between the people of England with respect to the benefits that they can obtain from the NHS. Further detail in respect of these duties is set out below.*

National Health Service Act 2006 (NHS Act 2006)

89. *Section 1C of the Act places a duty on the Secretary of State to have regard to the need to reduce inequalities between the people of England. This is in respect of both access to health services and the outcomes achieved, including any benefits that*

may be obtained by them. This duty encompasses the Secretary of State's functions in relation to both the NHS and public health. Section 1B also places a duty on the Secretary of State to have regard to the NHS Constitution in exercising his or her functions in relation to the health service.

90. *The Department's purpose is to support and advise the Government's health and social care Ministers by shaping policy and assisting in the setting of the strategic direction for the health and care system. Through this the Department fulfils the Secretary of State's statutory duty under section 1 of the Act to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of people in England and in the prevention, diagnosis and treatment of illness. The Department secures funds for the NHS and remains accountable for this funding, which is allocated to the most appropriate local level.*

91. *The Secretary of State also has a statutory duty under s. 2A of the Act to take the steps that they consider appropriate for the purpose of protecting the public in England from disease or other dangers to health. The Secretary of State also has a power under s. 2B to take steps that they consider appropriate for improving the health of people of England. The principal route for the discharge of these responsibilities was through Public Health England (PHE), with both the Department and PHE having responsibilities for planning for and managing the response to emergencies and health protection incidents and outbreaks in an extended team working across Government.*

Equality Act 2010

92. *Pursuant to Schedule 19 of the EA 2010, the Department is subject to the Public Sector Equality Duty (PSED), found at section 149(1), which states that in the exercise of its functions, it must have due regard to the need to:*

a. *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
b. *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
c. *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

93. *The Department, as a "service-provider" to the public, is also subject to section 29 of the EA 2010 which imposes a duty not to do anything, in the exercise of a public function, that constitutes discrimination, harassment or victimisation. More specifically, it is not to harass, victimise or discriminate: as to the terms of the service provided; by terminating the provision of the service; or by subjecting a person to any other detriment.*

Human Rights Act 1998

94. *Under section 6 of the Human Rights Act 1998 (HRA), the Secretary of State is required to act in a way that is compatible with the European Convention on Human Rights (ECHR), except in limited circumstances. Furthermore, under section 19 of the HRA, the Secretary of State has a duty to provide a statement confirming that the provisions of any Bill laid before Parliament are compatible with the ECHR.*

95. *In terms of how the Department approaches its duties in respect of equalities, any such impacts are routinely assessed and taken into account during the formation of policies and the decision-making process, which generally takes place in the usual Government fashion, i.e., by the provision of submissions to the decision-maker(s).*

96. *The Department also recognises that there are multifaceted socio-economic reasons that lead to inequalities in health, as well as systemic failures in institutions to recognise and address the health of particular groups, including those from ethic minority backgrounds, women, the LGBTQ+ community and those with disabilities.*

The Department's work is aimed at reducing the differentials in life expectancy between those and other such groups and the average through a 'whole system' approach and that is inherently central to the preparation for any pandemic.

97. *In respect of the Department's governance, it has run training for staff in respect of PSED since at least 2016, it has overarching equality objectives and mechanisms in place, for example templates for submissions, to ensure that equalities are considered.*

98. I have been asked to provide equality impact assessments that concern matters within the scope of Module 3. Below are some examples of equality impact assessments that have been produced by the Department:

a. to support development and implementation of the Coronavirus Bill, which included a number of measure of support and maintain NHS capacity and resilience **(MS2/53 - INQ000106231)**;
b. in support of the Coronavirus Act 2020 **(MS2/54 - INQ000236053)**;
c. in relation to the provision of primary care services **(MS2/55 - INQ000109191)**; and,
d. in a submission to Ministers regarding hospital discharge service requirements **(MS2/56 - INQ000327976)**.

99. The second witness statement in this Module, dated 3 November 2023, which I co-signed with Jonathan Marron and Professor Lucy Chappell, sets out in detail the steps the Department took to protect the vulnerable from COVID-19 infection through shielding at paragraphs 283 to 361.

100. Further information is provided in paragraphs 297 to 302 of Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, detailing the manner in which the Department considered how the advice, policies and guidance into which it had input might impact on vulnerable groups. In summary, the position as set out in that statement is as follows:

101. *The Department's consideration of vulnerable groups is reflected in the first version of the Battle Plan* **(MS2/11 - INQ000056110)**, *in which one of its six workstreams included: 'Protecting the most Vulnerable'; the Government initially sought to achieve this through providing specific advice to those who may benefit from 'shielding' [initially referred to as cocooning]. These two broad cohorts of vulnerable people identified above were then considered separately by the Department through two linked workstreams in version 2 of the Battle Plan: 7A: 'Shielding the clinically extremely vulnerable'* **(MS2/12 - INQ000107087; MS2/13 - INQ000106504; MS2/14 - INQ000106505; MS2/15 - INQ000106506; MS2/57 - INQ000106902)** *and 7B: 'Supporting other disproportionately affected groups and volunteering'* **(MS2/12 – INQ000107087)**.

102. *In respect of the implementation of measures designed to protect the vulnerable, on 5 March 2020 SAGE reviewed the evidence in support of the implementation of home isolation measures* **(MS2/58 - INQ000106152)**. *These measures were proposed at that stage in order to delay the spread of COVID-19, attempt to modify the epidemic peak and reduce mortality rates. Whilst the SAGE minutes recognise that for older and vulnerable patients the isolation would have to continue for a longer period, it was realised that such long periods of social isolation could also carry significant risks. All advice specific to the clinically extremely vulnerable (those shielding) was therefore at all times a recommendation and personal choice and never a requirement imposed by government.*

103. *In April 2020, the CMO commissioned PHE to review disparities in outcomes and risks from COVID-19* **(MS2/59 - INQ000106482; MS2/60 –** INQ000089741 *The resulting publication in June 2020, 'Disparities in the risk and outcomes of COVID19'* **(MS2/61 - INQ000106459)**, *was a rapid review of transmission, hospitalisation and mortality from COVID-19 data, which showed disparities in the impact of COVID19 at that time based on age, sex, ethnicity and deprivation. Following the PHE work, the Government commissioned further work through the then Minister for Equalities to improve understanding of drivers for disparities. The Race Disparity Unit which is part*

of the CO, led this work, with the Department inputting and undertaking periodic commissions and assurance reviews to ensure that its COVID-19 response was building in adequate responses for vulnerable groups (for example, ethnic minority communities and deprived populations).

104. *The impacts on vulnerable groups were considered in accordance with the public sector equality duty in, for example, the March 2020 'Hospital Discharge Policy', the May 2020 'Support Policy' and the June 2020* [update to the] *'Admissions Guidance'*, [which concerned admission and care of people in care homes rather than hospitals] **(MS2/62 - INQ000106249; MS2/63 - INQ000106403; MS2/64 - INQ000106442)**. *The public sector equality duty was implicitly considered by the Department on an ongoing basis during its response to COVID-19 insofar as one of the key Battle Plan workstreams was the protection of the most vulnerable and this necessarily entailed the development of policies for their protection.*

105. *In respect of testing of those hospitalised, the Department, together with PHE and NHSEI, ensured that testing capacity was prioritised for elderly and vulnerable residents until capacity was sufficiently expanded to deliver more widely.*

106. *The Oversight Board requested information from Battle Plan workstream SROs on 7 July 2020* **(MS2/65 - INQ000106522)**, *requiring that they review their workstream objectives and planned activities to ensure they reflected considerations for people from ethnic minority communities and deprived populations.*

107. *The* Department produced annual reports detailing the work it carried out to comply with its PSED in 2020 **(MS2/66 - INQ000184066)**, 2021 **(MS2/67 - INQ000184066** and 2022 **(MS2/68 - INQ000409898)**.

Communication and information sharing with the NHS

108. I am asked for details of the mechanism(s) in place during the relevant period for the Department to transmit emergency alerts or disseminate information, policies and guidance to the intended recipients (whether national bodies, regional bodies, individual Trusts or others). I am also asked for details of the mechanism(s) in place during the relevant period for those working on the frontline of healthcare to share information across healthcare systems (including between bodies in different countries of the UK) relating to problems encountered, solutions to problems, or other innovation in order to improve the response to the pandemic. Finally, I am further asked for details of the mechanism(s) in place during the relevant period to monitor the efficiency of communication within the healthcare system.

109. The Department's approach to information sharing and communicating with NHSE is set out in paragraphs 122 – 127 of the first witness statement in this Module. This describes the routine communications between policy teams in the Department with colleagues in NHSE.

110. During the pandemic, the Department had a role in maintaining common situational awareness of national and international impacts, and to enable this the Department established the Daily National Sector calls, referred to in paragraphs 32 and 33 of this statement. This also provided a route for organisations to raise awareness of ongoing issues and incidents with the Department and other organisations across the healthcare system. How the information was then shared and acted upon by the relevant frontline services would have been shaped by the operational procedures and management processes those organisations had in place. NHSE would be better placed to advise how this information was shared more widely with NHS Trusts and other organisations where required, and how information was then cascaded where necessary.

111. Further information on the Daily National Sector Calls is provided in paragraph 87 of Sir Christopher Wormald's Third Witness statement to the Inquiry dated 29 March 2023. This outlines that *The Department established and chaired Daily National Sector calls from 21 January 2020 to co-ordinate the health and social care system response and maintain a common situational awareness of the national and international impacts of COVID-19* **(MS2/69 - INQ000106045; MS2/70 - INQ000106046; MS2/71 - INQ000106254; MS2/72 - INQ000106260; MS2/73 - INQ000106314; MS2/74 - INQ000106372; MS2/75 - INQ000106374; MS2/76 - INQ000106376)**. *These continued until summer 2020. The agenda covered the current reported cases and testing, repatriation, case definitions, port health measures, clinical management, the picture across all four nations, and policy/operational decisions, and was attended by Departmental officials including communications officials, NHSEI, PHE and the Devolved Governments. The calls were informed by the Situational Report (SitRep) from the previous evening and were used to address key live issues and to inform the subsequent SitRep.'*

112. The Department also utilised the Central Alerting System (CAS) to ensure the quick dissemination of information across the healthcare system. This is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care **(MS2/77 - INQ000107091)**. This was in addition to the routine communication channels referred to above and to the Department publishing advice, guidance and information online to allow access by a range of stakeholders and audiences.

113. Paragraph 30 of Sir Christopher Wormald's Sixth Witness Statement to the Inquiry, dated 6 June 2023, set out the Department's approach to testing the robustness of communication within the healthcare system in the event of an incident. This outlines that: *The Department continues to engage the health and social care system to test the robustness of communications in the event of an incident. This occurs through regular interaction between the communications teams within the*

Department and others across the health and social care system, for instance with NHSE and the UK Health Security Agency (UKHSA). **(MS2/78 - INQ000205248; MS2/79 - INQ000205249; MS2/80 - INQ000205251)**.

Section 2 - Additional funding provided to the healthcare system during the COVID-19 pandemic

114. This Section includes evidence about Departmental financial management, planning and reporting which were and remain areas outside of my responsibility. Finance within the Department is the responsibility of the Director General for Finance, a position that is currently held by Andy Brittain. I have relied on Departmental records and briefings, and my understanding of the overall approach to the pandemic response in providing this information. Paragraphs 173 to 181 of the first witness statement in this Module set out the Department's responsibilities and accountability for resourcing and funding the healthcare system in accordance with 'Managing Public Money', guidance provided by HM Treasury (HMT) for handling public funds **(MS2/81 - INQ000279942)**. Paragraphs 182 to 189 of the first witness statement in this Module then provide information on how the healthcare system was funded during the pandemic, and how additional funds were secured via a Reserve claim process.

115. Before giving further details on the Reserve claims, it is important to highlight that during the pandemic the Government took significant and unprecedented steps to ease financial and operational pressures on the NHS.

116. The Department secured extra funding to support the NHS's response to COVID-19 with c. £20 billion provided in 2020-21 and c. £16 billion in 2021-22 **(MS2/1 - INQ000235008; MS2/82 - INQ000257323)**. In addition to extra funding, other measures were agreed by Government, including introducing full re-imbursement of any costs incurred by the NHS in its operational response to COVID-19. These measures included a simplified, temporary financial framework in 2020-21 (broadly kept in place into 2021-22), which gave organisations certainty over payment flows

and eased spending controls **(MS2/83 - INQ000087317**). I quote from the letter sent by the Chief Executive and Chief Operating Officers of NHSE to all NHS providers and commissioners on 17 March 2020: *"The Chancellor of the Exchequer committed in Parliament last week that "Whatever extra resources our NHS needs to cope with coronavirus – it will get." So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category"* **(MS2/83 - INQ000087317).**

117. Further details of the individual Reserve claims are set out in the following paragraphs.

Processes in place to consider requests for additional funding

118. I am asked for a description of the processes in place by which requests for additional funding for the healthcare system during the pandemic were considered. I am further asked for details of any key requests for additional funding relevant to the Provisional Outline of Scope for Module 3 and whether those requests were granted in whole, in part or declined.

