Witness Name: Saffron Cordery
Statement No.:1
Exhibits: 66
Dated: 19 January 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SAFFRON CORDERY

I, Saffron Cordery, will say as follows: -

1. I am Saffron Cordery, deputy chief executive of NHS Providers, a position I held during the relevant period of 1 March 2020 to 28 June 2022.
2. The statement is intended as an organisational response by NHS Providers and has been prepared with input from a number of key individuals. This statement has also been through a verification exercise to check the accuracy of the information contained herein. In providing this statement, I have received assurances from the key contributors and via the verification exercise that where information is not in my direct knowledge, it is accurate to the best knowledge and belief of NHS Providers, and in signing the statement of truth at the end of this statement I reasonably rely on those assurances. Where data and statistics provided by members of NHS Providers are quoted in this statement, NHS Providers has not undertaken verification of the accuracy of that third party data.

Role, functions, accountabilities, legal status and key decision makers at NHS Providers

3. NHS Providers is the membership organisation for acute hospital, mental health, community and ambulance services treating patients and service users in the NHS in England. We help our members deliver high-quality, patient-focused care by supporting them to learn from each other, acting as their public voice and helping shape the policy environment in which they operate. NHS Providers does not have stand-alone primary care providers (such as GPs, pharmacies and dentists) or stand-alone social care providers in its membership. NHS Providers represents NHS trusts and foundation

trusts in England.

4. NHS Providers offers a range of support programmes, events and networks for trust board members with a focus on peer learning, engagement and sharing best practice and learning. The majority of these are delivered as part of our core membership offering and are free to executive and non-executive directors employed by our member trusts to attend. Some elements of our development and training offer are delivered bespoke to trust boards on request at competitive rates. We also engage with trust board members via routes including our survey programme, visiting trust sites, roundtables, consultations, email and ad hoc contact seeking their views and feedback to inform our policy positioning and representation of trusts in the media and with stakeholders.
5. NHS Providers' membership is open to NHS Trusts as organisations not to individuals. Our work is predominately aimed at a trust board audience. Once a trust has joined the membership, any of its board level directors, executives and non-executive directors (and often other senior staff) can access our services, as described above.
6. NHS Providers is the only membership organisation solely representing NHS foundation trusts and trusts in England. We have 100% of those trusts in voluntary membership across the ambulance, acute, mental health and community sectors. The NHS Confederation is a membership organisation for healthcare organisations in England, Wales and Northern Ireland. Further information is available on their website however they represent a much broader umbrella of interests in the healthcare sector including trusts and other provider types, independent sector organisations, integrated care systems (ICSs) and primary care networks (PCNs). Membership of NHS Providers and membership of NHS Confederation is voluntary – as such, trusts can join either, both or neither.
7. Currently, and during the relevant period, all NHS trusts and NHS foundation trusts (which we collectively describe as trusts) in England were voluntary members of NHS Providers. Those trusts interact with more than five million patients and service users a week, employ 1.4 million people, and account for around £115bn of the circa £150bn budget held by the Department of Health and Social Care (DHSC).
8. NHS Providers is registered as the Foundation Trust Network (our brand name until 1 December 2014) with the Charity Commission (charity number 1140900) and at Companies House (company ref 07525114). We are required by charity and company law to act within the objects of our memorandum of association 'to enable our members to provide high quality healthcare within the NHS, thereby relieving sickness and protecting public health'. We uphold our duty of public benefit and deliver our charitable objectives by being an outstanding membership organisation influencing health policy

constructively on behalf of trusts, acting as their public voice and supporting trust boards by offering them a range of training programmes, networking and peer learning.

9. NHS Providers is therefore an independent organisation representing trusts as organisations and their boards in England (rather than individuals or professional groups within the NHS).
10. NHS Providers does not form part of the formal structure of the NHS in England. NHS Providers does not have a role in commissioning services, providing health or care services, or regulating providers. NHS Providers does not contribute to the production of clinical guidelines or play a role in the governance of healthcare provision or in clinical decision making locally or nationally.
11. In the relevant period, governance and decision-making structures at NHS Providers did not change, aside from moving to virtual board and committee meetings. Our board of trustees sets NHS Providers' strategic direction and ensures the organisation is led effectively and with financial probity. Our elected board is representative of our membership of trust chairs and chief executives and the service sectors we represent. We have a remunerated chair, a position currently held, and held during the relevant period, by Sir Ron Kerr.
12. Our Executive Management Team during the relevant period comprised:
    a. Chris Hopson, Chief Executive
    b. Saffron Cordery, Deputy Chief Executive
    c. Miriam Deakin, Director of Policy and Strategy
    d. Adam Brimelow, Director of Communications
    e. Kevin Rennie, Interim Chief Operating Officer
    f. Jenny Reindorp, Interim Director of Funded Programmes (from 1 February 2022).
13. NHS Providers ensures the majority of its income is generated from member subscriptions (from trusts) in order to maintain its independence. Additional annual income is derived from providing training services (predominately to members), commercial agreements and by working with partners to develop specific areas of support for trusts. During the 2020/21 financial year, NHS Providers received 75% of its income from member subscriptions, with 1.8% from NHS England and 13% from Health Education England to deliver agreed training and support for trusts. In 2021/22, 65% of our income came from member subscriptions, 10.5% came from NHS England and 12% from Health Education England to deliver agreed training and support for trusts. Our annual report and accounts provide further information.

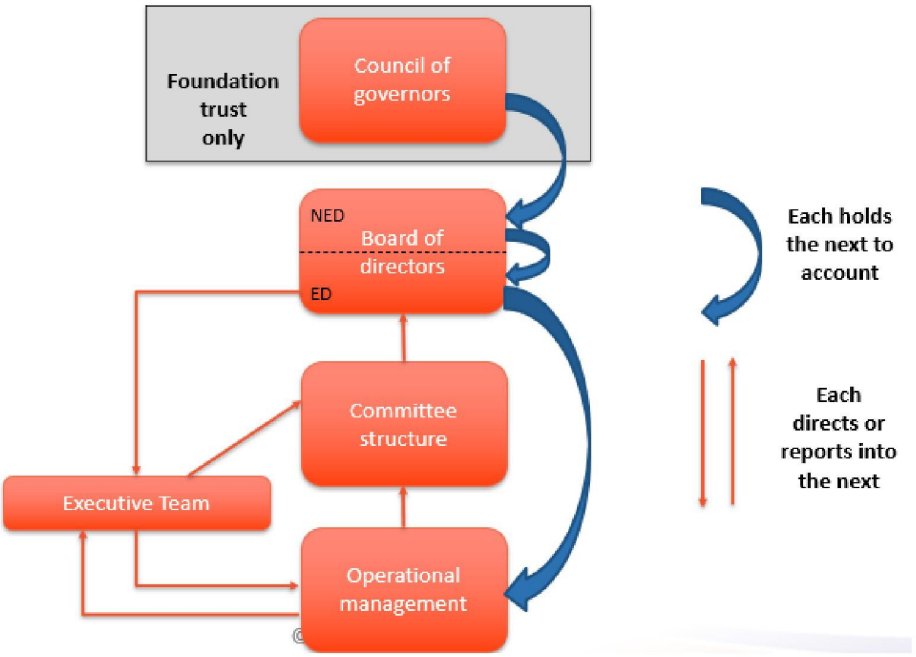
14. We use a variety of channels to engage, gather and share information between members and with national decision makers as well as to inform our public positioning in the media:
    a. To ensure we remain close to our membership and the challenges they face, as well as supporting peer learning, we host 12 networks for trust board-level roles (including chairs and chief executives), we hold conferences, roundtables and webinars, offer training and support aimed predominately at trust boards. We run a 'trust visits' programme, which over the relevant period became an opportunity for a virtual catch up with senior trust leaders, during the course of the pandemic;
    b. During the relevant period, we provided an online resource hub for members to share emerging practice and collate the national guidance on coronavirus that we were aware of;
    c. We host WhatsApp groups to enable trust leaders to share information and learning and to inform our work. The nature of these groups during the relevant period is set out in detail below in paragraphs 57 and 58;
    d. Our influencing and media work is informed by surveys of our membership and regular engagement with trust leaders.
15. In addition to our public voice in the media, our outputs include 'on the day' and 'next day' briefings on policy material for our membership, parliamentary briefings and publications aimed to inform a broad audience about the challenges and opportunities trust leaders face. During the relevant period, we published a series of twitter threads, briefings and podcasts to explain the pressures trusts were facing and their efforts to keep patients and staff safe, and to set out what trusts needed from government and national bodies to respond to the pandemic. For example, in April 2020 we produced a long read, *Confronting coronavirus in the NHS [*INQ000371137*]*, which drew on the WhatsApp groups and other communication we had with our trust chief executives and chairs, and from September 2020, our online publication *Restoring Services: NHS Activity Tracker [*INQ000371148*]* offered in-depth commentary on the monthly performance figures alongside case studies of trusts' achievements in challenging times. Other topics included the supply of Personal, Protective Equipment (PPE), digital transformation, the impact of lockdown, demand for mental health care, discharge into care homes and testing.
16. During the relevant period we continued to respond to statutory consultations where available, and to submit evidence to parliamentary inquiries during the relevant period including, for example: written evidence to the Health and Social Care Committee in September 2021 on clearing the backlog caused by the pandemic *[*INQ000371159*]*;

written evidence to the Public Accounts Committee in June 2020 on readying the NHS and social care for the Covid-19 peak *[*INQ000371170*]*; and written evidence to the inquiry on the UK's handling of the coronavirus outbreak which was conducted by the All-Party Parliamentary Group on coronavirus *[*INQ000371181*].*

17. In the early months of the pandemic, the focus of our work evolved rapidly to meet the changing needs of our membership. During the relevant period:
    a. We prioritised supporting our membership (particularly trust chairs and chief executives) by facilitating the sharing of concerns and learning with each other and with NHS England and NHS Improvement (NHSEI) and other national decision makers. The WhatsApp groups we created are an example of one important practical tool we used to allow trust chairs and chief executives to raise issues directly with directly with each other and with NHSEI officials.
    b. We supported communication to trusts by circulating government, DHSC, Public Health England (PHE), NHSEI and Health Safety Executive (HSE) pandemic-related announcements and guidance to members and by publishing them on the online resource hub we created for members. Our WhatsApp groups were also used for this purpose.
18. We spent significant time on media messaging, briefings for parliamentarians and other influential stakeholders to help to explain the impact of the pandemic on trusts and trusts' efforts to respond to support staff and patients. This included a series of publications we produced called Spotlight which included key information for parliamentarians on the impact of the pandemic on our members. The first was published on 22 April 2020 and covered the supply of PPE.

An overview of how healthcare is commissioned, funded, provided and regulated

19. NHS trusts and foundation trusts mainly provide secondary and tertiary care within acute hospital, mental health, community and ambulance settings to patients in England. A minority of trusts directly offer primary care provision or social care provision in partnership with local authorities and others.
20. The lines of internal accountability within NHS trusts and NHS foundation trusts are set out in the diagram below. Both trusts and foundation trusts are accountable to commissioners, regulators, and in the case of foundation trusts, directly to parliament.



21. In the relevant period, NHS services were commissioned by clinical commissioning groups (CCGs) and local authorities, as well as by NHSEI for specialised services. NHS trusts and foundation trusts are regulated by the Care Quality Commission (CQC) for quality. NHSEI offers oversight and performance management of trust finances and operational performance. NHS Providers has no role in any of these matters.
22. During the relevant period, NHSEI distributed the majority of NHS funding on behalf of the government (and DHSC), via CCGs in line with usual practice, and the commissioning responsibilities included:
    a. Planning services based on local population needs;
    b. Securing services that met those needs;
    c. Monitoring the quality of care provided.
23. Significant sums of health and social care funding also fund public health provision (via PHE as it was then, and local authorities) and social care (again via local authorities). The King's Fund outlined this in their diagram published in April 2020, "How funding flows in the NHS".
24. The role of trusts in the event of a pandemic was set out in the latest pandemic preparedness strategy available at the time (UK Influenza Pandemic Preparedness Strategy 2011). Further to this, as NHSE's website states, "All NHS-funded organisations must meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract, the NHS core standards for emergency preparedness resilience and response (EPRR) and

NHS England business continuity management framework." The national emergency preparedness resilience and response framework in place during the relevant period was published in 2015 (version 2).

Changes to commissioning and funding during the relevant period

25. When the NHS stepped up its response to coronavirus in March 2020, NHSEI established block contracts across the NHS provider sector to support trusts' operational response to the pandemic. This meant allocating fixed sums to providers, removing financial penalties, halting trusts' efficiency programmes, and compensating additional costs attributed to coronavirus activity. Contracting rounds between providers and commissioners were also suspended throughout 2020/21.
26. Integrated care systems (ICSs) and sustainability and transformation partnerships (STPs, the predecessors to ICSs), that is, the 42 partnerships of organisations across England which now plan and deliver joined up health and care services (and which replaced CCGs as commissioners), received financial allocations for the second half of 2020/21. These were built up from individual provider block allocations based on Covid-19 costs incurred during quarter 1 of the 2020/21 financial year. An elective incentive scheme was also introduced to encourage systems to reduce their backlogs of elective surgery and outpatient appointments.
27. In 2021/22, block contract arrangements were in place. System funding allocations were based on the envelopes from the second half of 2020/21. The 2022/23 planning guidance, issued in December 2021, confirmed a return to regular, pre-pandemic contracting arrangements. NHSEI are better placed to provide the detail of NHS funding during the relevant period.

Changes to regulation during the relevant period

28. Lines of accountability during the relevant period remained the same as prior to the pandemic. However, lighter touch regulation was introduced by both the CQC and NHSEI to enable provider organisations to focus on the delivery of crucial services. For example:
    a. In a letter to trusts on 28 March 2020, NHSEI set out its approach to oversight during the first quarter of the relevant period and instructed trusts to amend their internal governance functions for example, holding meetings virtually and focusing on critical issues, streamlining trust annual reporting requirements, suspending some national performance data collections, reducing training commitments and pausing long term planning. NHSEI issued a further letter on 6 July 2020 (with the subject 'Stepping back up of key reporting and

management functions') asking trusts to consider which governance and management meetings suspended in March 2020 could be reinstated virtually. The letter did not reinstate the reporting and assurance suspensions introduced in the letter of 28 March 2020.

b. On 4 March 2020, CQC wrote to all registered care providers setting out its intention to balance its duties to act in the best interests of service users with the need for providers to focus on care delivery. It noted that inspections would still be carried out, but inspection plans would be reviewed on an ongoing basis. On 16 March 2020, the CQC wrote to providers again to set out its adapted regulatory approach advising that routine inspections would cease as of that date, that they would introduce remote methods to give assurance on safety and quality of care, and that there would be limited inspection activity in cases where there were clear reports of harm. Routine inspections were still paused as of 12 May 2022 (as set out on its website page, 'How we do our job during the coronavirus pandemic').

NHS Providers' relationships with government, DHSC and national bodies

29. Below we describe our relationship with government, DHSC and other core NHS national bodies during the relevant period, alongside examples of channels of communications. Information on the functions and remits of each of the bodies below is evidence better given by the respective bodies.

