Witness Name: Daniel Mortimer

Statement No: 2

Exhibits:

Dated: 01.02.2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DANIEL MORTIMER

I am the Deputy Chief Executive (CEO) of NHS Confederation and the CEO of NHS Employers, which is part of the NHS Confederation, and I make this statement in response to the Rule 9 request dated 20th June 2023. I am best placed to provide the statement as Deputy CEO of the NHS Confederation throughout the relevant period and interim CEO for the majority of the relevant period (October 2020 to June 2021). As CEO of NHS Employers, I also have a strong understanding of how Covid-19 impacted the NHS workforce.

I have held board level roles (in HR/Workforce but also latterly strategy) in the NHS since 2001 and took up my role as CEO of NHS Employers in November 2014. I have been a member through examination and accreditation of the CIPD since 1996 and was made a Charted Companion of the Institute in 2019.

Overview of the role, functions and activities of NHS Confederation

General

1. The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole NHS healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure each year. We promote collaboration and

partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. We are a charitable company subject to the regulations of the Charity Commission (charity number: 1090329) and Companies House (companies' number: 04358614.) The Confederation is governed by a Board of Trustees. Unlike a number of membership bodies, our members are institutions rather than individuals. For example, our Acute Network is made up of hospital and foundation trusts, our Primary Care Network of primary care providers at scale (including Primary Care Networks and Primary Care Federations.) Our Mental Health Network has the most diverse membership with mental health trusts, voluntary organisations commissioned by the NHS to deliver services and private providers (again commissioned by the NHS) in membership. Within our work, we run a number of forums, working groups and smaller networks to support individuals in particular roles, such as first-time chief executives, non-executive directors, finance leads and HR directors. The NHS Confederation is a networked organisation and the only membership body that represents the whole NHS system.

2. In England, our networks are:

a. Acute Network (representing hospital and foundation trusts.) While the NHS Confederation has always represented NHS trusts in England, it formalized its membership offer as a distinct acute network in 2021. We also support ambulance trusts via agreement and contract with the Association of Ambulance Chief Executives (AACE)

b. Community Network (representing community healthcare services trusts - a network we run in collaboration with NHS Providers)

c. Integrated Care Systems (ICS) Network (representing all 42 ICS in England). Prior to the ICS Network, the NHS Confederation represented the predecessor commissioning bodies – called Clinical Commissioning Groups (CCGs) via network NHS Clinical Commissioners. This represented CCG leadership, e.g. CEOs, Clinical Chairs, Chief Nurses, Medical Directors, CFOs, and Directors of Strategy. With the Health and Care Act 2022, NHSCC dissolved and statutory ICBs assumed many CCG functions from 1 July 2022. NHSCC ceased operating on 31 March 2022

d. Mental Health Network (representing mental health services provided by the NHS, the private sector and the voluntary, community or social enterprise (VCSE) sector)

e. Primary Care Network (representing primary care networks and GP federations)

3. In Wales all NHS bodies are members of the Welsh NHS Confederation and in Northern Ireland all organisations within the integrated health and social care system are members of Northern Ireland Confederation for Health and Social Care (NICON). Throughout this statement my responses primarily deal with the position in England rather than in Wales and Northern Ireland as our organisation is not well placed to provide evidence on operational matters in Wales or Northern Ireland. I make clear when my comments are directed to matters concerning Wales and/or Northern Ireland.

4. The NHS Confederation had no formal pandemic response functions, nor any formal responsibilities regarding the response to Covid-19 or any pandemic.

NHS Employers

5. NHS Employers is the employers' organisation for the NHS in England, and part of the NHS Confederation. NHS Employers is commissioned by the Department of Health and Social Care (DHSC) to support workforce leaders and represents employers to develop a sustainable workforce and be the best employers they can be. NHS Employers also manages the relationships with NHS trade unions on behalf of the Secretary of State for Health and Social Care and the NHS.

6. NHS Employers leads the national and regional relationship with trade unions. During the pandemic NHS Employers:

- Convened regional meetings of employers and employers/trade unions to support engagement and co-ordination of workforce activities

- Chaired regular meetings with NHS trade unions to support pandemic response
- Took part in discussions regarding amendments to interim staff terms and conditions
- Participated in discussions to support staff and student deployment
- Published materials on behalf of NHS England and the DHSC
- Published and updated staff risk assessment guidance (INQ000391163)

Leadership support networks

7. The NHS Confederation also provides leadership support to NHS managers via our Health and Care LGBTQ+ Leaders Network, our Health and Care Women Leaders Network, our BME Leadership Network and our Non-Executive Leaders Network.

Key decision-making

8. During the relevant period, key decisions regarding how best to support our members, voice their experiences and influence national decision-makers on their behalf were made via a dedicated taskforce, consisting of senior colleagues from across the organisation including representatives from the executive team. In addition, the organisation's full executive team met on a weekly basis and the board of trustees met several times per year.

NHS Providers

9. Until 2011, the precursor to NHS Providers was a part of the NHS Confederation, in the form of the Foundation Trust Network. The NHS Confederation and NHS Providers continue to work closely together – staff across both organisations up to Chair of the respective Boards have regular meetings and there was regular contact throughout the period indicated above. A number of times a year NHS Providers and NHS Confederation run joint events, produce joint outputs and come together to work together on issues relevant to respective members. An example of some joint work through the relevant period was a joint briefing in September 2021 on the continuing cost of Covid-19 (**INQ000371145**). We

also continue to co-host the community network, which represents health leaders working across the community health sector. The relationship between the NHS Confederation and NHS Providers remained the same before, during and following the pandemic.

10. The NHS Confederation is a membership organisation. While we provide support for our members and advocate for them at the national policy level, we are not accountable for the commissioning or the delivery of services or funding.

England

11. For England, NHS England is best placed to explain its role in relation to the provision of healthcare in the devolved nations and the UK as a whole, particularly given the return to greater central 'command and control'

12. during the crisis period, as well as:

- how and by whom NHS healthcare services were commissioned and provided;
- the lines of accountability within the healthcare system;
- how funding for NHS healthcare services was obtained and allocated; and
- whether / how any of these arrangements changed during the relevant period.

13. The majority of NHS Confederation's members had a line of accountability to NHS England. The details of this are best sought from NHS England. The NHS Confederation worked closely with NHS England and DHSC to inform some of their guidance and policy, but there was no formal accountability relationship. For example, the Primary Care Network met NHSE and DHSC regularly to provide detailed commentary on the impact of Covid-19 on primary care and latterly on the implementation of the Covid vaccination programme of which primary care delivered 70% of vaccinations.

14. As mentioned above, during the relevant period NHS Employers managed the relationship with trade unions on behalf of the Secretary of State for Health.

15. The wider NHS Confederation (with the exception of NHS Employers) did not have a formal affiliation with any NHS England or DHSC committee, working group, specialist body or other decision-making body through which we cooperated during the pandemic. Rather, the NHS Confederation contacted relevant officials and communications teams directly at NHS England, DHSC, the Care Quality Commission (CQC), Public Health England (PHE) and UK Health Security Agency (UKHSA) with the purpose of sharing member insights and explaining the needs of our members.

16. NHS Employers co-chairs the Social Partnership Forum Strategic Group, which met twice a week during this period. A wider Social Partnership Group was regularly chaired by Minister Helen Whately (and latterly Ed Argar) during the pandemic. We understand that the DHSC has provided notes of all these meetings to the inquiry and we don't feel there were any issues with these group meetings that we wish to share in addition to their notes.

17. The NHS Confederation did not and does not have a formal role in the response of the healthcare system in England in the event of a pandemic (with the stated exceptions of the trade union-related, guidance and communication activities of NHS Employers). As a membership organisation, our role as agreed by our executive and the board was to aid communication and help cascade information from statutory bodies, and to collate insight from members about the reality on the ground, and then speak on their behalf – both publicly and privately – to national bodies and to the media when indicated.

Wales

18. Due to all Welsh NHS bodies being members of the Welsh NHS Confederation, during the period 1 March 2020 to 28 June 2022, the Welsh NHS Confederation provided corporate and secretariat support to a number of NHS Wales Executive Director Peer Group meetings. These meetings included Nurse Directors, Public Health Directors, Medical Directors, Assistant Medical Directors and Workforce and Organisational Development Directors (from within organisations that are part of the Welsh NHS Confederation's membership). At these meetings the response to the pandemic was discussed and Welsh Government officials would attend. In addition, we provided secretariat support to the Chief Executive meetings with the Welsh Government officials, taking a high-level note and sharing it with Government and the Chief Executives.

19. At the beginning of the pandemic many of the meetings would convene daily, with Assistant Medical Directors who lead on primary care meeting on the weekend as well, and others weekly or fortnightly. These meetings were arranged by the Welsh NHS Confederation on behalf of Peer Group chairs and high levels notes were taken to share with meeting participants. The Welsh NHS Confederation, while in attendance at meetings, was not involved in any operational matters or decisions made by Welsh Government or our members, the NHS bodies. In addition to supporting meetings, we collated guidance developed by Welsh Government, available information from other organisations and any feedback we received with our members, NHS leaders, and stakeholders, including third sector organisations and Royal Colleges in Wales twice a week via an email update to members. When relevant we would share feedback received from third sector organisations and wider stakeholders with the Welsh Government and also our members, including Public Health Wales NHS Trust.

20. The Welsh NHS Confederation represents and provides support to all the organisations that make up the NHS in Wales, the seven Local Health Boards, three NHS Trusts (Public Health Wales NHS Trust, Velindre University NHS Trust and Welsh Ambulance Services NHS Trust) and two Special Health Authorities (Digital Health and Care Wales and Health

Education and Improvement Wales). Due to our membership structure and support in Wales, during the period 1 March 2020 to 28 June 2022 the Welsh NHS Confederation provided corporate and secretariat support to Executive Director Peer Group meetings and provided secretariat support to the Chief Executives' meetings (both groups are part of the Welsh NHS Confederation membership) alongside the Welsh Government, taking a high-level note and sharing it with the UK government and the Chief Executives in attendance. The Welsh NHS Confederation, while in attendance as an observer at meetings, was not involved in any operational matters or decisions made by Welsh Government or our members, the NHS bodies.

21. The Welsh NHS Confederation is an observer on the Welsh Government NHS Wales Leadership Board. The NHS Wales Leadership Board is chaired by the Director General for Health and Social Services / NHS Wales Chief Executive and includes all the Chief Executives from NHS organisations in Wales and senior civil servants from the Welsh Government Health & Social Services department

Northern Ireland

22. The Northern Ireland Confederation represents and supports all the statutory organisations that make up the NHS in Northern Ireland, also known as Health and Social Care Northern Ireland (HSCNI). During the period in question, the Northern Ireland Confederation's membership included all six HSC Trusts (including the Northern Ireland Ambulance Service HSC Trust); the Public Health Agency, the Business Services Organisation, the Regulation and Quality Improvement Authority, the Health and Social Care Board (until its closure on 31 March 2022) and seven specialist HSC bodies.

23. The Northern Ireland Confederation was not involved in operational matters or decisions made by Government or our members, the aforementioned HSC bodies. Its primary role during the period in question was to support communication and the dissemination of accurate, reliable and up-to-date information from trusted sources via daily written briefings and online

briefing sessions, the latter of which featured presentations from a range of government officials and HSC staff in leadership roles.

24. During the period in question, the Northern Ireland Confederation provided secretariat support to the HSC Chairs' Forum, which comprised the Chairs of all HSC organisations. The Forum wrote to then Minister of Health, Robin Swann, in May 2020 requesting to meet to discuss ongoing developments and responses relating to the Covid-19 pandemic. The first joint meeting took place on 17 June 2020 and the Forum thereafter met regularly with Minister Swann (at approximately six-weekly intervals) throughout the period in question. A range of Departmental colleagues, including then Department of Health Permanent Secretary, Richard Pengelly, were also frequently in attendance at these meetings.

25. However, this was not a decision-making group; the primary purpose of these meetings was to improve lines of communication between HSC Boards and the Minister. Minister Swann also committed to providing Chairs with regular updates from the 'Rebuilding Health and Social Care Management Board', established in June 2020 (for an initial period of 2 years) to rebuild services, programmes and projects impacted by the Covid-19 pandemic, as per the Department of Health's 'Strategic Framework for Rebuilding HSC Services'.

UK Government Departments, Non-Departmental Public Bodies and Arm's Length Bodies, devolved administrations, regional and local governmental bodies

26. The wider NHS Confederation did not have a formal affiliation with any governmental, committee, working group, specialist body or other decision-making body through which we cooperated during the pandemic. Rather, the NHS Confederation contacted relevant officials and communications teams directly at NHS England, DHSC, CQC, Public Health England and later UKHSA with the purpose of sharing member insights and explaining the needs of our members both in relation to guidance and the situation 'on the ground'.

27. In England, the NHS Confederation had regular (more than weekly) contact with:

- DHSC
- NHS England
- NHS Employers had meetings twice a week with Social Partnership Forum Strategic Group.

28. Semi-regular (more than monthly) contact with:

- PHE (by the time the organisation had changed to UKHSA and OHID respectively, engagement had already become less frequent)
- Health Education England
- CQC
- NHS Employers meetings with regulators the Nursing and Midwifery Council, General Medical Council and Health Care Professions Council.

29. And less regular contact with:

- Medicines and Healthcare Regulatory Authority
- NHSX (as existed then).

NHS Confederation and the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser and others

30. The wider NHS Confederation did not have a specific working relationship with the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser or other government medical advisers or expert bodies.

England

31. Staff from the NHS Confederation would be invited to briefings at which such individual officers and advisers spoke, and we routinely attended the "Fortnightly Covid-19 Deputy Chief Medical Officer call with stakeholders" – this was largely a call to brief patient representative groups on policy changes. On occasion, a senior member of the NHS Confederation would be invited to a call with the Chief Medical Officer or one of the Deputy Chief Medical Officers for them to provide personal briefing to us on various plans just before they were announced to answer our questions and help us understand the plans so we could provide accurate

information to our members and/or explainers for the public via the media if we chose to do so. Examples include a change to vaccine policy or infection control plans. Senior NHS Confederation staff members were also intermittently invited to briefings on operational matters with Keith Willett, NHS England's national director for emergency planning and incident response. NHS Clinical Commissioners (now the ICS Network) had fairly regular contact with NHSE's Chief Nursing Officer's office including the Deputy Chief Nurse, Hilary Garrett. Additionally, the Primary Care Network hosted a fortnightly meeting with Jenny Hall, deputy Chief Nursing Officer (CNO) on the Covid vaccine the vaccine programme and Primary Care Network (PCN) nurse clinical directors. NHS Employers staff did work from time to time with members of the CNO and Medical Director teams on developing relevant guidance regarding the deployment of staff and students.

Wales

32. The Welsh NHS Confederation provided corporate and secretariat support for a number of Executive Director Peer Groups where the CMO, CNO, Chief Scientific Adviser and other government officials were in attendance. The Welsh NHS Confederation was an observer at the NHS Wales Leadership Board. The guidance and information published by Welsh Government officials we shared with NHS Wales leaders and our stakeholders to keep them informed of developments.