119. Departmental finance staff scrutinised cases put forward by Departmental and NHSE policy leads, seeking revised forecasts where necessary, to ensure accurate and evidence-based funding cases were put to HMT for consideration. The great majority of cases were approved, though a number were either rejected or only part-funded by HMT.

120. As soon as a case had been agreed between NHSE and the Department, it was submitted to HMT for a decision by the Chief Secretary to the Treasury (CST). CST's decisions to approve additional funding requests were typically accompanied by approval conditions, which were set on a case-by-case basis and recorded in formal communications from HMT. The Department holds a full list of approved cases for

additional NHS funding, which also details the associated conditions **(MS2/85 - INQ000391394)**.

121. I am asked whether additional funding beyond that agreed in the relevant annual budget for the NHS in England was made available during the relevant period. If additional funding was made available, I am asked to identify: the organisation responsible for providing additional funding; whether the additional funding had been requested by an NHS organisation, and if so, the body or bodies which made the request(s); when and how the additional funds were made available to the NHS; and whether there were any conditions or stipulations on how the funds were to be spent.

122. The "Covid Inquiry NHS Funding Schedule" **(MS2/86 - INQ000391373**) provides a summary of all additional funding requests approved for the NHS, how the spending was funded and how and when confirmation was provided to the NHS. Given the scope of this Module, this includes information covering expenditure in the NHS. Expenditure in Test and Trace and UKHSA and on the purchase of Personal Protective Equipment (PPE) and vaccines, is excluded.

123. The funding schedule sets out:

a. the amounts and brief descriptions of the programme/activity that was to be funded;
b. whether the funding had been requested by NHSE or the Department;
c. the source of the additional funding and, where appropriate, the HMT fiscal event that confirmed the additional funding;
d. details of how and when funding was approved; and
e. details of any conditions attached to the funding approvals.

124. The detailed breakdown in the funding schedule of the additional funding for COVID-19 related activity in the NHS is summarised in the following table:

Table 1: COVID-19 Funding provided to the NHS 2019-20 to 2022-23

(£ millions)	2019-20	2020-21	2021-22	2022-23
NHS COVID-19	175	17,995	13,387	6,096
Plus COVID-19 Initiatives managed outside of NHS but with some spending by the NHS -				
Test & Trace		412	401	192
Personal Protective Equipment (PPE)		521	0	0
Vaccines Deployment		950	2,376	915
Flu Initiatives		60	130	0
COVID-19 Medicines		52	0	0
Total COVID-19 Funding Provided to the NHS	**175**	**19,988**	**16,295**	**7,203**

125. The majority of this additional COVID-19 funding came from HMT via Reserve claims. In addition, a relatively small level of funding was transferred into the NHS from existing non-NHS Departmental group budgets to fund specific spending requirements. Full details are included in the funding schedule, but these budget transfers mostly relate to:

a. NHS Testing – NHS providers incurred expenditure on the testing of both patients and staff, and on laboratory usage by UKHSA. These costs were funded via budget transfers from the NHS Test and Trace (and latterly UKHSA) budget.
b. PPE – during the first part of 2020-21, alongside centralised efforts to procure and supply PPE, NHS Trusts were also directly purchasing their own PPE. The Department recognised that these efforts represented an additional cost pressure and agreed to fund those

initial costs incurred by NHS Trusts via a budget transfer from the central PPE budget.

c. Vaccine deployment – across the relevant period, the NHS led on COVID-19 vaccine deployment and the associated spending was fully funded via a budget transfer from the COVID-19 Vaccines budget, managed centrally by the Department.
d. Medicines - Funding to the NHS was required to secure additional stocks of some key medicines, which included tocilizumab and sarilumab, immunomodulating monoclonal antibodies, baricitinib JAK inhibitors and remdesivir antivirals.

Section 3 - NHS capacity: hospital beds

126. This Section covers evidence about hospital discharge, which includes references to guidance provided on discharge of people from hospital into adult social care services, including designated settings. Adult Social Care is the responsibility of the Director General for Adult Social Care, a position that is currently held by Michelle Dyson. I have relied on Departmental records and briefing, and my understanding of the overall approach to the pandemic response in providing this information.

127. I am asked for the number of inpatient and critical care beds available across the NHS in England as at 1 March 2020 (or the nearest recording period) and the levels of occupancy at that time.

128. Prior to the first wave of the pandemic, the NHS was operating at high occupancy levels. As at 1 March 2020, there were 97,868 general and acute (G&A) beds open, of which 91,780 were occupied: an occupancy rate of 93.8%. There were 3,636 adult critical care beds open, of which 2,888 were occupied: an occupancy rate of 79.4%. Significant interventions were taken during that month to reduce occupancy of G&A beds.

129. I am asked for details of the inpatient and critical care bed capacity and occupancy levels in the NHS in England during the relevant period, including if and how this changed and the reasons for any fluctuations.

130. The following table **(MS2/87 - INQ000409911)** demonstrates the changes to occupancy levels from March 2020 to June 2022:

Table 2: Number of available and occupied beds by bed type averaged over a complete month. Data for acute trusts with a type 1 A&E department.

	G&A beds available	G&A beds occupied	G&A occupancy rate	Adult critical care beds available	Adult critical care beds occupied	Adult critical care occupancy rate
March 2020	95,805	78,667	82.1%	3,766	2,661	70.7%
April 2020	90,554	52,998	58.5%	5,814	3,635	62.5%
May 2020	89,385	58,408	65.3%	5,726	2,863	50.0%
June 2020	88,952	64,589	72.6%	5,055	2,540	50.2%
July 2020	89,690	68,197	76.0%	4,639	2,528	54.5%
August 2020	89,827	72,610	80.8%	4,405	2,588	58.8%
September 2020	90,233	76,541	84.8%	4,264	2,727	64.0%
October 2020	91,002	77,889	85.6%	4,235	2,927	69.1%
November 2020	88,917	77,696	87.4%	4,292	3,237	75.4%
December 2020	89,140	77,515	87.0%	4,402	3,345	76.0%

January 2021	90,629	79,288	87.5%	5,654	4,850	85.8%
February 2021	89,857	76,713	85.4%	5,709	4,512	79.0%
March 2021	89,625	76,215	85.0%	4,660	3,256	69.9%
April 2021	90,293	78,011	86.4%	4,144	2,891	69.8%
May 2021	91,343	80,578	88.2%	4,024	2,847	70.8%
June 2021	91,778	81,870	89.2%	3,965	2,859	72.1%
July 2021	92,357	82,691	89.5%	3,971	2,969	74.8%
August 2021	92,444	83,310	90.1%	3,983	3,083	77.4%
September 2021	93,150	84,898	91.1%	3,958	3,082	77.9%
October 2021	93,619	86,344	92.2%	3,944	3,092	78.4%
November 2021	94,386	87,566	92.8%	4,005	3,220	80.4%
December 2021	94,390	85,598	90.7%	3,989	3,132	78.5%
January 2022	94,841	87,084	91.8%	3,966	3,007	75.8%
February 2022	95,890	88,753	92.6%	3,928	2,964	75.5%
March 2022	95,945	88,868	92.6%	3,936	2,955	75.1%
April 2022	96,625	89,440	92.6%	3,922	2,986	76.1%
May 2022	96,692	89,749	92.8%	3,912	2,960	75.7%
June 2022	96,370	89,656	93.0%	3,889	2,934	75.4%

131. As the table above shows, total general and acute bed occupancy fell from circa 95% to circa 50-60% in the first wave, and 80-90% in the second wave (although the impact of infection prevention and control measures meant higher pressures at lower levels of bed occupancy). Critical care bed occupancy was at 70.7% in March 2020, falling to a low of 50% in May 2020 due to the additional capacity that was created. Critical care bed numbers returned to circa 4,000 from April 2021.

Critical and acute inpatient bed capacity data: an overview

132. Paragraphs 85 to 87, 90 to 92, and 189 of Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, provide context regarding the oversight and provision of data relevant to the COVID-19 response, including data on hospital bed capacity and occupancy. In broad terms the position was as follows:

133. *As at January 2020, the lead role for the oversight and provision of data relevant to the COVID-19 response sat with different partners in the health and social care system. PHE was responsible for providing data on disease surveillance (including confirmed domestic and international cases) and data on the early stages of the testing programme (number of tests carried out and number of positive and negative test results). At later points, NHSEI provided operational data on bed occupancy/availability, the number of ventilated beds available/occupied, hospital capacity, staffing numbers and deaths.*

134. *In these early stages, data quality and returns provided to the Department by NHSEI were challenging and difficult to use, particularly due to low or non-availability of testing data (for example, in respect of regional and national hospital admission rates) which in turn meant that informed policy making was difficult for officials and ministers.*

135. *Following a series of informal updates to the Department's Ministers and Senior Officials from 9 January 2020, on 23 January 2020, Daily Situation Reports (SitReps)*

(MS2/88 - INQ000106052; MS2/89 - INQ000106112; MS2/90 - INQ000106209; MS2/91 - INQ000106309 ; MS2/92 - INQ000106352; MS2/93 - INQ000106432; MS2/94 - INQ000106512) *were produced for awareness and these continued until 29 June 2020 when they became weekly. As the pandemic evolved, the SitRep evolved accordingly. The Department sought further data on, for example, bed occupancy, cancelled operations, availability of ventilators and workforce absence rates.*

136. *From April 2020, the Department produced a daily SitRep* **(MS2/92 - INQ000106352; MS2/93 - INQ000106432; MS2/94 - INQ000106512)** *that brought together data on PPE, workforce pressures, bed availability/capacity, deaths and service notifications from CQC and COVID-19 outbreaks from PHE. This was developed over the course of the pandemic to both exploit new data sources and to monitor new priorities, for example, infection control data and information from NHS Test & Trace.* **(MS2/87 - INQ000409911)**

137. I am asked to particularise incidents in which there were substantial issues regarding bed capacity regionally and/or nationally and how the Department responded to any such issues. The Department was kept aware of bed capacity throughout the pandemic via established lines of communication with NHSE as explained in paragraphs 129 – 132 of this statement. One example of this is that the Department has a record of media reporting regarding an issue with bed capacity early in the pandemic at Northwick Park Hospital **(MS2/95 - INQ000468605; MS2/96 - INQ000468604)**. Incidents relating to local bed capacity pressures were effectively managed and resolved over the course of the period through the actions of the NHS and did not require action by the Department.

138. I am asked whether and how the pandemic affected the flow of patients through hospital and/or the ability to discharge patients from hospital. I am also asked for detail of any steps taken by the Department to address this and when.

139. Throughout the relevant period, discharge remained the operational responsibility of NHSE. NHSE are therefore best placed to address these questions at an operational level including whether/how the pandemic affected the flow of patients through hospitals. However, in accordance with its responsibility to support healthcare services, the Department took the following proactive steps in March 2020 to aid the flow of patients through hospitals and expedite safe discharge. These steps were intended to enhance existing discharge policy, should the pandemic affect the flow of patients through hospital, in order to in turn increase hospital capacity. These steps were:

a. Coronavirus Act (CVA) provisions: the CVA included provisions allowing for the appropriate discharge of patients through the relaxation of requirements on NHS Trusts to carry out continuing healthcare assessments ahead of discharge.
b. Discharge guidance: The Hospital Discharge Service Requirements were published on 19 March 2020, by the Department and NHSE **(MS2/97 - INQ000049702)**. The policy objective of the guidance was to prevent critical care services becoming overwhelmed and to create hospital capacity, by enhancing existing discharge requirements. The guidance sought to ensure the timely discharge of those considered to be fit for discharge, based on the clinical assessment of clinicians, in line with existing good practice on discharge. Implementing the service requirements was expected to free up 15,000 beds by 27 March 2020. At a meeting with the Prime Minister on 29 March 2020, NHSE confirmed that 32,904 beds had been made available for COVID-19 patients.
c. Discharge funding: As explained in Jonathan Marron and Michelle Dyson's supplementary statement to the Inquiry, dated 12 October 2023, *between April 2020 and March 2022, over £3 billion was made available via the NHS to fund national implementation of the Discharge to Assess (D2A) model through a standalone discharge fund known as the Hospital Discharge Programme (HDP). The funding was critical, especially in the early days of the pandemic, in*

enabling hospitals to free up beds for COVID-19 patients **(MS2/98 - INQ000114319)**.