<u>The Government</u>

30. In the normal course of events (outside of the relevant period), we maintain regular contact with government health advisers through regular meetings and correspondence as matters arise. These meetings are sometimes exclusively with NHS Providers and give us the opportunity to highlight members' concerns and influence the development of health policy and legislation. During the relevant period this continued, and our records show a number of letters, exchanges and virtual roundtables with senior government advisers, officials and NHS Providers' members. For example:

    a. In May 2020, we wrote and published a letter to then Prime Minister, Rt Hon Boris Johnson MP and the leader of the opposition, Rt Hon Sir Keir Starmer MP *[*INQ000371192*]*, on the discharge of patients from hospital into care homes. In October 2020, we hosted a roundtable with William Warr, the prime minister's special adviser on health, and several trust CEOs and chairs. Also in attendance were colleagues from the government's health policy team and the

Covid-19 taskforce covering NHS winter capacity. Issues discussed included social distancing measures for people queuing outside hospitals, the significant pressures facing mental health and community trusts, staff morale, and funding for discharging those who are medically fit to leave hospital but who may still require care (the 'discharge to assess' model).

b. In June 2021 we hosted an elective care recovery roundtable with the government. Chris Hopson attended with a number of trust CEOs. Government officials in attendance were Ed Middleton, senior policy advisor on health and social care, **Name Redacted**, expert adviser on NHS transformation and social care delivery, and Adrian Masters, health policy adviser. Issues discussed included: increased demand for urgent and emergency care, bed occupancy rates, constraints on increasing elective activity due to infection prevention and control measures, and staff burnout.

c. In January 2021 we wrote to William Warr and Philippa Davies, director of public services at HM Treasury, about the need for greater financial support and incentives to improve discharge capacity in January 2021, when some trusts were facing a capacity squeeze.

DHSC

31. In the normal course of our work (outside of the relevant period), we maintain contact with officials across the DHSC, including senior colleagues, the ministerial team and special advisors. This continued during the relevant period, including for example:

    a. We attended secretary of state and ministerial meetings and roundtables for stakeholders arranged by DHSC including: a discussion between myself, Chris Hopson, then chief executive of NHS Providers, Sir Ron Kerr, chair of NHS Providers and the then Secretary of State for Health and Social Care, Rt Hon Sajid Javid MP on 28 September 2021 on the challenges facing trusts and the recent financial settlement to the NHS*]*; and a briefing for a small group of representative bodies and health think tanks arranged by DHSC on 6 January 2022 arranged by DHSC on Covid-19 pressures, attended by Chris Hopson.

    b. We sought to ensure the secretary of state, special advisors and senior DHSC officials had sight of planned NHS Providers publications, or press releases, sometimes with the opportunity to comment in advance: for example, Chris Hopson shared a draft letter with the secretary of state's special advisor on 10 December 2020 which was subsequently sent to the prime minister. Our records suggest it was rare for ministers, special advisors or officials to respond to such emails with comments other than to acknowledge receipt.

c. We occasionally wrote publicly to the prime minister and/or secretary of state for health to highlight concerns: we wrote to the prime minister in February 2021 to urge caution about the easing of lockdown restrictions *[*INQ000371199*]*. In July 2021 we wrote to the prime minister, the chancellor and the health secretary about what the NHS needed in the face of extreme pressures *[*INQ000371200*]*, including continued funding for discharge to assess and replenishing the elective recovery fund. We responded to a DHSC consultation on making Covid-19 vaccination a condition of deployment for NHS staff in October 2021 *[*INQ000371201*]* and wrote to the secretary of state for health and social care to share learning from the exercise of making vaccination a condition of deployment in the NHS on 29 October 2021 *[*INQ000371138*]*.

32. We gradually returned to more business as usual levels of engagement with DHSC during the relevant period, with increased contact at official level on a broader range of issues, including the health and care bill, new hospital programme and the long-term workforce plan.

NHS England

33. As a national policy maker, commissioner and regulator, NHSE is one of the key organisations we seek to engage with on behalf of our membership, sharing evidence and views from the NHS provider sector to constructively shape policy making.
34. In the normal course of our work, we have regular meetings and maintain contact with officials across NHSE, including senior colleagues. We also correspond with officials when the need arises. This continued during the relevant period as follows:
    a. We shared feedback on behalf of our membership with senior leaders in NHSEI notably:
        i. Sir Simon Stevens, then chief executive of NHSE;
        ii. Amanda Pritchard, then chief operating officer of NHSE and chief executive of NHS Improvement, and as of July 2021, chief executive of NHSE;
        iii. Ruth May, chief nursing officer;
        iv. Pauline Philip, then national director for emergency and elective care
        v. Emily Lawson, then chief commercial officer and, from November 2020, senior responsible officer (SRO) of the vaccine deployment programme;
        vi. Simon Enright, then director of communications.
    b. We maintained a pre-existing chief executives' advisory group in which a select group of trust chief executives met monthly (virtually) during 2020 and every

few months for the first half of 2021 with Simon Stevens and Amanda Pritchard, and with Chris Hopson and me to share concerns and progress in a safe space. Our records include notes of meetings and unedited transcripts of participants 'chat text' which show that in this forum a wide range of pertinent concerns were discussed. In 2020, key issues included: surge capacity; effective infection prevention and control; the care backlog; pressures on community services; increased demand for mental health services; the impact of the pandemic on staff in terms of workload and mental wellbeing; shortfalls in local authority funding and testing capacity; shared learning on hospital discharge; and the vaccination programme. Over the course of 2021, participants flagged the need to address the concerns of ethnic minority communities with regards to the vaccination programme; discussed emergent Covid-19 variants and initiatives they had put in place to support staff alongside the care backlog and the need for investment. By February 2022 the conversation had moved on to how to change the narrative to living with Covid-19, particularly in relation to infection prevention and control guidance, which members of the advisory group thought needed to change.

35. We added Amanda Pritchard to two of our WhatsApp groups for trust chairs and chief executives at the start of the relevant period (these groups are described further in paragraphs 57 to 60). Other senior NHSE colleagues including Pauline Philip were added to the chief executives group. David Prior (then chair of NHSE) and Dido Harding (then chair of NHSI and latterly chair of National Institute for Health Protection) were added to our chairs WhatsApp group when it was created on 19 March 2020. We draw on those discussions throughout this statement.
36. We attended NHSE organised stakeholder fora. By 6 May 2020 senior NHS Providers staff (including the Chris Hopson, myself as deputy chief executive, our director of policy and strategy, director of communications, and head of policy or a policy advisor) were attending weekly calls convened by NHSEI with Professor Chris Whitty, DHSC chief medical officer, Keith Willett, NHSEI incident director, Simon Enright, director of communications, and with Claire Murdoch NHSEI national mental health director's national team and Matthew Winn, national director for ageing well for mental health and community services respectively. These became less frequent and then ceased towards the end of the period in question.
37. We brought together groups of trust leaders in virtual roundtables to discuss concerns directly with NHSEI leaders (sometimes initiated by ourselves, sometimes at the request of NHSEI leaders). For example, Ruth May requested a roundtable on 3

August 2020 with nursing leads to share lessons learned from infection prevention and control implementation to date.

38. We shared draft communications to trust chief executives with NHSEI in advance to seek feedback and to ensure we were appropriately supporting public health messaging. For example, on 11 April 2020, Chris Hopson shared a draft twitter thread on supplies of Personal Protective Equipment (PPE) at the time with Emily Lawson, NHSE chief commercial officer, to check for accuracy [INQ000371139].
39. We shared information from our broader membership from phone calls, emails, surveys, exchanges on our WhatsApp groups, meetings and conferences. For example, on 21 March 2020, Chris Hopson sent an email listing key themes of trust feedback to Simon Stevens, Amanda Pritchard and other senior NHSEI leaders [INQ000371140]. He mentioned challenges accessing personal protective equipment (PPE), Covid-19 testing policy, national performance reporting during the pandemic, and queries about whether a national ethics framework would be forthcoming, as issues trust leaders wished to be addressed.
40. We responded to requests for feedback from NHSEI where we felt able to do so. For example:
    a. On 13 May 2020, I offered comments via email to Amanda Pritchard on draft slides on the 'operating framework for safe services' [INQ000371141]. In that response, I was clear that NHS Providers could not comment on the clinical aspects of the draft guidance, but flagged the need to be more explicit about the relevance for mental health, ambulance and community services.
    b. On 18 June 2020, Chris Hopson responded to an approach from Ruth May for comments on draft infection prevention and control guidance [INQ000371142]. We did not comment on the clinical aspects of the guidance but offered advice on communicating a coherent strategy to the NHS with clear, realistic actions.
    c. On 30 July 2020, Chris Hopson provided Amanda Pritchard with comments on a planned letter from NHSE to the NHS with instructions for responding to what NHSE then described as 'phase 3' of the pandemic response [INQ000371143]. He identified some policy content he believed had been omitted (such as ensuring appropriate use of the independent sector and covering rising costs of medical awards during the pandemic). For the most part his comments otherwise focused on ensuring clear and coherent communication to trust leaders and the wider NHS.
41. Often during the relevant period, because of time constraints, colleagues in NHSEI flagged emergent guidance to Chris Hopson or me to ensure we remained up to speed with policy frameworks and could then support in briefing trust leaders, with limited or

no real opportunity for comment prior to publication. For example, our records show Julian Kelly, joint chief finance officer of NHSEI, contacted Chris Hopson on 15 March 2020 to brief him on changes to the financial regime supporting trusts during the pandemic and a move to block contracts.

HM Treasury

42. In the normal course of events (outside of the relevant period), we have regular meetings and maintain contact with officials from HM Treasury to inform the comprehensive spending review process and make the case for additional investment. These meeting are exclusively with NHS Providers.
43. Our records show we had a number of meetings and roundtables with senior officials during the relevant period. For example:
    a. In June 2020 Philippa Davies, the Treasury's director of public services, briefed us on a capital funding/infrastructure announcement and the implications for managing the pandemic and managing upcoming winter pressures, including measures to mitigate extra capacity issues linked to Covid-19 such as social distancing protocols and use of PPE.
    b. In September 2020, Treasury officials met members of the Community Network (a group which acts as the national voice of NHS community providers and which is hosted jointly by NHS Providers and the NHS Confederation) at a roundtable. They discussed the comprehensive spending review process and the case for additional investment in community health services during the Covid-19 response.
    c. In September 2020, Chris Hopson and I met Philippa Davies and discussed increases in demand for mental health services in the wake of the pandemic.
    d. In April 2021, July 2021 and May 2022, Chris Hopson and I met Dharmesh Nayee, deputy director for health and social care at HM Treasury. We discussed concerns around funding for discharge to assess and the impact of infection prevention and control policies.
    e. In October 2021, we wrote to Dharmesh Nayee and Will Garton, director for public services at the Treasury, in advance of the comprehensive spending review, highlighting the need for an appropriate capital settlement to ensure ongoing Covid-19 recovery.

UK Health Security Agency (UKHSA)

44. We have no record of routine contact with PHE during the relevant period. We did however meet with senior officials from its successor organisation, the UKHSA to

discuss the role of trusts in the pandemic response, and we established an advisory group of a small number of trust leaders at their request. For example, in June 2021 we arranged a roundtable for trusts leaders to meet with UKHSA chair Ian Peters and chief executive Jenny Harries where they discussed the role of directors of public health, the role of trusts in the pandemic response and the importance of finding the right national model to complement local joint working, UKHSA's national role in providing guidance and information, and opportunities for a greater role for trusts in public health and health improvement. Our respective organisational chairs, Sir Ron Kerr and Ian Peters, met during the relevant period to share insight from trusts and keep up to date with UKHSA's work.

45. Following the roundtable and at the request of UKHSA, we established a UKHSA advisory group involving a small group of trust leaders along with Ian Peters and Jenny Harries, and Chris Hopson. This met quarterly throughout the remainder of the relevant period and agendas were set jointly. Agenda items included: the ongoing Covid-19 operational situation, winter planning, and developing a future public health workforce. Pandemic preparedness was a standing item.
46. There was also engagement on an ad hoc basis when UKHSA and trusts had a mutual interest in an emerging issue, such as an exchange between Jenny Harries and me regarding news coverage on vaccination statistics for NHS staff in October 2021.

Care Quality Commission

47. In the normal course of our work, we have regular meetings and maintain contact with officials across the CQC, including senior colleagues. This gives us the opportunity to inform the development and implementation of the CQC's regulatory approach. These meetings are exclusively with NHS Providers. We also correspond with officials when the need arises. This continued during the relevant period when the focus was on their regulatory approach during that period, for example:
    a. From May 2020 we had monthly catchups between our respective policy teams to share key priorities for our respective organisations, recent or forthcoming outputs and issues of mutual interest. We had ad-hoc conversations, for example relating to the changing approach to inspection during this time. There were also occasions where we engaged on a specific issue, such as responding to comments CQC had made over the discharge of patients from hospitals to care homes. We sat on their external strategic advisory group, which met bi-monthly.
    b. In December 2020 we wrote to Professor Baker and Ian Trenholm, CQC chief executive, advising them of members' concerns about the impact of regulatory

activity during what was then expected to be a second major wave of Covid-19 [INQ000371144].

c. From July 2021 we commenced quarterly meetings between Chris Hopson and Professor Baker, which typically focused on CQC's approach to inspection in the context of the pandemic.

d. Sir Ron Kerr had regular, though not frequent, meetings with CQC chair Peter Wyman. These meetings served as a touch point between the two organisations, helping to maintain the relationship by keeping each other sighted on key issues and concerns. Sir Ron and Mr Wyman would discuss trust leaders' current priorities and concerns, and current policy issues such as evolving regulatory priorities in the context of the pandemic, and the development of statutory system working.

e. In March 2021 we convened a roundtable with trusts and Professor Baker on CQC's use of prosecutions of trusts during the pandemic.

Deputy chief medical officer (DCMO) and the chief nursing officer (CNO)

48. We had limited engagement with government medical advisers and experts during the relevant period. Much of our information from senior government medical or nursing advisers was received through webinars and virtual briefings held by DHSC or NHSEI. These were used to share the latest government or NHSEI intelligence, directives and policy with regard to the pandemic response. These were attended by many stakeholders including medical royal colleges and other membership bodies.

49. At the outset of the pandemic DHSC set up a fortnightly stakeholder call to help share the latest news and guidance relating to Covid-19. These calls were scheduled up until the end of 2020. The deputy chief medical officers (DCMO) attended these calls to answer questions from stakeholders on a range of issues, with a member of our staff attending to take notes. NHSEI set up a regular stakeholder call in or around March 2020 with the medical royal colleges and other key stakeholders to provide the latest information on Covid-19 and to allow stakeholders the opportunity to ask questions and raise concerns. This continued throughout the relevant period. We also joined NHSEI's 'Beneficial Changes Network', which was established in August 2020 in order to embed learning from Covid-19 across the health and care sector.

50. We held a series of virtual roundtables for our members, held under Chatham House rules, with Ruth May and members of her team. In September 2020 and January 2021, we discussed learning with regard to infection and prevention control; in October 2021, we discussed how to develop and support nursing and midwifery leadership in the context of a rapidly changing and high-pressure, complex environment.

51. From mid-2021, our organisational approach to stakeholder engagement began to return to a business as usual approach.

NHS Confederation

52. NHS Providers maintains regular contact with NHS Confederation, including collaborating on key projects which add value for our collective memberships, and jointly hosting the Community Network.
53. During the relevant period, NHS Providers and NHS Confederation maintained usual interactions at a senior level. We did not set up additional arrangements to co-ordinate activities but we did continue to work together to support the Community Network, including calling for additional funding to support hospital discharge to be continued. We also occasionally issued shared messaging publicly, for example, a joint report, 'A reckoning: the continuing cost of Covid-19', published 2 September 2021 [INQ000371145].

Communication and information sharing

54. As NHS Providers is an independent membership body and not a statutory body, there are no formally agreed mechanisms in place for us to input or share data from our members as part of our work to represent their interests. There are no statutory requirements for us to input or share data. NHS Providers has no formal role in transmitting emergency alerts or disseminating information, policies and guidance within the NHS. We do not facilitate the sharing of information between frontline NHS staff, or between different national and regional NHS bodies.
55. The mechanisms in place are mutually agreed and developed over time and include both scheduled and ad hoc contact.
56. However, during the relevant period, we sought to support the flow of information, intelligence and good practice between trust leaders and with national decision makers, on behalf of trusts by using all of the channels described in paragraph 14. Our evidence as a whole reflects the concerns raised with us by trust leaders and the key actions we took to share that information with national decision makers.
57. In addition to the channels set out above, we hosted four WhatsApp groups to rapidly gather intelligence and identify concerns. Two of these groups were established in 2019, and two during the relevant period. Of these:
    a. The "NHSP CEO + board group" WhatsApp group comprised trust chief executives and NHS Providers' trustees. Some trust chief executives in the group also held national roles, such as Claire Murdoch, NHSEI national mental health director. By 10 March 2020 it was agreed that Amanda Pritchard, then

NHSE chief operating officer, would be added to the group to aid communications. Other NHSEI officials joined shortly afterwards, including Pauline Philip, national director for emergency and elective care.

b. The "NHSP chairs group" WhatsApp group comprised trust chairs. Amanda Pritchard, David Prior (then chair of NHSE) and Dido Harding (then chair of NHSI and latterly chair of National Institute for Health Protection) were added on 19 March 2020 when the group was created.

c. The "NHSP Comms directors" group was set up in April 2019 and comprised directors and leads of trusts' communications functions. NHSEI officials were not part of this group at any time.