Northern Ireland

33. The Northern Ireland Confederation did not have a specific working relationship with the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser or other government medical advisers or expert bodies. However, a number of ad hoc online briefings were provided to Northern Ireland Confederation members during the period in question. These included a briefing from then Chief Nursing Officer, Charlotte McArdle, on surge plans and the establishment of a Nightingale Hospital in Belfast. The Chief Scientific Officer, Ian Young, also attended the September 2021 meeting of the HSC Chairs' Forum to provide an update on the latest Covid-19 modelling for

Northern Ireland. The latest modelling information was also provided periodically by the Chief Scientific Officer and/or his colleagues to HSC Chairs' Forum members throughout the period in question.

NHS Communications and Information-sharing within the NHS

34. NHS England has the statutory responsibility to share information within the healthcare system in England. The NHS Confederation and NHS Employers worked to amplify this information shared by NHS England through dissemination via our Daily Member Bulletin, regular network bulletins and weekly member email. NHS Employers also did this through their weekly workforce bulletin to HR directors and their teams across the NHS.

35. Where there were asks from members for more detailed information, we also produced member briefings on topics including:
    - Implementation guidance issued by NHS England at the start of the different phases of the pandemic (INQ000391214), (INQ000391215) and (INQ000391170)
    - The PHE review of inequalities on the impact of COVID-19 on racialised communities (INQ000391202)
    - Test and trace and vaccines mutual aid (INQ000391186)

Wales

36. The Welsh NHS Confederation has no statutory role in relation to information sharing. Prior to the pandemic structures and processes were put in place to disseminate Welsh Government information around the implications and developments of the UK leaving the EU to frontline staff, including those working in primary care. During the pandemic the structures developed pre- March 2020 were again used to ensure key information was disseminated to the frontline.

37. The Welsh NHS Confederation is part of the Welsh Government health and social care communication group with NHS Wales communications leads and communication leaders within Welsh Government. We would cascade

all press releases, guidance and updated policies shared by Welsh Government with NHS leaders and stakeholders across Wales. Throughout the pandemic NHS Wales organisations Heads of Communication worked closely together to ensure clear and consistent messages, both at a national and local level. There was a range of guidance and public facing campaigns developed by Public Health Wales NHS Trust and implemented across health and social care, and wider sectors.

38. The Welsh NHS Confederation was an observer at the Welsh Government meeting with NHS Wales Chief Executives and would share any feedback received from stakeholders, including Royal Colleges and third sector organisations. If feedback was received from stakeholders in relation to the accessibility of the information being published by Welsh Government or NHS Wales bodies, we would highlight this to the relevant agency.

39. The NHS Confederation in England undertook regular conversations (both spoken and via email) with members across the country to understand the key challenges they were facing in the delivery of care in the context of the pandemic. This intelligence was compiled to produce an internal 'sit rep'. Where members identified particular challenges that we considered NHS England or the Department of Health and Social Care or another decision maker might be able to resolve, we shared the relevant insight with them as appropriate. Member insights were shared with wider partners reflected in paragraphs 29, 30 and 31. Ad hoc at request and particular concerns were raised during regular meetings with senior officials, as appropriate.

40. The NHS Confederation in England, Wales and Northern Ireland is not formally required to input or share information we receive from members with government or arm's length bodies; we may choose to do so when we consider this to be helpful to our members but in all three devolved administrations there are formal national structures in place where information from our members is systematically collected and flows directly to national bodies. Questions about this data can therefore be answered

by these bodies. Below we set out our member engagement channels in more detail.

Acute care

41. During the relevant period the NHS Confederation's contact with acute leaders at the forefront of the NHS's response to the pandemic increased. This was largely done on an ad hoc basis given the extent of the pressures on acute services. We set up several feedback mechanisms to gather intelligence and feed it directly back to government departments and NHS England. From mid-June 2020 we met with NR from the Prime Minister's Implementation Unit (which became the Number 10 Delivery Unit in 2022). At that time the focus had shifted to service recovery. These meetings (which involved colleagues drawn from our member organisations) therefore focused on learnings from the first phase of the pandemic and how this impacted on the emerging picture of continued pressures. Meetings took place every six weeks or so. They were designed to provide a link between frontline staff and advisors writing the briefings for the Prime Minister. They were very informal and Chatham House, often with no agenda, and the meeting being driven by whatever issues the advisers were working on at the time. "Chatham House" rules refers to a meeting in which attendees agree that the content from the meeting can be shared but not the identity of those who shared the information. This is a widely used format for meetings the NHS Confederation holds with members as it fosters a dynamic of openness and mutual trust, allowing us to share intel from the system without putting our members reputations or relationships at risk. This format was agreed with the Prime Minister's Implementation Unit.

42. Key topics covered and learnings shared in these meetings were access to PPE, infection prevention and control measures and the impact of changes on operational efficiency and capacity, levels of staffing and the impact of the pandemic on staff to deliver care, innovate and recover, the need for capital investment in estates, and the differing impacts of old and new estate on trusts' ability to provide care.

43. They found it useful to hear frontline operational experiences to help inform briefings and develop their understanding of issues. The findings were not shared with NHSE, though from time-to-time DHSC staff joined informally. Later our contact at the Number 10 Delivery Unit was Name Redacted and discussions focused on Urgent and Emergency Care pressures, how to reduce discharge delays, reducing winter impact, elective recovery and industrial action.

44. We also met with NHS trust chairs from England, Wales and Northern Ireland, as well as ICS chairs from May 2020 onwards. These virtual meetings were held monthly on issues affecting Chairs and provided a mechanism for chairs to raise current issues with us. Meetings were based on strategic issues affecting boards – in 2020 and 2021 discussions included governance, social care, health inequalities, Brexit and Covid-19. Meetings included external speakers on specific topics and were Chatham house discussions. Any issues that arose requiring further action were escalated internally to consider how best to respond.

45. We have had Acute Trusts in membership for many years, but in November 2021 we recognized that we needed to represent the acute perspective as a key player within the new vision for integrated care systems and started to dedicate more resource and activity in this space. Over the course of 2 years, we moved from an Assistant Director for the Acute Network Lead, to a director with membership of the executive Team in October 2022, to a team of people dedicated to the issues that our Acute membership faces. Since late 2021 we have run an Acute Network which more explicitly represents acute leaders.

Primary care

46. The NHS Confederation has provided a direct membership offer to primary care providers since December 2019. Initially, this offer was just to primary care networks (PCNs) before expanding to at scale primary care organisation above the PCN level too including GP Federations. PCNs

were introduced in July 2019 as a way of enabling general practices to work together, and are typically structured around populations of 30,000 to 50,000. Nearly all practices are part of a PCN and there are around 1200 PCNs across England. PCNs provide services over and above core general practice such as enhanced access, access to a wider range of professionals such as physiotherapists, pharmacists, and paramedics. Generally, PCNs are not legal entities – their service contracts and staff employment are held by a lead practice within the PCN. GP Federations were introduced in 2007 and typically cover populations of around 200,000. They deliver services on a larger scale than PCNs but equally support PCNs. Federations are legal entities, and they are either commissioned directly by ICBs or by their PCNs to deliver services on their behalf. They can also provide a range of 'back office' support functions for general practice and PCNs.

47. For PCNs, our offer is to support their development. This includes a suite of support products, an app, representation to government and other stakeholders and forums, events that provide connections within primary care and elsewhere in the health service, Integrated Care Systems (ICSs) and the wider health systems.

48. For Federations our offer also includes 'raising the profile' of federations and the role they play in optimising economies of scale with national and system leaders. The two networks were merged to become one NHS Confederation Primary Care Network from 1st April 2022. At the beginning of the pandemic, therefore, engagement channels and relationships were just being established. The membership of our Primary Care Network covers leaders of Primary Care Networks and at scale primary care organisation above the PCN level, not individual general practices. We primarily engage with clinical directors and PCN managers. The intelligence received by our Primary Care Network is therefore not representative of the whole of general practice across the country.

49. Notably, PCNs are the delivery vehicle for COVID-19 vaccinations, although they may and can be administered by GP surgeries. The information we receive from PCNs largely focuses on:

- Operational issues, including vaccine supply
- Clinical issues e.g. surges of Covid, situation regarding StrepA
- Organisational issues i.e. how their PCN is developing
- Systems development i.e. how their local ICS is developing, particularly the inclusion of primary care.

50. GP Federations use their knowledge of the primary care landscape, relationship with practices, PCNs and other system partners to deliver services, back off support and leadership for their members at a larger scale. Some federations hold alternative provider of medical services (APMS) contracts. The information we receive from PCNs largely focuses on:

- The relationship between primary care and other partners at place and system
- Business/back office specialism in primary care
- Out of hours access services
- Leading vaccination programmes across a place/system
- Supporting practice resilience.

51. The primary methods of gathering intelligence during the relevant period were through WhatsApp groups and ad hoc Teams calls with the Network members. The Primary Care Network shared insights with NHS England and DHSC through regular email reporting (varying from daily in March/April 2020, to monthly in 2021-2022), through a NHSE Primary care clinical stakeholder forum (weekly moving to fortnightly then monthly), a monthly call with DHSC and NHS England and a monthly PCN Nurse Clinical Director Vaccinations meeting with NHSE nursing director.

52. The Primary Care Network shared NHSE guidance through our WhatsApp groups and our app to ensure members could access all the guidance through multiple routes.

Mental health

53. The Mental Health Network had ad hoc meetings with the mental health team at NHSE including with Claire Murdoch, its National Director for Mental Health. Regular meetings with NHSE's mental health team via the Mental Health Policy Group (an informal group consisting of the Mental Health Network at NHS Confederation, Mind, Rethink Mental Illness, Royal College of Psychiatrists, Mental Health Foundation, and Centre for Mental Health which meets fortnightly). MHPG discussed a number of topics including:

- Parity of esteem for mental health including access to vaccinations and testing
- Law and treatment of people detained under the Mental Health Act during pandemic
- Addressing and meeting high demand for mental health services, whilst adapting to meet needs of mental health patients
- Modelling demand for mental health of the population, recognising projected figures and estimates for a delayed mental health impact on the population after the pandemic
- Children and young people's experience of the pandemic, and specific support needs whilst not in school
- Children and young people's rise in eating disorders and disordered eating services, due to rise in the pandemic

54. The topics discussed with Claire Murdoch's team at NHSE included:

- Remote Mental Health Act Assessments
- Electronic Mental Health Assessment forms
- Oxygen
- End of life drugs/support
- Mental health input into Nightingale hospitals
- Step up and step down guidance

- Learning from Italy and Spain about impact on mental health services and demand
- Evaluation of service changes – how, barriers and innovation
- Regulation by the Care Quality Commission
- Pensions/abatement
- Staff numbers.

55. The Mental Health Network also produced publications to advocate for changes for their members, including in particular, *Reaching the tipping point: children and young people's mental health* (INQ000391210) and *Running hot: the impact of the pandemic on mental health services* (INQ000401412). These were both supported by media and comms plans to raise the profile of the work and the intel included and follow up meetings with NHSE. Issues were escalated and shared with the NHSE team through meetings or emails, so they were aware of what our members were experiencing and could use the information in turn to develop their plans and responses.

56. During the early stages of the pandemic, the Mental Health Network set up a forum for Mental Health Trust chairs to meet virtually (weekly) to share concerns, peer support etc. We also set up a group for our Independent Sector members to share concerns and provide peer support. Topics discussed at the Mental Health Trust chairs weekly meeting included:
    - Governance arrangements / adaptations (including arrangements for virtual meetings and streamlined governance papers and record keeping)
    - Staff wellbeing (including of executive team and wider staff body)
    - Ethics committees
    - Mental Health Act reviews
    - Adapting mental health services including community teams in light of social distancing
    - Access to testing for Mental Health Trust staff
    - Social distancing in inpatient settings for staff and patients
    - Access to PPE.

57. There was a sustained focus on this being a space for sharing good practice and learning between Trust Chairs as they adapted to the new situation. We have repeatedly heard that this was a useful forum for Chairs to learn from peers and connect and share and escalate concerns or good practice with key external stakeholders such as NHSE and CQC.

58. The Mental Health Network shared member's concerns through a number of mechanisms. In April 2020, Claire Murdoch, National Director for Mental Health, NHSE, joined a Medical Directors Forum meeting, to hear directly from medical directors, working mental health services, about the reality on the ground during Covid. In June 2020 the Mental Health Network and Primary Care Network ran a joint webinar on how to prepare for the expected increase in demand in mental health support, with speakers from member organisations. A similar webinar was run jointly by the Mental Health Network and the NHS Clinical Commissioners Network in September 2020; speakers included member organisations and Public Health England. In May 2021 the Mental Health Network ran a round table with members from across the NHS Confederation exploring the impact of additional mental health demand on the wider system which included speakers from across our membership.

Clinical commissioners

59. The NHS Clinical Commissioners network offered some clinical advice to CCGs in support of their continuing health care functions – this was a rapidly unfolding story, where guidance was produced to minimise the assessment process and move patients to care homes. During the Covid-19 crisis, NHS Clinical Commissioners' (NHSCC) Nurses Forum ran a short series of virtual meetings with NHSE's Chief Nursing Officer's office. These meetings discussed and gathered good practice on issues affecting lead CCG nurses during the health crisis being faced by the NHS and local communities. Topics included:
    - Integrated hospital discharge
    - Integrated support offers
    - Supporting and testing in care homes

- Following discharge pathways
- Supporting patients with personal health budgets and trusted assessors
- Safeguarding
- System capacity
- Infection prevention and control training
- NHSE guidance on Care Homes support in England during Covid-19 lockdown.

60. NHS Confederation shared insight obtained from our members with relevant officials at DHSC and NHSE throughout the pandemic, largely by emailing or speaking with officials responsible for that topic area. We also held ad hoc webinars and round tables to facilitate shared learning set out in (INQ000391162).

61. The NHS Confederation's Chief Executive, Deputy Chief Executive and Directors regularly provided member insight as part of the commentary we provided in the media; for example, the Director of the Primary Care Network appeared on television and radio to discuss the impact of Covid-19 on primary care as well as the roll out of the vaccination programme.

Individual trusts and primary care networks sharing information with the public

62. Individual Trusts and primary care networks have their own external communications arrangements; part of NHS England's pandemic response included a nationally-coordinated pandemic response plan for external communications. Our members told us that part of this involved increased scrutiny and permissions required from NHS England for external communications arising from our members in order to present clear and coordinated communications with the public, for example in terms of media engagement.

63. A key role of the NHS Confederation is to use member insight to help build a national picture of on-the-ground experience in the NHS, to present this picture to the public and to decision-making bodies and to lobby for change where necessary. The NHS Confederation provided a mechanism for our members to provide insight and input to inform external communication messages when it was not considered appropriate or practical for these members to communicate directly, or where the message benefitted from amalgamating member perspectives.