Guidance on admissions, movement, discharge, and testing before discharge

General involvement in guidance on admissions, movement and discharge

140. I am asked for details of guidance given during the relevant period by the Department on the approach that general practitioners and ambulance services should take regarding whether to admit patients to hospital. I am also asked, if such guidance was issued, for details of the contents of that guidance and how it differed from any guidance in place prior to the relevant period.

141. During the relevant period, in line with its responsibility for arranging the provision of services for the purposes of the health service in England, NHSE issued operational guidance on COVID-19. This included Standard Operating Procedures **(MS2/99 - INQ000410597 MS2/100 - INQ000000024)** for general practice in the context of COVID-19 and guidance for ambulance services.

Guidance for hospitals on movement or discharge of non-COVID-19 patients

142. I am asked for details of any guidance given during the relevant period by the Department on the approach NHS Trusts should take to discharging patients from hospital. In particular I am asked about the criteria for assessing whether a patient was medically fit to be discharged, and whether these criteria differed from that in place prior to 1 March 2020. As explained above, the CVA included provisions to allow for the appropriate discharge of patients. Implementation of these in the form of criteria for discharge was the operational responsibility of NHSE. NHSE are therefore best placed to provide a detailed response on how criteria differed to that in place prior to 1 March 2020.

143. Throughout the relevant period, guidance on discharge was published by the Department, NHSE and UKHSA. The guidance documents listed below are only those published by the Department (either individually or with others). This included guidance for care homes, published by the Department to explain the measures introduced to support care homes and enable implementation of the hospital discharge guidance. The mandatory introduction of testing prior to admission to a care home is explained below, as this was contained within DHSC guidance. Guidance on testing people prior to discharge to their own home is not included as this was the operational responsibility of NHSE. Details of the designated settings scheme is also included, as a practical measure to facilitate the discharge of people with a positive COVID-19 status.

144. As explained above, the COVID-19 Hospital Discharge Guidance was published by the Department and NHSE on 19 March 2020. As explained in Jonathan Marron and Michelle Dyson's Supplementary Statement to the Inquiry dated 12 October 2023 *"the policy objective of the "COVID-19 Hospital Discharge Service Requirements" guidance was to prevent critical care services from being overwhelmed – and, therefore, catastrophic consequences for anyone needing those services, including older people and other vulnerable groups who were more likely to be hospitalised by COVID-19 - whilst ensuring the safe discharge of individuals during the pandemic. It sought to do so by ensuring the timely discharge of those considered to be fit for discharge, based on the clinical assessment of clinicians, in line with existing good practice on discharge."* **(MS2/101 - INQ000325245)**.

145. Guidance was published on 2 April 2020 by the Department, PHE, and NHSE on admission and care of residents in care homes during COVID-19. It provided guidance for care homes on how to safely accept patients discharged from hospital, including in respect of isolation **(MS2/102 - INQ000325255)**.

146. Guidance entitled Our Action Plan for Adult Social Care, published on 15 April 2020, provided a comprehensive summary of the action the Government was taking

to support social care. With relevance to the scope of this Module, *this guidance included a move to institute a policy of testing all residents prior to admission to care homes. This was to begin with all those being discharged from hospital.*

147. In light of the publication of this guidance, The Hospital Discharge Service Requirements were updated on 20 April 2020 **(MS2/103 - INQ000087450)**, indicating that the guidance was being reviewed following publication of the adult social care action plan.

148. Updated discharge guidance was published on 21 August 2020 on behalf of both NHSE and the Government **(MS2/104 - INQ000058130)**, in particular to reflect changes in funding arrangements.

149. As explained in the following extract from the Fifth Witness Statement of Chris Wormald to the Inquiry dated 25 August 2023 **(MS2/104A - INQ000253807)**, "*in September* 2020*, discussions began for a 'designation scheme' in conjunction with the Care Quality Commission (CQC) to identify and prepare premises, known as designated settings, which were safe for people leaving hospital who have tested positive for COVID-19 or are awaiting a test result. The Department's Adult Social Care Winter plan, published in September 2020, contained a commitment to deliver on the designation scheme, this was announced in letters to local adult social care systems in October and November 2020* **(MS2/105 - INQ000234612; MS2/106 - INQ000234564)**.

150. These *included the new requirement that "no one be discharged into or back into a registered care home setting with a COVID-19 test result outstanding". The first designated settings were opened from November 2020 and guidance was published on 16 December 2020* **(MS2/107 - INQ000234652)**. *The designated setting scheme remained in place for winter 2021/2022. T*o improve the discharge flow to home from acute settings, other schemes were in place. These included the use of hotel

accommodation and Independent Sector Providers (ISPs) and were managed directly by NHSE.

Use of independent sector hospitals

The use of independent sector hospitals before the pandemic

151. I am asked, in relation to the use of private hospitals to treat NHS patients in England during the relevant period, whether the private healthcare sector in England had provided services or facilities to the NHS in England prior to the pandemic.

152. ISPs have played a role under successive Governments in delivering NHS-funded care for patients, in addition to their work for privately funded patients (who are either self-funded or insurance funded). Historically, NHS commissioners have been able to put in place contracts with ISPs who hold an NHS provider license to deliver services for NHS patients. Such licenses are issued by NHSE. In addition, NHS Trusts have also been able to sub-contract services they have been commissioned to provide to ISPs. Such sub-contracts **(MS2/108 - INQ000391314; MS2/109 - INQ000391313; MS2/110 - INQ000391395; MS2/111 - INQ000391348; MS2/112 - INQ000391349; MS2/113 - INQ000391396)** include a range of conditions to ensure that the services provided are of an appropriate standard. These arrangements allow NHS commissioners and Trusts to secure the capacity needed at any given time to meet the health needs of their local population.

153. All healthcare providers carrying out regulated activities specified in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including in the independent sector, are required to register with the CQC and meet the fundamental standards, which are set out in the 2014 Regulations **(MS2/114 - INQ000287652)**.

154. During the decade from 2010-11 to 2020-21, commissioners' annual spending on healthcare from non-NHS providers (ISPs, charities and local authorities) did not significantly increase as a proportion of total health spending. It represented 9% of total health spending in 2010-11 (£8.4 billion) and 10% of total health spending in 2020-21 (£18.4 billion) **(MS2/115 - INQ000409852; MS2/1 - INQ000235008)**.

The use of independent sector hospitals during the pandemic: rationale, decision-making processes and national contracting arrangements

155. I am asked for a brief explanation of how and why the decision was made to use the private healthcare sector during the pandemic, and the extent of the involvement of the Department in the decision-making process and formulation of these arrangements. I am also asked whether it was intended that private hospitals would be utilised by the NHS in England for the care and treatment of patients with COVID-19, or for non-COVID-19 elective or emergency care.

156. At the start of the pandemic, the high numbers of patients requiring hospital treatment for COVID-19 placed exceptional demands on NHS hospital capacity. It was necessary to ensure that the NHS could secure the maximum hospital capacity possible for the duration of the pandemic to enable all patients requiring urgent and emergency treatment, whether for COVID-19 or other conditions, to access it.

157. The independent healthcare sector was identified as a key avenue for increasing hospital capacity. ISPs had hospital beds, many with piped oxygen and some with ventilators, alongside clinical staff and resources which could be accessed at very short notice.

158. I am asked about any contract or agreement(s) with the private healthcare sector to make additional capacity available to the NHS to assist in the response to COVID-19 in England during the relevant period. I am also asked about the funding arrangements for any contract or agreement referred to. I am further asked if the

private healthcare sector in England had provided services or facilities to the NHS in England prior to the pandemic, and the extent to which the arrangements for the provision of private healthcare services to the NHS during the relevant period differed to these previous arrangements.

159. In March 2020, NHSE secured national contracting arrangements with 26 ISPs to block book 100% of their capacity from specific listed facilities which could be used flexibly to meet local needs **(MS2/116 - INQ000270019)**. The predominant aim of the March 2020 contractual arrangements was to secure additional oxygenated and Intensive Therapy Unit (ITU) bed capacity for the NHS, but the independent provider facilities subject to the arrangements also included inpatient and diagnostic activity, urgent elective treatment, and cancer treatment. The contracts provided for reimbursement of the ISPs on an at-cost basis, with open book accounting and independent auditing. This ensured that the ISPs were only paid for costs incurred.

160. NHSE negotiated these contracts through the Independent Healthcare Providers Network (IHPN), the representative trade body for the independent healthcare sector. The Department was not directly involved. Rather, the Department's role was principally to:

a. implement a Direction giving NHSE the power to commission services normally commissioned by Clinical Commissioning Groups (CCGs) **(MS2/117 - INQ000409855)**;
b. in coordination with what was the Department for Business, Energy and Industrial Strategy (BEIS), implement an Exclusion Order to disapply certain aspects of competition law from these arrangements, since it was necessary for ISPs to coordinate with one another in a way which would have otherwise been unlawful (the Exclusion Order did not, though, permit the sharing of information on costs or pricing between the ISPs) **(MS2/118 - INQ000409856)**; and

c. lead discussions with HMT to secure additional funding for national contracting arrangements where necessary.

161. The national contractual arrangements took effect on 23 March 2020 and provided the NHS with access to 8,000 beds (including 6,000 with piped oxygen), over 16,000 clinical staff, and more than 1,000 ventilators, to aid it in continuing to provide urgent treatment for patients with COVID-19 and other conditions.

162. No specific national targets were set for the number and type of treatments to be undertaken in independent hospitals. Rather, the working arrangements between the NHS and the ISPs in question was organised on a local level in accordance with local need. Many areas used independent sites as designated non-COVID-19 sites for the continued treatment of patients with other conditions, in order to limit their infection risk. To this end, a number of NHS bodies relocated services such as chemotherapy, cystic fibrosis treatment and some urgent surgery services into independent provider facilities. In some areas, equipment and/or staff were transferred from independent sector sites to NHS sites in order to increase NHS capacity.

Adjustments to national contracts made over the course of 2020

163. Initially, to ensure that the most pressing needs of NHS patients were met, the ISPs subject to the contractual arrangements had not been permitted to provide non-urgent elective care for NHS or private patients. In May 2020, a de-escalation notice was triggered by NHSE which allowed the ISPs and local NHS bodies to discuss and negotiate the hospital capacity which could henceforth be used for non-urgent elective procedures for NHS patients, and also for privately funded treatment. Under this arrangement, the NHS did not pay for the proportion of the ISPs' capacity being used for private patients.

164. In August 2020, the contractual arrangements were adjusted by agreement between NHSE and the relevant ISPs so that the NHS contracted for 75% (as opposed

to 100%) of their capacity, with the remaining capacity left available for privately funded care. This evidently reduced the cost of the arrangements to the NHS. The adjusted arrangements included a trigger clause, however, which could be invoked with 7 days' notice to enable the NHS to access 100% of the ISPs' capacity again on a "surge basis", in the event of an increased level of demand. This clause could be triggered on a local, regional or national basis as necessary.

165. The total number of ISPs included in the contracting arrangements decreased during 2020 (initially 26, as explained above to 14) to ensure that the agreements did not exceed the needs of the NHS and continued to represent value for money.

The fourth quarter of the financial year 2020-21

166. The national contracting period with ISPs was due to come to an end on 31 December 2020, with a move back to business-as-usual commissioning of NHS services from these providers. However, in November 2020, NHSE reported the outcomes of a stocktake they had performed to determine the extent to which healthcare systems were ready for this change. They identified considerable risks in moving away from the national contracting arrangements, particularly in light of the potential for a wave of COVID-19 infections in December 2020 / January 2021. The identified risks included an abrupt end to the NHS being able to use ISPs' capacity (particularly if suddenly needed on a surge basis), and the destabilisation of established pathways for non-COVID-19 patients as a result of having to repatriate NHS services which had hitherto been hosted in independent sites. In light of such risks, NHSE sought and obtained agreement to extend the national commissioning approach to the end of March 2021.

167. NHSE prepared new contracts to cover the fourth quarter of the financial year 2020-21 (Q4 2020-21) with the 14 ISPs still involved in the national arrangements at this time. Whilst the original contracts provided for ISP capacity to be paid for "at-cost" on an audited cost-recovery mechanism, the new contracts were volume based,

meaning they were based on the volume of activity delivered locally. Payment would be based on a guaranteed value in January and a guaranteed volume of activity in March (determined through local activity planning), with a glide path between the two in February. This allowed for improved value for money, given that payments under the new contracts related to the delivery of locally agreed volumes of activity rather than simply covering all incurred costs.