58. The terms of reference for these three groups set out expectations of respect for a 'safe space' in which information could be shared in a timely manner. NHS Providers managed the group. Members commented in these groups with the understanding of them being that safe space with their professional colleagues.

59. A further WhatsApp group was also established for part of the relevant, called "Vacc: hosp hubs & NHSE/I". This group comprised trust chief executives and some of their senior responsible officers (SROs) from the 50 vaccination hospital hubs and senior NHSEI colleagues leading the vaccination workstream. We hosted this group from December 2020 to January 2021. The group had limited traffic but was intended to be used for sharing information and good practice.

60. These WhatsApp groups were used by trust leaders to share information across healthcare systems in England relating to problems encountered, propose solutions to problems and help improve the response to the pandemic. From March 2020 the "NHSP CEO + Board group" was occasionally used as a means for trust leaders to flag pressing operational issues to NHSEI. We produced daily analysis of the issues raised in the WhatsApp groups for internal use at the time and to inform our influencing and media work.

Challenges with information sharing

61. An ongoing issue reported by our members were problems with chief executives receiving timely communications from NHSEI.This was particularly acute in March 2020 when the absence of guidance on PPE was causing serious operational issues because staff felt unsafe. Trusts were often frustrated at receiving new instructions and guidance late from the centre, often with the expectation of immediate implementation. In June 2020 trusts were given only a week to implement new national mask guidance. We held a roundtable in September 2020 on infection prevention and control (IPC) where trusts raised concerns about the timing and communication of policy

announcements and updated guidance. They said that announcements made late in the week could cause delays to implementation, given practical challenges of meeting new requirements. Members also said that where late announcements were made, some flexibility around implementation would have been helpful, for example, to help organisations adapt to the context of local lockdowns. This was a key reason for us in expanding our chief executives and chairs WhatsApp groups to include leaders from NHSEI and for the creation of our web hub to collate national guidance and notes from national stakeholder meetings providing updates on how the pandemic and the national response was evolving.

62. In addition, trust leaders frequently expressed concern about an NHSEI 'command and control structure' around communications at national and regional level, saying it hampered their ability to communicate with local audiences. As early as February 2020 there is reference to a 'blanket order to refer all Covid-19 media inquiries to the DHSC'. NHS Providers shared this feedback from trust communications directors directly with then NHSEI national director of communications, Simon Enright. We also sought to bring together NHSEI and trust communications leads to improve relationships in February 2021.
63. NHS Providers offered feedback on how communications from government, NHSEI and other national bodies had been received by trust leaders. For example, we wrote to the secretary of state and the leadership of NHSEI and PHE [INQ000371146], and made a public statement, on 13 June 2020 [INQ000371147], to seek to agree a set of protocols for all future announcements affecting the operations of NHS trusts. Text messages between NHS Providers then chief executive Chris Hopson and Amanda Pritchard, NHSE, from the relevant period show Chris offering to support them with clearer communications with trust leaders.
64. NHS Providers was occasionally, but not routinely, invited to comment on whether proposed communications and guidance were clear. Given the membership we represent, we sought to add value by commenting on the managerial and operational aspects of guidance. For example, as described earlier, on 30 July 2020 Chris Hopson provided Amanda Pritchard with comments on a planned 'phase 3' letter from NHSEI to the NHS.

Concerns raised about clinical guidelines, guidance, advice or instructions – and opportunities to input into formal consultations

65. NHS Providers does not offer clinical advice to its membership or seek to influence or inform clinical aspects of national policy or local decision making. However, via our

WhatsApp groups and other communication channels, trusts did raise a number of concerns with us, including on clinical guidance, as set out below.

Frequency of updates or changes, and feasibility/implementation difficulties

66. The timely publication and communication of national guidance and amendments to national guidance were a challenge. We heard from trust leaders throughout the pandemic that, while they understood the need to update guidance swiftly as our understanding of the virus improved, it was challenging to action the volume of guidance and to ensure clear communication with staff and patients. They often sought clearer communications from the relevant national bodies. For example, when PPE guidance changed in April 2020, trusts told us they struggled to identify what had changed because they were sent a link to a list of documents when what they needed operationally was one document clearly setting out the key differences.
67. Trust leaders were often frustrated at receiving new instructions and guidance with the expectation of immediate implementation. For example, in June 2020 they were given a week to implement new national mask guidance, with concerns raised about a lack of consultation on changes to visiting guidance aimed to reduce the spread of infection. We brought these concerns to the attention of Sir Simon Stevens, Amanda Pritchard, Baroness Dido Harding and Duncan Selbie, as well as the then Secretary of State for Health and Social Care, Rt Hon Matt Hancock MP [INQ000371146], and we briefed the media [INQ000371147]. Concerns of this nature were sustained throughout the pandemic, with a particular focus in the early months on PPE, IPC and patient visiting policy.
68. In July 2021, members raised concerns about changes to IPC guidance, when the government changed the law on wearing of face masks in public. Members called for clear national messaging on this issue which we reflected in a press statement in response. It was felt by some trust leaders that the lack of clarity regarding the public being required to wear masks in healthcare settings was particularly challenging at this point in the pandemic. Some trusts also reported via WhatsApp in July 2021 that members of the public did not want to comply with mask wearing and that they were seeing non-compliance in some settings. They urged clear guidance on IPC and mask wearing.
69. Throughout the relevant period there were a number of changes to PPE guidance and, despite being assured that the changes were based on scientific expertise, trusts told us that changes in guidance often damaged the confidence of frontline staff in the equipment and approach. We explore the difficulties trusts experienced with regard to PPE in greater depth in paragraphs 179 to 190.

70. In April 2020, noting a drop in the number of patients presenting with conditions other than Covid-19 (such as cancer, stroke, heart attacks, paediatrics, mental health and safeguarding), members on our WhatsApp groups pointed to the complexity of the clinical guidelines and some of the differing positions taken by the medical royal colleges about what procedures could or could not take place. Members also raised concerns at a roundtable in September 2020 about IPC guidance being produced by alternative sources such as trade unions (that is, not national guidance produced by NHSEI or the DHSC) and the anxiety this created for staff early on in the relevant period with the potential for different interpretations, which was challenging and meant patient experience varied.
71. As NHS Providers does not help to inform clinical guidance we were not best placed to pick these issues up directly on behalf of trusts.

Incompatibility with other guidance and negative impacts, and feasibility/implementation difficulties

72. In March 2020 there were four issues raised in our CEO and Board WhatsApp group which presented NHS leaders with significant challenges to delivering healthcare during the early weeks of the pandemic (and where they consequently sought national and government guidance and support): PPE; testing capacity; ventilator capacity; and oxygen system delivery capacity. Some trust leaders also flagged concerns about the impact of Covid-19 on other planned care, the impact of the pandemic on staff time, and the impact on operations and care quality of the requirements created by the pandemic such as necessary IPC measures reducing capacity and slowing down procedures.
73. I explore PPE, testing capacity and IPC measures in depth within dedicated sections in this statement and do not repeat those here. We received much less feedback about ventilator capacity and oxygen supply, but the feedback we did receive showed the depth of concern among some trust leaders about how these challenges were being addressed in the early days of the pandemic. For example, in late March 2020, a chief executive of an acute trust texted NHS Providers' then chief executive, Chris Hopson, to say they had 234 of the 569 ventilators needed for the county with a query as to whether politicians were taking this shortage sufficiently seriously. Chris replied to say he didn't feel close enough to the politicians' thinking or the process for ventilators specifically at that time, but that we would flag the need publicly. A text message from another trust chief executive at a similar time, also to Chris Hopson, confirms delays in delivering ventilators to the frontline. In terms of oxygen supply, we received messages from trust chairs and chief executives in the early days of the pandemic

reflecting their concerns about supply and whether the hospital infrastructure would withstand the increased demand for oxygen.

74. At times, trusts voiced concerns that government advice was at odds with service needs. For example, the decision in the early days of the pandemic not to test staff for Covid-19 was a concern as large numbers of staff had to self-isolate. This issue was raised with Amanda Pritchard on our CEO and board WhatsApp group on 16 March 2020. A readout of an NHS Providers board meeting discussion in May 2020 reported that trusts felt government was extending testing criteria without a long-term strategy.
75. As recorded in our CEO and director team report in May 2020, concerns were also expressed about national messaging to 'stay at home', as while it was necessary to prioritise the NHS response to Covid and support its use of available capacity, the NHS had seen an 'artificial' drop in demand.
76. In the early weeks of the pandemic, on a number of occasions, trusts raised concerns about guidance or requested further guidance, information, best practice or clarification. Issues mentioned on our CEO and Board WhatsApp group, which was visible to NHSEI, in the first half of 2020 included:
    a. Modelling to predict PPE need, what trusts could use as alternatives when stock (such as gowns) became constrained, ways of reducing the number of interactions with each patient and advice on how much stock to hold;
    b. The need for dedicated guidance for healthcare workers prompted by confusion regarding guidance on isolation rules information on a community prioritisation framework and guidance on discharging patients;
    c. Clarification on staff testing protocols, and advice on self-isolation for staff with long-term conditions and staff wellbeing;
    d. National contingency plans for laundry provision;
    e. Plans regarding oxygen in the community;
    f. How the government / NHSEI planned to convey messages on social distancing to the public;
    g. National guidance on temporary Health and Care Professions Council registration given that final year students were offering to help provide care during the Covid-19 pandemic;
    h. The distribution of relocatable CT scanners;
    i. If the government would be covering the costs of trusts providing free parking and subsidised food;
    j. Advice on CQC inspections and whether they would be suspended;

k. Clarification of the Health and Safety Executive's (HSE) guidance on reporting of injuries, diseases and dangerous occurrences (RIDDOR) in the context of staff dying or becoming seriously unwell from Covid-19;

l. Whether private hospitals could take on medically safe patients and whether critical care staff and equipment to be transferred to the NHS during the pandemic;

m. Guidance on risk assessments for staff.

77. In addition:

a. On our CEO and Board WhatsApp on 27 April 2020, members discussed a letter from the British Association of Physicians of Indian Origin (BAPIO), *Covid-19: disproportionately hight mortality rates in BAME health and social care (HSCW) workers,* dated 22 April 2020 **INQ000120826**. The letter suggested that ethnic minority staff were more at risk and BAPIO advocated an approach which was inconsistent with national guidance. Our members felt that they needed a national steer so that they could respond.

b. In July 2021, trust leaders expressed the need for a national framework around social distancing measures and that they were concerned that political messages were running ahead of the service.

c. Members expressed strong feelings in January 2022 that the national guidance on mandatory vaccination of staff wasn't sufficiently clear to back a national, legal mandate.

Consultation

78. Given the need for time-critical decision making by government and NHS national bodies, many of the usual channels of consultation (including statutory consultation) on draft guidance were suspended during the period from 1 March 2020 until early 2021. During this period, we focused our efforts on ensuring that written and verbal feedback from trust leaders about the key challenges they were facing was shared with national policy makers in a timely fashion.

79. During the relevant period (and predominantly from early 2021 onwards), we responded to 27 national consultations, commissions and parliamentary inquiries relating to health and care provision. These covered matters such as the planned comprehensive spending review, taking account of the impact of Covid-19 in September 2020, the National Audit Office inquiry on NHS backlogs and waiting times in the context of the pandemic in October 2021, and the DHSC consultation on mandatory staff vaccinations in November 2021. A minority of these consultation responses were directly relevant to the NHS' ability to respond to the demands of the

pandemic, for example, our response to a DHSC consultation on making vaccination a condition of deployment.

NHS capacity

Capacity concerns pre pandemic

80. Trust leaders believe that the source of the pressures the NHS now faces predate, but were exacerbated by, the pandemic. In June 2022, at the end of the relevant period, we published a report on the operational and financial challenges facing trusts in 2022/23 [INQ000371150]I which have built up over the previous decade as four long-term fault lines:
    a. The longest and deepest financial squeeze in NHS history;
    b. A growing mismatch in capacity and demand resulting in growing pressure on national performance standards, evident as the NHS entered the pandemic;
    c. Staff vacancies and the need for better national workforce planning; and,
    d. An underfunded social care system in need of reform.
81. In the months leading up to the pandemic we published two survey-based reports which identified similar pressures on NHS performance and concerns about NHS infrastructure *State of the NHS Provider Sector* (published October 2019) [INQ000371151] and *Rebuilding our NHS* (published February 2020) [INQ000371152].
82. Sixty-one percent of respondents of our *State of the NHS Provider Sector* survey [INQ000371151] told us that they were worried about whether their trust had the capacity to meet demand over the next 12 months. This message was reiterated in the results of a similar survey of trust leaders in November 2021 which identified concerns about an overstretched workforce, high bed occupancy rates, longer waiting lists for care and longer ambulance response times, and associated safety risks. Our 2021 report also highlighted trust leaders' concern about severe funding constraints for services outside the NHS core budget (notably social care and public health) and the risk that preventative support for people would be deprioritised, driving up demand for NHS services. Ninety percent of survey respondents were worried that sufficient investment was not being made in social care.
83. Our 2019 *State of the NHS Provider Sector* report [INQ000371151] also reinforced the concerns many trust leaders had about the adequacy of their estates and the level of capital funding available to maintain buildings, modernise facilities and invest in new technologies. In our February 2020 *Rebuilding our NHS* report [INQ000371152], 94% of trust leaders said restricted funding posed a high or medium risk to patient experience, while 82% said there was a high or medium risk to patient safety. In 2021, trust leaders continued to emphasise the need for additional capital investment,

including to be able to expand capacity and comply with infection prevention and control guidelines. While the October 2021 comprehensive spending review announced national funding for elective recovery to enable trusts to expand bed capacity (from 2022/23), limited access to capital investment (predating and during the relevant period) constrained whether trusts could expand their capacity.

Ambulance services

84. The response to the pandemic and IPC measures in place across the NHS had an impact on ambulance trusts' capacity, productivity and finances. In some parts of the country, ambulance activity and demand remained high while presentations at emergency departments were very low, as reported by members on our CEO and Board WhatsApp on 7 April 2020. To address productivity and capacity issues ambulance trusts expanded the provision of the "hear and treat" model of services during the pandemic. This model requires placing additional clinical capacity in call centres to triage calls more effectively, so that fewer patient transportations were required, as outlined by an ambulance trust chair in our internal briefing on the results from our annual *State of the provider sector survey* in October 2020 [INQ000371154]. These challenges began at the start of the relevant period and were still being highlighted in August 2021.
85. In the early weeks of the relevant period, concerns and queries were raised in our CEO and Board WhatsApp group including reports of very high demand on NHS 999 and 111 services, as public concern about the virus and reporting of potential symptoms rose. Questions about the impact on safe staffing in call centres and ambulances due to new self-isolation rules and remote work guidelines was also highlighted by members in the same group.
86. By May 2020 our survey data (*Pulse Survey, A new normal,* May 2020 [INQ000371153]) revealed how social distancing and infection control measures were impacting capacity of NHS trusts, with 80% of respondents from ambulance trusts agreeing or strongly agreeing with the statement, 'physical/social distancing reduces our available capacity'.
87. In our annual *State of the provider sector survey* conducted during August 2020 [INQ000371154], members expressed concerns that the ambulance sector was not being engaged in national or regional capacity and ongoing Covid-19 response planning. Ambulance trusts were also reporting measures they were putting in place to mitigate levels of operational risk. This included investing in additional capacity across their fleet of vehicles, ongoing recruitment drives, a focus on the health and

wellbeing of their existing workforce and continued engagement with their integrated care systems.