64. For example, the NHS Confederation raised concerns publicly regarding:

- The policy of mandatory Covid-19 vaccination for health and care staff (INQ000391161).
- The need for a one-month extension to the Brexit transition period following the increase in Covid-19 cases in November and December 2020 (INQ000391188).
- The need to pause retendering local authority contracts for community health services to reduce bureaucracy on these teams as they delivered vital services (INQ000391180).
- The need for NHS leaders to be able to have quicker access to capital funding and medium-term financial certainty to support the delivery of care and help tackle the elective backlog (INQ000391179)
- The chronic undersupply of NHS staff and issues with retention (INQ000391183)
- Need to embed leaner, more agile approach to regulation to improve care (INQ000391182)
- Need to address budget uncertainty for financial year 2021-2022 due to the pandemic (INQ000391193) (INQ000391189)
- The need for a clear operational strategy to help the health service deliver test and trace (INQ000391198).
- The need for additional funding to support discharge to assess policy to become permanent (**INQ000371161**).

65. In Wales, the Welsh Government developed a range of communication assets that all NHS bodies in Wales could use, including those working in

primary care, to communicate the change in guidance/ key developments with the public. This included social media cards and standard text to use. The NHS Confederation cannot provide further information about information flows in Wales, beyond what I have described above. NHS bodies in Wales would have highlighted operational issues directly to the Welsh Government in good time.

Concerns raised around clinical guidelines, guidance, advice or instructions for healthcare providers and clinicians

Gaps

66. At various points during the relevant period, our members shared concerns about gaps in some guidance produced by NHSE and other bodies, while recognising that it was necessarily being developed at speed. The main area of concern was having clear and robust guidance around infection control and guidance around vaccination delivery that took into account the complexity of the situation on the ground. For example, in April 2020 one of our community members raised concerns around insufficient guidance around management of Covid-19 patients who are discharged from Intensive Care Units (ICU) into the community. One member said at the time: "there is little /no guidance for how community hospital wards and community pathways should be adapted to manage the safety and quality of care and increasing demand or any guidance on when to trigger any peak clinical decision making / escalation tools to then trigger a process of aligning care decisions to the clinical frailty score etc." Members reported a lack of co-ordination between primary and community teams in March 2020 and told us that each service was receiving different guidance without clear pathways between the services, creating a potential gap in services and care.

67. Throughout the pandemic there were calls for clarity in guidance around the use of PPE, particularly when there were supply or distribution challenges. Concerns focused on: supply and distribution problems; fit and quality problems; clarity of communication to the public about what to expect with PPE in healthcare settings; and clarity of guidance relevant to

implementation in different settings. (INQ000087234). In February to March 2022, our members welcomed increasing flexibility in IPC guidance, but sought further clarity on changes/implications in terms of staff testing and isolation and on NHS staff having the second Covid-19 booster jab given the impact high staff absence was having on service delivery. Our GP Federation members were concerned that guidance was exclusively aimed at PCNs, requiring Federations and their partner PCNs to struggle with implementation to enable Federations to continue their significant role supporting PCNs and delivering the vaccination programme at scale.

Timing and communication of guidance from NHS England and other bodies

68. In March/April 2020, guidance produced by NHS England (and other bodies) was being revised and sent out rapidly. While our members welcomed guidance, they soon started to report that they were becoming overwhelmed as they were receiving rapidly updating guidance from multiple sources. For example, our primary care members described receiving guidance from CCGs, Trusts, NHSE and DHSC. They reported hours being 'wasted' on reading multiple versions of similar guidance and identifying whether what they were reading was the most recent version. In conversations with various people working on infection prevention and control in NHSE, we requested that guidance be sent from a single source at NHSE with date and time stamped along with changes highlighted to simplify the process of keeping track of the latest updates or changes. However, guidance continued to come from various sources and members continued to raise that this was both challenging and time consuming to access, absorb and implement at speed. For example, in February 2021, primary care leaders were concerned about the risk of burnout of vaccine leaders and vaccinators due in part to the frequent changing of guidance at short notice. I provide more information about this in the example below.

69. Our members also raised concerns about the timing and communication of changes and updates to clinical guidance. For instance, there were instances of delays to publication of urgently-needed guidance, but our

members also reported how difficult it was when they did not hear about changes to guidance until the last minute; sometimes healthcare leaders found out about decisions impacting the way they delivered services at the same time as the public, who sought to immediately access the new services. As members tried to rapidly implement the announced changes, these announcements created public expectations that meant valuable capacity had to be diverted to explaining to patients when services would be available. For example, healthcare practitioners and leaders did not receive any forewarning ahead of the Prime Minister's announcement of the expansion of the vaccination programme to 24/7 on 13 January 2021. Our members found it stressful and practically challenging to deliver the substantial and logistically complex change that had been promised and was expected immediately, with no notice. Some members noted that this meant some staff felt the need to work late hours and work during their much-needed days off to implement these changes expected to be delivered with immediate effect, creating exhaustion that contributed to staff burnout.

70. In July 2020, members expressed some frustration that infection prevention and control (IPC) guidance was issued to the public and to industries, without thinking through implications for healthcare. One said: "Plea to government: try to sort and consult before the policy is issued, not after." As another example, in April 2022, our members expressed their concerns about receiving late notice of the continuation of free lateral flow tests for staff – this hampered timely communication with staff with impact on staff morale and engagement.

71. This was a particular issue for guidance on vaccination as a condition for deployment (VCOD). Members were frustrated in November 2021 that they heard about the guidance via politicians before the guidance had even been written, and there was a lag before it became statutory, with several delays to the guidance being released. NHS Employers worked closely with colleagues from NHSE and DHSC as well as national trade unions to shape and inform progress with the legislation.

72. For primary care members, the implementation times for guidance were often very short, and members struggled to find capacity to implement changes on top of delivering core general practice services and a national vaccination programme, which saw primary care deliver over 75% of Covid-19 vaccinations by the end of 2021. Through 2020, into 2021 members faced short implementation times for the new guidance, which was frequently published on Friday afternoons and had to be read, understood and enacted over the weekend. The short turnaround and requirement to work over the weekend contributed to feelings of stress and burnout among GP partners. Those involved in the delivery of the mass vaccination programme shared concerns about guidance availability and were often left with questions around important practicalities such as storage requirements, and interpretation of the guidance contained in the Green Book was often left to local determination. One community NHST Trust CEO stated: "Communications from NHSE need to be simpler. CEOs don't have time to read 64-page briefings. NHSE need to invest in simple plain comms to explain plans for the distribution of the vaccine."

73. Personal protective equipment (PPE) was an issue which members felt was especially poorly communicated. In 2021 there were continuing calls from across the health sector and wider commentators for PPE guidance to be updated in consideration of the new Covid-19 variants. As one acute CEO reflected in July 2022: "Some of the guidance from the centre has been terrible. The face mask guidance was awful, both the announcement and then the subsequent guidance. Some sectors are better briefed like nursing - whereas the medical directors are not as well informed." This was backed up by a community CEO: "Absurd and late announcements, e.g. face masks - just have to interpret locally and support staff and patients." Another acute CEO expressed frustration that in one weekend, six different revisions to the guidance were issued. In early 2022, our members faced challenges due to different guidance on IPC between health and care settings, and where patients are handed between settings.

Feasibility and implementation

74. Our members also raised concerns about difficulties relating to the feasibility and implementation of guidance. A number of issues were raised in relation to IPC guidance and the huge impact this had on reducing capacity. For example, in July 2020, one community trust CEO noted that the 2-metre rule reduced their bed capacity by 20%, another estimated 30%. An acute trust CEO cited "risk-averse guidance being issued by the professional bodies" as a significant barrier to optimising use of estate capacity and said that if they were to stick to professional guidance, giving diagnostics as an example; where their capacity would otherwise be 20 people per day, it would have to reduce to three people per day because of the need to keep people with Covid-19 separate from people without Covid-19, the need for everyone to socially distance (including in the waiting rooms), and the need for extra time needed to deliver more rigorous cleaning protocols between patients. Additionally, the need to self-isolate before a procedure reduced some elective procedures as low as 40% because some people receiving care could not afford to do so as they would not receive prolonged sick pay while isolating pre-procedure.

75. In November 2021, as the mandatory vaccination date for staff approached, many members expressed concerns about implementation, tracking and recording and the impact on staff. When the guidance came out in December 2021, workforce leaders warned of the impact on capacity of losing staff either by choice or termination of employment. By January 2022, members were concerned at the amount of resource for implementation required of HR teams at the cost of any usual business. We also heard of instances of abuse being directed at those working to implement the guidance, including HR professionals, managers and even trade union officers.

76. Operational planning guidance from the centre is crucial for providers to plan for the level of staffing and activity needed to reach clinical targets. Delays to operational planning guidance, particularly in July 2020, therefore made it difficult for our members to plan for the level of capacity hospitals were

being asked to run at. Members raised concerns about the planning guidance being regularly changed, not covering everything and being overly risk-averse and inflexible. A recovery lead and clinical chair reflected: "There has been continuous guidance, but what we're not seeing is the ability to mobilise to respond and restore." Many leaders called for more local discretion on guidance they considered to be overly restrictive, for example "blanket provisions" which might not be as appropriate for specialist settings. There was dismay about the expectations within the Phase 3 guidance which was aimed at setting priorities to accelerating the return to near-normal levels of non-Covid health services, preparing for winter demand pressures and supporting delivery of these aims in a way that took account of lessons learned during the first Covid-19 peak. The expectations contained in the guidance were deemed "extremely challenging", "naïve", "unachievable" and ultimately demotivating. The NHS Confederation published a briefing on the phase 3 planning guidance (INQ000391215) including feedback from members. The feedback on the phase 4 guidance in April 2021 was less critical.

Lack of clarity

77. Our members also shared some frustrations about guidance at times lacking clarity, which left them confused about the actions they should take and how best to answer the high volume of questions from patients. For example, in April 2022 our primary care members expressed concerns at the lack of clarity in the Joint Committee on Vaccination and Immunisation (JCVI)'s IPC guidance around which circumstances would require them to ask patients to get tested, and that the lack of detail on patient testing could lead to an increase in request to GPs so that patients can access free testing. A lack of clarity sometimes led to some discrepancies in interpretation. This happened, for instance, in relation to NHSE's national PPE guidance, which was being questioned by some national bodies including unions. Guidance was occasionally contradictory, and members highlighted examples where they were receiving mixed messages, such as Public Health England's high consequence infection diseases (HCID) guidance which stated *"As of 19 March 2020, COVID-19 is no longer*

considered to be a high consequence infectious disease (HCID) in the UK." Our members were aware that on the same date, the World Health Organization (WHO) continued to deem COVID-19 a Public Health Emergency of International Concern (PHEIC), and that social restrictions were still in place.

78. Ahead of publication of guidance on making vaccinations a condition of deployment, HR teams and line managers shared concerns about the scale and complexities involved in implementation and how much time and effort this would require from already stretched HR teams and line managers. The initial phase of the guidance published in December 2021 fell short of providing the clarity and detail being sought from the services. In December, HR Director (HRD) networks worked collaboratively to mitigate the inconsistencies in the guidance by looking at taking region wide approaches, utilising National Engagement Service WhatsApp groups and dedicated task and finish groups to identify solutions. Members were frustrated about the phased policy approach currently focused on engagement; when their HRDs and their staff wanted to know about what would happen if staff members didn't receive vaccinations as this was unclear and caused confusion. There were also challenges around the scope of the guidance, including inconsistencies about how to define 'patient-facing roles' and whether people in patient-facing roles but who were not employed by the NHS were in scope, such as social workers.

Accountabilities for producing guidance

79. Our members raised concerns around accountabilities for producing clinical guidance becoming confused, which at times led to duplication and confusion. In July 2020 some NHS Confederation members highlighted concerns about blurred accountability for public health decision-making. According to one Director of Public Health, fragmentation of the health, social care and public health systems at national, regional and local levels had led to duplication and poor communication; a lack of understanding about the role of Public Health England, the public health functions of NHS

England and Improvement, and local government. A community CEO made a similar point: “The problem with the issuing of national guidance is that various, individual bodies hold different responsibilities for different risks - PHE, DHSC, NHSE so what is meant to be national, is still piecemeal. So you just have to put in place what is right as you have staff to inform and services to run."

80. The NHS Confederation raised these concerns to the relevant bodies at regular points both formally and informally. For example, the Primary Care Network Director frequently passed on members' questions about new guidance to the NHSE Primary Care Team over email, each time requesting further detail and clarification, which would then be shared with our members so they could begin implementing the guidance. Members shared their concerns that there was often an issue of clarity and understanding for the mechanisms in primary care that would be needed to implement the guidance. The Primary Care Network also called on NHSE to investigate the impact of a decision in one sector on its system partners to ensure that guidance given to one part of the system did not create additional workload in another. Issues raised such as PPE shortages, up to date guidance, shielding, vaccination supplies were submitted weekly and responded to within a few days. These responses would provide additional information where available, but solutions were not always readily available, especially in the case of PPE and vaccine supply/cohorts.

Interventions made by the NHS Confederation

81. The NHS Confederation was in regular communication with people responsible for the various guidance in order to convey member views and encourage improvements that our members considered would benefit the NHS. When there were very significant concerns, we made formal interventions. For example, in May 2020 the NHS Confederation wrote to the Secretary of State for Health and Social Care to raise members' concern about the lack of clear strategy for NHS Test and Trace and their fear that it

would see a second wave of infections with the planned easing of lockdown rules (INQ000391175). Our Primary Care Network wrote to Jo Churchill MP on 20/11/2020 (in her capacity as Parliamentary Under-Secretary in the Department of Health and Social Care) stating that primary care needed 'a more considered and respectful approach to be adopted regarding how announcements affecting them and their patients are released publicly (INQ000391176). The fact that briefing the media [on vaccine cohorts] appears to have been prioritised over giving prior warning to the primary care sector is unacceptable' and left members feeling like they were the last to know what was needed from them. This had a knock-on effect for patients who would hear the news and be concerned, causing them to ring the GP for clarification despite the GP having not yet received the guidance.

82. In May 2021, we wrote to the Secretary of State for Health and Social Care calling for a review of social distancing guidance in hospitals in light of falling rates of COVID-19 infection (INQ000391206). This letter was the result of concern raised by members that infection prevention and control measures were both disproportionate to the levels of infection and stymieing the ability of NHS organisations to prioritise tackling the elective backlog, as instructed by government.

83. In November 2021 we wrote to the Secretary of State for Health and Social Care calling on him to publish their risk assessment on making Covid-19 and flu vaccinations mandatory for NHS staff (INQ000391194). This letter was sent following the policy being introduced and also called for the anticipated introduction of the policy to be extended to social care staff to be extended until after winter. This letter came after members raised concern about the impact of the policy on staff vacancy rates (which already stood at over 100,000 in both the health and social care sectors) over the busiest winter months for the health service.