168. The new contracts permitted the NHS to access "surge" capacity through ISPs where NHS facilities were required to deal with COVID-19 related suspension of elective services, subject to authorisation by the central NHSE team. This provided additional security in the event that the number of patients requiring hospitalisation for COVID-19 should rise. During this quarter, 70 independent sector sites activated surge capacity.

Return to Business-as-Usual arrangements: April to December 2021

169. Paragraphs 185 to 192 of Sir Christopher Wormald's Eighth Witness Statement to the Inquiry, dated 30 August 2023, explain the arrangements between the NHS and ISPs from April to December 2021. In summary, the position was as follows:

170. *Arrangements with independent sector providers returned to the pre-pandemic business as usual arrangements from 1 April 2021, this reflected the reduced rates of COVID-19 at the time. Also, it was in line with Treasury conditions for the additional spend provided for national contracting arrangements in the financial year 2020/21 which came to an end on 31 March 2021.*

171. *Throughout the period of the return to "business as usual arrangements" (1 April 2021 to 6 January 2022), NHSE sought to ensure independent sector capacity was effectively utilised by NHS bodies in order to reduce backlogs for elective treatments which were exacerbated by the pandemic. A target of 120% of baseline, pre-pandemic*

activity for the NHS from independent providers was put in place, with a national NHS team to aid in coordination and resolving issues.

172. *The Independent Healthcare Provider Network (IPHN) is the membership network for independent healthcare providers across the UK. On 7 December 2021, the Secretary of State met with IHPN Chair, Lord Patel, and IHPN CEO, David Hare, to discuss the continuing partnership between the independent sector and NHS. During this meeting, the Secretary of State noted the potential challenges ahead presented by the Omicron variant and the importance of contingency planning between the NHS and independent sector providers. The Secretary of State asked IHPN to start discussions with their members on how they could best support the NHS through the impact of this new variant.*

173. *On 20 December 2021, as the potential impact of the Omicron variant became clearer, the Secretary of State asked officials for advice on what steps would be required to enable a return to national contracting with independent sector providers, to again provide maximum NHS capacity in the event of high levels of COVID-19-related hospitalisations.*

174. *On this basis, a statutory direction was prepared giving NHSE legal powers for responding to an emergency. In this case, the direction gave NHSE the power to commission services from independent sector providers, which were normally commissioned by Clinical Commissioning Groups (CCGs) (as the local commissioning arrangements at the time), for the purpose of responding to the emergency presented by the Omicron variant. This direction was prepared by officials and lawyers and signed by William Vineall, the Director of NHS Quality, Safety and Investigations, on behalf of the Secretary of State.*

175. *An agreement was reached with BEIS officials and the Secretary of State to implement an Exclusion Order (a statutory instrument used to allow an exemption from Competition Law for an exceptional and compelling reason of public policy) to facilitate*

coordination between independent sector providers. The Exclusion Order excluded activity under the national contracting arrangements from the scope of competition law in the following ways:

a. *Sharing information about capacity to provide certain services;*
b. *Co-ordination on deployment of staff;*
c. *Sharing or loan of facilities;*
d. *Joint purchasing of goods, facilities or services; and*
e. *Division of activities, including agreement to limit or expand the scale or range of services supplied by one or more providers.*

176. *The Direction referred to above was made on 23 December 2021, and IHPN were informed of the intention of the Secretary of State for BEIS to make the exclusion order in the new year, with effect from 7 December 2021 to 31 March 2022.*

177. *With these measures in place, NHSE was able to make arrangements with independent sector providers. Draft Heads of Terms were sent out and agreed in principle with a range of independent sector providers on 24 December 2021. These terms were based on the Q4 2020-21 contracting arrangements, providing for a minimum income guarantee and the option to activate surge capacity, taking over 100% of independent sector facilities in systems where surge is activated. Given the providers involved, an estimate of up to 3,000 fully staffed beds could be accessed by the NHS through these arrangements."*

178. NHSE data **(MS2/119 - INQ000409908)** suggests that the target of 120% of baseline, pre-pandemic activity for the NHS from ISPs was met.

179. Beyond the business-as-usual arrangements in place during this period, NHSE also put in place a framework to give commissioners and NHS Trusts and Foundation Trusts an easily accessible list of pre-approved providers of a wide range of clinical services including elective treatments. This was the Increasing Capacity Framework, which was operational from 26 November 2021 **(MS2/120 - INQ000409875)**. This

framework sought to streamline procurement processes for contracting between NHS bodies and participating ISPs. Around 90 ISPs were signed up to the framework.

180. From April to December 2021, Hospital Episode Statistics data shows that almost 3.4 million episodes of care (meaning individual contacts with a patient such as an outpatient appointment or a surgery, rather than the entire patient pathway) were delivered for NHS patients by ISPs.

January to March 2022

181. Paragraphs 193 to 198 of Sir Christopher Wormald's Eighth Witness Statement to the Inquiry, dated 30 August 2023, explain the arrangements between the NHS and ISPs from January to March 2022. In summary, these were as follows:

182. *On 7 January 2022, Amanda Pritchard, the NHS England Chief Executive, wrote in her capacity as the NHSE Accounting Officer to the Secretary of State seeking a ministerial direction to proceed with the national contracts with independent sector providers, on the basis of value for money concerns. Ministerial directions are formal instructions from Ministers requiring their department to proceed with a proposal, despite concerns from their Accounting Officer. A written direction is required from a Secretary of State, when a decision for spending does not meet all four tests of regularity, propriety, value for money and feasibility.*

183. *The request noted that the national contracting arrangements had been explored because of the request by the Secretary of State for NHSE to maximise the NHS use of the independent sector. The request from the NHS England Chief Executive identified value for money risks in the proposed contract and highlighted the proposed mitigations NHSE had put in place. The letter also noted that NHSE believed the terms reached were the most favourable which were possible given the time available for the negotiations to take place considering the need to act quickly against the Omicron variant. However, due to the value for money risks, Amanda Pritchard, in*

her position as Accounting Officer, sought a written ministerial direction for this spending. The Second Permanent Secretary consulted the Principal Accounting Officer and they concurred with her assessment. On 8 January 2022, a submission was sent to Ministers by Department officials recommending agreement to the ministerial direction sought by NHS England and this was agreed by Ministers the same day.

184. *On 8 January 2022, the Secretary of State responded, directing NHSE to proceed with the contracts on the basis that the risks of the reasonable worst case scenario of Omicron infections overwhelming NHS capacity outweighed the potential costs of the arrangements.*

185. *The national contracts came into effect and were announced on 10 January 2022. 10 independent providers were signed up to these arrangements.*

186. *The Exclusion Order agreed with BEIS was made on 10 February 2022 and came into force on 9 March 2022, with retrospective application to 7 December 2021 to cover the time from which the Secretary of State asked IHPN to start discussions on supporting the NHS through Omicron.*

187. *During the January 2022 to March 2022 period, the surge element of the arrangements was not triggered in any system across England. Independent sector providers covered by these arrangements continued to deliver NHS activity at above baseline levels, and above the minimum income guarantee set out within the arrangement. This contributed towards efforts to reduce elective backlogs.*

Return to Business-as-Usual arrangements: April 2022

188. The national arrangements with ISPs, and all measures facilitating them, came to an end on 1 April 2022, when business-as-usual arrangements were restored.

Contracting with ISPs returned to local arrangements, as described for the April to December 2021 period above.

189. NHSE increased their target of independent sector activity for the NHS to 130% of pre-pandemic levels, as part of the plan to tackle the elective treatment backlog. According to the latest data from NHSE this target has been reached.

Awareness of data on the use of independent sector hospitals

190. In 2019/2020 the Department recorded expenditure of £9,692 million **(MS2/1 - INQ000235008)** in relation to ISPs. This rose to £12.139 million in 2020/2021, before falling in the following year to £10,854 million (2021/2022) **(MS2/82 - INQ000257323)**. The overall proportion of NHSE's spend on ISPs has not increased significantly over recent years. In 2013-14, 6.1% of total health spending was spent on purchase of healthcare from ISPs (£6.9 billion). In 2021-22, this was 5.9% (£10.9 billion).

191. I am asked about the number of private hospitals involved in the provision of healthcare for NHS patients in England during the relevant period, and how many beds, including ICU beds, were made available. I am also asked whether patients were treated for COVID-19 in private hospitals in England and if so, the numbers treated, and if not, the reason. Furthermore, I am asked about the number and type of treatments undertaken in private hospitals in England on behalf of the NHS.

192. The Department does not hold central data on the number of independent sector hospitals involved in providing NHS care, or the number of independent sector beds used for NHS care. Nor does it hold data on the number of patients treated for COVID-19, or the number and type of treatments, including outpatient appointments and procedures, undertaken in independent sector hospitals during the relevant period. NHSE holds the operational detail in this regard.

The impact of the use of independent sector hospitals on the capacity of healthcare systems

193. The extent to which ISPs contributed successfully to supporting the NHS varied on a local level according to how effectively NHS bodies and the ISPs in question could coordinate. There are examples of localities where independent sites enabled NHS services to continue and patients to be treated when this would not otherwise have been the case **(MS2/121 - INQ000216434; MS2/122 - INQ000399132)**. The transfer of staff and resources to NHS hospitals to increase critical care capacity (for example, the 1,000 or so ventilators the NHS gained access to) helped with treating more COVID-19 patients. Similarly, the relocation to independent sites of important services (especially for immunocompromised patients such as those with cancer and cystic fibrosis whose treatment needed to continue) enabled these vital services to be provided and reduced the infection risk for vulnerable individuals.

194. The Department does, however, recognise that not every locality maximised the effective use of independent sector capacity. In April 2021, NHSE produced a 'Covid-19 Response Lessons Learnt Paper' **(MS2/123 - INQ000412033)** which reflected on six key learning themes and provided recommendations to support future ISP involvement in elective recovery. Since then, NHSE has continued to support NHS bodies in working effectively with their ISP counterparts as the NHS seeks to tackle elective treatment backlogs.

The overall cost of the national contracting arrangements and value for money considerations

195. The cost of the arrangements with ISPs has been approximately £2.1 billion for the 2020-21 contracts, and approximately £270 million for the 2022 contracts. Given the emergency nature of the situation, the limited alternative options, and the potential grave impact that inaction could have had (the NHS being unable to offer healthcare to individuals requiring urgent treatment, leading to many preventable deaths), the

Department considers that the relevant costs were appropriately incurred. ISPs had facilities, resources and staff which could be utilised much more quickly than any alternative option. Looking to this sector as a source of assistance for the NHS was appropriate and provided a level of immediate support which otherwise would have been challenging to deliver.

196. NHSE negotiated arrangements to provide the best value for money in each phase, including reducing contracted capacity as the situation evolved, and moving towards activity-based models when block-booking was no longer the optimal approach.

Use of Nightingale Hospitals

The creation of Nightingale hospitals: rationale and decision-making

197. I am asked for a brief explanation of the rationale for the creation of Nightingale Hospitals. I am also asked for details of when the decision to set up the Nightingale Hospitals was taken and by whom, and any relationship between that decision and bed, care or ventilator capacity in hospitals.

198. The creation of Nightingale hospitals was proposed by NHSE during the first wave of the pandemic. Paragraphs 162 to 163 of Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, set out the rationale for their establishment, which may be summarised as follows:

199. *The Department worked with the NHS to provide legal oversight for the establishment of the Nightingale hospitals and then to ensure sufficient resourcing during the pandemic. The first NHS Nightingale hospital opened at the ExCel Centre in East London on 3 April 2020* **(MS2/124 - INQ000106324)**. *The Nightingale hospitals were established in the early days of the pandemic and the facilities provided resilience during uncertain times by ensuring that the NHS had capacity to support*

patients across England if needed and saw the use of both NHS staff and members of the armed forces to help staff them.

200. *The Nightingale hospitals were specifically designed to provide extra national surge capacity to help ensure that all those who needed care were able to access it. At the beginning of the pandemic, the NHS's focus was on ensuring that extra support was available for critical care or ventilated care. The Nightingale hospitals were therefore set up to provide overflow support for the most critical patients requiring ventilated care, rather than being designed to provide routine NHS care. Given the number of people in hospital with COVID-19 during the various waves, it would not have been practical, in terms of number of patients, to place all COVID-19 patients in a Nightingale hospital, nor would it have been clinically appropriate or desirable.*

201. NHSE was operationally responsible for the creation and running of the Nightingale hospitals and was given support by the Department, the MoD, ProCure22 (a Construction Procurement Framework administrated by NHSE for the development and delivery of NHS and social care capital schemes in England), and other partners **(MS2/125 - INQ000109220)**. The Department worked with the NHS to provide legal oversight for the establishment of the Nightingale hospitals and to ensure they were sufficiently resourced during the pandemic. The Department's role included, in particular, issuing a Direction **(MS2/126 - INQ000391316)** to NHSE to enable it to perform certain functions necessary in order to set up and run the Nightingales. The Direction permitted NHSE to exercise:

a. various functions of CCGs (to commission health services from NHS Trusts and Foundation Trusts for the purposes related to COVID-19):
b. various functions of NHS Trusts and Foundation Trusts (to, where appropriate in connection with the Trusts' COVID-19 response, acquire and dispose of property, enter into contracts, accept gifts of property, and employ staff);
c. various functions of the Secretary of State (to take ancillary action to assist NHS Trusts and Foundation Trusts in their COVID-19 response, such as

providing goods, materials or other facilities, facilitating the recruitment and management of staff, and developing or operating information or communication systems).