88. As the second major wave of infections began in autumn 2020, members raised concerns on 7 October 2020 on our CEO and board WhatsApp group about overall pressure on emergency departments impacting ambulance capacity and rising handover delays.
89. Via informal conversations and email correspondence during 2020, including with the Association of Ambulance Chief Executives (AACE), we noted concerns being raised about the following issues:
    a. Provision of adequate PPE supplies specifically for telecare provider community response teams (as these teams help to reduce demand on ambulance services) and more general support for all staff anxious about PPE supplies;
    b. Supporting staff and patients from ethnic minority backgrounds who were at higher risk during the pandemic and seeking to address mental health challenges and burnout across the staff team;
    c. Rapid stand-up of procurement arrangements and implications for existing contracts during the pandemic;
    d. Input to NHSEI's Beneficial Changes programme, for example consideration of a '111 first'/'talk before you walk' initiative;
    e. Implications of Covid-19 on NHS finances beyond the pandemic and learnings around resilience and being ready for 'the next big thing', for example the benefits of relaxing financial constraints;
    f. A feeling that integrated urgent and emergency care models were better placed to deal with the challenges that Covid-19 posed;
    g. Primary care capacity being freed up and retired GPs coming back to work leading to additional availability of remote clinical support;
    h. The impact of handover delays on patients, staff and ambulance service capacity; and
    i. Good examples of mutual aid across the country to help manage demand.
90. Members also reported very high demand across the ambulance sector in summer 2021, compounded by high rates of self-isolation among staff. Some trusts paid enhanced overtime and brought in agency staff to cover gaps.
91. A September 2021 joint publication by NHS Confederation and NHS Providers, *A reckoning: the continuing costs of Covid-19* [**INQ000371145**], highlights extra cleaning costs for emergency and non-emergency patient transport as a factor in increasing costs and reducing efficiency. Separately, in patient transport services, social

distancing requirements meant patients often had to travel alone, where previously a group may have travelled together. We estimated, in September 2021, that the additional recurrent annual cost linked to Covid-19 for the ambulance service would be over £225 million.

92. We also published a number of outputs focused on ambulance services and Covid-19 in 2020-21, some jointly with AACE. For example:
    a. On 4 June 2020, we published a blog by Heather Lawrence OBE, then chair of the London Ambulance Service NHS Trust [INQ000371156] on measures to support staff, such as the provision of emergency accommodation as the number of calls taken rose from 5,000 to 11,000 a day.
    b. In October 2020, we published an interview with Daren Mochrie, chief executive of North West Ambulance Service NHS Trust and chair of AACE [INQ000371157], where he set out some of the key lessons learned from ambulance services' experiences during the early part of the pandemic.
    c. On 16 November 2020, we published a briefing, *'Securing the right support for ambulance services'* [INQ000371158], which highlighted the historical underfunding of ambulance services.
93. From 2021 onwards, the focus of our conversations with AACE and individual ambulance trusts moved more to recovery (for example, we published a joint report focused on the role of the ambulance sector in transforming services and coping with the long-term impact of Covid-19), ongoing staff concerns regarding PPE, handover delays, operational pressures (particularly over winter), and other operational and strategic issues not directly related to Covid-19.
94. The issue of rising handover delays – where a patient ready to be transferred to an emergency department cannot be transferred due to lack of capacity in hospital – was a persistent concern during the relevant period. In this circumstance the patient remains under the care of the ambulance crew, preventing the ambulance team from responding to new calls and creating knock-on delays.

Capacity challenges

95. In our WhatsApp group messages members did not report any instances of demand exceeding bed capacity at hospital, trust or regional level. Whilst there are no specific instances reported, it is clear that over the second wave from, autumn 2020 to April 2021, and the third wave, from autumn 2021, members routinely flagged a list of factors impacting capacity. These included the need to separate patients into Covid-19 positive and Covid-19 negative physical spaces, the availability of critical care beds, and increased levels of staff absences. These concerns were highlighted by several

members over the Christmas period in 2020. As I have raised elsewhere in in this statement, they also raised concerns about oxygen supplies.

96. As I detail later in this statement, in the autumn of 2021 members described how issues with out of hospital and social care provision were impacting capacity as they were unable to discharge patients. Trust leaders told us that unlike the first wave from March 2020 when some services were temporarily suspended to ensure sufficient capacity for Covid-19 patients, later waves presented them with much more challenging capacity constraints as they were also having to manage busy emergency departments and continue elective activity.
97. In the first few weeks and months of the relevant period, members shared with us a number of changes made or underway to increase capacity. These included:
    a. The creation of the 'Nightingale' hospitals;
    b. Prioritising critical care and delaying non-critical appointments;
    c. Undertaking routine appointments by telephone or using a new online platform;
    d. Internal reconfiguration of premises, particularly focused on providing ventilation support, to expand critical care capacity;
    e. Expanding the number of staff able to look after critically ill coronavirus patients through training and nurses and doctors volunteering to return to the NHS;
    f. Using independent sector capacity to provide additional hospital beds, ventilators and clinical staff;
    g. Ambulance trusts increasing the size of their available fleets of vehicles, including refitting non-emergency response vehicles and accelerating the purchase of new vehicles. They also incorporated additional crew members from fire services;
    h. Launching a coronavirus 111 service;
    i. Community services delivering consultations by phone and video call, as well as increasing the number of home visits while suspending certain home services according to how critical and high risk they were, and swiftly employing and inducting new staff;
    j. Mental health providers reconfiguring their accommodation – particularly secure units – to equip them to deal with Covid-19 patients. They also created empty wards to enable hospitals to transfer non-Covid-19 patients.

Major incidents

98. We did not track trusts' declarations of major or critical incidents, but did receive feedback from members via WhatsApp and our surveys highlighting the considerable operational pressures trusts were experiencing during the relevant period.

99. During the first weeks of the relevant period, trust leaders reported, via WhatsApp and email, concerns around the supply of oxygen and availability of portable oxygen cannisters. We also heard in January 2021 from a trust chief executive that his trust had narrowly avoided running out of oxygen.

100. Availability of ventilators, continuous positive airway pressure (CPAP) devices and extracorporeal membrane oxygenation (ECMO) machines also featured as prominent concerns within the member WhatsApp groups during the first weeks of the relevant period and in early 2021. This included concerns about the number of ventilators available and best clinical practice for treating Covid-19.

Efforts to alleviate pressure on NHS capacity

National guidance or advice on the approach to discharging patients (including criteria for discharge, advice on testing prior to hospital discharge and whether the criteria for discharge differed before and after 1 March 2020)

101. As I have stated previously, NHS Providers has no role in issuing guidance on clinical or operational matters in the NHS including with regard to hospital discharge. However national policy on hospital discharge (and testing prior to discharge) remained an important aspect of the pandemic response for our membership and DHSC and NHSEI issued a number of iterations of guidance aimed to support timely discharge from hospital. Below I list the relevant national guidance and advice, to the best of NHS Providers' knowledge.

102. On 17 March 2020, NHSEI issued 'discharge to assess' guidance to NHS trusts and foundation trusts (among other recipients) focused on enabling patients to leave hospital as soon as they were medically fit and could be supported at home or in community settings. This approach was based on the principles of 'home first', a model of care promoted as best practice by NHSEI (and supported by many trust leaders) since 2016. Then director of strategy at NHSEI, Ian Dodge, contacted Chris Hopson on 20 March 2020 to check NHS Providers had seen the refreshed guidance which Ian described at the time as a more 'radical' approach than previous discharge policy. To the best of our knowledge, this guidance was updated on 22 March 2022 and withdrawn on 1 April 2022.

103. On 15 April 2020, DHSC published its adult social care action plan which announced:

a. All patients must be tested prior to discharge to a care home whether they had symptoms or not on discharge from hospital;

b. Patients waiting for test results should be discharged and isolated as suspected Covid-19 patients. If the test result was negative, the guidance still recommended isolation for 14 days;

c. If care homes were unable to meet isolation requirements, alternative arrangements would need to be made by the local authority, assisted by NHS primary and community care.

104. This approach was reiterated to accountable officers of all hospitals (public and private sector) working for the NHS and discharge teams, amongst other recipients, in a letter from NHSEI on 15 April 2020: *New requirements to test patients discharged from a hospital to a care home.* On 14 May 2020, the new operating framework for urgent and planned care in hospitals stated that all patients being discharged to a care home should be tested up to 48 hours prior to discharge. On the same day, the government published a document entitled *Coronavirus (Covid 19): care home support package,* outlining support for care homes, which emphasised the risks of asymptomatic transmission of Covid-19 in care homes via both residents and staff. To the best of our knowledge, this guidance was updated on 1 April 2021 and then withdrawn on 6 April 2022.

105. According to our records, on 21 August 2020, NHSEI updated the hospital discharge guidance, first published on 19 March 2020, to instruct the health and care system to continue implementing the 'home first' discharge to assess model.

106. From 21 August 2020, six weeks of centrally funded care, approved by government, to support timely hospital discharge was introduced. Further information was published on use of this funding in April 2021 and again in September 2021 with a reduction in the support available to four weeks care. The funding was in place until 31 March 2022. In June 2021 we made the case to HM Treasury for an extension of permanent, dedicated, additional government funds to support people's care needs once discharged [INQ000371160]. NHS Providers and NHS Confederation wrote jointly to the secretary of state in August 2021 [INQ000371161], alongside other organisations including Healthwatch, to seek an extension of additional funding to support hospital discharge during this period.

107. On 21 October 2020, DHSC sent a letter to directors of adult social services with local authority chief executives, clinical commissioning group chief executives, acute trust chief executives and directors of public health in copy. The letter outlined:

a. New requirements for designated care settings for people discharged from hospital with a Covid-19 positive status;

b. Anyone with a positive test result being discharged into, or back into, a care home setting must be discharged into an appropriate designated setting and be cared for there for the remainder of their isolation period;

c. No one will be discharged into a care home setting with a Covid-19 test outstanding or without having been tested within 48 hours preceding their discharge;

d. Everyone being discharged into a care home must have a reported result and this must be communicated to the care home prior to the person being discharged from hospital.

108. On 13 December 2021, NHSEI sent a letter to the chief executives of all NHS trusts and foundation trusts, amongst other recipients, asking hospitals to work with local partners to maximise capacity across acute and community settings by reducing the number of delayed discharges by half.

109. On 31 March 2022, DHSC published the 'hospital discharge and community support guidance' reiterating the principles on which successful hospital discharge should operate (encouraging early discharge planning and advocating for multidisciplinary support for patients and service users for example).

110. NHS Providers published a 'Spotlight' briefing on 19 May 2020 which, based on discussions with members, found that some trusts were already testing patients and care home residents with symptoms ahead of the national guidance wherever testing capacity allowed, but this capacity was not reliably and consistently available across the country before mid-April 2020 [INQ000371162].

<u>Concerns raised by members regarding the discharge of patients receiving treatment for conditions other than Covid-19</u>

111. The majority of the feedback we received relating to patient discharge focused on a need for sustained national funding to support timely hospital discharge (explored above); on the interface between the NHS and social care; and on the need for support for care homes.

112. In March 2020 members discussed patient discharge on our WhatsApp groups, noting a rapid trajectory to discharge medically fit patients and raising concerns about the capacity needed for social care visits and packages. They also flagged concerns about the availability of PPE in social care settings with an example of an acute trust sending its own stocks to a local authority to facilitate acute discharge, during this early stage of the pandemic. One trust also directed a request to NHSEI for urgent guidance for residential and nursing homes because of the problems they were experiencing

trying to discharge patients. In March 2020, a mental health trust leader requested similar discharge guidance to that received for acute settings.

113. Some trust leaders contacted us around this time to tell us what procedures they were putting in place locally above and beyond the national guidance to protect care home populations. For example, one trust chief executive told us in May 2020 that they 'didn't think anywhere would knowingly be discharging Covid positive patients without a discussion with where they are being discharged to allow IPC precautions to be put in place. We have been really clear on positives and suspected positives when discharge plans are drawn up and now with testing this is much easier.' Another serving trust chief executive at the time emailed Chris Hopson to say 'it is a complex and nuanced picture where people have honestly done their best in the circumstances with the resources available at the time; and most people have actually gone home with or without support depending on their needs, or to a community rehab bed, and care homes are and remain a minority destination.'

114. Our records also show that a number of trust leaders recognised the inherent risks in government and national policy. For example, a trust chief executive emailed Chris Hopson on 14 May to flag that some Covid 19 positive patients would have been discharged to care homes 'before testing was introduced, some would be false negatives and some asymptomatic.' That chief executive agreed with NHS Providers' assessment that this was not 'systematic.'

115. In response to a survey in June 2021 [INQ000371163], trust leaders also welcomed the additional, government funded 'discharge to assess' funding to facilitate timely and safe discharge and to flag issues with delayed discharge impacting capacity. As explored above, NHS Providers was one of a number of health charities and representative bodies to make the case for this dedicated fund to be extended.

116. Over the course of 2021, member feedback on the need for timely hospital discharge reverted to the need to respond to broader operational pressures rather than increases in Covid-19 patients specifically. This was reflected in members responses to our October 2021 *State of the provider sector survey* where 84% of trust leaders were very worried about having the capacity to meet demand [INQ000371164].

Concerns raised by members regarding hospital admissions criteria

117. On 25 April 2020, NHS Test and Trace's director of testing, Sarah-Jane Marsh, contacted trust chief executives to highlight a letter that had been sent to trusts from NHSEI setting out requirements to test all emergency admissions and thereafter, elective admissions, from the following week. In response, trust chief executives fed back a range of concerns around the practical implementation of this directive. These

included the impact on admission times and emergency department capacity if tests took too long to return. Trusts also highlighted the fact that the guidance would only be relevant to acute trusts, and did not reflect the specific needs of mental health, learning disability, community or ambulance providers and the ethical considerations varied substantially between settings.

118. Some trusts had implemented this change prior to the guidance from NHS Test and Trace coming into force. Besides this, we have no record of trust admissions policies differing from national guidance. We are not aware that trusts developed their own admissions criteria.

Public messaging

119. NHS Providers and our members expressed concerns about patients in need of treatment delaying or avoiding accessing healthcare from early March 2020 although we cannot be clear whether this was in direct response to government public health messaging during the relevant period. For example, one of our members raised concerns via the CEO and Board WhatsApp group on 6 March 2020, highlighting patients not coming to outpatient appointments and a "big drop in minors at A&E". This theme continued, with similar concerns being discussed in the group in March and April 2020. These discussions often included concerns regarding a reduction in patient referrals, documented in our briefing, *Spotlight on the new normal: balancing Covid-19 and other healthcare needs*, in May 2020 [INQ000371165].

120. NHS Providers took opportunities to flag the message, 'stay at home, protect the NHS, save lives' publicly in press releases and blogs throughout April 2020 [INQ000371166]. While taking on board the range of feedback we received from trust leaders at the time, we also sought to balance that with a message that the NHS was still there for people who needed it, as seen in an April 2020 press release. Our "core script" document [INQ000371167], which was regularly updated and used as a source of our media and stakeholder messaging at the time, stated on 12 April 2020: "We've seen a dramatic fall in non-Covid-19 A&E attendances, which may be related to people thinking carefully before going into hospital. We absolutely support the advice to stay at home unless necessary, but it is vital that patients who need emergency care do continue to use A&Es as late presentation can impact negatively on patient outcomes".

121. In April 2020, NHSEI launched a new public messaging campaign called "Help us to help you". An edition of the Covid-19 NHS Leaders Update, a newsletter sent by NHSEI, announced the following on 24 April 2020: "From tomorrow, the NHS is launching a major new drive to persuade the public to seek the urgent care and treatment they need. Delays in getting treatment pose a long-term risk to people's

health, so our message to the public is clear; help us help you to get the treatment you need". NHS Providers publicly welcomed the launch of the campaign in a press release the following day.