84. On 26 October 2021 the NHS Confederation made a formal submission to the consultation on the proposals to make Covid-19 vaccination as a condition

of deployment for NHS and later social care staff working in CQC-regulated organisations (INQ000391169) and (INQ000391213). This submission strongly emphasised the need for the policy to consider the impact that such a policy would have in terms of the risk of losing staff through this winter period and to enable a well-planned implementation. As such, the consultation response said any such policy if introduced should not take effect until at least September 2022. It was also clear that the majority of employers did not believe that the flu vaccination should be mandated.

Consultation by NHS England or other bodies on guidance

85. Due to the rapid nature of guidance development during the pandemic, the NHS Confederation was not routinely consulted in its initial development by NHS England or other bodies and did not have a role in making defining decisions regarding such guidance. NHS Confederation members were sometimes invited to briefings which occasionally provided the opportunity to feed in views.

86. The main way in which the NHS Confederation contributed to guidance was via the incorporation of rolling feedback from members that set out concerns identified by members and opportunities to improve policies, guidance and processes that we shared with NHS England and other relevant bodies as outlined above. Officials would generally take the insight about our member experiences on board and consider whether/how to use that insight to make improvements, but the judgement about whether to implement any changes or incorporate this feedback into guidance lay with NHSE and other bodies setting the policy, guidance and processes.

Primary Care

87. At the beginning of the pandemic, general practice was having to deliver fewer face-to-face appointments than usual due to the restrictions, but some clinicians conducted home visits in urgent circumstances. In 2020 general practice had to adopt a total triage model that saw appointments

delivered virtually or over the phone, although some practitioners continued to do home visits according to need.

88. In March 2020 colleagues became increasingly concerned that they were losing control of demand for home visits by primary care staff as discharges increased and the initial Covid home management service became overwhelmed. Lockdown policies caused some confusion and some members reported GPs and others struggling to access care homes to treat patients due to lockdown policies. Prior to publicly accessible testing, it was hard to manage demand for at home visits where patients had respiratory symptom.

89. In March 2020 we raised the issue of the lack of national guidance for hospital admission pathways for patients with suspected COVID-19 to NHSE on Microsoft Teams. This meant individual teams in hospitals were having to spend time devising their own pathways in a context where teams were already incredibly overstretched. Local areas were sharing their solutions but there was variation and no answers to indemnity queries around referral.

90. There were a number of ways in which the height of the first wave of the COVID-19 pandemic created new situations for clinical teams that would not usually be covered by existing indemnity schemes. This included where staff were forced to backfill roles as colleagues were moved to managing COVID-19 patients, and thus were practising outside the scope of their role. It also extended to cover Local Authorities undertaking testing and tracing operations, and to cover referrals from primary to secondary care for COVID-19 patients. The new indemnity scheme was brought in to law as part of the Coronavirus Act 2020.

91. From April 2020, triaging procedures differed across the country, with some members doing their own phone triaging, some making capacity to take on 111 calls and others moving to online solutions.

92. Online systems created a significant administration burden as patients did not fully understand how to make best use of the new systems and often submitted multiple requests or insufficient symptoms to assist diagnosis. These requests would require sorting and follow ups from GPs.

93. In a meeting with the NHS England primary care team on 1 April 2020, the British Dental Association (BDA) shared their concerns that they were not able to do their own triaging and 111 was sending patients to dental practices, which were closed during lockdown creating confusion and unmet demand.

94. With no national guidance on supporting housebound, digitally disenfranchised people or patients who would need additional support accessing care (particularly older people) each PCN and Federation had to develop its own solutions, risking exacerbating existing health inequalities. There was initially no national guidance regarding virtual repeat prescription requests so services developed their own process, some requiring consent from patients before virtual repeats could be processed, increasing the administrative burden on staff, while others contacted the patient afterwards offering the opportunity to opt out.

95. PCNs and Federations also had to individually address the challenge of implementing procedures for patients without digital access.

96. Our members raised concerns at various points during the relevant period on access to primary care and the impact this had on staff and patients. Despite the pandemic restrictions, some clinicians, including District nurses, continued to deliver in-person consultations where there was a significant need. NHS Digital data reveals that primary care quickly scaled up in-person consultations as pandemic restrictions lifted: of the 310.2 million primary care appointments delivered in 2020, 162.4 million face to face. In 2021, 178.5 million of the 309.5 million total appointments were

face to face. By 2022 this had risen to 220.1 million of the 335.7 million total appointments.[1]

97. In many cases due to estates issues – in particular a lack of physical space – it was difficult to manage patient flow through practices whilst maintaining safe distance. This was also impacted by staff who were ill with Covid-19 so restricted available staff to see patients face to face.

98. Throughout 2021 and 2022, media commentary about needing face-to-face appointments grew and led to a huge increase in demand for face-to-face appointments, anti-vaccination demonstrations and abuse of staff. We heard anecdotally that this had an impact on staff retention in some places, particularly of reception staff, which in turn increased members' difficulty increasing appointments, and made it harder for shielding patients to access practices. One member said: "The verbal abuse is getting intolerable too and the complaints are through the roof. I'm just fed up. Why NHSE aren't defending or helping? It's soul destroying at times but trying to keep morale up for the staff is even harder." Members were concerned that there was little support for increasing appointments and dealing with the backlog that developed during lockdown and we supported their calls for a funded recovery plan for long term conditions that incorporated inequalities and prevention.

99. Primary and secondary care members both raised concerns around blanket Do Not Attempt cardiopulmonary resuscitation (DNACPR) notices. Secondary care wanted more clarity over patient and family wishes to be shared by primary care. Many non-Covid patients had not been referred through general practice and both sectors called for clarity on the impact of DNACPR on those patients. We raised these issues during meetings with NHSE's primary care team. On 8th April 2020 we asked for greater clarity

[1] It is worth noting, however, that this data does not capture the totality of practice workload that relates to patient care but is not direct appointments e.g., signing prescriptions, arranging social care support, making referrals to other services, reviewing incoming tasks and communications (from hospitals etc), reviewing pathology results, training and supervising team members including GP trainees.

via Teams on DNR for primary care, as secondary care sources were concerned that blanket DNRs were not in line with patient or family's wishes. There also seemed to be confusion about how to handle non covid patients who had come into hospital without going through primary care and instead attended via A&E.

Ambulances

100. Analysis of NHS capacity and performance were made publicly available on the NHS Confederation website (INQ000391155) (INQ000391152) (INQ000391156) (INQ000391154) (INQ000391157) (INQ000391151) (INQ000391149) INQ000391157) (INQ000391150) (INQ000391153) INQ000391154) during the relevant period.

(

(

101. Ambulance services were under high levels of pressure throughout the relevant period due to increasing numbers of people presenting with Covid-19 and other conditions as well as delays due to delayed discharges in hospital settings which resulted in slower ambulance response times and in some circumstances ambulances queuing outside hospitals waiting to transfer and handover patients.

102. During the initial phase of the pandemic, this increased demand was largely driven by high incidence of Covid-19. In April 2020, 999 calls more than doubled and ambulance services were having to ask ex-staff to return. An additional challenge for ambulance trusts was down-time required to clean ambulances after transporting infected patients to prevent cross-contamination. This pressure continued into November 2020, when, for example, a 999 centre said they had 150 of 500 staff off with Covid-19 and noted that "one outbreak is enough to wipe out an ambulance station."

103. Throughout 2021 and 2022, hospital handover delays had a significant impact on ambulance trusts' ability to respond to the increasing number of incidents, and the issue became critical across a number of acute trusts, described by some acute members as the "greatest risk to the service". With demand levels in January 2021 above the peak of the first wave (one

ambulance trust described their calls on one January day as being their highest ever number in their history), the number of patients waiting more than an hour to be handed over rose steeply. One ambulance trust described ambulances having to wait 8-10 hours outside hospitals in order to hand over Covid-19 patients. By April 2022 many acute members reported patients waiting more than 12 hours in A&E.

104. Staff sickness was a big constraining factor throughout the period due to exposure. Levels of staff sickness led on some occasions to people waiting for several minutes for 999 calls to be answered. In July 2021 in one ambulance trust 13% of staff were off sick or isolating (including due to mental health problems and burnout). One region told us that on 4 January 2021 their handovers had accounted for 759 hours of crews' time, equivalent to taking 63 ambulances off the road. Due to social distancing measures, Patient Transport Services could only convey one patient at a time, where they would previously convey 3-6 patients at once. Several Ambulance trusts had to declare critical incidents due to the volume of calls and access to emergency departments.

105. A Critical Incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe, requiring special measures and support from other agencies, to restore normal operating functions. The calling of a critical incident reflects the seriousness of the situation, and the need for a co-ordinated response by all system partners. NHS services all have a Major and Critical Incident Plan which sets out how such an incident will be manged by the organisation should it occur.

106. In July 2021, members reported that due to pressures and capacity problems in primary care, patients were having difficulty securing appointments and were therefore more likely to call an ambulance or present to A&E. Around this time, ambulance leaders described the level

of demand they were experiencing as “New Year’s Eve every day”; they were not commissioned for the scale of demand in 111 calls.

107. Ambulance leaders described the level of demand for services in October 2021 as “unprecedented” and some made appeals for patients to only call 999 in life-threatening emergencies. One ambulance service told us they anticipated that in October over 15,000 hours will be lost due to handover delays – putting them at the highest risk level in the trust’s history. This caused significant staff stress, affecting both staff in ambulances and those in call centres. Within this context, our members were frustrated at a letter from NHS England on 27 October 2021 which requested that they cease long ambulance handovers; one said: “how are they expected to resolve it 'just like that'?”.

108. During the 2021 winter period, our members continued to miss operational targets and were particularly concerned about the impact on patient safety and experience, as well as the mental health of ambulance crews and other staff.

109. In January 2022, members reported having to divert A&E patients to a partner hospital due to ambulance handover delays for the “first time ever” and some put out calls encouraging people to seek alternatives to attending A&E, or to encourage them to find their own transport rather than calling an ambulance. Nationally, more than 38,000 patients were put at risk of harm due to long waits in ambulances outside hospitals over March, according to figures collected by the Association of Ambulance Chief Executives and reported by the Health Service Journal on 29 April 2022.

110. By June 2022, delays with ambulance call handling and handovers had remained, often relating to the lack of social care workforce and consequent inability to discharge medically fit patients from acute care into the community as patients were not able to receive packages of care and instead remained in hospital, reducing bed capacity.

111. This was exacerbated by the ambulance sector's recruitment challenges with emergency care assistants and emergency call handlers, for similar reasons.

NHS Capacity

112. In terms of factors that were present prior to the Covid-19 pandemic which impacted upon the NHS's ability to respond to the pandemic, NHS leaders have told us that the decade of austerity leading up to the Covid-19 pandemic reduced the NHS's ability to respond optimally. The NHS received close to flat funding for most of the decade, which in part led to more than 100,000 vacancies across the NHS in England alone. The NHS went into the pandemic under significant pressure, with a range of performance targets not being met. Since its creation, NHS spending has increased by an average of 3.7% per year in real terms. But from 2010/11 to 2018/19, NHS funding growth slowed to 1.4% per year, according to 2019 figures from the Health Foundation.

113. Members of the NHS Confederation told us that low investment in NHS capital since 2010 had a negative impact on infrastructure and estates, including infection control measures, which impacted the response to Covid-19. The 2018 NHS funding settlement had only covered frontline NHS services – so-called 'revenue' spending – but it did not cover a number of other key areas, including investment in new buildings and technology, known as capital spending. By January 2020 England was spending just over half the OECD average for capital spending on health with a consequent impact on clinical infrastructure and facilities. For example, as widely reported, the UK entered the pandemic with five times fewer ICU beds than Germany.

114. The configuration of many NHS estates, particularly older buildings, were not optimised to enable isolation of large numbers of patients; to enable the segregation of Covid-19 negative, Covid-19 positive, and as-yet-undetermined patients entering health facilities and being admitted to hospital; to enable optimal ventilation of rooms, or to support the increase

in demand for high flow oxygen delivery. However, the NHS was successfully able to expand its provision of high dependency and intensive care facilities to accommodate the increased need. In Wales the NHS has an ageing estate that was not designed with current demands in mind and led to challenges during the pandemic relating to infection prevention and control measures. Many hospitals in Wales were built in the 1960s or earlier, with 12% of the estate built pre-1948 and only 6% post 2015, meaning significant investment is required to bring them in line with modern standards.

115. Digital infrastructure and NHS workforce digital skills were also found to be in their infancy and were not ready for the sudden, vast increase in digital consultation. For example, there was a national directive to move to remote consulting overnight and remote team working, and particularly within general practice, there was limited support for the digital capabilities required to provide patients with continuity of care. The NHS app had limited functionality, and alternative, innovative solutions had to be deployed.

116. Due to political decisions about NHS funding and efficiency over more than a decade, the NHS operates with a small staff and bed capacity margin. This means that when there is a demand surge, the NHS often has to redeploy capacity from planned care to meet more urgent needs (including physical space and workforce). That can result in suspension of non-urgent activity, expediting safe discharge of patients to increase the number of beds available, and diverting some demand to providers with more current capacity. Pre-Covid-19, by around February of a non-pandemic year the high level of pressure that usually occurs in the winter months would be expected to subside, enabling NHS recovery.

117. We did not hear of any specific incidents or occasions where our members were concerned that demand might imminently exceed bed capacity. Healthcare leaders did everything they could to avoid this situation occurring, including at times cancelling elective care and discharging

patients to free up beds. The fact that the Nightingale Hospitals were barely used is evidence that the worst-case scenario in terms of bed capacity that healthcare leaders had prepared for was ultimately not borne out. In March 2020 NHSE sent a letter to healthcare leaders advising them to urgently discharge all hospital inpatients who are medically fit to leave. This was, however, reversed in a letter in April 2020 which imposed a requirement to test patients being discharged from hospital to a care home.

118. The NHS Confederation was not involved in conversations with members regarding discussions on individual admissions criteria.

119. During the first wave of the pandemic, people were also scared to present for care so demand was not as high. However, when the omicron variant hit in December 2020 to February 2021 the demand for beds – in particular ICU beds – became a concern as the impact was worse than expected based on earlier waves. That said, our members did regularly raise concerns around capacity relating to a lack of adequate beds, hospital space, equipment and staff.

120. Bed capacity was a persistent issue throughout the relevant period, although it was subject to fluctuation due to waves of Covid-19 occurring at different times across the country impacting on recovery locally and winter pressures. Members were generally able to ensure adequate numbers of suitably equipped beds by postponing significant amounts of planned care. But after the first wave of Covid when our members had hoped to resume that work, they shared capacity concerns with us. For example, in November 2020, some members told us that Covid-19 patients were still occupying around 15-20% of all beds and in January 2021 one member described their hospital inpatients being 50% Covid patients. An acute COO shared some of the reasons for reduced capacity: "Post Covid and with new infection control, cohorting and social distancing measures, our capacity has been significantly reduced (loss of theatre sessions, 20 beds removed from plan for IPC/social distancing and diagnostic productivity

losses of 25%-50%). Capacity remains a challenge due to staffing and segregation of critical care pods. Elective Inpatient activity remains low. CT and MRI backlog is also a concern."