202. The Department also supported requests made by NHSE to the MoD for military aid for the construction of the Nightingales.

203. I am asked how the number and location of Nightingale Hospitals was decided upon, and the rationale for this.

204. According to a planning document produced by NHSE dated 28 March 2020 **(MS2/125 - INQ000109220)**, the criteria for selecting locations included regional population size, travel isochrones for intubated patient transfer, and the reasonable concentration of nearby NHS hospitals from which to redeploy clinical staff. There were associated logistical requirements which affected the choice of sites and the speed at which they could be operationalised, including appropriate venting, the ability to access oxygen supplies, bed space, staff accommodation, clean / dirty segregation, vehicular access for high numbers of patient unloading per hour, and the ability to develop temporary mortuary facilities.

205. In light of these requirements, the planned phasing was as follows:

- Tranche 1: Excel, London
- Tranche 2: Manchester Central and Birmingham NEC
- Tranche 3: Bristol (University of West England) and Harrogate Convention Centre
- Tranche 4: Sunderland, Exeter, Nottingham, and Farnborough International Exhibition & Conference Centre

206. In the event, seven Nightingale hospitals were set up (in London, Birmingham, Manchester, Bristol, Harrogate, Sunderland, and Exeter). A briefing document was provided to the Secretary of State on 12 April 2020 **(MS2/127 - INQ000391322)**, which

explained that these seven hospitals would open in a staged way over the following few weeks, initially providing an extra capacity of 3,000 beds, with up to 10,000 extra beds in total if required.

Recruitment of staff

207. I am asked how staff were recruited, deployed or redeployed to work in Nightingale Hospitals, the specialisms of staff working there and any challenges in recruiting appropriate staff.

208. The Department was not involved in operational decisions around staffing in the Nightingale hospitals. As explained below, the deployment and management of staff within the NHS is the responsibility of the NHS working with Health Education England (HEE) and the University sector in relation to student deployment.

209. The Department supported NHSE by seeking additional assistance through the MoD with regards to constructing and resourcing the Nightingale hospitals. As explained in Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, if there *is an emergency in the UK, local emergency services provide the first response; however, Government Departments or civil authorities may then request military assistance from the MOD through MACA procedures. MACA provides deployment of clinically trained staff or other military capabilities such as logistics, security and construction. Requests can be made when there are issues with human resource in the health and social care sectors due to very high levels of staff absences or a sudden and unexpected increase in demand. Once requests are granted by the MOD, military staff will be made available as required. Examples of how MACA was used over the period of this statement include: the construction and resourcing Nightingale hospitals, supporting UK testing capacity and logistics management and the distribution of PPE* **(MS2/128 - INQ000139113)**.

Treatment of patients

210. I am asked for details of the different types of treatments available at the Nightingale Hospitals. I am also asked for an explanation of whether the Nightingale Hospitals had the capacity or capability to provide care for patients with COVID-19 or other conditions. I am also asked for the number of patients admitted to and treated by the Nightingale Hospitals during the relevant period and an explanation of how the types of patients admitted to Nightingale Hospitals differed from patients in non-Nightingale hospitals.

211. Between 19 March 2020 and 6 April 2021, 381 people were admitted to a Nightingale hospital with COVID-19. Detailed questions concerning the type and number of patients admitted and treated by the Nightingale hospitals and the type of treatments available are best directed to NHSE, which had operational responsibility for these matters. That said, not only did the need to admit patients to Nightingale hospitals turn out to be lower than expected, in part as a result of the effectiveness of other measures including non-pharmaceutical interventions, evolutions in clinical practice in respect of COVID-19 also reduced the need to rely on Nightingale capacity. I quote from Chapter 10 of the Technical Report on the COVID-19 Pandemic in the UK: "*By the end of the first wave, the management of hospitalised patients had evolved significantly. Seriously unwell patients were often trialled on non-invasive rather than invasive ventilation…*". As set out above, the Nightingale hospitals were consistent with the clinical model prevalent at the time of their commissioning, largely designed and equipped to provide additional capacity for invasive ventilation.

Admissions process

212. I am asked how patients were admitted to Nightingale Hospitals, including how patients were transported from other mainstream healthcare settings.

213. NHSE led the arrangements for admitting patients to the Nightingale hospitals, including the transportation of patients from other healthcare settings. The Nightingales served as an escalation measure, so their use constituted an operational decision that varied from area to area according to local demand and local clinical decisions.

Changing use and decisions on closure

214. I am asked for an explanation of any challenges faced in making effective use of the Nightingale Hospitals. I am also asked for details of any decisions to close or cease using the Nightingale Hospitals.

215. Paragraphs 310 to 319 of Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 23 August 2023, explain the evolving use of the Nightingale hospitals and the decisions taken to close them. The position in summary is as follows:

216. *From an NHS capacity perspective, the surge on bed occupancy during the first wave of COVID-19 was unlike the usual pressures on the NHS during winter. During a usual winter, general and acute (G&A) bed occupancy increases, which impacts on 'patient flow' through hospital and leads to patients queuing in emergency departments and ambulances queuing outside to hand over patients. From 2 November 2020 to 31 January 2021, during the second wave of COVID-19, the average G&A bed occupancy in all Acute Trusts in England was 87% and pressure was also felt in the intensive care units within hospitals* **(MS2/129 - INQ000257496; MS2/130 - INQ000257497; MS2/131 - INQ000257498)**. *Critical care beds expanded from usual levels of 4,000 beds to over 6,000 beds reported as available, and the success of our interventions meant that none of the Nightingales were required to function to their initial planned capacity. However, retention of the Nightingale sites was one of the measures expected to support capacity planning for the winter period – a period where the NHS usually experiences greater pressure.*

217. *In July 2020, the PM announced an additional £3 billion of funding to the NHS in England to get ready for winter* **(MS2/132 - INQ000234406)**. *The funding was intended to allow the NHS to continue to use the extra hospital capacity acquired from the independent sector and also to maintain the Nightingale hospitals until the end of March 2021.*

218. *Planning assumptions based on SAGE-endorsed SPI-M-O reasonable worse case scenarios were that over winter, at peak up to 5,000 ICU (critical care) beds would be required with a total of 21,500 beds for COVID-19 patients- compared to 19,000 during the first peak in April. The modelling also suggested that a second wave could require up to a total of 323,000 hospitalised patients – higher than the first wave and would require a significant amount of NHS capacity* **(MS2/133 - INQ000234114)**.

219. *The additional capacity was planned to be met through mitigations announced as part of the £3 billion winter support package including £516 million to maintain 7 Nightingale hospitals for surge capacity and £1.87 billion to continue independent sector capacity, along with a range of other measures.*

220. *In October 2020 NHSE wrote to HMT outlining its proposed process for activating the Nightingales* **(MS2/134 - INQ000235004)**.

221. *On 21 October 2020, a submission was made to the Minister for Health for information outlining HMG support for the activation of Nightingale sites in response to increased demands on existing NHS capacity driven by COVID-19. A national activation point would be when the COVID-19 prevalence rates suggested nearing full capacity in three weeks and no mutual aid was available. At that point, NHSEI was anticipating that sites in Manchester, Harrogate and Sunderland would need to be reactivated. Discussions were taking place with HMT to confirm the exact process for authorisation as HMT had previously stated that approval would need to be granted on a case-by-case basis* **(MS2/135 - INQ000234576)**.

222. *On 5 January 2021, the PM met with the Secretary of State and Sir Simon Stevens, the Chief Executive of NHSEI, to discuss NHS capacity. One of the potential interventions discussed was accelerated discharge into social care and intermediate step-down facilities including Nightingale hospitals. The Secretary of State emphasised that he had asked NHS colleagues to look at what more could be done to use Nightingale hospital capacity as step-down both in London and elsewhere.*

223. *Demand peaked in late January 2021, cases of COVID-19 in England steadily declined, with pressures on bed occupancy and critical care reducing accordingly. In early March 2021, it was announced publicly that the Nightingale hospitals would start to close from April 2021. Throughout April 2021 ministers worked closely with NHSEI to confirm decommissioning plans.*

224. *In April 2021, the NHS transferred the patient care provided in Nightingale hospitals back to local NHS services.*

225. *On 30 December 2021, NHSEI announced it was setting up Nightingale surge hubs at hospitals across the country* **(MS2/136 - INQ000087576)**. *The first eight of the surge hubs were planned at the following hospitals:*

a. *North West – Royal Preston;*
b. *North East and Yorkshire – Leeds, St James' site;*
c. *Midlands – Solihull Hospital and Leicester General Hospital;*
d. *East of England – Lister Hospital, Stevenage;*
e. *London – St George's;*
f. *South East – William Harvey Hospital, Ashford; and*
g. *South West – North Bristol.*

Costs and funding arrangements

226. I am asked about the total costs to the Department and/or NHSE in setting up, operating and decommissioning Nightingale Hospitals.

227. The funding and budget arrangements for all seven Nightingale hospital sites in Manchester, Harrogate, Sunderland, the Midlands, Exeter, Bristol and London were considered together as one programme and spending approval process.

228. The set-up of the first Nightingale site in London, and some initial works on other sites, were undertaken under a MACA arrangement with the MoD. On 15 July 2020, as part of a wider NHS capacity package, HMT provided retrospective approval for spending incurred so far and all costs for rest of the year **(MS2/137 - INQ000233886)**. At that point, estimates were that costs could reach up to c. £516 million, although final budget and outturn would be lower. This provided spending approval and, in doing so, ensured that NHS use of the Nightingales was not delayed.

229. Each Nightingale site was attached to a lead NHS Trust and those Trusts would pay for all costs incurred using income received via payments from commissioners received in advance each month, under new temporary block contract arrangements. Commissioners would be fully reimbursed for the costs they would incur under these arrangements via uplifts to their allocations, funded from NHS budget increases finalised later in the year.

230. The July 2020 approval allowed for all sites to be kept in a mothballed state until such time that the additional capacity was required. Opening of some sites was approved straight away and using regular updates from NHSE, the Department would keep usage and expected running costs under constant review and would brief HMT officials on the latest position on a weekly basis. If, at any point, NHSE evidence suggested that extra capacity was needed, Department officials would work with HMT

officials to build a case to reopen a specific site for a specific amount of time, which would then be referred to the Chief Secretary to the Treasury (CST) for approval.

231. This approach of weekly review and ongoing requests for HMT approval continued until the end of the financial year, though the final budget was properly ratified via the 2020-21 Supplementary Estimates. A final budget of £466 million was agreed with HMT and as with many other COVID-19 programmes, this was separately ring-fenced to fund spending only on the Nightingales. This is confirmed in 2020-21 Revised Financial Directions to NHSE **(MS2/138 - INQ000399107)**.

232. Against that budget, the NHS spent c. £362 million on all set-up, fit-out, leasing, staffing and other running costs, including costs incurred when kept in a mothballed state (e.g. leasing, facilities management, etc), plus the costs of decommissioning all sites. Spending was under budget as usage of all sites was below expectations at the point at which the budget was finalised in the Supplementary Estimates.

233. It was a condition of HMT's approval of the final funding request that all seven temporary Nightingale Hospitals were decommissioned by 31 March 2021.

Medical Equipment

234. Details regarding the availability of medical equipment, and action taken in respect of increasing the availability of ventilators and other equipment required for the care of patients with COVID-19, has been covered in the second witness statement of this Module, dated 3 November 2023.

Section 4 The NHS's workforce capacity

NHS staffing at the start of the pandemic

235. The Department's primary workforce objective throughout the pandemic was to ensure, working with national partners, that as many suitably qualified and experienced people as possible were enabled to make their best possible contribution to caring for patients and assisting their colleagues, and to support them in their efforts to do so.