122. NHSEI also made campaign materials available to NHS organisations. From an internet search, it is clear that many trusts used this public messaging on their websites, but we undertook no analysis or sought feedback from members at the time.

123. Our public messaging evolved again in August 2020, in response to a public broadcast from the prime minister, in which he stated: "If we let this virus get out of control now, it would mean that our NHS had no space – once again – to deal with cancer patients and millions of other non-Covid medical needs." Then chief executive of NHS Providers, Chris Hopson, said in a press statement [INQ000371168]: "While the prime minister wanted to stress the importance of protecting the NHS, the words he used, implying that the NHS was providing a Covid-only service during the first peak, were untrue, unfair and potentially dangerous". We sought to reinforce this message in subsequent public messaging, for example the September 2020 edition of our *NHS Activity Tracker* blog stated: "These figures highlight that the NHS is open for everyone and people must come forward to seek treatment if they need it" [INQ000371148].

124. In terms of additional steps taken by trust leaders to mitigate the impact of the public messaging of "stay at home, protect the NHS, save lives" leading to patients in need of treatment to delay or avoid accessing healthcare, our briefing, *Spotlight on the new normal: balancing Covid-19 and other healthcare needs* [INQ000371165], sets out the member intelligence on this that we received at the time. This included the following:

a. Mental health trusts set up mental health A&Es to help ease pressures on emergency departments and support people in crisis;
b. Social distancing and segregating wards into 'hot' and 'cold' areas to separate patients with coronavirus and other patients;
c. Many outpatient clinics were moved online or over the phone, and trusts explored how technology could enable some patients to access care remotely;
d. Some A&E departments were reconfigured to create dedicated Covid-19 areas complete with floor-to-ceiling walls in place of curtains to minimise the risk of cross-contamination;
e. Providing local populations with reassurance that they were welcome and encouraged to seek help for serious health problems via local radio for example;

f. Local collaboration to ensure pathways of care continued to operate and meet people's needs – for example, a specialist trust contacted GP surgeries early in the outbreak to make clear they remain open to urgent and emergency referrals, and for routine referrals with longer waits.

Staffing in healthcare settings

Details of any changes in the availability of healthcare staff in the NHS in England during the relevant period

125. The availability of healthcare staff in the NHS in England during the relevant period was affected by a variety of factors. This included vacancy rates at the start of the pandemic, staff sickness absence, the availability of testing for staff, self-isolation requirements (including for those living with a member of staff) and policies on staff shielding and risk assessments. Staff capacity was also influenced by the requirements of infection prevention and control policies and requirements about how to safely wear and remove PPE. For context, according to NHS Digital data, the staff sickness absence rate between October and December 2019 immediately before the pandemic was 4.73%. By Quarter 3 of 2019/20, the NHS in England had 99,924 vacancies, equating to a vacancy rate of 8.1%. NHS Digital will be able to provide the Inquiry with data on the staff sickness rate for a comparable period during the pandemic, and the methodology they use to calculate vacancies.

126. We do not have verifiable information on the geographical differences in staff availability during the relevant period, although we have highlighted below some of the examples of anecdotal feedback we received. We do not hold information on staffing gaps for different professional groups but we have included below, feedback from trust leaders about particular roles facing high levels of vacancies.

127. We did receive regular feedback about trust leaders' concerns to support staff and shore up their availability to protect service capacity. For example:

early in the pandemic, in March 2020, trust leaders told us in WhatsApp groups that the 14-day isolation period for those who had been in contact with a confirmed or suspected case of Covid-19 was impacting staff availability. One trust in the West Midlands reported a combined isolation and sickness rate of 21%, while another in the south west reported a rate of 5%. Trust leaders expressed their concern at the rate at which infections were increasing and that conflicting isolation advice was causing confusion at that time, with PHE suggesting a 7-day isolation period and NHS 111 suggesting 14 days.

128. Sustained concerns are reflected in a survey we conducted in May 2020, entitled *Pulse survey 2020 – resuming non-Covid services* [INQ000371153] where

trust leaders told us they were concerned about staff capacity to deliver non-Covid services because of staff exhaustion, absence and slower processes due to PPE requirements:

a. 47% of respondents agreed that the number of staff absent due to sickness or redeployment to Covid-19 areas would restrict the non-Covid services they could offer. 70% of respondents agreed that there had been a much higher rate of staff absence since pre pandemic. Leaders at acute (83%) and combined acute and community trusts (79%) were most likely to agree with this statement, and community trust leaders (39%) the least. By December 2020, trust leaders continued to experience staff availability pressures due to self-isolation rules and an increased prevalence of Covid-19 infections. Chris Hopson flagged emergent pressures in the east of England and the south east with DHSC in January 2021.

129. These concerns continued over the remainder of the relevant period:

a. In July 2021, trust leaders flagged on WhatsApp that they were again experiencing staff availability constraints due to self-isolation;

b. At an NHS Providers board meeting in July 2021, trustees were concerned that the removal of self-isolation rules could result in more staff being absent due to sickness;

c. In July 2021, one trust predicted a 20% absence rate which would result in 900 lost operations;

d. Via WhatsApp, one trust leader reported that 25% of their emergency department junior doctors were absent due to receiving a 'ping' from the NHS Test and Trace App.

130. In October 2021 we responded to the government's consultation on plans to introduce Covid-19 vaccination as a condition of deployment (VCOD) for health and care staff, setting out our concerns about the impact of a vaccine mandate on NHS staff, providers and patients. We surveyed our members on this issue as part of our work to develop our November 2021 *State of the Provider Sector* report [INQ000371164]. Ninety-one percent of respondents expected they would need to redeploy staff as a result of this policy. When asked about the prospect of losing staff as a result of this policy, 89% of respondents reported concerns. The government planned to introduce VCOD in April 2022.

131. In December 2021, trust leaders again raised the issue of staff absence as a result of increasing infection rates on the WhatsApp group. In December 2021, Chris Hopson posted a Twitter thread outlining the increased rate of Covid-19 infections across the country and how this was adding to staff availability pressures. In January

2022, we published a blog on our website noting increased levels of staff absence, which grew by 10% in that week, and were spread across England. Some trust leaders reported accepting support from the armed forces to help fill workforce gaps [INQ000398127].

132. On 31 January 2022, the government announced its intention to revoke VCOD, which were due to come into force in April 2022, subject to consultation and parliamentary process. We submitted a response to the government's subsequent consultation, outlining our support for revoking the policy. In March 2022 we wrote a letter to the secretary of state for health and social care, raising our concerns about the impact of implementing and then revoking VCOD, and the impact this had on staff/employer relationships.

133. Although we do not hold verifiable information on the correlation between staffing gaps and care quality, our member survey on workforce planning in March 2022 found 97% of respondents agreed that workforce shortages were having a serious and detrimental impact on services [INQ000371169]. These challenges predate the pandemic but were exacerbated by it. Trust leaders noted shortages across the board, especially for nurses, midwives and radiographers, health visitors, allied health professionals, specialty registrars, speciality and specialist grade (SAS) and trust grade doctors, and healthcare support workers. Trust leaders further noted shortages in psychiatry, community district nursing and for ambulance call handlers.

134. During the relevant period, we also sought to share the initiatives trusts were taking to support staff and build capacity. In October 2020, we published a briefing, *Workforce flexibility in the NHS – utilising Covid-19 innovations* [INQ000371171], which outlined details of the flexibilities that trusts had put in place to reduce administrative burden and speed up staff deployment. This built on a briefing from April 2020 called, *Confronting Coronavirus in the NHS – the story so far* [**INQ000371137**], which outlined initiatives trust leaders were introducing to mitigate the impact of staff absence on service capacity including:

a. training to increase the number of staff who could look after critically-ill coronavirus patients;
b. trusts recruiting nurses and doctors who volunteered to return to the NHS;
c. the ambulance sector incorporating members of the fire service into their teams;
d. staff re-deployment in community trusts was facilitated through additional training, while staff in mental health trusts were retrained to help provide physical care;

e. NHSEI coordinating with the independent sector to increase the number of clinical staff available.

Testing of staff

135. We cannot offer definitive analysis of the effect that testing policy had on the availability of healthcare staff to work in face-to-face settings. However, the government and NHS approach to testing for health and care workers, and for the general population, was a topic frequently raised with us by trust leaders during the relevant period, and particularly over the course of 2020. In this section we summarise key amendments to government testing policy and guidance, trusts' feedback in response, and how we sought to share their feedback with decision makers nationally.

136. From February 2020 government guidance advised those in the same household as someone who had, or was suspected of having, Covid-19 to self-isolate. In March 2020, we were told via the CEO WhatsApp group that this significantly reduced the availability of healthcare staff. As stated in our March 2020 briefing to the Health and Social Care Committee to maximise staff numbers, some trusts took steps such as offering accommodation to staff who had not been in contact with family members with Covid-19 in hotels. They were clear however, that widespread staff testing was needed urgently to stabilise the situation and identify who could return to work before the end of their self-isolation period.

137. On 16 March 2020, the government announced self-isolation rules requiring 14 days isolation if a member of a household displayed symptoms of Covid-19. Trust leaders reported via the WhatsApp groups that the announcement of this policy without prior warning resulted in a significant and "immediate impact" on the number of staff calling in sick at short notice, which resulted in the need to "reprioritise clinical activity". Text messages between NHS Providers then chief executive, Chris Hopson and NHSEI's Amanda Pritchard, Pauline Philip, Sarah Jane-Marsh (in the capacity of supporting the national testing programme at this point) and Simon Enright show Chris asking NHSEI to be clearer with trust leaders about the constraints on testing capacity for NHS staff at that point and to give a clearer sense of when 'block testing' for NHS staff might become available.

138. By the end of March 2020, trusts were given permission to use 15% of their testing capacity to test staff. We welcomed this but noted the critical need for testing to be further expanded at pace to improve the availability of staff.

139. On 1 April 2020, trusts were given permission to increase staff testing but trust leaders reported via WhatsApp that the shortage of swabs, reagent and testing kits was limiting capacity, as well as the need for approval to use the in-house testing

capacity created by trusts and the need to lift restrictions on how laboratory capacity was being used. Our press release responding to this announcement included a case study from Northampton General Hospital NHS Trust, which had been a member of a national staff testing pilot scheme. This detailed that, as a result of testing, 157 staff in critical roles were able to return to work.

140. Between 3 and 10 April 2020, trust leaders continued to share their concerns about the rollout of staff testing via WhatsApp, particularly with regard to the testing of staff household members under the age of 18. At that time, a trust leader reported that over 100 of their staff were isolating at home due to their child having a suspected case of Covid-19. Other trusts reported that they still did not have any access to staff testing.

141. Towards the end of April 2020, members discussed the testing of asymptomatic staff. Some trust leaders noted that an expansion of testing to all unplanned patient admissions was displacing the number of tests they could use for staff. On 24 April 2020, we welcomed the expansion of testing to all key workers, their families and household members, but noted continued trust concerns over capacity and testing supplies, as well as reports that the booking system was being overwhelmed. We also published a publicly available briefing called *Spotlight on testing: questions in testing times* on 30 April 2020 **INQ000162249**, summarising testing announcements and progress to date, and outlining six questions trust leaders felt an updated strategy needed to address. This briefing noted that staff accessing non-NHS testing facilities had experienced difficulties with test site locations, with some having to drive for two hours to reach the site, while others had been turned away when arriving without an appointment. Trust leaders were calling for clarity on a movement to systematic regular testing of all NHS and care staff.

142. These concerns were echoed in a survey of our members in May 2020 on the challenges of balancing Covid-19 and non-Covid-19 care **INQ000371153** Fifty-seven percent of respondents agreed that there was insufficient testing capacity to safely resume all services. Comments also showed concerns about testing supplies to ensure asymptomatic testing for staff, access to rapid testing, and local laboratory capacity for smaller trusts in particular. On 6 May 2020, we called for an updated testing strategy, to better enable staff availability in an article published in the Independent, *We need an updated testing strategy* [INQ000371175]. In this we called for more localised testing infrastructure and careful planning.

143. On 28 May 2020, trust leaders shared their concerns with us via WhatsApp about the 14-day isolation rule if a colleague showed symptoms of Covid-19, and the need for an exemption for NHS staff. There was discussion as to whether this exemption should only be for "frontline" staff or all NHS staff, with trust leaders noting

the critical contributions of all staff and the need for a 'one NHS team' approach. It was confirmed by NHSEI in response to these messages that there would not be an exemption for NHS staff, but that contact tracing would be done by the trust or local director of public health and their team instead of by NHS Test and Trace call centre handlers. Trust leaders noted that this could reduce staff availability.

144. In June 2020, our evidence to the House of Lords Public Services Committee inquiry on lessons from coronavirus [INQ000371176], outlined trust leader concerns about staff testing. On 25 June, we published a response to a ministerial statement and letter sent to NHS frontline on staff testing the day before, and on the release of the latest weekly NHS Test and Trace data, highlighting problems with testing capacity [INQ000371177].

145. In early September 2020, trust leaders shared their concerns via WhatsApp about staff testing capacity as children returned to schools. A trust running in-house testing reported a 50% increase in demand. Staff also reported that they were unable to access testing via NHS 111. A trust leader based in the south-east told us a member of staff had been offered a test in Inverness. Another trust leader said, "this failure of the national testing programme is causing serious problems for staff and patients". Our press comments on 15 and 17 September 2020 publicly reflected these concerns:

a. On 15 September 2020, Chris Hopson said:

"It's clear that there are current capacity problems with the testing regime. Trust leaders from Bristol, Leeds and London have all raised concerns over the weekend about the lack of testing availability leading to greater levels of staff absence. It's not just access for tests for staff members themselves, it's also access for their family members as NHS workers have to self-isolate if their family members are unable to confirm if they have COVID-19 or not.

"The problem is that NHS trusts are working in the dark – they don't know why these shortages are occurring, how long they are likely to last, how geographically widespread they are likely to be and what priority will be given to healthcare workers and their families in accessing scarce tests. They need to know all this information so that they can plan accordingly. For example, trusts need to know if they should try to create or re-establish their own testing facilities as quickly as possible.

"The problem is that NHS trusts are working in the dark – they don't know why these shortages are occurring, how long they are likely to last."

"Trusts also have a concern about the impact of testing shortages on patients who need to be tested prior to planned hospital treatment. We're aware of a small number of examples of patients being unable to get such tests, which

cuts across trusts' ability to restore services in the way they have been asked to do. We are concerned, for example, that patients waiting for hospital treatment can no longer highlight this fact when applying online to access a test. We need to prioritise tests for healthcare workers and their families and patients coming in for treatment, many of whom have already waited longer than normal.

"We need to prioritise tests for healthcare workers and their families and patients coming in for treatment, many of whom have already waited longer than normal."

"Our recent survey showed how concerned trust leaders were about the impact of inadequate testing on their ability to restore services and it's disappointing that no detailed information on the current problems has been shared. Given the Importance of an effective testing regime, not just for staff, but also for NHS patients and the general public, trust leaders want the Government to be honest and open about what is going on here.

"Trust leaders are frustrated that, throughout the pandemic, the government has always seemed more concerned with managing the political implications of operational problems rather than being open and honest about them - shortages of PPE and testing reagents earlier in the pandemic being good examples. The Government response has often been to rely on a random, impressive sounding, overall statistic - the number of tests performed or PPE items delivered - or to set out a bold future ambition - a world class test and trace service by June, or a moonshot testing regime at some point next year. Both approaches ignore the operational problem at hand. Neither helps the frontline organisations that actually have to deal with the problem.

"The NHS frontline, and the public, need honesty so they can plan and look for their own solutions to the problem in order to provide patients with the care they need."

b. On 17 September 2020, I said:

"Yet again, we are deeply concerned by the significant increase in the number of positive cases of COVID-19 recorded across England. This week we have seen a 75% jump, and as not everyone is able to access a test, the actual number of cases may well be higher than the figures show.