121. By June 2021, Covid-19 prevalence was lower and areas with rising community prevalence did not see the demand for beds experienced in the previous peak – something which some members attributed to the success of the vaccination programme. However, with another Covid-19 peak in December 2021, members reported having an "extremely high run rate" and "unprecedented increase in demand", with significant growth in attendances, including ongoing high numbers (child and adult) in emergency care, and that it was challenging to meet targets. According to one member, "bed occupancy of >98% consistently causing exit block (inability to move patients in a timely way to inpatient wards)". In April 2022, several trusts and systems called critical incidents due to a lack of beds.

122. The availability of mental health beds was a particular issue. At various points there were big increases in demand for children's mental health services including CAMHs Tier 4 and eating disorder services, with initial presentations becoming more serious and with very limited bed capacity across the country to meet this demand. On some occasions there were no community beds available to support people with mental health problems' discharge from hospital across the whole country.

123. In many places, where demand temporarily exceeded supply of critical care beds, they relied on mutual aid from local and in some cases further afield hospitals for support.

124. As discussed elsewhere in this submission, infection prevention and control (IPC) measures were a constraint on hospital space. For example, in November 2021, one acute CEO told us that 12% of their beds had Covid patients, but due to separation of red/green areas, this amounted to the

loss of a full third of capacity. In April 2022, member reported that some beds had to be closed due to IPC protocols.

125. As noted above, in May 2021, the NHS Confederation wrote to the Secretary of State for Health and Social Care calling for a review of social distancing guidance in hospitals in light of falling rates of COVID-19 infection. This letter was the result of concern raised by members that infection prevention and control measures were both disproportionate to the levels of infection and stymieing the ability of NHS organisations to prioritise tackling the elective backlog, as instructed by government.

126. Staffing issues were also a big constraining factor in meeting increasing levels of demand during the relevant period. Many staff were redeployed from other areas, requiring non-Covid activity to be significantly reduced. By January 2021 many members had significantly increased their intensive care capacity and general ward capacity and had redeployed staff to these settings. A key point we stressed in our public comments was that this constituted an unprecedented increase in capacity (particularly high dependency and critical care) which meant that staff numbers were being spread far more thinly than would be typical. This was a profoundly challenging set of compromises for clinical teams and leaders and our members reported 'moral injury' faced by many of their staff. Staff availability was further compromised by illness/self-isolation. Moral injury is defined in as an injury to an individual's moral conscience and values caused by an action they took which they deem to be morally transgressive. This can have a profound impact on their mental health. When we refer to this in the context of the pandemic, observers noted and some healthcare professionals reported a moral conflict between the professional standards they signed up to and the way they were being asked to work, such as for, instance having insufficient resources and/or colleagues to provide care and/or witnessing poor standards of care.

127. In January 2022 growing staff shortages impacted mental health services in particular. One member reflected: "despite the national messages about

keeping everything going this is simply not possible and we are having to pause activities to divert staff to the hardest hit teams." This included in particular redeploying staff from community services to inpatient wards, which was sub-optimal due to the different skill set required. In April 2022, members reported that insufficient staff led to some beds having to be closed and some trusts declaring critical incidents, although staff absence was less of an issue overall by this time.

128. As mentioned above, in April 2021, the NHS Confederation wrote to the Prime Minister to raise members' concerns about the chronic undersupply of staff within the NHS workforce and the impact of this on the ability of NHS organisations to tackle the elective backlog whilst managing fluctuating rates of COVID-19 infection (INQ000391183). This was however a more general point than about shortages of specific roles.

129. In relation to equipment, in December 2020, at least one level 4 major incident was called as intensive care/ventilator capacity was almost full, resulting in patients being transferred to other hospitals. Our members were at times concerned that there would be an insufficient number of ventilators (which in the end only affected a minority of our members); the other was concerns that older hospitals did not have the equipment infrastructure to support so many patients requiring high flow oxygen. At various points during the relevant period, including in April/May 2020 and April 2021, members cited access to sufficient diagnostic equipment as a limiting factor for recovering elective activity. Our members told us there were shortages of diagnostic equipment linked to cuts to capital funding over the previous five-year period. However, they were not specific about which types of diagnostic equipment were lacking. Oncology and gastroenterology were reported as clinical areas where diagnostic capacity was at times lacking. Examples of diagnostic equipment used to support treatment in these areas are CT (Computed Tomography) and MRI (Magnetic Resonance Imaging) scanners, X-ray machines and endoscopy equipment. It is worth saying that diagnostic capacity was also limited by other issues such as infection prevention and control measures and

patients being reticent to attend routine screening due to concerns about the hospital environment.

130. A particular challenge was delayed discharges due to lack of out-of-hospital capacity. It was noted in January 2021 that the average length of stay for Covid patients had increased since the first wave. In October 2021 one member said a quarter of the people in their beds were medically optimised but unable to be discharged due to a lack out-of-hospital capacity. In April 2022, issues in domiciliary/social care capacity, including step-down care provision, led to significant discharge delays. There were challenges with community bed capacity in community services in some areas, with reports of approximately 20% of capacity being used for patients who are medically fit for discharge. We heard that these patients were unable to be discharged for re-ablement or domiciliary care support due to challenges with workforce support and retention for this group of staff.

131. Major incidents are a matter for individual organisations and are subject to review between NHSE and that NHS organisation. These would not be routinely reported to NHS Confederation, so any questions about major incidents should be directed to NHS England and to the relevant NHS organisations. That said, issues that contributed to major incidents in the relevant period sometimes came up in discussions with our members, largely related to Covid-19 and operational pressures across trusts and systems. More specific issues included availability of ventilators, portable oxygen supplies and/or medical gas pipeline systems (particularly throughout April 2020), issues around PPE supply, particularly in April to May 2020 and a few instances relating to other medical equipment and medicines.

132. It is also necessary to note that the threshold for what constituted a serious incident was higher during the relevant period – particularly in the winter of 2020-21 when the numbers of Covid-19 patients in hospital were so high.

133. NHS England is best placed to provide details of any Major Incidents that occurred during the relevant period.

134. NHS Confederation was not involved in the development, with NHS England, of a decision-making tool for critical care "rationing".

135. Our members would have raised any concerns about the discharge of people with conditions other than Covid-19 to NHS England, the Welsh Government or to the Northern Ireland Executive. We do not have a record of them raising this topic directly with us. We did hear more generally from members and from our partners in the social care sector that some patients were being discharged from hospitals into care homes without Covid-19 testing, following NHSE guidance in April 2020 to maximise capacity. Some members told us how they had worked with partners to innovate and provide alternative solutions. In Hertfordshire the council opened two closed care homes within seven weeks and repurposed them as Covid hot sites. That enabled local hospitals to discharge patients who were unable to return home – potentially due to family members shielding, or patients being unable to return to their care home. The homes were a joint venture with the NHS funding the beds and loaning the equipment.

136. The public messaging of "stay at home, protect the NHS, save lives" coincided with the impression from some members that people were presenting at the Emergency Department at later stages of their illness that they might have expected, and speculated that some people may have delayed or avoided accessing healthcare at various points during the relevant period. Primary care members reported that the messaging was contributing to patients believing general practice to be closed as they could not visit in person. This then evolved into a key part of the media and public messaging of 2021, which suggested that general practice was closed to patients. In 2021 primary care began to see more patients who had delayed presenting and had deteriorated or received a late-stage diagnosis as a result. Many patients reported wanting to protect the NHS and being concerned about catching Covid as reasons for delaying

seeking care. However, we are not in a position to judge whether or not government messaging contributed to this.

137. In Wales, both the Welsh NHS Confederation and its members disseminated messages aimed at the public to access healthcare if it was required and that emergency services were still available and that primary care was available, even if the service was being provided in a different format online.

Staffing in healthcare settings

138. Further to my comments above in relation to capacity within the NHS, primary care frontline staffing faced particular challenges. In Autumn 2020 vaccinators were in short supply. Lots of the additional staff provided through additional support (for example, military personnel) were not vaccinators and required supervision, creating additional workload at some sites. In 2020 the ARRS (Additional Roles Reimbursement Scheme), which provides general practice with funding for a range of clinical and non-clinical practitioners, was still new and many PCNs were struggling to recruit their full quota as potential recruits were often working elsewhere in the health system and running recruitment would have used up valuable time and resources. Some areas of primary care faced competition when shared roles were short in one sector. In some areas ARRS staff would be asked to work outside of general practice, such as community pharmacy. As ARRS roles are employed at Primary Care Network (PCN) level, moving them to another part of the system would impact multiple practices. Optometry saw 300 additional locums drop off the register in 2020, likely due to a lack of work. This then led to shortages as lockdowns lifted.

139. We know there were varying numbers of staff off sick with Covid-19 over the relevant period but due to the numbers of students and retirees joining the workforce, the net gain or reduction in staff would be very small.

140. There were key differences to approaching staffing in primary and secondary care during the vaccine rollout. Primary care sites relied heavily on volunteers and retired doctors returning to practices but struggled to attract workforce from elsewhere in the system. Conversely, primary care staff, such as pharmacists, were often pulled to support secondary care to run mass vaccination sites.

141. Anecdotally, we were informed that primary care faced more staff shortages than secondary care due to the instruction from NHS England and the Department from Health and Social Care that the key priority was to roll out the COVID-19 vaccine. In secondary care, the issue was more of a mismatch of staff in terms of where they were proportionally based within a hospital. During winter 2020-21 for example, a higher proportion of staff in secondary care were caring for Covid-19 patients.

142. When the government introduced a system whereby geographical areas were tiered from 1-4 based on Covid-19 incidence in 2020, it created greater variation in staff availability in some geographical areas than in others as members in higher tier areas reported far more staffing issues due to lack of childcare, isolation requirements, community services moving staff out of primary care Multi-disciplinary Teams (MDTs) and on to wards, and higher rates of Covid-19 among staff.

143. One of the most significant reasons for absence of staff across primary and secondary care in 2020 was staff sickness and isolation requirements. Staff sickness during Covid waves included significant absence directly due to Covid-19 in terms of the staff being infected, the staff's family being infected and requiring care and staff having to isolate pending negative Covid-19 tests at the prescribed times.

144. In primary care this led to additional shortages caused by the inability to reallocate funds to hire locums to cover sickness or demand increases. This was due to a number of reasons. Some of practices' funding is

allocated via the Quality and Outcomes Framework (QOF) and is paid at the end of the year, meaning there would not yet be the funds to allocate. The 2019 GP Contract introduced the Directed Enhanced Service Specification (DES), which allocates funding based on participation in a Primary Care Network. This provides funding to the PCN and not practices. Practices would have to then re-allocate funding amongst themselves to cover locum shifts, which isn't practicable. Moreover, some of PCNs' funding is allocated via the Investment and Impact Fund (IIF) and is paid at the end of the year, meaning there would not yet be the funds to allocate In 2021 growing staff burnout, fuelled by a significant increase in media attention on GPs, led to reception and clinical staff requiring time off for their mental health, and many left the sector entirely. In secondary care dramatic increases in capacity meant that available staff were spread more thinly than would typically be the case.

145. Due to the pressures of running the vaccine campaign and core general practice appointments, members in England did report reduced capacity due to issues with staff availability in Autumn/Winter 2020 – Winter 2021. To aid capacity in primary care, some clinical prevention measures in funding streams like the QOF and Investment and Impact Fund (IIF) were paused to allow PCNs to redirect their capacity to the Covid-19 response. Primary care did not entirely stop clinical prevention work during this time, but the scope and impact of non-vaccination prevention work was reduced.

146. The QOF was introduced in 2004 to remunerate practices for providing good quality care to their patients and to help drive improvement in the quality of care. QOF is a fundamental element of the General Medical Services (GMS) contract and practices are incentivised to achieve 'QOF Points'. The IIF is an incentive scheme introduced as part of the Network Contract DES in 2020; this incentive scheme is designed to reward PCNs based on performance against key priorities. The difference between QOF to IIF is that is the calculation of attainment and payment is made at the network

(PCN) level rather than practice level.

147. In Wales, this would be for NHS organisations to answer in their responses to the inquiry because it relates to operational issues.

148. In Northern Ireland, HSC organisations and the Department of Health are best placed to answer this question as it relates to operational issues.

149. In England issues were raised to the NHS Confederation by our members at various points during the relevant period on the impact of staff testing on the availability of staff in face-to-face settings. In primary care testing was slow to rollout and we raised queries and concerns around access to tests for staff with NHSE throughout March and April 2020.

150. The timescale of the staff testing rollout was unclear and there was confusion over whether primary care staff would have to travel to hospitals to access tests. Isolation rules did cause some staff shortages, but primary care leaders came together and innovated to resolve this. For example, PCNs facilitated buddying arrangements between practices to ensure they had enough face-to-face capacity if a practice has to close due to Covid-19 or isolation. Then, as testing became more widely available, primary care was able to prioritise testing staff which were in highest demand to reduce shortages.

151. In October to December 2020 staff testing was seen as one of the biggest issues in running an acute hospital, with many people having to isolate while awaiting test results. Concerns were expressed about the significant impact of administering the staff testing programme at a time when staff were already flat out and there was staff resistance to testing. Asymptomatic staff testing was piloted in hospital settings in November 2020 to reduce nosocomial infection – something which many members saw as unnecessarily burdensome given the low rates of staff infection. In April 2022, some members called for an end to asymptomatic staff testing

as the benefits of additional capacity were felt to outweigh the risks of staff with Covid-19 continuing to work.

152. NHS Employers argued for the removal of the NHS surcharge for non-UK healthcare staff and were pleased to see government enact this policy. It was both practically important in the context of the need for additional staff but to also send an important message during a crisis given the reliance of the NHS on overseas staff generally.

Temporary hospital facilities

153. We did not play a role in the creation, commissioning, operation and decommissioning of temporary hospitals in England, Northern Ireland or Wales. Two members of NHS Confederation senior staff were seconded to work in the London and Harrogate facilities and were under the direction and line management of staff responsible for those facilities,

154. In some areas Nightingale hospitals were used as a last resort or not at all; our members told us they considered this was due to two reasons:

155. First, there was an insufficient number of available staff to operate the temporary facilities. There were several instances where an intention to repurpose Nightingale hospitals was inhibited due to workforce supply issues. In many cases, local planning did not rely on Nightingales. Further, in December 2020 during the second Covid-19 wave, securing staff for "standing up" the Nightingale facility within 72 hours was seen as more challenging than the first wave, and it was clearer that it was much more effective to stand up surge capacity within individual hospital sites than at the Nightingale facilities, although staff already had the skills and competencies required for the staffing model, which negated the need for upskilling programmes.

156. Secondly, our members shared concerns that the facilities available within these temporary hospitals had been prepared to provide urgent capacity for a slightly different type of clinical need than that which transpired. By

the stage in the pandemic it was clear most patients with Covid-19 needed more complex care that was less easy to deliver in these temporary settings. Members considered that in many (if not most) cases, patient care was in the event more appropriately delivered in pre-existing clinical settings. It was, members reported, more effective to establish and staff 'surge' facilities in acute hospitals where existing staff could be deployed and supported.