236. The role of the Department was to:

a. work with stakeholders, other government bodies and the Devolved Governments to put in place policies on pay, pensions, education and training, and student loans which would help increase the availability of clinical staff;

b. support the Nursing and Midwifery Council, General Medical Council and other regulators to put in place emergency changes to their rules to enable deployment of additional staff;

c. agree emergency changes to relevant rules, regulations and legislation to support this work; and

d. work with NHSE to address workforce issues, such as supporting staff health and wellbeing, which would support the highest possible appropriate participation of the workforce in providing care to patients for both COVID-19 and essential healthcare services.

237. While the Department led the NHS workforce actions that needed to be taken by central Government to deliver additional capacity, the deployment and management of staff, and deployment of students to services within NHS Trusts, was the operational responsibility of NHSE (working with HEE and the university sector in relation to student deployment).

238. NHSE (and previously NHS Digital) publishes monthly figures for staff in post in the Hospital and Community Health Sector[1], which includes NHS Trusts, but excludes staff in General Practice (GP) settings. These statistics show the number of staff in NHS Trusts had been growing up to 2020 and continued to grow through the pandemic.

239. I am asked whether the availability of healthcare staff in the NHS in England was reduced during the pandemic. I am asked which roles (such as nurses, doctors, paramedics, clinical support staff, laboratory staff, estates, management and other staff types) had the greatest reductions in staffing levels; what the Department considers to be the reason(s) for reduced staff availability; and whether the Department considers that any reductions had an impact on the quality of care given and/or capacity of the NHS and, if so, what that impact was. I am also asked whether any areas of the NHS in England, whether by geographical location, specialism or otherwise, that experienced any significantly greater reduction in the availability of healthcare staff than comparable areas, and the reason(s), if known, for this greater reduction in staff availability.

240. The main impact on the availability of staff in the NHS in England during the pandemic was increased absence: predominantly sickness absence, although the Department does not hold data where sickness can be reliably separated out from other COVID-19 related absence such as shielding.

241. Over the pandemic, sickness absence in the NHS largely followed the same pattern as sickness absence through the community more widely. (The exception to this was April and May 2020 where the service saw high levels of absence in the NHS which did not appear to reflect wider infection rates). All regions saw similar increases in staff absence. There were some minor differences in timing between regions,

[1] NHS workforce statistics - NHS Digital

reflecting the timings of the waves of the pandemic in different parts of the country. There were no significant differences in the impact on different staff groups.

242. All the data relies on staff in NHS Trusts accurately reporting and recording sickness absence. It is possible that the demands of the pandemic at times had an impact on the quality of data submitted. The statistics do not capture the variation in experience within NHS Trusts. They do not, for example, capture absence in particular wards, or between different medical specialities.

243. Operational decisions on redeployment of staff to cope with absence and increased demand due to COVID-19 were made locally by NHS Trusts based on knowledge of staff skills and the operational demands on the workforce. Given the local nature of these decisions and the speed at which they needed to be made, it is not possible to centrally identify the impact of absence on the capacity of the NHS from other factors such as increased demand, or increased infection control.

244. Historically, there has been long standing variation in levels of reported sickness absence between staff groups and regions. Pre-pandemic sickness absence has been higher in the North East, Yorkshire and the North West and lower in London and the South East. Recorded sickness absence also varies by staff group, with doctors recording lower levels of sickness absences and nurses, ambulance staff and support to clinical staff recording above NHS average sickness absences. Some of this variation may relate to reporting differences by staff group. These differences continued through the pandemic **(MS2/139 - INQ000409907)**.

245. As part of the COVID-19 response, NHS Trusts cancelled some activity and redeployed staff. They redeployed staff based on local knowledge of staff skills, staff availability, their own caseload and expected COVID-19 cases. Staff sickness absence will have had an impact on capacity and volume of treatments, but it is not possible to identify the specific impact of sickness absence. Separately, decisions on wider prioritisation will have been affected by a range of factors including but not

limited to: infection, prevention and control measures; patient behaviours (e.g. reluctance to attend hospital); wider capacity constraints resulting from higher level of COVID-19-positive patients such as critical care capacity; and reprioritisation of anaesthetic and other clinical staff.

246. NHS Trusts are responsible for ensuring the quality of care provided to patients. They work within existing frameworks to make decisions on care on a daily basis based on the local circumstances and clinical judgment. All NHS Trusts are accountable for continuously improving the quality and safety of healthcare services. This involves monitoring systems and processes to provide assurance of patient safety and quality of care across the organisation.

Steps taken to increase staffing levels

247. I am asked for details of any steps taken by the DHSC to increase staffing levels in any area of the NHS in England, whether by geographical location, specialism or otherwise, including the extent to which such steps were successful. I am also asked about the rationale for removing the NHS surcharge for non-UK healthcare staff and what the DHSC considers to be the impact of its removal.

248. The Department took a variety of steps to increase availability of staff, as was summarised in Sir Christopher Wormald's Third Witness Statement to the Inquiry, dated 29 March 2023, paragraph 167:

> *The Department adopted measures and enacted plans to increase the workforce through encouraging former staff to return to the NHS, allowing medical students in their final year of training to take up roles more swiftly and putting measures in place to enable overseas nurses to continue to come to the UK safely during the pandemic.*

249. The main measures, discussed below, were:

a. establishing temporary emergency registers of retired health professionals to enable them to return to practise;
b. graduating final year medical students early so that they could be deployed to patient care;
c. deploying final year nursing students to clinical services;
d. changing the Performers List rules for primary care services so that all doctors could work in general practice;
e. establishing an NHS reserve;
f. sustaining international recruitment during COVID-19 travel restrictions (including changes to the Immigration Health Surcharge);
g. changing pension rules to enable retirees to return to service without financial penalty and support those who had returned to work for longer;
h. introducing free and fast-track Disclosure and Barring Service (DBS) checks to enable rapid deployment of returners and recruits to front line care; and
i. working with NHSE to facilitate volunteering.

250. In addition, the Department worked with NHSE, employers and trade unions to introduce practical services and contractual changes to support staff during the highly pressured COVID-19 period.

Temporary Emergency Registration

251. Details on the NHS Emergency Register were set out in Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 25 August 2023, at paragraphs 335-339. In summary, the position was as follows:

252. *In response to the COVID-19 pandemic, the Government enabled some healthcare professional regulators to establish temporary registers. The Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) established emergency registers using powers conferred to them under the*

Coronavirus Act 2020 (the CVA). The General Medical Council (GMC) and the General Pharmaceutical Council (GPhC) established emergency registers using their existing powers.

253. *The GMC granted temporary registration to doctors in good standing who had left the register in the last six years.*

254. *The NMC opened a temporary register to nurses and midwives who had left the register in the last five years and overseas nurses already working in the UK who were part-way through the NMC's application process.*

255. *The GPhC and Pharmaceutical Society of Northern Ireland granted temporary registration to pharmacy professionals in good standing who had left the register in the last three years.*

256. *The HCPC granted temporary registration to former registrants who had left the register in the last three years and third year students on UK-approved programmes who had completed all of their clinical practice placements.*

257. The professional regulatory bodies wrote to those who had come off their registers and who were now eligible to return, asking if they wanted to return to work to ease pressure during the pandemic, either on the frontline or in support roles. This made additional staff available for deployment into clinical roles. NHSE was responsible for the deployment of temporary staff in England and released 'Deploying our people safely' guidance to support NHS staff and the organisations in which they were working.

258. Estimates suggest between 49,272 and 60,811 former professionals (doctors, nurses, midwives, Allied Health Professionals and pharmacists) were on the temporary emergency registers at any one time throughout the pandemic (based on data published by the relevant regulators). Employment rates for the period September

2020 – January 2021 were between 2,208 and 2,831, representing a c. 5% employment rate (based on NHSE data). The low employment rates were thought to be due to an inability to match returning staff to existing vacancies, for example because returning staff could not work existing shift patterns or were not suitably qualified for the vacant post. Anyone who returned through local arrangements with trusts rather than through "Bring Back Staff" (the national programme for returning staff operated by NHSE) would not be recorded in national data, so these figures probably represent an underestimate of the total deployment.

259. Temporary emergency registration remained open through the pandemic period and registers closed in March 2024.

Graduating Medical Students Early

260. Paragraphs 326 to 328 of Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 25 August 2023, referred to medical staff graduating early from their degrees to boost the NHS workforce.

261. In the first wave *of COVID-19, nearly 4,000 final year medical students graduated early from their degrees and joined the NHS in Foundation Interim Year One (FiY1) roles.*

262. *FiY1 roles offered more supervision than a standard Foundation Year 1 role, but also an opportunity for medical graduates to help on the COVID-19 response.*

263. *Students then started their standard Foundation Year 1 roles as usual in August 2020.*

Student Nurse Deployment

264. At the end of March 2020, the Nursing and Midwifery Council (NMC) introduced a set of emergency standards for nursing and midwifery education. These allowed students to undertake extended placements to support the health and care workforce. Usually, whilst in clinical training students are not counted as part of the staffing required for safe and effective care in that setting and are also not employed or paid to provide care. The NMC emergency standards for nursing and midwifery education meant that:

a. For students in the final six months of their education programme, the student nurses could volunteer to complete their training in appropriate placement settings by taking part in a paid clinical placement.
b. For students who had passed their first year of study and had longer than six months left on their education programme, students could opt in to spend 80 percent of their time in a paid clinical placement.

265. The hours spent in a paid clinical placement could contribute to their education practice placement hours to count towards their final qualification requirements. The emergency standards provided education institutions with flexibility to enable students to continue training and support the workforce during the COVID-19 emergency.

266. The National Audit Office **(MS2/140 - INQ000114319)** reported their analysis of NHSE data that 7,048 student nurses and midwives were deployed to support the NHS in England as of 30 April 2020. As of 17 July 2020 **(MS2/141 - INQ000391398)** 28,108 student nurses and midwives had opted to (and were are eligible to) take up a paid-placement/work opportunity.

Performers Lists Regulations

267. On the 9 April 2020, The National Health Service (Performers Lists) (England) (Coronavirus) (Amendment) Regulations 2020 came into force. This removed the requirement for doctors to be on the GMC's GP register and on the Medical Performers List ("MPL" or 'the list') to provide NHS primary medical services. This change intended to allow all doctors and not just GPs to work in primary care. NHSE invited GPs who left the MPL in the past three to five years to be put back on the list as an emergency registered practitioner. The National Health Service (Performers Lists, Coronavirus) (England) Amendment Regulations 2021 also exempted people from the requirement to be included on the MPL to deliver services set out in the COVID-19 vaccination ES (Enhanced Service Specification).

268. The changes to the MPL allowed any doctor on the GMC register with a prescribed connection[2] to work in a primary care setting without the need for them to join the list. The exemption from the requirements of the list means that NHSE do not know precisely how many medical practitioners are currently working in primary care under this amendment (which remains in force). However, NHSE also used this emergency legislation to exempt approximately 8,000 GP Registrars (GPRs), who started their training in 2020 and 2021, from the requirement to be included on the list. NHSE are now seeking to ensure all of these GPRs are added to the list once their training is complete and they join the GP workforce **(MS2/142- INQ000409909)**.

269. Provisions in the CVA also put in place emergency arrangements for medical practitioners in Wales and Scotland. These allowed a person registered as a GP to

[2] [2] The term 'prescribed connection' refers to the connection between a doctor and a designated body under The Medical Profession (Responsible Officers) Regulations 2010. Designated bodies are organisations that employ or contract with medical practitioners and all designated bodies appoint a Responsible Officer (RO). Doctors must connect to the RO for the purposes of revalidation.

perform primary medical services despite not being included in the primary medical services performers list, provided they made an application for inclusion and were not rejected or deferred. The number of applications received by the Devolved Governments is not held by the Department.

NHS Reservists

270. NHS Reservists are trained, supplementary, NHS staff committed to a number of days of service each year. The Secretary of State requested exploring options for creating an NHS Reserve, similar to the model used by the armed forces and the police during emergencies, following a proposal from Alan Mak MP in August 2020. Alan Mak MP subsequently introduced a ten-minute rule bill on an NHS Reserve in the House on 24 November 2020. NHSE ran pilots across health and care systems in England, to test the concept of a staff reserve.

271. The then Secretary of State, the Rt Hon Sajid Javid MP, announced the launch of the NHS Reserves programme on social media in November 2021 **(MS2/143 - INQ000399122)**. In March 2022, NHSE reported that over 17,000 had joined the programme since the pilots launched and announced the expansion of the NHS Reserves programme. By May 2022, all Integrated Care Systems in England had received funding to support the mobilisation of a local reservist service **(MS2/144 - INQ000409892; MS2/145 - INQ000409893)**.

International recruitment

272. As was set out in Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 25 August 2023, paragraphs 329-334 on international recruitment, the Department took the following steps to increase workforce capacity in relation to international recruitment.