"Equally troubling is that only 85% of these were transferred to the Test and Trace system. This is roughly the same as last week but these two consecutive weeks have marked the only times the rate has fallen below 90% since June.

"Of those positive cases transferred to the system, 82% were reached this week. This means 2,695 positive cases in the system were not reached.

"While the percentage of close contacts reached improved this week, it is still falling well short of SAGE's target of 80%.

"Although there were 27% more people tested this week, turnaround times for pillar 2 tests, which is for the wider population, remain a big worry - with only 14% of tests returned within 24 hours, marking a significant drop from already low figures.

"Trust leaders are increasingly concerned with the current testing shortages impacting on NHS service recovery and winter preparations due to staff and their family members being unable to access a test resulting in increasing NHS staff absences.

"Additionally, with the number of positive COVID-19 cases increasing, but a reduction in the proportion being contact traced, we are looking at renewed pressure on the NHS.

"Trust leaders are concerned that they do not have the detail on why there are shortages, how widespread they are or how long they will last.

"We are a long way off where we need to be with testing."

146. On 9 November 2020, we responded in a press statement to the introduction of asymptomatic testing for all staff working directly with patients, welcoming this move as it could help avoid unnecessary staff absence [INQ000371178]. However, we also noted that a high return of positive test results would reduce the number of staff available and that advance warning of this announcement would have helped trusts and their staff better plan for implementation.

147. On 16 November 2020, NHSE published guidance for trusts on asymptomatic staff testing and in early December 2020, trust leaders told us that they would welcome more asymptomatic testing kits for staff, particularly as the tests they had were returning a high number of positives. Between 26 and 30 December 2020, trust leaders reported via WhatsApp that the increasing number of staff testing positive for Covid-19 was putting a strain on staff availability and discussed how staff isolation rules would need to be reviewed when the Covid-19 vaccines were rolled out.

148. On 29 December 2021, trust leaders reported via WhatsApp that staff were having difficulty accessing the laboratory-processed polymerase chain reaction (PCR) tests. One trust leader based in the north west reported that it was taking five days to get test results.

149. In March 2022, we welcomed news that NHS staff would continue to have access to testing once free universal Covid-19 test access ended for the wider public.

Nightingale hospitals

150. NHS Providers was not involved in the creation, commissioning, operation or decommissioning of the Nightingale Hospitals and Surge Hubs.

151. While the potential additional capacity offered by the Nightingale Hospitals and Surge Hubs was welcomed, trusts also told us in summer 2020 that they were worried about any future expectations to release clinical staff to work in the Nightingale facilities, and that it was not possible to staff all the Nightingales in a meaningful way. We also heard about the limitations of the clinical use of Nightingales as they were never intended to be fully functioning hospitals, wherein they had limited facilities (for example, they lacked patient toilets) and temporary staffing arrangements.

152. As per the consolidated 2020/21 provider accounts, in aggregate, NHS providers incurred total gross costs of £252m in 2020/21 to operate and staff the Nightingale Hospitals. NHS England reimbursed these incremental operating costs directly to individual providers.

Partnership with the independent health care sector

153. In this statement I refer to both private hospitals and the "independent sector", which covers a range of non-NHS provision (for example, as well as private hospitals, it can include other clinical services such as community care).

154. NHS Providers was not involved in the decision to use private hospital capacity, or the specifics of the agreement made on 21 March 2020 between NHSEI, DHSC, and the membership body acting on behalf of private providers, the Independent Healthcare Partners Network (IHPN). We were also not involved in decisions relating to the referral or transfer of patients to private hospitals and were not involved in the local management or clinical decisions our members would have been making about use of private capacity. We have no specific references from our members on how the treatment of NHS patients in private hospitals impacted the quality of care provided at NHS hospitals.

155. In discussing the use of private hospitals on our WhatsApp group, some members directed their comments towards the NHSEI senior leaders who at that time were also in the group. For example, on 17 March 2020, one chief executive asked for "national thinking and direction for all private hospitals to take [out] en masse our medically safe patients [and] for their crit[ical] care staff and equipment to be transferred to us".

156. After the initial deal with private hospitals was announced on 21 March 2020, members would occasionally use our WhatsApp channel to raise issues regarding

making use of that capacity. For example, on 24 March 2020, one of our members asked NHSEI whether there was any clear guidance setting out how money could work in dealing with independent providers. On 21 April 2020, another expressed frustration at private sector operating capacity "being left idle and not being 'allowed' to refer cancer surgery patients to it".

157. In subsequent weeks, we incorporated a focus on what trusts needed from NHSEI and DHSC to make best use of private sector capacity, in our messaging. For example, in a long-read document published on 15 April 2020, we said trusts want "more help and best practice sharing on the best way to use the extra capacity that the private sector can bring".

158. In response to a request from Rt Hon Jeremy Hunt MP, then chair of the health and social care committee, NHS Providers conducted a short survey of chairs and chief executives between 21 and 31 May 2020 [INQ000371179]. In responding to the survey, 57% of respondents said their trust had used independent sector capacity, with trusts leaders telling us they primarily used the private sector as a 'cold site'. The term 'cold site' usually describes where elective or planned care takes place, as opposed to a 'hot site', where emergency or unplanned care is given. At the time however, the term was used to indicate a site that had no Covid-19 positive patients. This enabled them to continue non-Covid-19 activity including elective surgery, cancer care, diagnostics, outpatients, and IVF. NHS hospital capacity could then be used to flexibly respond to Covid-19 surges and the changing number of Covid-19 admissions and those requiring ventilation.

159. In briefings and submissions during May and June 2020 [INQ000371153], INQ000371153, INQ000371170, INQ000371176, [INQ000371183], we said trusts needed NHSEI and government to have a clear approach to capacity planning as we approached winter and given a further potential peak in Covid cases and a significant care backlog. This included needing an answer as to whether private sector capacity would continue to be contracted beyond the end of June 2020, as members had raised concerns with us about the loss of this capacity.

160. Our note from a meeting between Chris Hopson and HM Treasury's deputy director for health and social care, Philippa Davies, on 19 June 2020 shows that although the Treasury was unhappy at the reportedly low use of the capacity available, members were telling us they were nervous about their ability to meet the need to recover services, while treating Covid-19 patients, maintaining infection reduction measures and maintaining surge capacity. The concern of trusts to retain private sector capacity was also raised at a roundtable with the Number 10 health policy team in June 2021.

161. In September 2020 we asked members about the use of private sector capacity. Members told us they had valued the availability of private sector capacity as a "release valve". It had been valuable in some areas for 'step down' use by supporting the move of individuals from inpatient services back to the community and had helped trusts manage local waiting lists and maintain the flow of patients for emergency care. This was most useful to trusts which were not already using significant amounts of private capacity before the pandemic, where the private beds represented genuine additional capacity. We heard that despite a reduction in capacity, community trusts had been able to maintain business as usual thanks to additional beds run by independent providers. For some trusts, where for example surgeons or anaesthetists working in the private sector were primarily employed by the NHS, it was less clear that using private providers had brought an increase in capacity.

162. Throughout the relevant period, we had regular meetings with the IHPN chief executive, David Hare, and its policy leads, where we shared issues of concern to our respective memberships. This included, in November and December 2020, discussing concerns about the new framework agreement which in the new year would replace the national deal. Trusts had told us they were worried that independent providers would remove some of the capacity that had previously been available to the NHS at that point. We also raised these concerns with Julian Kelly, chief financial officer at NHSEI, and at an NHSEI advisory group meeting (attended by NHS Providers and trust chief executives) meeting in December 2020.

163. In June 2021, NHS Providers hosted a roundtable with No.10 health adviser, **Name Redacted** and trusts, which included discussion of the use and impact of the independent sector on NHS hospitals. Members highlighted that contracting of the independent sector was being carried out at a local and national level. Trusts said they did not want to lose the ability to make regional or local negotiations.

164. In the March 2020 deal, private providers – including those subcontracted by trusts – were nationally funded, meaning the spending on private providers broadly did not come from trusts, and was not diverted from monies that would otherwise have gone to trusts. However, we did hear that mental health trusts had seen a surge in inpatient bed usage and had to rely more on the independent sector. In doing so, rather than have a centrally purchased resource, some had to set up individual contracts for beds. This national funding for private providers ended from 2021/22 and there was effectively a return to pre-Covid arrangements of local commissioning of private providers via local budgets.

165. In January 2022, in response to the Omicron Covid-19 variant, NHSEI set up a time-limited national contract for independent sector provision, placing private

hospitals on standby to provide additional surge capacity if required. This framework was only in place for the final quarter of 2021/22 and to the best of my knowledge had no impact on trust finances or capacity.

Healthcare provision and treatment for Covid-19

End of life care for patients critically ill with Covid-19

166. We did not find records of members raising concerns with NHS Providers about national guidelines to support the escalation of care for patients seriously ill with Covid-19. However, in early April 2020, there was a discussion on the Chair's WhatsApp group about whether national guidelines would be published to support ethics committees and also whether and how other trusts were approaching formulation of ethics committees. There was subsequent brief mention on the group of ethics committees, the drafting of a Critical Care Decision Tool, royal college guidance and the creation of a national Moral and Ethical Advisory Group. NHS Providers was however not involved in the development of any of these aspects of guidance and support.

167. Another policy that was referenced briefly by members in March 2020 in relation to end of life care were the changes to general visiting guidance. Our chief executive WhatsApp records from 11 March 2020 show that trusts started to restrict visiting policies for all patients and that from 16 March 2020 members were calling for national guidance on visiting policies. In subsequent days, some trusts explained that they had stopped visiting but exceptions to this included those receiving end of life care or they were allowed on 'compassionate grounds'. One member asked whether other trusts were allowing visitations from chaplaincy or faith leaders in their call for national guidance. However, there are no specific references to visiting Covid-19 patients.

Infection prevention and control (IPC)

168. The *Health and Social Care Act 2008: code of practice on the prevention and control of infections*, published in 2015, applied to trusts and was taken into account by the CQC in its registration decisions. The code was not mandatory, with a provider able to demonstrate that it met regulations in an equivalent or better way. In addition to this code, PHE published guidance on infection and prevention control for seasonal respiratory infections including SARS-CoV-2 / Covid-19. This guidance included recommendations and principles for infection prevention and control but did not supersede existing legislation and regulations. The guidance was published on 10 January 2020, and withdrawn on 27 May 2022. Further guidance was published for

winter 2021 to 2022 by the UKHSA, which was also withdrawn on 27 May 2022. Both were superseded by the NHS national infection prevention and control manual.

169. Some trust leaders raised concerns about the frequency and timing of changes to national IPC guidance during the pandemic which I address further in paragraphs 66 to 71.

170. During the relevant period, IPC measures were designed to limit infection acquired in a healthcare setting (nosocomial infections). These measures meant trusts had to limit the numbers of patients that could be seen or treated in any setting, including reducing the number of beds and changing the layout of wards and the way patients entered, exited and moved around care settings.

171. In their initial response to the outbreak, acute trusts rapidly reorganised theatres, wards and post-operative recovery areas to create Covid-19 units. This included moving staff with the relevant training to care for patients outside their usual specialties. Emergency care departments were sometimes reconfigured to create dedicated areas with temporary floor-to-ceiling walls in lieu of curtains to help meet the requirements set out in the guidance in order to minimise infection.

172. Our June 2020 report, *Recovery position: what next for the NHS?* [INQ000371179], included statements from trust leaders pointing out that the need for social distancing reduced the number of beds on a ward, and A&E departments had to provide adequate distance between patients and treatment bays which also reduced capacity. Our May 2020 publication, *Spotlight on…The new normal: balancing Covid-19 and other healthcare needs* [INQ000371153], described how trusts had to find ways to adhere to strict IPC measures while retaining the capacity to deal with future outbreaks and heightened demand across emergency care pathways, also known as 'surge capacity'.

173. We received feedback about the difficulties of adapting IPC and PPE guidance for community and mental health settings, about accessing sufficient PPE and about a lack of priority accorded to staff and patients in those settings in the early days of the relevant period. For example, in March 2020, a serving mental health and community trust chief executive texted NHS Providers' then chief executive, Chris Hopson, to highlight his concerns in accessing sufficient PPE from NHS Supply Chain, citing their response that 'because we were a community and mental health trust, we were not a priority for supplies'. Chris Hopson encouraged the chief executive to join our WhatsApp group, which would also facilitate his access to Michael Wilson, a serving trust chief executive who was playing a national lead role in supporting PPE coordination at the time. In April 2020, trust leaders informed NHS Providers that physical constraints in small or old-fashioned community, mental health and learning

disability facilities exacerbated the challenge in meeting the requirements of the IPC guidance. There were practical challenges in grouping patients when some trusts only had one ward for male patients and one ward for female patients, while older buildings often offered less flexible use of space and made 'one way systems' to move patients between care settings difficult to implement. Many of these messages were reiterated in a roundtable with trust leaders as late as January 2021.

174. At a roundtable in January 2021, trusts told us they were at full capacity, as non-Covid-19 services were resuming, making it harder to adhere to IPC guidance. Members also reported at this roundtable that a shortage of IPC specialist nurses was a huge challenge in many places. This affected their ability to implement the guidance as well as their ability to run fit tests.

175. Staff absences due to sickness, and at times isolation requirements, compounded the problem of limited physical capacity. Records of text messages between NHS Providers' then chief executive Chris Hopson, and Simon Stevens, Amanda Pritchard and Pauline Philip of NHSEI show Chris Hopson flagging concerns he had heard from one acute trust chief executive that, were he to adhere to strict measures on staff isolation requirements in the intensive care unit following the identification of two Covid-19 positive patients, 'he won't be able to run [i.e. staff] a hospital tomorrow'. Records show Pauline Philip then spoke directly to the chief executive in question with regard to the guidance and our records suggest that chief executive was then reassured.

176. In addition, staff needed additional time to safely put on and take off personal protective equipment. We do not have an estimate for the extent to which IPC guidance was a constraining factor in efforts to increase hospital capacity, but in June 2020, we surveyed our members about restoring non-Covid-19 care, and 92% of respondents agreed that physical distancing requirements reduced their available capacity.

177. IPC requirements also impacted trusts' cost base. As we highlighted in our briefing in September 2021, trusts with particularly old and small estates had to absorb a higher cost impact, given the limited number of side rooms and the increased space allowance needed for each bed.

178. We heard of some confusion regarding guidance over aerosol-generating procedures after an update on 2 April 2020. However, given NHS Providers has no role in clinical guidance this was not something we were best placed to take up with the relevant bodies.

<u>The availability and suitability of PPE</u>

179. Trust leaders found themselves responsible for supporting their staff and ensuring they were as safe as possible over the course of the pandemic, and for working with the national NHSEI team and often local commercial partners to ensure as steady a supply of PPE as possible.

180. In the early stages of the pandemic trusts told us it was sometimes difficult to follow PPE protocols, due to supply issues and difficulty accessing certain types of PPE. In addition, members raised concerns about the supply of gowns on multiple occasions in the early stages of the pandemic. Alongside working with local partners to manufacture PPE, over the course of 2020 we received some feedback from national decision makers that a small minority of trusts had sought international procurement of PPE in contrast to national policy for this to be centrally co-ordinated by NHSEI. Our records show this was a concern of NHSEI's at points in 2020, rather than validating that this was the case.

181. During the early stages of the relevant period some members highlighted a lack of confidence in the PPE guidance on the CEO and Board WhatsApp group. This peaked on 21 and 22 March 2020 following government changes to PPE advice. Members drew comparisons with practices in other countries, particularly around the use of FFP3 masks. Chris Hopson informed the group on 22 March 2020 that he had made a request to national colleagues for a credible national statement on current PHE guidance and why it was downgraded, why it is appropriate and explaining any difference to World Health Organisation (WHO) or other countries' guidance. A letter from NHSEI's Professor Stephen Powis, PHE's Professor Yvonne Doyle and the Academy of Medical Royal College's Professor Carrie MacEwen on the supply and safety of PPE was sent to trust leaders on 28 March 2020 and this clarified that the PHE guidance was more rigorous than WHO guidelines on the use of FFP3 masks.