157. We do not hold figures on whether temporary hospital facilities impacted directly or indirectly on the budget of NHS Trusts in England this but our members told us that temporary hospital facilities were not utilised during the relevant period and were seen as a last resort.

Private hospitals

158. The NHS Confederation encouraged NHS England and DHSC to mobilise all available capacity across the whole health system in the UK, to include private hospitals. We know that our members needed additional capacity from private hospitals and paying for this will have had some impact on their budgets. However, we do not hold figures on this. We also heard from members that NHSE's decision not to continue the contract in same way had a big impact on many trusts' ability to recovery elective care as they could no longer afford this additional capacity. We were not involved in decisions relating to the referral or transfer of individual patients for treatment at private healthcare facilities.

159. The Independent Healthcare Providers Network left the NHS Confederation on 31 March 2020 in order to become its own legal entity. Prior to their departure, in their final month when they were still part of the NHS Confederation, they worked to broker a deal between the NHS in England and the private sector to put the full capacity of the private sector at the disposal of the Covid response.

160. We cannot speak to the position in Wales, which is best addressed by the Welsh government and Welsh NHS organisations. In Northern Ireland,

HSC organisations and the Department of Health would be best placed to speak to the use of private hospitals because the Northern Ireland Confederation had no direct involvement in agreements to utilise private hospitals to treat HSC patients.

161. NHS hospitals relied on the independent sector for diagnostic support and electives throughout the relevant period. For example, the independent sector in London was used in May 2020 to effectively implement physical separation between 'red zones' and 'green zones' to avoid transmission of the virus. In November 2020, some members described the benefits of their good partnership with the independent sector in managing cancer services, long waits and cross-system working.

162. However, NHS leaders faced some challenges in getting the most from the additional capacity offered by the private sector due to various issues. They faced difficulties in encouraging patients to use the independent contract as some patients did not like having to travel farther to a private hospital and preferred to wait for treatment at their local trust. Members reported challenges in getting the independent sector to pay for less profitable high complexity treatments, which would have most helpfully freed up NHS capacity to focus on higher volume low complexity work to get through electives.

163. Crucially, many of the independent workforce (especially medical staff) are also trust staff - by requiring more NHS time of these staff due to the demands on NHS staff because of the pandemic, it reduced the ability to use independent sector capacity for non-Covid care as the medical staff were busier with NHS work. This was particularly an issue across specialties such as orthopaedics, where many surgeons work across the NHS and independent sector. In Wales, this would be for NHS organisations to answer.

Healthcare provision and treatment for Covid-19

164. NHS Confederation members are overwhelmingly not clinicians and not involved in clinical decision-making. As such we had no role in gathering, analysing or disseminating information in order to develop the understanding of the optimal clinical management of Covid-19.. NHS England will have been largely responsible for encouraging liaison with international clinical colleagues, sharing understanding and innovation from clinical experience across NHS Trusts; facilitating interdisciplinary collaboration within the NHS; and online learning opportunities for clinicians. We did provide some guidance on specific topics through our NHS Clinical Commissioners Nurses Forum, as detailed above.

165. Members of the NHS Confederation in England did not raise significant concerns to us about the escalation of care for patients seriously ill with Covid-19 or palliative care for Covid-19 patients, nor did they raise significant concerns to us regarding end-of-life and palliative care for patients critically ill with Covid-19. They may have raised them to NHS England.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices

166. In April 2020, primary care raised issue of DNACPR to NHSE on a stakeholder call regarding challenges from secondary care to the non-individualized DNACPR policy and their request for information on the patient and relatives' wishes regarding DNR. This was an issue because relatives were unable to attend acute care settings to be consulted. Primary care members raised the issue that many patients who were admitted for non-Covid related conditions had not attended a primary care practice and so primary care could not provide guidance to secondary care colleagues on patients; wishes. Members requested an exploration of the short, medium, and long-term effect of blanket DNACPR notices on these patients.

167. In Dec 2020, CQC published an "interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic" (INQ000235491.)

168. In Wales, this would be for NHS organisations to answer to highlight any feedback that they provided Welsh Government and how the implemented any guidance or policies developed in relation to DNACPR.

169. In April 2020, NHS Clinical Commissioners released a press statement that said most CCGs will already have end of life care pathways in place, based on national guidance and developed long before the COVID-19 pandemic in collaboration with member GP practices and palliative care clinicians (INQ000391207).

Infection prevention and control

170. In England, IPC guidance was largely provided at the national and regional level which was interpreted locally. Healthcare leaders (including IPC leaders appointed in each trust) followed national guidance, but ultimately had to make decisions about how to deliver care safely based on their local circumstances, including local outbreaks and the condition of their estate. Our members asked for more local determination in IPC measures which we lobbied for on their behalf but ultimately their calls were not heeded (INQ000391206). The challenges associated with interpreting and implementing IPC guidance, including the condition of estates, are explored elsewhere in this response.

171. The Welsh NHS organisations and Welsh government are best placed to speak on their IPC guidance and its implementation.

172. The condition and layout of the available NHS healthcare infrastructure was a significant issue in the implementation of IPC guidance for many of our members given the scale of the NHS maintenance backlog. Older hospitals, for example, tend to have more beds within a unit, which increases the risk of nosocomial infections and reduces staff efficiency. In

July 2020, members highlighted the issue of the lack of capital or revenue funding being available for IPC in general practice to stratify the estate or guidance on how to do it. Again in March 2021, for example, a member reflected on concerns about the unsuitability of their existing estates to meet the demands of Covid-19 (e.g. providing non-invasive ventilation on high-dependency respiratory wards), and the requirements for infection control (maintaining green and red zones both short term during Covid peaks, and longer-term). In April 2021, some trusts reported feeling disproportionately affected by having older estates and the loss of significant capacity due to infection control-related requirements.

173. On the more positive side, for example, in September 2020 an acute CEO described plans for a new hospital and noted that they were integrating new infection control guidance and flexibility into the design of that new building.

174. In May 2021, the NHS Confederation wrote to the Secretary of State for Health and Social Care calling for a review of social distancing guidance in hospitals in light of falling rates of COVID-19 infection (INQ000391206). This letter was the result of concern raised by members that infection prevention and control measures were both disproportionate to the levels of infection and stymieing the ability of NHS organisations to prioritise tackling the elective backlog, as instructed by government but it this was after the busiest time for hospital capacity and about recovery rather than COVID-19 treatment.

175. In addition, a small number of NHS Confederation members and I met virtually with then-Minister Ed Argar on 3rd March 2021 where they raised that older hospital estates had more limited recovery capacity due to it being harder to segregate patients in to 'hot' and 'cold' areas. They asked for investment for temporary facilities but this was not forthcoming at the scale needed.

176. In Wales, this would be for NHS organisations to provide specific detail to the inquiry in relation to the impact that conditions and layout of the available infrastructure had on implementing new IPC guidance. As highlighted previously, the NHS estate in Wales is extremely old and not designed with current demands in mind, with only 6% of the estate build post 2015.

177. In Northern Ireland, it would be for HSC organisations to provide specific details relating to concerns about infrastructure when implementing IPC guidance. The Northern Ireland Confederation did not highlight any specific concerns in relation to infrastructure during the period in question.

178. Turning to the guidance itself, our members regularly raised concerns about cconstraints on capacity and elective recovery caused by infection prevention and control requirements and challenges accessing capital to address these constraints. In April 2021, members described that "some departments are running at reduced capacity purely because of infection control concerns" and questioned the continuing need for restrictions such as the 2 metre rule following the roll-out of the vaccination programme. In March 2022, acute members welcomed flexibility in IPC restrictions at a national level, as it helped increase capacity in a safe and appropriate way, improving the efficiency of care pathways and patient flow, supporting further progress on the elective backlog. At this time, the situation varied across the country; for example, while recognising it is not "a decision (to) take lightly", some acute providers continued to postpone elective procedures and suspend visiting due to rising Covid cases in the community and increasing numbers of patients with the virus, while local IPC teams maintained a 'close and regular' review of the situation. Others said: "it is asymptomatic patients who are causing more disruption to flow than symptomatic", and encouraged "small incremental changes in IPC guidance".' As there was still a difference between the IPC expectations in healthcare settings and in general public spaces, members were concerned about patient/visitor compliance and impact on staff.

179. This availability and suitability of PPE was the dominant theme in the first phase of the pandemic. The national approach to PPE supply was very focused on the acute sector and social care and primary care settings found it particularly difficult to get access to adequate PPE. Some members were able to secure local suppliers – such as in Manchester - but then those local arrangements were nationalised (local suppliers producing PPE to be shipped across the country) which then meant there was less available locally than there had been before.

180. The NHS did not initially have access to the necessary PPE, which was not available in the correct quantities, types and sizes to fully meet its needs due to both inadequate supply; and a lack of ordering and distribution system suitable to meet this sudden increased need. New national procurement and distribution arrangements in England were rapidly designed and implemented but frustrated our members by being initially unreliable, leaving some of our members feeling powerless to resolve supply issues at a local level.

181. Our members described being unable to plan for surgical procedures, for example, due to lack of access to the necessary PPE, and unable to assure the safety of their staff. Primary care members reported having to rely on local shops, beauty and tattoo parlours to access PPE supplies, at times having to use crowdfunding to buy equipment. Our members raised issues around inadequate availability of PPE throughout 2020. This led to a lack of trust and confidence of staff over PPE supply, which was exacerbated by media coverage.

182. As explored above, persistent revisions to PPE guidance added to uncertainty. There was a focus on getting PPE to the acute sector, sometimes at the expense of community, mental health, third sector and social care settings. NHS procurement rules sometimes stood in the way of opportunities, for example making use of appropriate stock held by commercial organisations. This led some organisations to reach out for community donations. Availability of PPE was also a big issue for social

care providers, which also had to turn to community donations. In March 2020, we raised concerns about PPE in primary care with the Deputy Chief Medical Officer, Professor Jenny Harries, on a regular stakeholder call alongside other national health organisations. Unfortunately, due to the fast-paced nature of developments at the start of the pandemic, we don't have a note of the exact date this call took place.

183. In March 2020 we contacted NHS Procurement to address the challenge of innovations in PPE not being able to enter the NHS market due to lack of CE certification and we sought encouragement and endorsement from NHS Procurement for local initiatives to access PPE.

184. In March 2020 the Primary Care network began reporting back to NHS England on PPE shortages reported by members, including Clinical Directors having to crowdfund to buy kit and sourcing from local closed businesses. During this time primary care felt that there was very little support from their CCGs. The national helpline for PPE supplies faced delays and difficulties, which meant that primary care did not benefit from its work in the early days of the pandemic. During a meeting the Royal College of GPs reported that "even when we get [PPE] it's underwhelming" and the British Dental Association shared their concerns that they were "stuck outside of the system" and had no PPE. General practice members reported that it became increasingly difficulty to source clinicians willing to work in hot hubs without access to PPE, with the multi-source supply and confusing messaging leading to low confidence in the PPE supply system.

185. In April 2020, a group of Mental Health Chairs led by Norman Lamb wrote to the Secretary of State for Health and Social Care regarding the clinical need for PPE within mental health settings. Issues were raised about inconsistent PPE supply around the country. While in some areas supply chains were seen as well-coordinated, in others PPE supply was seen as "a total disaster". In April 2020, one trust CEO commented that "National statements on tonnage and number of items are meaningless". In response to these concerns, the NHS Confederation's CEO Niall Dickson

called for transparency on PPE supplies (INQ000391177). In May 2020 a community CEO commented that: "There are 2 parallel purchasing systems in place. We have mutual aid through routes of primary and social care which has also supported swapping PPE as per need."

186. In May 2020 we shared results from a survey of our PCN members on testing and PPE with NHSE which revealed that while awareness for the PPE guidelines was high, only 33% of primary care staff agreed that they had sufficient access to PPE to meet the guidelines, 24% were able to access more PPE when they needed it and 77% were using PPE for all face to face consultations irrespective of the guidance. 25% of respondents agreed that they were clear on plans to roll out testing across the NHS and 39% agreed that they had sufficient access to staff testing (INQ000391200).

187. Additional PPE was rolled out a few days after the survey closed, and we called on NHS England and NHS Improvement to continue to communicate directly with primary care, ensuring that the PCN workforce feels listened to and their questions answered.

188. In May 2020, the NHS Confederation sent a private letter to Emily Lawson then chief commercial officer at NHSE and Jonathan Marron Director General for PPE and Public Health at DHSC highlighting member concerns on procurement (INQ000391177).

189. Our members raised issues around the suitability of PPE throughout the relevant period. In some cases, for example, masks were procured that failed fit tests. In May 2020, we raised the issue of masks being issued in sizes that disadvantaged women to members of the NHSE team (INQ000391177). NHSE provided assurances about moving to better PPE distribution, providing different sizes, mask styles etc, although they said they "can't guarantee there won't be more bumps in the road as it is a very difficult space."

190. In June 2020, we held a webinar on PPE with Emily Lawson and Lord Deighton, who were NHS England's Chief Commercial Officer and the Prime Minister's 'PPE Tsar' respectively. About 50 members participated. The following issues were raised:

- The allocation of push stock is not representative of what trusts require, forcing them to source their own materials, in many different areas across England at different points. The NHS Confederation does not have the data from members to show what dates this happened where, as members were already overwhelmed by responding to the pandemic. We did however know it was a concern across a broad swathe of our membership.
- Lack of transparency e.g. FFP3 deliveries stopping completely in one area, forcing trusts to use the emergency request system. The NHS Confederation heard this information second-hand, without the area being disclosed.
- Mask variation - one member asked for data to be requested centrally and captured locally on failed and successful fit testing and links with ethnic background and gender, to inform procurement for future waves; another expressed concern about being able to use transparent masks for use with patients who have learning disabilities, autism, deafness, who may have difficulty with standard masks.
- Concerns about supply of sterile surgical gowns, including not being able to procure gowns until 48 hours before running out of stock.

191. The root of these problems seemed to be that there was a lack of information on local requirements at the centre and issues distributing PPE from the stockpile. The time lag between it being clear what PPE was needed and it being available to use, the Parallel Supply Chain could barely satisfy local organisations' requirements. Later, the Parallel Supply Chain better estimated what would be needed by talking regularly to local trusts and resilience forums which allowed them to collect data.

192. In August 2020, our chief executive sent a follow-up letter to Emily Lawson again seeking reassurance on PPE stock and supply (INQ000391178). By October 2020, we heard that members were feeling much more confident about PPE, although the issue was raised again by one member in March 2021.

193. In Wales, this would be for NHS organisations to provide specific detail to the inquiry.

194. Healthcare leaders undertook an enormous amount of innovation at pace to continue to deliver care in line with government restrictions. Given differences in personal circumstance, digital literacy, access to technology and preference, there was variation in how much of an impact increased use of technology and remote consultations had on both patients and clinicians, which is linked to inequalities.