273. *On 31 March 2020, as part of the response to the COVID-19 pandemic, the government announced that NHS frontline workers visas would be extended* **(MS2/146 - INQ000215578)** *and on 29 April 2020, it was announced that other frontline health and care workers would also receive visa extensions. Healthcare professionals whose visas were due to expire between 31 March 2020 and 1 October 2020 were given a free, year-long extension* **(MS2/147 - INQ000257377)**.

274. *On 30 November 2020, it was announced that this had been extended to cover visas expiring between 1 October 2020 and 31 March 2021* **(MS2/148 - INQ000257409)** *and on 9 April 2021, a further extension was announced that would cover visas expiring up until 30 September 2021. Since starting the free extensions on 31 March 2020, the Home Office extended the visas of 10,000 people across the UK and it was expected that this further extension could benefit a further 14,000 applicants* **(MS2/149 - INQ000234855)**.

275. *The NHS programme of international nurse recruitment continued during the pandemic period, in spite of challenging travel barriers. Additional funding was provided to the NHS in 2020/21 to increase the rate of overseas arrivals of nurses.*

276. *The Department also introduced an exemption from the requirement to quarantine in Managed Quarantine Service (MQS) facilities (hotel quarantine) for newly recruited nurses from overseas, as long as they could quarantine under the same conditions in hospital-arranged accommodation. Advice on the impact and options for international recruitment during the pandemic was provided in May 2020 to the Department's DG for Workforce.*

277. *As a result of high COVID-19 rates in India in April 2021 and extreme pressure on its health system, officials provided advice to Ministers on continuing recruitment even with MQS exemptions in place. This resulted in a six-week pause on recruited Indian nurses travelling to the UK to take up employment.*

278. The impact of these measures was set out in paragraph 204 of Sir Christopher Wormald's Eighth Witness Statement to the Inquiry, dated 30 August 2023, on international recruitment. *On 23 February 2023, Home Office Management Information indicated that there was a total of 19,912 extensions granted to health workers, care workers and their dependents, under these policies. The NHS programme of international nurse recruitment continued during the pandemic period, despite challenging travel barriers. Additional funding was provided to the NHS in 2020/21 to increase the rate of arrival of nurses from overseas* **(MS2/150 - INQ000257099)**.

NHS surcharge for non-UK healthcare staff

279. As part of this work the Prime Minister announced on 21 May 2020 that NHS and Care staff would be exempt from paying the IHS. The rationale for this decision was twofold. First, to ensure that the payment of the IHS was not a barrier to recruitment of health and care workers. Second, during the pandemic, the Prime Minister decided that the health and care workforce should be reimbursed the IHS payment due to the exceptional contribution they were making to supporting the unprecedented demands on the NHS and care system.

280. As the IHS is a UK wide scheme but healthcare is devolved, the Devolved Governments were engaged on the policy and its communication.

281. Representatives from NHS Employers; National Care Forum; the Local Government Association; Unison; UK Home Care Association; Skills for Care; and the Care Provider Alliance were engaged to understand the breadth of staff within scope of the scheme in order to inform guidance development.

282. In terms of impact, the Home Office and the NHS Business Services Authority (NHSBSA) hold operational data on the number of people issued a Health and Care Workforce visa; those who benefited from a full or partial refund; and those who

qualified under the NHSSBSA reimbursement scheme for six-month block reimbursements (and how many reimbursements were received). The Department led on the production of a PSED assessment that was completed in August 2020.

NHS Pension Scheme Changes

283. To boost service capacity during the pandemic, some of the abatement rules in the NHS Pension Scheme were temporarily suspended through Section 45 of the CVA, legislation that was put in place by the Department. Section 45 suspended the 16-hour rule and pension abatement for pensioners with Special Class Status (SCS) and those staff who had drawn down on some of their pension from the 2008 Section and 2015 Scheme.

284. The 16-hour rule restricted the amount of work that pensioners could do when returning to NHS employment. It applied to pensions drawn from the 1995 Section of the NHS Pension Scheme and provided that no more than 16 hours per week could be worked in the first month after returning to NHS employment following retirement. Where staff worked more than this limit, their pension benefits were temporarily suspended until their hours had reduced to satisfy the 16-hour rule. Suspending this rule therefore allowed retired staff to work as many hours as they wished in the first month of their return during the pandemic without it having an impact on their pension.

285. SCS is a historic reserved right in the 1995 Section of the NHS Pension Scheme that allowed nurses and other certain professions, subject to qualifying criteria being met, to retire at 55 instead of 60 without the normal early payment reduction being applied to their pension. SCS abatement rules provide that where the individual returns to work before age 60, then their pension income plus earnings from NHS employment cannot exceed their pre-retirement NHS earnings. Where there is excess, the pension is reduced (abated) accordingly. Abatement ceases to apply at age 60. Suspending pension abatement intended to provide an incentive for retired SCS staff to return to the NHS frontline, and for those staff who had already returned to increase their

working commitments during the pandemic as there was no longer any impact on their pension from working more hours.

286. Draw-down abatement applies to 2008 Section or 2015 NHS Pension Scheme members who claim a portion of their pension benefits whilst continuing to work. Abatement rules require members to reduce their pensionable pay by at least 10% upon each election to draw down their benefits. Suspending these abatement rules therefore intended to provide an incentive for partially retired staff to increase their working commitments during the pandemic, as it would not impact their pension.

287. These measures were provided by Section 45 of the CVA from March 2020 to March 2022 and initially continued until 31 October 2022 via temporary amendments to scheme regulations. This allowed skilled and experienced staff to do more work for the NHS, providing a valuable capacity boost during peak periods of the pandemic response.

288. Following concerns from stakeholders that these measures should be retained for longer, the Department consulted on an extension of these easements, and as a result Ministers decided to extend the easements for the 16-hour rule and draw-down abatement to 31 March 2023 and the suspension of SCS abatement to 31 March 2025 **(MS2/151 - INQ000409895)**.

289. As part of the 2022/23 pay deal for Agenda for Change staff, the Department plans to permanently remove SCS abatement from 1 April 2024. Further detail on this is set out in the recent consultation on changes to the NHS Pension Scheme from 1 April 2024 **(MS2/152 - INQ000468603).** This consultation ran from 26 October 2023 to 7 January 2024. The 16-hour rule was permanently removed as part of a separate package of NHS Pension Scheme changes on 1 April 2023. Draw down abatement resumed on 1 April 2023.

Retire and Return Easements

290. In March 2020, a number of "retire and return" rules in the NHS Pension Scheme, set out above, were suspended to allow retired and partially retired staff to return to work or increase their working commitments without having the payment of their pension benefits abated or suspended.

291. These measures were originally provided by Section 45 of the CVA and, following regular engagement with the Royal College of Nurses, have since been continued via temporary amendments to NHS Pension Scheme regulations. They have allowed skilled and experienced staff to do more work for the NHS, providing a valuable capacity boost during peak periods of the pandemic response. The 16-hour rule was permanently removed on 1 April 2023 and the Department subsequently consulted on a permanent amendment to the regulations which would permanently remove abatement rules for staff with SCS.

Temporary emergency free and fast track DBS checks

292. In March 2020, the Home Office agreed to introduce temporary measures under secondary legislation which allowed employers to obtain a fast-track DBS check for eligible health and social care workers against the Children's and/or Adult's barred lists. Barring checks were carried out and made available within 24 hours. The full enhanced DBS check was still processed in the normal way, however, if there was no match against the Children's or Adult's barred lists, employers could allow individuals to commence work, where additional safeguards were put in place to mitigate any risks in advance of the outcome of their full disclosure certificate being made known. The same legislation also waived the DBS check fees for health and social care workers in COVID-19-related positions. Although this allowed for free DBS checks for employers or employees in specific groups covered by the emergency arrangements, funding was provided by the Department to reimburse the Home Office for costs associated with DBS checks that were processed under the emergency provisions.

The DBS reported that between March 2020 – May 2023, it had processed an average of 25,000 checks per month under the emergency provisions. Between 2020 and 2023, this equated to an average cost to the Department of Health and Social Care of £11 million per year. For all other non-COVID-19 related positions, employers in health and social care were required to obtain checks through the normal DBS route and the usual fees applied.

293. While the volume of checks in 2022/23 continued to fall compared to 2020/21 and 2021/22, this did not drop as much as we would have expected at this time. The DBS reported that on average they were receiving 25,000 applications per month. Given engagement with NHSE had indicated that there were no national campaigns which would drive this, this may have indicated that employers were now using the emergency provisions to address other underlying recruitment issues which was not the intended purpose. Officials from the Department worked with NHS Employers, the DBS, and partners in adult social care to strengthen pre-existing guidance to ensure the service met its intended aim of supporting recruitment into COVID-19-related roles and drive the volumes down.

294. The arrangements supported the timely, safe, and efficient recruitment of staff coming through the temporary emergency registers, NHSE's roll out of the COVID-19 vaccination programme and the Bring Back Staff campaign which saw over 4,000 clinicians return to employment, providing valuable support to health and social care in frontline acute services and other settings, such as the COVID-19 vaccinators.

NHS: Volunteers

295. Additionally, as set out in Sir Christopher Wormald's Fifth Witness Statement to the Inquiry, dated 25 August 2023, at paragraphs 340 to 342, volunteers also stepped forward to assist with workforce availability.

296. *The NHS Volunteer Responders programme (NHSVR) was launched in March 2020 to support the NHS and people who were shielding or self-isolating. Volunteers provided help with collecting prescriptions, shopping, welfare calls, plus delivery of equipment for the NHS and patient transport. In December 2020, the vaccination steward role was added to ensure support to vaccination clinics across the country.*

297. *Over 2.5 million tasks have been undertaken through the NHSVR since the first tasks were carried out on 7 April 2020, including over 1 million hours of support to over 1,000 vaccination venues which started 17 December 2020. The vaccination centre support programme remains ongoing.*

298. *Of the 750,000 volunteers who initially stepped forward to help in March 2020, over half of these have been active.*

299. Information in relation to GP services is set out at paragraphs 13 - 68 in the Department's Fourth Statement to this Module, which I signed on 22 March 2024.

Testing

300. I am asked about the effect, if any, that the availability of COVID-19 testing had on the availability of healthcare staff to work in face-to-face settings. I am also asked if the Department considers that the availability of testing (or lack thereof) caused a reduction in the availability of healthcare staff, any steps taken to address the issue.

301. In January 2020 there was no test for COVID-19 and no infrastructure for delivering any testing at scale. Significant technical development and scale-up was required to increase testing capacity. While testing capacity increased, the Department took steps to prioritise testing for those in clinical need (e.g. being admitted to hospital) and NHS staff. Symptomatic NHS staff were prioritised for testing as were their families from 27 March 2020. Once increased testing capacity was established, the testing of staff was left to the NHS to manage at an operational and local level, in line

with testing and isolation guidance. The Department was regularly updated with the various pressures being faced by the NHS.

Section 5: Support for healthcare staff

302. I am asked whether the Department gave consideration to providing additional support to healthcare staff and other workers in the healthcare system, such as mental health support, childcare, access to food and/or transportation, adjustments to work schedules and distribution of workloads. I am also asked for details of any steps taken by the Department to monitor the mental health and well-being of those working in the healthcare system during the relevant period; and any financial, well-being, mental health or other support made available by the Department for workers in the NHS during the pandemic.

303. The Department, working with NHSE, trade unions and employers, put in place a range of measures to support staff. This work included:

a. measures to support staff resilience and wellbeing;
b. changes to monitoring of staff engagement and wellbeing;
c. changes to car parking facilities for staff;
d. designation of staff as key workers to access key services;
e. temporary changes to terms and conditions;
f. introduction of a system of COVID-19 Sick Pay;
g. Introduction of a COVID-19 life assurance scheme for staff; and
h. easements to policy on retire and return schemes.

Social Partnership Forum

304. A significant proportion of these changes were agreed through a dedicated group of an established mechanism for discussing staff issues. The national Social Partnership Forum (SPF) is an engagement forum, chaired by a Health Minister. It brings together the Department with the main healthcare trade unions ("NHS Staff

Side"), NHS Employers and ALB partners to discuss non-pay policy and strategy issues where there are implications for the NHS workforce.

305. In response to the pandemic, the SPF rapidly adapted its ways of working to increase access between employers, trade unions and the Minister for Care and SPF chair, Helen Whately, and workforce and system leaders from the Department and the ALBs, including NHSE, HEE and PHE.

306. From March 2020, the SPF switched to meeting online instead of face-to-face, and met far more frequently. This enabled the two-way sharing of key intelligence between employers, trade unions and system leaders, timely discussions, and prompt escalation and action.