182. PPE guidance was also problematic for some trusts as they did not always have access to the correct equipment to undertake fit testing (for example, shortages of fit testing fluid). In addition, as many masks were designed around caucasian male measurements, they did not fit all staff members effectively. The use of PPE, while essential, also slowed down how quickly staff could see patients because of the requirements around putting the equipment on and taking it off.

183. As early as March 2020, we were made aware of trust leaders' concerns about the supply and distribution of the correct PPE. Our submission [INQ000371184] to the health and social care select committee the same month highlighted a number of concerns raised by members through the CEO and Board WhatsApp group:

a. Receiving deliveries of different brands of masks, requiring each relevant clinician to do a time-consuming new mask fit test;

b. Access to mask fit testing liquid which had been in increasingly short supply;
c. Stock being re-labelled with a later 'use by' or 'expiration date'. We noted that while we had been reassured by national leaders that this stock had been robustly tested and was fit for use, we understand why, without this explanation, frontline users of PPE equipment may have concerns and these needed to be allayed;
d. Wanting reassurance that there will be sufficient stocks of PPE in the medium term;
e. Wanting reassurance that PPE supplies would reach all sectors – acute, community, mental health and ambulance services – alongside those that need it in primary care and social care;

184. At this time, we received regular updates from NHSEI on PPE supplies. For example, an update email from NHSEI on 25 March 2020 and an invitation to join a webinar with health and care leaders on 27 March 2020.

185. We joined a stakeholder call to be briefed by NHSEI and PHE colleagues ahead of further new guidance on PPE being published on 2 April 2020. We flagged trusts' commitment to offering staff the correct PPE as well as concerns about possible shortages. Some trusts continued to tell us they were concerned that the guidance was taking too long to be issued. These concerns were shared with NHSEI privately at the time.

186. NHSEI officials Emily Lawson and Keith Willett briefed us and other stakeholders on 17 April 2020 with a further update to PPE guidance which would include instructions for trusts in the event that different categories of PPE ran out. At the time, there was particular concern about shortages of gowns. The relevant guidance was subsequently published later that day. As with similar updates, we shared the guidance on our website, issued a press response and shared a confidential note of the stakeholder call and the guidance via our WhatsApp groups.

187. While trust leaders recognised the level of effort that was made to increase the supply of PPE, there were several issues that continued to occur during 2020. We received reports of PPE stocks running very low from a number of trusts at frequent intervals, in particular between 3 March 2020 and 3 May 2020 when shortages were common and of challenges receiving push deliveries from NHS Supply Chain. This is verified by the findings of an NAO report in late 2020 to which we contributed.

188. The discussions on our WhatsApp group during this period focus heavily on calls for mutual aid between trusts, and communications between trust chief executives with additional lead responsibilities for supporting the co-ordination of PPE delivery and communications with the trust sector on behalf of NHSEI. Trusts' concerns

at this time particularly related to the supply of FFP3 masks, fluid-repellent gowns and visors.

189. Trusts also reported to us that they had received the wrong items in PPE shipments. For example, some received surgical masks instead of FFP3 masks, and there could be issues with suitability even when the right category of PPE was received wherein the wrong brands being delivered meant staff had to undergo time-consuming fit tests. We raised these issues with NHS England leaders and published a public briefing on the supply of PPE on 22 April 2020 [INQ000371186].

190. In addition to keeping in close contact with DHSC and NHSEI over the course of 2020 to understand the position on PPE and share trust leaders' concerns, NHS Providers was publicly open about the constraints on PPE and the additional support required. For example, on 17 April 2020 we issued a press statement saying that 'the supply of gowns was now critical' [INQ000371185] and we published a briefing on the supply of PPE on 22 April 2020 [INQ000371186].

Use of technology and remote consultations

191. The pandemic saw the NHS expand its use of digital technology and remote consultations. Many of the technologies used were not new, but the scale and speed at which they were rolled out, and the shift in mindsets among trust leaders, was notable. Supporting more staff to work from home and more patients to access care remotely were viewed as key to reducing risks of infection, especially for vulnerable groups. Early in the relevant period, one chief information officer at a trust explained that digital had gone from being an issue that chief executives considered on the list of "things that can get me the sack" to a tool that could keep staff and patients safe. Another trust leader said an increased use of technology and digital tools was key to wrapping their staff in "cotton wool" as they worked around the clock in the fight against Covid-19.

192. Some members also highlighted the limitations of digital approaches. For instance, in our survey of chairs and chief executives between 21 and 31 May 2020 [INQ000371153], one respondent acknowledged that digital tools do not meet the needs of all patients and carers, and effectiveness is not "absolute", meaning further evaluation of these tools is needed.

193. When we surveyed trust leaders in 2021 [INQ000371164], the most chosen step amongst acute service providers taken to increase elective activity and manage waiting lists was digital innovation across specific pathways (89%).

194. Mental health trusts used digital channels where possible to deliver outpatient services and carry out remote consultations, particularly for vulnerable groups, to limit

disruption to service delivery as much as possible. Some services reported positive experiences from increasing their use of digital, including better engagement with services users, increased attendance of group therapy, and better use of patient and staff time. However, trusts leaders were also conscious of the need to overcome key barriers – including accessibility, information governance issues and the appropriateness of a digital setting for some therapeutic interventions – and of the need to assess and evaluate the effectiveness and impact of delivering services digitally properly.

Shielding

195. NHSEI issued a letter on 10 April 2020, asking trusts to fully complete the task of identifying and supporting patients who were at the highest risk of 'severe morbidity and mortality from coronavirus (Covid-19) advised to shield for at least 12 weeks', to a very short deadline of 13 April 2020. On 12 April 2020, chief executives discussed on the WhatsApp group whether they had received this letter and who was undertaking the work in their system.

196. The discussion reflects a degree of confusion with some members reported on NHS Providers' CEO and Board WhatsApp group that this work was being led by CCGs and primary care providers only, while others reported their understanding that trusts were to undertake the work too.

197. On NHS Providers CEO and Board WhatsApp group on 16 April 2020, several trust leaders directly asked Amanda Pritchard to give clear guidance to trusts on how to support vulnerable staff. Most trusts were already taking action in this regard but were concerned by the lack of a national steer. Amanda responded that there would be a letter published the next day with national guidance on the matter.

198. Trust leaders quickly highlighted the impact of the shielding policy on staff availability. For example, on NHS Providers CEO and Board WhatsApp group on 11 May 2020, a conversation began about percentages of staff shielding in trusts ranging from 1% to 3.5%. These are not verified figures.

199. Responses given by members to a survey run by NHS Providers in May 2020 [INQ000371187] included repeated references to normal levels of care provision being limited by, among other factors, numbers of staff who were shielding.

200. We did not collect any information regarding the administrative burden on GPs of maintaining the shielded patients list, as NHS Providers represents trusts and foundation trusts, rather than primary care providers.

Healthcare provision and treatment for conditions other than Covid-19

201. As I have said, NHS Providers does not offer its membership clinical guidance. We do not hold information about how the private sector supported specific services of interest to the inquiry, namely colorectal cancer, ischaemic heart disease, hip replacement surgery or child and adolescent mental health services (CAMHS).

202. Members however occasionally cited pressures in the delivery of specific services in their communication with us to illustrate operational pressures rather than to involve us in clinical and pathway management. We have however captured key examples of anecdotal feedback about those diseases of particular interest to the inquiry, from our records, below.

203. In our CEOs and board WhatsApp group, there is one specific reference to colorectal cancer diagnosis, where a decline from an average of twenty diagnoses a month to zero in the first two months of the relevant period is reported. In a survey of our members, published in October 2020 [INQ000371154], we heard specific concerns about achieving NHSEI's diagnostic recovery targets in endoscopy, including the following quote from a chief executive of a combined acute and community trust: "While we will achieve the targets in part, it is unlikely that we will manage to do so across the board. Particular constraints are in diagnostics (endoscopy). The constraining factor is staff – particularly in those specialties which have borne the brunt of Covid, ICU expansion, and additional precautions for surgery – anaesthetists/ICU/recovery nurses/ODAs/etc".

204. We found no specific reference to ischaemic heart disease in our records but did hear reference to cardiology presentations reducing substantially in the first wave of infections. We also heard reports of demand for non-Covid-19 services rising above pre-Covid-19 levels in the aftermath of the first wave. In a survey we carried out in June 2020, around half (53%) of trust leaders viewed this as being a result of either pent up demand or because of the wider effects of lockdown on physical and mental wellbeing. In June 2022, in our podcast, *Providers Deliver: tackling hospital backlogs*, we talked about a new approach one trust's cardiac service was taking, via the use of remote home monitors, to follow-up with and manage the heart devices of thousands of patients who had been shielding.

205. We found no specific references to hip replacement surgery in our records. We heard reports from our members that following the first wave of infections and hospitalisations, as services began to resume, a substantial backlog of elective care was developing. This would have included (but not specific to) disruption to trauma and orthopaedic pathways, of which hip replacement surgery would be one treatment.

206. Throughout the course of the relevant period, trust leaders highlighted to us that mental health services for children and young people faced a significant treatment gap prior to the pandemic in addition to demand stemming from the pandemic.

207. We are not able to distinguish entirely between comments on adult mental health services and CAMHS services in some of our records. Trust leaders do not always distinguish between the pressures on inpatient capacity and community based mental health services, often citing system wide pressures such as staff shortages. We have however drawn-out specific feedback on CAMHS and on inpatient or community based care where we can.

208. Overall, members were voicing the following general concerns via WhatsApp, survey responses and emails throughout the relevant period:

a. many who needed mental health care and support were not always accessing services until they reached a crisis point;

b. community mental health services were caring for a considerable number of additional patients with complex conditions, and a potentially long period of rehabilitation ahead, who had been discharged from hospital to help manage the increase in patient demand and care for the most critically ill in acute settings;

c. social distancing made it challenging to progress home leave or visiting other services in preparation for discharge in some cases, and discharging some individuals with the right community support package was particularly difficult;

d. the restriction of wider services provided by local government and public sector changes due to Covid-19, such as schools closing, had an operational impact on trusts and demand for services as it made preventative approaches and early intervention services in many areas less available;

e. falls in funding experienced by the voluntary sector was having an impact on people who rely on the sector's services.

209. In May 2021, we conducted a survey of chairs and chief executives of mental health and learning disability trusts and combined trusts that provide mental health services for children and young people (CYP) [INQ000371188]. Our findings included:

a. 91% of respondents agreed (41%) or strongly agreed (50%) with the statement 'Presentations to children and young people's mental health services are more acute and complex than in the past';

b. 85% of respondents said they could not meet demand for children and young people's eating disorder services. Two thirds said they were not able to meet demand for community services (66%) and inpatient services (65%);

c. The top three reasons why trust leaders said demand for services not being met were: increased complexity/acuity of caseloads due to the Covid-19 pandemic (88%); additional demand due to the Covid-19 pandemic (42%); and lack of suitable social care provision (42%);
d. 84% said the amount of time children and young people were having to wait to access treatment for services was significantly (25%) or moderately (59%) increasing compared to waiting times six months ago;
e. 61% disagreed (29%) or strongly disagreed (32%) with the statement 'There are enough inpatient mental health beds for children and young people in my trust/local area(s)';
f. 83% were extremely (37%) or moderately (47%) concerned about staff wellbeing and current levels of stress and burnout across their workforce.

210. These findings were echoed in later surveys including a *Pulse survey on the backlog of care* conducted of trust leaders in July 2021 [INQ000371189], when asked which services they were seeing increases in demand for that they were most concerned about and why, mental health services were mentioned frequently– specifically children and young people, eating disorders and autism services.

Initiatives and innovative solutions by trusts to enable screening, care and treatment for patients with conditions other than Covid-19 to be maintained

211. Almost all (99%) of trust leaders responding to a survey in May 2020 [**INQ000371153**] agreed that they had seen rapid innovation in how they deliver services since the start of the relevant period. Responding to an August 2020 survey, trust leaders told us about the initiatives undertaken to enable service delivery to be maintained for conditions other than Covid. These included: virtual clinics, drive-through phlebotomy, Covid-19 free surgical pathways, patients being 'bleeped' when their appointment is ready rather than being in a waiting room, and remote staff working. In our October 2020 report, *Providers deliver: resilient and resourceful through Covid-19* [INQ000371190], we highlighted changes including: thermal imaging cameras to identify people with high temperature, a dedicated 999 Covid-19 call handling hub; and an ambulance trust redeploying furloughed airline cabin crew and ground staff into call handling roles.

212. We did not hear from members about specific initiative or innovations to maintain colorectal cancer, ischaemic heart disease or hip replacement surgery. Rather, we heard more generally about approaches to maintaining non-Covid-19 services. Where members highlighted initiatives relating to these specific services, they are describing the business-as-usual approaches to improvement and efficiency.

For example, in January 2022 we published a case study [INQ000371191] about one trust's approach to tackling its backlog of hip replacement surgeries which had included increased patient liaison prior to surgery, changes to theatre management, and better patient pathway management. In mid-2022 we published a case study of the impact of an orthopaedic outpatient assessment centre that was established to tackle care backlogs [INQ000371193]. At the time, the service had seen 31% more patients using the same paid staffing model as before, with volunteers helping run the centre. This meant that, at the time, the total waiting lists had reduced by 52% and the number of people waiting the longest reduced by over 90%.

Child and Adolescent Mental Health Services

213. In a May 2021 *Pulse survey* of chairs and chief executives of mental health and learning disability trusts and combined trusts that provide mental health services for children and young people **INQ000371188** , we were told about a number of initiatives to enable screening, care and treatment for children and young people's mental health services to be maintained during the relevant period. The themes from the responses included: waiting times initiatives; working with schools and other system partners – including local authorities/social care and primary care – with a focus on prevention and early intervention; digital solutions where appropriate; and working with commissioners to get the investment needed for specific services.

The impact of the Covid-19 pandemic on the provision of treatment for existing mental health patients receiving community and home treatment services.

214. As I have explained above, we are not able to distinguish entirely between comments on adult mental health services and CAMHS services in some of our records. We have however drawn out specific feedback on community based care where we can.

215. Mental health trusts worked to shift service provision in the first few weeks and months of the pandemic towards home-based care and neighbourhood teams. They increased support to ambulance and police liaison services, as well as support to their crisis teams with hospital at home services. Other trusts highlighted a wellbeing hub for staff and a mental health redirect pathway and continued work on the implementation of a clinical decision support software to address issues around waiting times for mental health patients and provide support for GPs in managing more complex mental health presentations. Trusts also looked for ways to overcome the challenges posed by social distancing, such as through completing virtual

assessments between teams, to ensure onward transfers between units and discharges home where appropriate continued.

216. Mental health trusts also set up mental health A&Es to help ensure people in crisis, with a mental health need but no physical health issue, were still able to access support in a setting that felt safe, while also helping to ease pressures on emergency departments in acute trusts. Feedback from a number of trusts we heard from was positive, but trust leaders were conscious these models needed to be properly evaluated.

217. Given the need to support a significantly higher number of patients in the community, mental health trusts providing community services identified at the start of the pandemic services that could be temporarily de-prioritised so that staff could be re-deployed, with appropriate training, to more urgent tasks. However, we heard subsequently from a number of trusts that they were focused on how to keep as many services running as possible throughout each wave of the pandemic. A number were able to do this, albeit with some services scaled back or delivered in a different way during some waves, but not all trusts were able to do so.

The impact of the Covid-19 pandemic on CAMHS inpatients

218. As I explained above, we are not able to distinguish entirely between comments on adult mental health services and CAMHS services in some of our records. We have however drawn out specific feedback on inpatient care where we can. We could not find references to changes in patient reviews in our records.

219. Mental health trusts worked to identify areas, such as wards with ensuite bathrooms, to cohort patients with Covid-19 and/or symptoms. There was an issue with the availability of appropriate places in mental health trusts given there were 350 dormitory wards in operation across England at the time. Much of the NHS estate was (and remains) unfit-for-purpose and mental health estates were not designed to contain contagious disease. Cohorting patients was a particular challenge for those trusts with patients held in secure accommodation, where the flexibility to reconfigure physical space was heavily constrained.