195. In December 2021 the NHS Confederation reflected this issue of digital exclusion in a briefing entitled 'Integration and Innovation in Action: virtual care' (INQ000391173). This briefing included best-practice examples of how NHS organisations were and are working to mitigate this risk. In September 2021 we published a briefing 'Building Back Inclusively' in partnership with Boeringher Ingleheim which also reflected these concerns (INQ000391159).

196. In primary care, clinicians had to adapt to the unexpected strain of back to back calls and building the trust and rapport required for a successful intervention remotely. Some members reported a lack of sufficient laptops for their primary care teams, including social prescribers and care coordinators. For patients experiencing isolation, remote consultation was difficult and they lacked the mental health benefits that an in person appointment may have offered. The types of remote consultation varied between practices. Clinicians with access to video consultation praised the ability to view any physical symptoms, which telephone consultations lacked.

197. In December 2021 the NHS Confederation repeated concern about digital exclusion in a written evidence submission to the Public Accounts Committee inquiry on NHS backlogs and waiting times (INQ000391191), and again to the Health and Social Care Select Committee's inquiry on digital transformation in the NHS in June 2022 (INQ000391190). We were pleased to see these concerns reflected in the Select Committee's inquiry report. In Wales, this would be for NHS organisations to provide specific detail to the inquiry.

Shielding

198. There was initially very little available guidance on which organisation was responsible for compiling the shielding and clinically extremely vulnerable lists and we communicated concerns of primary care leaders to senior NHSE and NHS Digital staff at various points via various calls and emails. Discussions with Commissioning Support Units (CSUs) confirmed that lists were being composed by CSUs and sent out to relevant organisations, but that each system working in isolation. CSUs provide external support, specialist skills and knowledge to support Integrated Care Boards in their role as commissioners. Such services can include business intelligence, clinical procurement services or business support such as HR. They are funded by NHS England.

199. The recipients of the shielding list varied nationally, with some CSUs sharing it with local councils rather than primary care, which caused additional confusion as patients called their GP to find out if they were on the shielding list, before lists made it to practices.

200. In December 2020 our members continued to struggle with conflicting messages around how they should support shielding/extremely clinically vulnerable staff, which we escalated to DHSC for resolution. This was a wider issue of contradictory formal guidance in relation to all clinically vulnerable and extremely clinically vulnerable people from the government and Public Health England (PHE.) This included saying clinically extremely

vulnerable people should work at home wherever possible, including if that meant a change of role, but other guides saying this may not be appropriate. Public Health England also published a press release that mixed up clinically vulnerable and clinically extremely vulnerable people and this mix up was reflected in official guidance, causing more confusion.

201. That said, members reported that they largely adapted to the situation, redeploying shielding staff to roles they could do from home.

202. The situation regarding staff availability changed over the course of the pandemic. Actions to make students available to support clinical teams were welcomed and there were examples of returning staff (from retirement or other employment) being of real assistance. Existing staff were redeployed to clinical areas outside their normal practice, and this increased during the peaks of demand.

203. In November 2020 our members shared concerns about capacity and staffing ratios and cited shielding as one of the contributing factors, alongside staff sickness, isolation and the additional pressures of potential staffing needed for Nightingale sites and vaccination rollout. In January 2021, Human Resource Directors asked NHSE to revisit national guidance to evaluate the potential for clinically extremely vulnerable (CEV) staff who have received vaccinations to return to work.

204. In April 2021, all trusts reviewed their clinically extremely vulnerable (CEV) workforce. Staff return from shielding was complex and had impacts on the health and wellbeing of some CEV returners, including psychological effects associated with having been distant from the workplace, and health anxieties complicated by feelings of guilt (including concerns about potential responses from staff who worked in healthcare settings throughout the pandemic). Staff and any family members falling into the CEV category had to shield. This had a disproportionate impact on primary care given the smaller proportion of staff in each practice.

205. There was an additional challenge for employers in how those NHS staff unable to work due to Long Covid were subject to different conditions in terms of their sick leave – including being in receipt of full pay up until July 2022.

206. Maintaining the shielded patients lists was a serious administrative burden on primary care that ran into 2021. Clinical Directors across the country reported that their lists needed a lot of manual intervention as data was missing, or inaccurate. As late as October 2020, members were struggling to deal with influx of patient queries about shielding lists. Primary care reported being overstretched and unable to respond to all the calls, and unequipped to answer lots of the questions they received as guidance was slow to arrive. The reintroduction of shielding in the second wave aggravated this issue and members continued to struggle to access guidance. The additional burden of wasted clinical time placed additional strain on practices. In February 2021, a clinical director in the South East informed us that "we are all picking up the pieces of another centrally directed shielding programme which is completely flawed, on top of the day job, on top of vaccinating".

207. In Wales, this would be for Welsh Government and NHS organisations to provide specific detail to the inquiry.

Healthcare provision and treatment for conditions other than Covid-19

208. NHS Confederation members generally have managerial and operational rather than clinical expertise so we did not receive detailed concerns on the maintenance of care pathways and treatment for patients with conditions other than Covid-19, to include such issues as colorectal cancer, ischaemic heart disease and hip replacement surgery. However, our Mental Health Network received significant concerns regarding Child and Adolescent Mental Health Services.

209. It was clear from NHS Confederation members in England that there were significant pressures on children and young people's mental health

services (CYPMHS) during the pandemic, due to an increase in demand, especially for eating disorders and CAMHs Tier 4, as mentioned in my comments on NHS Capacity in preceding paragraphs. It will be for the for the Welsh NHS organisations to provide specific detail as to the position in Wales. In England, these pressures were felt across mental health services, but also the wider NHS including acute services and primary care, local authorities, schools, voluntary sector, digital and independent sector services. We produced the report Reaching the tipping point in August 2021, which highlights members concerns.

210. The number of young people accessing community eating disorder (CED) services and completing an urgent pathway for eating disorders increased by 141% between quarter four in 2019/20 and quarter one in 2021/22. The standard for urgent cases is for 95% of children and young people to access CED services within one week. Given the significant increase in demand, there were challenges in meeting this target and at its worse, only 59% of urgent cases were seen in 1 week. The numbers waiting for services, even for urgent case increased during the pandemic. In Spring, 2020-21, 20 children and young people who urgently needed the CED service were waiting more than 1 week, but by winter, 2021-22, this increased to 213. The numbers waiting were even higher for non-urgent cases.

211. There were also pressures on inpatient beds. When a child cannot be placed on a CYP mental health ward or in a specialist eating disorder bed, they may be placed in a paediatric bed, an adult mental health bed, section 136 units, or in A&E. A report from the Royal College of Paediatrics and Child Health on the impact of COVID-19 on child health services published in June 2021 found that the number of children and young people in paediatric beds with a mental health need nearly doubled between September 2019 and December 2020 **INQ000268033** Whilst CYP may need to be admitted to paediatric bed to stabilise them or provide assessment, there were significant challenges for the service, as staff may not have had the training in mental health or providing

interventions such as nasogastric feeding. Over 38% of paediatric services said that they did not have an effective joint pathway with CAMHS. Whilst, admitting a child or young person to a paediatric bed may be considered part of the pathway, the number of admissions and the length of stay were high. We know that there was also an increase in the number of children and young people admitted to adult mental health beds. Under the Mental Health Act 1983 (as amended), this should only be a last resort or because of clinical need, because there can be safeguarding concerns. CQC reported that there was a 32% increase in the number of under 18s admitted to adult psychiatric wards in 2021/22 compared to 2020/21. This is a reflection of the pressures facing children and young people's mental health services at that time.

212. Our members shared concerns that NHS waiting lists for mental health care were driving children and young people in particular to unregulated services, including overseas, where quality of care may be poor. In November 2020, issues were shared with us about increased use of crisis mental health services (including delaying seeking help then presenting in crisis), increased first-onset psychosis, CAMHS demand that exceeds pre-Covid levels, high bed occupancy, and concerns about the risks going into winter, staff absence and impact on service provision. At the time primary care was reportedly seeing increasing levels of anxiety and depression, which they felt they were able manage but if absences and reduced capacity occurred in primary care, this was be felt in the mental health system. Members highlighted that the extra demand on mental health will be long term and funding should reflect this. From 2021, primary care members have consistently raised concerns with us regarding the huge increase in demand for child and adolescent mental health services. General practice struggled to recruit mental health practitioners that were able to work with children and young people due to workforce shortages in this field, meaning that many children were placed on long waiting lists for secondary care, and often presented in primary care multiple times while they waited, due to continued deterioration.

213. In April 2022, the Mental Health Network held a meeting with chairs who expressed concern about the pressure demand was placing on members. The issues were raised internally and incorporated into wider NHS Confederation policy and communications work which called on NHSE and the CQC to be cognizant of this when inspecting services.

214. Into 2022, members continued to tell us they were concerned about the backlog and restoration of children and young peoples' services, including CAMHS, speech and language therapies, community paediatrics services and children's occupational therapy.

215. Members tried to devise innovative solutions to enable the screening, care and treatment of patients during the pandemic. For instance, Greater Manchester was rethinking its eating disorder service models to improve its assessments, taking a "waiting-well" approach to support those on waiting lists and to look at how to manage risk in a better way. (INQ000391210). The city region was also looking at alternatives to admission and was keen to tap into the skills and resource available in the voluntary sector.

216. There are two pathways in Greater Manchester for children and young people with eating disorders: One around ARFID (Avoidant/Restrictive Food Intake Disorder). The other focuses on day provision/intermediate care pathway, so that children and young people with eating disorders, who are typically admitted in order to physically stabilise them, could be managed with day provision. They will receive the same level of support but will not need to be admitted.

217. During the pandemic, Doncaster saw a significant increase in the number of presentations to A&E due to young people self-harming, or with suicidal intent. In response, the Doncaster health and care system set up the Doncaster Social and Emotional Mental Health group, a multi-agency forum that includes key influencers and decision makers across the Doncaster Children's Partnership. Multi-agency partners present cases at

weekly meetings, which is an important step as some schools were unaware that pupils had attended A&E due to self-harming and/or with suicidal intent, which made it difficult to provide appropriate support. The multi-agency team undertook a deep dive to establish which pupils from which schools attended A&E due to mental health issues. It worked with the provider for children and young people's mental health services to ensure that pupils received appropriate support, especially those with the highest level of need. The police form part of this team. As a result, they are more sighted on local children at risk, who may have become more vulnerable during the pandemic. The force also supports parents and carers who may be at risk of domestic violence (INQ000391210).

218. In primary care, members across England trialled virtual group consultations for a range of conditions to speak to as many patients as possible and build support networks while lockdown was in place. Some members established teams who would work directly with unhoused populations and asylum seekers in their area who would otherwise not have access to care and screening.

219. We did not receive detailed intelligence on the provision of private healthcare for colorectal cancer, ischaemic heart disease, hip replacement surgery, and Child and Adolescent Mental Health Services.

220. Private healthcare providers in England, including many digital mental health services are commissioned using NHS funding to provide children and young people's mental health services. They play a key role, whether that is providing inpatient beds for the most acutely unwell children and young people, or digital mental health services for those who have a range of mental health issues, and the severity can range from mild to relatively severe. This was the case before, during and after the pandemic. The increase in demand for children and young people's mental health support during the pandemic put significant pressure on these services as well as NHS and other services.

221. In Wales, this would be for NHS organisations to provide specific detail to the inquiry.

222. There were challenges with the capacity to treat existing Child and Adolescent Mental Health Services (CAMHS) and Children and Young People's Mental Health Services (CYPMHS) patients receiving community and home treatment services within specialist children and young people's mental health services even before the pandemic, where we often saw long waiting times, and referral criteria was often tightened as a result, so only the most ill young people were accepted into services. The surge in demand linked to the pandemic put significant additional pressure on CYPMH services.

223. Analysis by the NHS Confederation of NHS England data revealed that there were 66,113 referrals to children and young people mental health services in February 2022, 76.6% higher than the equivalent month in February 2020, before the pandemic (INQ000391155). According to NHS England data the number of children and young people accessing mental health services also increased, with the number having one direct contact increasing from 572,912 in March 2021 to 701,839 in April 2023. This impact on services is still evident.

224. Schools were closed for a considerable amount of time, which likely impacted on children and young people with emerging mental health needs being picked up early. There was an increase in urgent referrals to crisis services for children and young people during the pandemic, which also suggested that emerging difficulties were not picked up early enough. There was a move to telephone or video consultations, which was generally positive, but we heard that it made it harder to check on young people with potential eating disorders, as they can disguise their size and mask other symptoms. Digital services came into their own, and we know from our members such as Kooth (a digital mental health provider) and Healios (an online mental health, autism and ADHD service provider for

children, young people and families), that they also saw an increase in demand and in the acuity of the young people they were supporting.

225. Mental Health Network members reported that there were significant pressures in specialist children and young people's mental health services, especially eating disorder services, during the pandemic. There was an increase in the severity and complexity in the needs of the children and young people they were seeing in services.

226. There was an increase in children and young people presenting with eating disorders such as anorexia nervosa, but also an increase in those presenting with eating difficulties and ARFID (Avoidance/Restrictive Food Intake Disorder, which refers to problems with eating that are not necessarily linked body image and self-esteem).

227. There were significant pressures on beds for children and young people with mental health needs, especially for eating disorders. Pressures were particularly high in the south and southeast of England, but members across the country, in both acute and mental health trusts, reported that they were also facing pressures. There have been concerns about whether there were enough children and young people mental health beds, which wasn't helped by the closure of some independent sector beds.

228. Our members reported that children and young people were staying longer in inpatient units. Also, we know that more children and young people were admitted to paediatric beds, and to adult mental health beds.

229. We do not have the data for Wales and if needed the Welsh NHS organisations should be asked to provide specific detail to the inquiry.

Ante-natal care, maternity services, postpartum and neonatal care

230. The NHS Confederation heard little feedback from our members on the impact of the Covid-19 pandemic on the delivery of ante-natal, maternity and neonatal care.

231. In January 2020, one region told us they have had to suspend home births due to Covid and ambulance pressures. In August 2020, several acute CEOs told us that the capacity lost due to rising demand and flu and Covid-19 considerations would necessitate losing efficiencies in diverting certain treatments, like specialist or maternity services, to a single site. In February 2021, we heard of evidence of increased services as Covid-19 cases reduced, for instance several members reported reinstating home births. In December 2021, we received reports that maternity services in some regions remained particularly challenged with some sustaining 50-60% staffing for several successive months. Community midwives in one region reportedly left their roles as they felt unsafe managing emergency birthing complications without ambulance service support.

232. NHS organisations in England are better placed to provide further detail on the impact on the provision of these services during the relevant period in England. We hold no details for the position in Wales and Welsh NHS organisations will be better placed to provide specific detail to the inquiry.

Impact on NHS workers

233. As part of our 'NHS Reset' campaign (INQ000391148), we undertook surveys of NHS leaders with regard to NHS workforce wellbeing and the impact of COVID-19 in both summer 2020 and summer 2021. These surveys led to two reports, produced with Novartis in a commercial partnership, the second of which set out five priority areas of focus for local NHS leaders to take to support staff (INQ000391187) (INQ000391146). The reports also included case studies sharing best practice. The survey results and resulting reports were shared with NHS Confederation members, stakeholders across the sector and national decision-making bodies.