307. A new SPF group was established called the "COVID-19 SPF Engagement Group". The Group's first meeting was 30 March 2020. It met weekly up to 21 July 2020, after which, meetings were fortnightly with more "business-as-usual" arrangements being gradually reintroduced in 2022 **(MS2/153 - INQ000049964; MS2/154 - INQ000050023; MS2/155 - INQ000050126)**.

308. The COVID-19 SPF Engagement Group focused exclusively on pandemic-related workforce issues including the NHS pandemic response, IPC, PPE, NHS Test and Trace, staff deployment, risk assessments, racial inequalities, staff health and wellbeing matters, and the COVID-19 vaccination programme. It also received updates from the NHS Staff Council Terms and Conditions COVID-19 working group and received updates on pandemic-related national directions/communications to the NHS.

309. SPF Wider Group meetings were held fortnightly between April and July 2020 **(MS2/156 - INQ000050371; MS2/157 - INQ000050645; MS2/158 - INQ000050811; MS2/159 - INQ000051120; MS2/160 - INQ000051389)** and then approximately monthly until December **(MS2/161 - INQ000058421; MS2/162 - INQ000118189;**

MS2/163 - INQ000059156) and slightly less frequently from 2021. They were usually chaired by the Minister for Care and had largely pandemic-related agendas.

310. The COVID-19 SPF Engagement Group continued until November 2021, when it was stood down and COVID-19 related business was mainstreamed into "business as usual" SPF meetings, with a caveat that the group could be reconstituted as required.

311. The SPF also agreed two industrial relations statements **(MS2/164 - INQ000192690; MS2/165 - INQ000192877)** during the first wave of the pandemic, in April 2020 and refreshed in July 2020. These stated that partnership working in organisations may need to be streamlined and organisational change, employment processes and industrial disputes put on hold to assist the NHS in managing the pandemic. A further statement was issued in September 2020 confirming that local agreements would resume and there were no plans to issue any further statements on industrial relations **(MS2/166 - INQ000192986)**.

Supporting NHS staff resilience and wellbeing

312. NHSE lead on national support for NHS staff wellbeing including mental health, with individual employers putting in place their own local arrangements to support their employees and managing day to day operational decisions on working patterns.

313. Sir Simon Stevens, NHS Chief Executive, in a letter to the NHS about handling COVID-19 on 17 March 2020, asked NHS leaders to make available enhanced health and wellbeing support for frontline staff, including suggesting adjustments for staff members at increased risk according to PHE's guidance (such as pregnant women) **(MS2/83 - INQ000087317)**. This was reinforced in the second phase letter on 20 April 2020 **(MS2/167 - INQ000087412)** which also highlighted the importance of supporting staff at increased risk of COVID-19.

314. On 20 March 2020, NHSE shared details with the Department on a proposed staff wellbeing package, summarising the potential approaches, workstreams and related timescales **(MS2/168 - INQ000192664)**. The package included:

a. Access to self-help apps
b. 24/7 National Helpline
c. End of life bereavement support services
d. Fast tracked mental health services

315. NHSE established a national mental health hotline **(MS2/169 - INQ000192711**) on 8 April 2020 and a national staff bereavement helpline on 29 April 2020. NHSE continued to support the NHS Practitioner Health service, that was available pre-COVID-19, to doctors and dentists in need of mental health support.

316. Throughout the pandemic, the Minister for Care received regular advice from NHSE and held regular meetings with NHSE staff and officials from the Department on the progress of the well-being package and people plan, along with briefings on the wider staffing situation and updates of the mechanisms and tools being put in place to ensure staff were properly supported **(MS2/170 - INQ000049921; MS2/171 - INQ000049922; MS2/172 - INQ000050360; MS2/173 - INQ000050361; MS2/174 - INQ000050362; MS2/175 - INQ000050453; MS2/176 - INQ000050454; MS2/177 - INQ000327885; MS2/178 - INQ000050456; MS2/179 - INQ000327884; MS2/180 - INQ000050906; MS2/181 - INQ000109470)**.

317. Staff and wellbeing issues were also discussed at the SPF.

318. Prior to publication, Departmental Ministers were consulted on the development of the People Plan. This included a submission to the Secretary of State and the Minister for Care on 8 July 2020 seeking steers **(MS2/182 - INQ000109507; MS2/183 - INQ000109508)**. In July 2020, NHSE published the NHS People Plan 2020/21: action for us all **(MS2/184 - INQ000292624)**. This outlined a range of actions for NHSE and

local employers to take to support staff health and wellbeing, tackle discrimination in the workplace, maximise skills and experience and grow the workforce.

319. The NHS People Plan focused on building staff resilience through the pandemic, with targeted action to support staff health and wellbeing, promote flexible working, strengthen leadership, and address inequalities in the workforce. It was organised around four pillars:

a. looking after our people – with quality health and wellbeing support for everyone.
b. belonging in the NHS – with a particular focus on tackling the discrimination that some staff face.
c. new ways of working and delivering care – making effective use of the full range of our people's skills and experience.
d. growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

320. From Autumn 2020 onwards, NHSE established regional staff mental and wellbeing hubs with around £40 million invested annually in these in 2021/22 and 2022/23. These provided proactive outreach and assessment services, referring staff to specialist support where needed. They were funded on a non-recurrent basis using additional funding from Government as a short-term response to the pressure on the workforce from COVID-19.

Support for staff at increased risk from COVID-19

321. As it became apparent that COVID-19 was adversely impacting some staff, including those from ethnic minorities, the Department worked with NHSE to ensure that additional precautions and support were put in place. In April 2020, NHSE established an urgent programme of work focused on protecting staff and ensuring staff and their networks were well informed of risks. This was shared with Ministers

and the SPF. As part of this, NHSE wrote **(MS2/185 - INQ000409912)** to all NHS Trusts, advising them to carry out risk assessments for staff from ethnic minority backgrounds and referring to the work PHE had been asked to carry out to investigate higher death rates from COVID-19 among people from ethnic minority communities.

322. NHS Employers provided supporting guidance on 30 April 2020 and 28 May 2020, including a risk assessment tool **(MS2/186 - INQ000223041)** to help NHS organisations to enhance their existing risk assessment processes, particularly for at risk and vulnerable groups. This included staff returning to work for the NHS and existing team members who were potentially at increased risk due their race and ethnicity, age, weight, underlying health conditions, disability or pregnancy.

323. NHSE subsequently wrote to NHS organisations again on 24 June 2020 **(MS2/187 - INQ000051089)**, reminding them of their legal duty to protect the health, safety and welfare of their staff and reiterating the importance of completing risk assessments for at risk members of staff, with organisations asked to publish and share with staff their own metrics on numbers of staff risk assessed.

324. The NHS People Plan published by NHSE in 2020 would then go on to reinforce the importance of the safety and health of NHS staff, stressing to employers the importance of risk assessments for vulnerable staff, effective infection prevention and control procedures and access to PPE.

Monitoring NHS staff engagement and well-being

325. The main route for monitoring staff engagement and experience is the annual NHS Staff Survey **(MS2/188 - INQ000399133)** which is led and run by NHSE each Autumn. To provide employers in the NHS with more frequent data on their workforce, NHSE also established a (fortnightly and then later monthly) online people pulse survey in July 2020. This was a voluntary and anonymous short survey made available to NHS organisations to help them understand how their staff were feeling. Data was

made available to participating NHS Trusts, but unlike the annual NHS Staff Survey, it was not published at a national level. Not all NHS Trusts participated in the people pulse survey as some already had similar arrangements in place locally.

Car parking for NHS staff

326. On 25 March 2020, in response to the emergency period of the COVID-19 pandemic, the Government committed to providing free hospital car parking for NHS staff. This policy cost £90 million per year. This was a temporary measure and ended on 31 March 2022 as part of the Government's 'Living with COVID' strategy.

327. Additionally, the Department for Levelling Up, Housing and Communities (DLUHC) introduced a parking pass in March 2020 whereby local councils in England voluntarily offered free car parking to all NHS workers, social care staff and NHS volunteer responders. The pass was withdrawn in June 2021 following the end of the emergency response period of the pandemic.

Keyworker status

328. The Government agreed a list of staff groups who were classified as key workers. This enabled NHS staff with children to be able to access in-person schooling for their children.

Temporary change to terms and conditions of employment

329. There were a variety of temporary changes to terms and conditions of employment made to support staff off work with COVID-19 or who were self-isolating, which the Department kept under review.

330. On 2 March 2020, Professor Keith Willett, NHS Strategic Incident Director at NHSE wrote to the NHS on "COVID-19 NHS preparedness and response" **(MS2/189 - INQ000087445)**. The letter set out that the NHS should "*Ensure that any member of staff, including bank staff and sub-contractors, who has to be physically present at an NHS facility to carry out their duties, receives full pay for any period in which they are required to self-isolate as a result of public health advice".*

331. The Department set up a COVID-19 Terms and Conditions Steering Group consisting of Departmental officials, NHSE and NHS Employers. The Department worked with the NHS and trade unions colleagues through the NHS Staff Council to ensure that the operation of national terms and conditions reflected the unprecedented nature of the pandemic and the reliance on NHS staff. The Department's temporary non-contractual guidance was hosted on the NHS Employers website on 27 March 2020 and covered issues such as pay, annual leave and staff absences. The guidance was regularly reviewed throughout the COVID-19 emergency period to ensure it was fit for purpose and permitted maximum flexibility and discretion around terms and conditions during the pandemic.

Pay Arrangements for COVID-19 Sickness and Self-Isolation

332. COVID-19 sick pay arrangements were put in place from March 2020 to ensure NHS employees who were unable to work due to COVID-19 related sickness continued to be paid on full pay **(MS2/190 - INQ000391333)**. In summary:

a. NHS employees who contracted COVID-19 who were required to self-isolate and unable to work from home also had access to special leave on full pay **(MS2/191 - INQ000409888; MS2/190 - INQ000391333)**.
b. These arrangements were temporary and as part of the COVID-19 Response: Living with COVID-19 strategy, they were withdrawn from 7 July 2022.

c. Staff who were in receipt of COVID-19 sick pay as a result of being unwell prior to 7 July 2022 and continued to be unwell, reverted to their normal contractual sick pay entitlements on 1 September 2022, which included consideration for NHS injury allowance.

Life assurance scheme

333. On 27 April 2020, the Department announced the NHS and Social Care Coronavirus Life Assurance Scheme **(MS2/192 - INQ000319539)**, for families of staff who sadly died after contracting COVID-19 at work. The Scheme paid a £60,000 lump sum to the families. NHS Employers produced a useful flow chart as to how the Scheme worked **(MS2/193 - INQ000391397)**.

334. The Scheme recognised the increased risks that frontline NHS and social care staff were thought to face in carrying out their roles during peak periods of the pandemic. It sought to give these workers extra assurance of financial security for their families during that time, particularly where individuals may not have any death benefit cover from occupational pension scheme membership or separate life assurance policies.

335. Following detailed policy work on the design of the Scheme, the Government formally launched the Scheme on 20 May 2020. This would cover NHS funded and publicly funded social care staff. It was subsequently extended to cover students on placement **(MS2/194 - INQ000059810; MS2/195 - INQ000050020)**. Pharmacy staff were automatically included in the Scheme if they were based in a hospital or GP practice setting.

336. Following engagement with HMRC, the Scheme was also made exempt from income tax when paid on 13 July 2020 (The Coronavirus Life Assurance Scheme (English and Welsh Schemes) (Excluded Benefits for Tax Purposes) Regulations 2020) **(MS2/196 - INQ000192852)**.

337. In January 2022, Departmental officials approached HMRC for access to employer data, as analysis of the available data within the Department had noted that there was a gap between the number of social care staff deaths and claims received. For confidentiality reasons, HMRC was not prepared to release data that may have allowed the Department to contact these employers and facilitate further claims.

338. In the press release dated 27 April 2020 announcing the Scheme, the Scheme's closing date had been signalled as coinciding with the ending of the period for which the NHS workforce provisions in the CVA 2020 were in force. The Department decided to close the Scheme to new deaths on 31 March 2022 when the rate of staff deaths from COVID-19 had fallen sharply, in part due to the success of the vaccine rollout to staff **(MS2/197 - INQ000193803)**.

339. The Scheme remained open until 30 September 2023 to allow families to submit claims in respect of deaths that occurred before 31 March 2022.

340. As of 8 January 2024, there had been a total of 806 claims to the Scheme in England. Of these, 739 claims had been successful and six remained under consideration on that date. The remainder had been rejected as they did not meet the eligibility criteria for the Scheme. As of 8 January 2024, the Scheme had received a total of 46 claims in Wales, of which 44 had been successful and two had been rejected.

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.

Personal Data

Signed:

Dated: 19 April 2024