220. IPC measures also impacted the capacity of mental health inpatient services. One trust leader told us in August 2021 that on occasion their trust had to close wards to admissions where they had cases of Covid-19 which added to the pressure on beds in the system.

221. Inpatient rehabilitation and therapy in some trusts were delivered on wards instead of attending groups elsewhere across the trust to reduce risk of transmission while still enabling levels of meaningful activity for individuals to be maintained.

222. NHS Benchmarking Network data from its 2019 programme involving all mental health trusts in England showed lengths of stay for children and young people in England were circa 60 days. In May 2021 we were hearing from members that lengths of stay in some services, such as tier 4 children and young people's mental health services, were very long. One trust leader explained to us that children and young people on existing caseloads were staying longer in service due to increased risks and complexity. Another trust leader told us there was increasing complexity leading to 50% increase in length of stay.

Any changes to mental health inpatient discharge process or criteria

223. I cover broad changes to discharge policy in paragraphs 101-116, however we do not hold detailed, clinical information about changes to discharge criteria for mental health inpatients.

224. Community mental health services were often caring for a considerable number of additional patients with complex conditions, and a potentially long period of rehabilitation ahead. These patients were often rapidly discharged from hospital to free up acute capacity. Trust leaders raised concerns that some people being discharged from services may encounter difficulties self-isolating effectively, which could add further pressure on services as staff found themselves needing to deliver a greater level of care and support to those individuals.

225. Trust leaders also told us that in some cases, while a significant number of medically fit mental health service users were supported to move out of hospital and back to their own home or an appropriate care or community setting, social distancing made it challenging to progress home leave or visits for service users to familiarise themselves with other services in preparation for discharge. Discharging older people and individuals with a learning disability or autism with the right community support package was particularly difficult. Trusts looked for ways to overcome the challenges posed by social distancing to ensure onward transfers between units and discharges home where appropriate continued, such as through completing virtual assessments between teams.

226. In November 2020, a mental health trust leader commented on challenges they were experiencing to safely discharge people from services, especially when individuals were living in less stable or multiple occupancy households. Reduced family, social and community support as a result of the pandemic and the corresponding lockdowns and restrictions were key factors driving the challenges the trust was facing around discharge.

Impact on NHS workers

227. The NHS Staff Survey, owned by NHSE, collates national and local level data on staff experience, including measures on physical and mental health, and on staff wellbeing. While we did not monitor trust-level data on staff physical and mental health, wellbeing or staff turnover rates (which are available via datasets published by NHS Digital), we conducted surveys of trust leaders at regular intervals during the period in question, which offer insights into the physical and mental health and wellbeing of NHS staff:

a. In June 2020 a survey briefing, *Recovery Position – what next for the NHS* [INQ000371179] highlighted that 92% of respondents said they had concerns about stress and burnout among their staff alongside concern about high levels of staff absence;

b. This theme was echoed in our October 2020, annual survey on the *State of the Provider Sector* report [INQ000371195] where 99% of trust leaders told us that they were concerned about staff burnout across all staff groups. At this point, trust leaders also expressed concern that the convergence of Covid-19, winter pressures and Brexit would negatively impact staff availability and wellbeing;

c. In May 2021, we held a series of three roundtable workshop sessions in collaboration with the NHS Leadership Academy to discuss concerns around staff recovery with trust leaders. Attendees believed recovery would look different for different members of staff across different trust types and regions but welcomed resources offered by NHSEI. Trust leaders also shared concerns about the availability of continued funding for staff recovery initiatives and sought better support for line managers.

d. In November 2021, in our annual *State of the Provider Sector* report [INQ000371164], 94% of trust leaders said they were extremely (56%) or moderately (38%) concerned about the current level of burnout across their workforce. These messages were reiterated in our April 2022 annual remuneration survey, when asked what impact Covid-19 was having on retention and recruitment and whether the pandemic had had an impact on trust leader morale. 39% of respondents reported executive director morale had slightly worsened (37%) or significantly (2%) worsened as a result of the pandemic, while 53% reported it had stayed the same. 23% of respondents said executive directors were slightly (21%) or significantly (2%) more likely to leave the NHS or retire in the next 12 months. 55% of respondents said there was likely to be no impact on the retirement or retention of executive directors.

228. In addition to surveying trust leaders to highlight the pressures on staff, we sought to share good practice. In June 2021, an NHS Providers survey of trusts' preparedness for further waves of Covid-19 [INQ000371196] showed that 98% of respondents said at that point that they had made progress on staff ability to take annual leave;100% of respondents said they had made progress in undertaking individual health and wellbeing conversations with staff; 100% of respondents said they had made progress on the availability of occupational health and wellbeing support for their staff. In November 2021, we published our *Providers Deliver* report [INQ000371197], which focused on case studies related to recruiting, retaining and sustaining the NHS workforce. Mid Yorkshire Hospitals NHS Trust's case study included in the report focused on their approach to looking after the physical and mental wellbeing of their staff.

229. We did not undertake any specific surveys or other monitoring activity to assess inequalities in the impact of the pandemic on NHS staff. However, we did receive insight from our members on inequalities experienced by NHS staff from ethnic minority backgrounds as a result of the pandemic through WhatsApp correspondence and via two general surveys.

230. WhatsApp correspondence with trust leaders reveals a concern among some trust leaders that Covid-19 had added impetus and urgency to the need to address well documented health inequalities by ethnic minority staff. For example, there are instances when members acknowledge the disproportionate death rate among ethnic minority staff, for example in June 2020: "BAME [staff] feel they are being targeted due to high mortality rates", as well as several references to the proportion of ethnic minority staff testing positive for Covid-19 antibodies.

231. Some trust leaders mentioned in our chief executives, chairs and communications leads WhatsApp groups in March and June 2020, steps they were taking to protect against inequalities experienced by staff members, particularly in light of high mortality rates of ethnic minority staff members. Protective measures included completing risk assessments to inform shielding advice for ethnic minority staff, hearing and raising concerns through ethnic minority staff networks/staff listening events, and building on existing good practice within trusts. This theme was also captured in our State of the Provider Sector 2020 report in October 2020 [INQ000371195]. In response to the question "what is the trust doing to support and promote staff wellbeing?" we identified a number of trust initiatives including ensuring ethnic minority staff could be transferred away from Covid-19 wards, increasing equalities and monitoring reporting, and bespoke communications to ethnic minority staff.

232. In October 2021, we conducted a survey and interviews with our members on race equality and health inequalities, *Race 2.0: Time for real change [*INQ000371198*]*. Qualitative responses highlighted inequality of Covid-19 outcomes experienced by ethnic minority staff. Trust leaders shared examples they had taken within their services to reduce inequalities either during or post Covid-19, including enhancing employment opportunities into the NHS (accessibility of application and onboarding processes), mentoring programmes, staff networks, leadership programmes, and harnessing the role of provider collaboratives which are partnerships between two or more trusts.

233. As previously indicated, NHS Providers does not offer clinical guidance for trusts. However, many bodies issued guidance or advice to providers regarding the need to conduct individual risk assessments in relation to the risk of staff contracting Covid-19 in the workplace. These included NHSEI, NHS Employers, trade unions, medical royal colleges, and others. NHS Providers has no official role in collecting data relating to the number of staff who contracted Covid-19 or died as a consequence of Covid-19. This data was reported directly to NHS England. However, our members discussed staff sickness and mortality on our WhatsApp groups, for example highlighting "alarming staff sickness/isolation rates" in March 2020, with examples from several trusts across different regions reporting staff figures ranging from 5% to 21% (data accuracy outside of our knowledge). Chief executives also reported "significant levels of self-isolation" and sickness that month.

234. Additionally, in May 2020 and in June 2021 there were WhatsApp conversations on how staff deaths should be recorded with references to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to the Health and Safety Executive (HSE), as well as health and safety investigations. We do not hold this data.

Lessons learned and recommendations

235. The evidence and feedback we received during the relevant period shows that trusts and colleagues in the wider health and care system worked tirelessly to meet the unprecedented challenges presented by Covid-19. Their collective and personal achievements in transforming care at pace to ensure the NHS was not overwhelmed are significant.

236. The benefits of reducing regulation and bureaucracy and the impetus for providers to offer mutual aid, and to work together with partners in health and care systems, offer vital learning for the day-to-day operation of the NHS as well as future pandemics.

237. In July 2022 we surveyed our members to assess the impact of the pandemic. In response to a question about what worked well during the pandemic, the most common responses included:

a. the vaccination programme;
b. greater partnership working at place and system;
c. the speed and agility of response, collaborative teamwork, and the 'command and control' nature of operational activities directed, and centrally and regionally co-ordinated by the NHS;
d. the resilience and flexibility of staff, embracing new digital ways of working;
e. the emphasis on patient care and safety.

238. However, the pandemic also laid bare and exacerbated a series of 'fault-lines' which impacted the NHS' ability to respond to the pandemic. These include:

a. A growing mismatch between capacity and demand, as the population ages and people live longer, often with multiple conditions and a need for more complex treatment and care;
b. The need for effective national workforce planning backed up with appropriate funding from government. This has recently been mitigated by the welcome publication of the NHS Long-term Workforce Plan but there is much more to do to ensure the NHS and social care are in a position to train, recruit and retain health and care professionals in the right numbers, and to plan more effectively for future healthcare needs;
c. The need to provide more capital investment in the NHS to ensure patients and staff have access to modern day, safe buildings and equipment and to provide therapeutic environments for mental health services. Social distancing was much more difficult in old hospital buildings where useable space was less flexible;
d. Years of underfunding in social care with a need for cross party support to reform the social care system and place it on a sustainable footing;
e. The need to invest in prevention, public health and addressing health inequalities, ensuring the NHS model does not become skewed unduly towards 'treatment' of disease which could be preventable with better public information and earlier intervention.

239. Trust leaders are committed to learning lessons from the findings of the Inquiry and any interim reports it may publish. To mitigate the impact of a future pandemic on the health and care system, NHS and care workers, and patients and the public, it is essential that lessons are also learned by government and relevant national bodies.

240. In our July 2022 survey of trust leaders, respondents highlighted the following aspects which could have been done better including:

a. the procurement, distribution and management of personal protective equipment;
b. the timing and cascading of national guidance with realistic timeframes for implementation– and clearer guidance and communication from the centre;
c. the national approach to the discharge of patients into care homes earlier in the pandemic.

241. Taking this survey and the range of intelligence and feedback we gathered from trusts and national decision makers over the relevant period, we believe it is critical for the UK government to shore up the country's resilience and preparedness for a future pandemic. We recommend clearer government focus on:

a. *Improving the UK's preparedness for a future pandemic.* Alongside an improved cross-government response, we would expect this to include appropriate investment in a strong UKHSA able to monitor global disease partners, learn swiftly from international partners, simulate and plan for different scenarios.
b. *Addressing the well-publicised challenges of securing a sufficient, steady supply of PPE.* This may require consideration of manufacturing resilience in the UK, early PPE demand modelling in the event of a pandemic, and learning about procurement, usage, and distribution.
c. *Reviewing and learning from the UK's approach to testing, including test and trace.* The experience of the Covid-19 pandemic suggests that any testing strategy would need to be established as soon as possible in the event of a future. Pandemic testing was heavily constrained in the early part of the Covid-19 pandemic.
d. *Learning from the Covid-19 vaccination programme.* This includes the production of vaccinations, insights and learning on balancing clinical benefit and risk, and rapid rollout, communications to the public, and particularly to offer targeted information and support to groups more likely to be vaccine hesitant to enable people to make an informed decision on whether to take up a vaccine offer.
e. *Ensuring that clear communication channels between the various bodies responsible for government and national decision making, and with frontline care organisations are more coherent and more robust.* Communications between government, national bodies and frontline organisations were, perhaps understandably, confusing at many points over the relevant period.

National bodies including government departments and arm's-length bodies must learn from the immediate difficulties they faced in identifying the correct leadership contact details for frontline service organisations. Policy making rightly moved at pace during the pandemic but there are lessons to be learned to ensure clear lines of communication. There needs to be greater clarity on what guidance frontline organisations should be following and realism about the lead-in times required for updated guidance to be implemented at the frontline, even in a national emergency. Guidance should also be adapted and tailored for different care settings, such as acute, ambulance, mental health, community services and social care settings.

f. *Sufficient ongoing investment in public health infrastructure*. It is essential that local and national public health infrastructure is maintained to protect the public and offer evidence-based advice to inform government policy decisions in the event of any future health crisis.

g. *Investment in prevention, and action to address health inequalities, exacerbated by the pandemic.* In the event of another pandemic, we would recommend an early focus on reducing the impact of health inequalities on patient outcomes, by identifying the most at risk groups and putting strategies in place to reach these groups. It is critical that we learn from, and understand fully, the disproportionate impact of the Covid-19 pandemic on people in more vulnerable communities, on black and ethnic minority populations, on disabled people, and on care home residents, for example.

h. *Ensuring a data led approach which informs the balance of services which continue to operate during the height of any pandemic.* While decisions during the relevant period were taken with the best intentions, and on the basis of the available data, the impact of the pandemic on waiting times and demand for NHS care suggest learning for the future about the balance of services which could be operated in similar circumstances in future. There may be more to be learned about the impact on patients and the public of the understandable requirement to stand down or reduce non Covid-19 services in the early days of the relevant period.

i. *Ongoing support for and investment in social care.* Longstanding political failure to reform and invest in social care left colleagues in social care, and the service users they support, vulnerable during the pandemic. To withstand a future pandemic, the social care sector urgently needs long-term, sustainable funding and reform to address severe challenges. A resilient social care system

would enable the NHS to discharge medically fit patients swiftly, creating additional capacity where needed.

j. *Investment in community health services and in mental health provision is vital for the resilience of any modern health and care system.* In the event of a future pandemic there must also be earlier recognition of the likely impact on demand for mental health services with appropriate investment to tackle the inevitable a rise in people reaching crisis point and needing to be admitted for inpatient treatment. Outpatient mental health services should also remain open for people where possible.

k. *Recognition for, and investment in support for staff*. This must include any required training if staff are redeployed, protected time off to be away from the frontline, and access to mental health support which acknowledges the potentially sustained impact of enduring extreme and unprecedented working conditions, such as those inevitably generated during a pandemic, particularly in the early days when little may be known about how to best manage the risks presented by a new disease. More broadly, government should consider the longstanding impact of the experience of health and care staff during the pandemic in estimates about leaver rates and as they seek to implement the NHS Long-term Workforce Plan and support recruitment and retention.

Areas where we have no relevant information to share

242. Having reviewed our records, we could not find and do not hold information on the following areas of interest to the inquiry:

a. The development of a decision-making tool in the event that intensive or critical care "rationing" was considered to be necessary;

b. Details of any guidance given during the relevant period by NHS England on the approach that general practitioners and ambulance services should take in relation to decisions whether to admit patients to hospital, including the nature of any such admission criteria, or concerns about admissions criteria and whether trusts developed their own admissions criteria;

c. The removal of the NHS surcharge for non-UK healthcare staff;

d. The gathering, analysis and dissemination of information within the NHS regarding the developing understanding of the optimal clinical management of Covid-19 during the relevant period;

e. Issues raised by members of NHS Providers regarding instances of Covid-19 patients failing to receive palliative care at the end of life and any action(s)

taken in response; or issues regarding lack of resources in hospital palliative care teams and any action(s) taken in response;

f. Trusts' concerns in relation to the inappropriate issuing of DNACPR notices;

g. The ways in which private healthcare providers were utilised to provide treatment and care for specific conditions and how this affected capacity within NHS hospitals;

h. The impact of the Covid-19 pandemic on the delivery of ante-natal, maternity and neonatal care during the relevant period.

243. NHS Providers did not commission internal or external reviews, lessons learned exercises or similar in relation to any of the issues in the Provisional Outline of Scope for Module 3.

Statement of Truth

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

Signed: Personal Data

Dated: 19 January 2024