234. Following engagement with members, the NHS Confederation made public interventions regarding policies and guidance relating to health and care staff. A call in March 2022 for free COVID-19 tests to remain available to NHS staff after the publication of the government's 'Living with Covid' plan – due to come in on 1st April 2022 – set out plans to bring an end to free universal symptomatic and asymptomatic testing in England (INQ000391204). This intervention followed a survey in which 94% of NHS leaders told us they thought tests needed to remain free for health and care staff (INQ000391205).

235. 210. NHS Employers undertook significant activity as part of the DHSC Covid-19 Terms and Conditions (TCS) sub-group and NHS Staff Council Executive Covid-19 working group; working constructively and in partnership with national trade unions to address specific terms and conditions responses to the pandemic:

- Guidance documents (e.g. HRD Covid-19 guidance) and detailed FAQs developed in conjunction with DHSC and trade unions – all published on NHS Employers website for use by NHS organisations.
- Existing NHS Employers machinery used for feedback from employers: for example - Medical and Dental Workforce Forum, Medical Contracts Expert group, HRD networks, regional Social Partnership Forum (SPF) meetings.[2] This enabled feedback from employers to be provided to DHSC and NHSE and a means of raising and addressing key TCS clarification points with employers and trade unions.
- In the medical staff group the decision taken in response to relax some of the 2016 junior doctor contract rules was key to relieving some pressures and enabling safer local service delivery decisions to be taken.
- NHS Employers acted as host organisation for NHSE/I and/or DHSC policy positions to be communicated to employers via its main website.
- NHS Employers provided and facilitated employer input to urgent COVID-19 response work on adaptation of recruitment and employment

[2] The SPF brings together NHS Employers, NHS trade unions, NHS England (NHSE), and the Department of Health and Social Care, to contribute to the development and implementation of policy that impacts on the health workforce.

processes, employment of foundation interim year 1 (FiY1) doctors (medical schools graduates that graduated early and volunteered to join their foundation year 1 (FY1) programme early to support the pandemic response), expansion of flexible training options and impact of the pandemic on training progression.

236. In addition, NHS Employers worked with partners to provide advice; drafting, coordination and commenting on sections of guidance (health and wellbeing of staff);

- NHS Employers worked alongside Health Education England (HEE) to address impacts to junior doctors training programmes.
- Sharing and promoting links to employers on the Covid related e-learning training modules and statutory and mandatory training.
- Employer voice at stakeholder meetings chaired by NHS England
- Seeking agreement on changes to employment checks to support quicker deployment. One such example is securing agreement from DHSC and Home Office that ID could be checked by employers online rather than in person, free and fast track DBS Checks for those working in COVID-19 settings or in vaccination rollout settings.
- Asked for changes on end point assessments for apprenticeships: Provided advice on options and discussed with DHSC and DfE to secure new arrangements for temporary workers. Communicated these changes to employers.

237. Working with members across Wales and trade union partners, the Welsh NHS Confederation published a briefing in January 2021 (INQ000401414) to showcase some of the initiatives that have been introduced across NHS Wales to support staff health and wellbeing throughout the pandemic.

238. With funding and support from the Health Foundation, in December 2020 the NHS Confederation published a report based on interviews with over 100 members of the NHS Confederation's BME Leadership Network (**INQ000237273**). The research study was undertaken in response to the early warning signs of a disproportionate impact of COVID-19 on black

and minority ethnic (BME) communities in order to assess inequalities. Participants pointed to long-standing inequalities and institutional racism as root causes. Interviewees were united in the view that government had not taken sufficient action to address the underlying issues.

239. The report called on government to commission a review of the availability of translation services after a lack of appropriate communications strategies regarding COVID-19 targeting BME communities was one of the more widely reported institutional failures in the interviews **(INQ000237273)**

240. In relation to the health and care workforce, interviewees reported BME professionals were more likely to take on high-risk roles due to fears contracts may not be renewed or shifts reduced (particularly with regard to agency staff, or staff with vulnerable immigration status.) Interviewees also suggested this was compounded by BME employees being less likely to raise concerns.

241. The NHS Confederation Health and Care Women Leaders Network undertook surveys of members in summer 2020 (INQ000391164) and summer 2021 (INQ000391165), which highlighted the change in work-life balance for women working in health and care at this time. The average respondent was working 11.22 additional hours each week of non-work caring responsibilities, but only reduced their working hours to take account of these responsibilities by 1.44 hours each week. This average rose by a further 1.5 hours a week to an additional 12.81 hours in 2021.

242. The survey reports made a number of recommendations to employers and managers across the NHS and NHSE to advocate for better support for flexible working and supporting women's health and wellbeing in relation to the workplace.

243. NHS Employers published a survey of NHS staff living with a disability with regard to their experience of the COVID-19 pandemic in March 2022 (INQ000391192) the survey found 79% of respondents that self-identified as disabled were not aware of communications from their employer about the Workforce Disability Equality standard (WDES) and 87% said they did not have any opportunities provided by their employers to be involved in WDES conversations. (WDES is a set of ten specific measures that enables NHS organisations to compare the workforce and career experiences of disabled and non-disabled staff. NHS organisations use the data to develop and publish an action plan.)

244. In response to these findings, the report made a number of recommendations to NHS England, NHS Improvement and NHS Employers.

245. NHS Employers was directed by the NHS England Chief People Officer to devise guidance available online to assist employing organisations with risk assessment processes to understand and minimise risk of contracting Covid-19 in NHS workplaces.

246. The first iteration of this guidance was rapidly prepared and published by NHS Employers at the end of April 2020 (**INQ000331022**). This incorporated comments and advice from trade unions, the Faculty of Occupational Medicine and research from the University of Leicester. The content was regularly updated to include additional resources and advice:

- 30/4/20 - New web page created to house information on risk assessments for staff, particularly for vulnerable groups and those at a greater risk according to age, disability, gender or pregnancy.
- 12/5/20 – Web Page updated to include a link to an independent paper to support employers with risk assessments for staff and to consider the risks and concerns of BME employees
- 15/5/20 - This webpage was updated to include additional guidance from the Royal College of Psychiatrists on BME staff in mental healthcare settings.

- 29/5/20 This webpage was updated to include a new diagram to assist with assessing risk assessments, new tools to support conversations with staff, and updated to links to guidance from organisations and NHS trusts.
- 3/6/20 This webpage was updated to include an example of a system-wide risk assessment tool being used by NHS Wolverhampton.
- 5/6/20 This webpage was updated to include a resource on health & safety risk assessments from NHS trade unions.
- 10/6/20 This webpage was updated with new versions of the system-wide tool to undertake risk assessments during COVID-19, and the individual risk assessment proforma, both from NHS Wolverhampton CCG.
- 26/6/20 - webpage updated to include a link to new guide from NHSE on risk assessments and beyond
- 2/7/20 - this webpage was updated to include a letter from NHSE to employers on deploying risk assessments and publishing metrics.
- 20/7/20 - this webpage was updated to include information about a Covid-age tool from the Association of Local Authority Medical Advisors. The page also contains new links to guidance and templates from Huddersfield and Calderdale trust.
- 14/9/20 - Update to risk reduction framework and tools and resources section on website.

247. The NHS Confederation does not hold detailed figures or information on staff who died from Covid-19 infection. NHS Employers published a summary of the benefits payable to dependents of members of the NHS Pension Scheme on death in service. This accompanied the information provided for employers on the separate and newly created Coronavirus Life Assurance Scheme. NHS Employers advised members on the administration of this scheme.

Lessons learned and Recommendations

248. From May 2020 to July 2021, the NHS Confederation ran an NHS Reset campaign (INQ000391148) in order to take stock of the pandemic experience, including what worked well and which should be retained or followed in the event of a future pandemic. This was the only major review

conducted by the NHS Confederation on lessons learned from the pandemic, with two network-specific reports INQ000391210 and INQ000391211. The campaign was split into three phases:

- **Recognise** - recognising both the sacrifice and achievements of the health and care sector's response to COVID-19, including the major innovations that were delivered at pace
- **Rebuild** - Rebuilding local service provision to meet the physical, mental and social needs of communities affected by the severe economic and social disruption
- **Reset** - Resetting our ambitions for what the health and care system of the future should look like, including its relationship with the public and public services.

249. Four key areas of activity shaped the delivery of the campaign:

- **Informing members** on the latest developments to ensure they were regularly updated, and receiving the guidance they needed, including by synthesising and making sense of the vast range of guidance that is being sent to them.

- **Collection of member insight** to ensure we had access to the views of the front-line – across all parts of our membership – in real time. This was collected through a variety of mechanisms and fora including member surveys, round tables, meetings, webinars and other online events.
- **Analysis of member insight** to ensure we were able to understand pressures across the system, as well as in specific sectors, and group up concerns and needs into key themes. This was achieved via informal feedback calls and the distribution of discussion papers.
- **Action** on issues that members raised concerns over, including recommending action that reduces the administrative burden on members while they were dealing with the virus. This was conducted both privately and through public-facing communications.

250. To inform the campaign, we drew insights from five main channels:

- Private, back channels through our conversations with senior figures in NHSE and government.
- National media through our role as a leading commentator
- Direct communications to our members – including the NHS Confederation trustee board and network member boards; first-time CEOs cohorts; regional team relationships with members and ongoing feedback and WhatsApp groups. We also held a dedicated virtual conference in November 2020.
- Social media channels
- Both the NHS Confederation and NHS Employers' websites are an authoritative source of guidance and advice for members.

251. In January 2021 the campaign shifted to focus on Reset and Recovery, focusing on having an honest conversation about the scale of the challenge. This phase of the campaign was delivered across three strands, focusing on the health and wellbeing (including mental health) of our staff; recovery of the elective backlog and learning to live with Covid-19.

252. Our 'NHS Reset' campaign had ten key themes which spanned a range of issues affecting how health and care services are planned, delivered and experienced across the UK. Some of these recommendations are specific to the Covid-19 experience; others are wider but recognised to be important within that context. The campaign deliverables are listed in document INQ000401410 with a summary of their main recommendations and the extent to which these have been implemented. This document references the following exhibits: (INQ000391166) (INQ000391208) (INQ000391166) (INQ000391185) (INQ000391171) (INQ000391197) (INQ000391174) (INQ000401411) (INQ000401415) (INQ000391167) (INQ000391196) (INQ000391172) (INQ000401413) (INQ000391146) (INQ000391195).

253. As part of the campaign, we published blogs on our website by members discussing the report findings. In addition to the points raised in the

paragraphs above, NHS Confederation would make the following recommendations to improve the response and operation of the healthcare system in the event of a future pandemic, to including mitigate the impact of a future pandemic on workers in the healthcare system.

Future workforce capacity and wellbeing

254. Workforce capacity was one of the biggest constraining factors in the country's response to the Covid-19 pandemic. Pre-pandemic, vacancies meant that the existing workforce had already been overstretched to compensate. An extended increase in demand and pressure due to Covid-19 combined with a reduction in available workforce due to staff sickness, shielding and isolation to reveal the challenges in flex and resilience within the system to cope with similar shocks when they extend beyond the short term, resulting in staff burnout and the need to reduce provision of non-Covid services, contributing to the current waiting list backlog.

255. The recently published NHS workforce plan, plus resolution to current industrial action, will be crucial to help ensure future services are appropriately and sustainably staffed. This will require appropriate investment. This should be combined with excellent planning to ensure that in the event of a future pandemic or similar, staff have access to personal protective equipment, a safe workplace, and sufficient rest time outside of work, ensuring that inequalities are taken into account.

Capital investment for resilience

256. The pandemic demonstrated that underinvestment in capital over many years led to difficulties for the NHS in enacting infection prevention and control protocols with negative impacts on capacity in the physical estate sufficient access to diagnostic services including equipment and laboratory estate; challenges in scaling up digital delivery; and even problems with the infrastructure for oxygen delivery.

257. The NHS needs (1) a significant increase in capital budget so NHS estates and equipment can be updated to better respond to a future pandemic,

and (2) more efficient access to capital funding in the event of a future pandemic so that NHS organisations can get prompt access to the funds they need to make essential, urgent changes. We hope this will largely be addressed in the upcoming capital review announced by government.

Investment in the health and social care system beyond the NHS

258. The reforms enacted by the Health and Care Act 2022 offer the opportunity to consider the health and social care system in its entirety and can be resourced to improve resilience and capacity during a future pandemic. For example, inadequate social care funding and staffing capacity during the pandemic led to people spending longer than necessary in acute care. This caused less available capacity in the acute sector, and greater deconditioning of frail patients as well as poorer rehabilitation and 'step down' care. The additional funding for social care proposed in 2020 and substantive reform of the sector have continually been delayed. In order to protect often vulnerable people in social care settings and to alleviate pressure on the NHS (due to delayed discharges) and provide resilience for future pandemics, the government must provide adequate long-term funding for social care services and its workforce.

Effective, pre-planned systems for reducing spread of infection during a pandemic

259. The Covid-19 pandemic response saw a great many plans and policies being developed while the response was underway. This delay in planning and policy formation caused numerous problems but particularly in the ability to curtail the spread of infection. The UK must learn from this and ensure that in future, plans and infrastructure are in place in advance and are ready to be efficiently adapted to act promptly to reduce the spread of the infection in question. This must include:

a. clear protocols for various stages of public and NHS-building infection control, extending up to lockdown and release;

b. access to a pre-existing efficient and effective test, trace and isolate system;

c. agreed infrastructure and processes for mass vaccination;

d. strong remote/digital health infrastructure; and

e. access to suitable infection prevention equipment for health and care staff, patients and the general public, including a robust and well-communicated plan for procurement and dissemination of this equipment.

This should be underpinned by:

f. an appropriately-funded preventative model of population health

g. overseen by a strong public health system that reduces health inequalities; this should also avoid the need for disruptive changes to public health infrastructure during the pandemic response.

260. There also needs to be

h. an understanding of the impact of wider government policy, for example the impact of statutory sick pay on people's ability to isolate when indicated.

Well-designed and efficient communications

261. For the NHS, a clear, joined-up process is needed for cascading information about key changes to guidance and policy coming from a wide range of guidance-issuing bodies, with excellent version control. Healthcare professionals/leaders should be made aware of changes ahead of the media/public with a discipline of ensuring they have adequate time to plan and deliver.

262. For the public, in a future pandemic the government and relevant arm's length bodies should have plans in place for clear public messaging about (1) infection prevention and control measures (e.g. social distancing) informed by communications professionals, behaviour change psychologists and other appropriate expertise, and (2) the appropriate ways to use health services depending on levels of pressure. This would help ensure expectations are aligned, empower the public with confidence and insight, and consequently help people know what to expect and what is expected of them. Doing so would reduce the concern voiced by some of our members that patients were being dissuaded from accessing

important healthcare, and help reduce the abuse of NHS staff caused by such misunderstandings.

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: 01.02.2024