IN THE MATTER OF THE INQUIRIES ACT 2005

THE UK COVID-19 INQUIRY

WRITTEN CLOSING SUBMISSIONS ON BEHALF OF

THE DEPARTMENT OF HEALTH AND SOCIAL CARE

FOR MODULE 3

Introduction

1. This submission starts by thanking the staff who operated in all health settings during the pandemic. They acted selflessly to care for those with COVID-19 and to keep as many healthcare services as possible running throughout the pandemic given the very severe strains on the system. The Department recognises that this work was often relentless and caused them anxiety and worry given the risk to their own life and the health of their loved ones. It has placed a considerable toll on the health and wellbeing of staff in all aspects of healthcare to this day.

2. The Department has carefully listened to the powerful evidence from healthcare staff and recognises the debt of gratitude owed to them by us all. The Department also recognises the importance of building a health service which protects its workforce as well as patients.

3. The Department has also heard the voices of those bereaved who desperately wished to see their loved ones in their final hours, of those who had learning disabilities who did not have the support that would usually be available and so were alone when they most needed their relatives, and of those receiving news about the health of them or their baby whilst receiving maternity care alone and without support. As such, the Department has taken steps, by the introduction of Regulation 9A of the Health and Care (Regulated Activities) Regulations 2014 which requires hospitals and hospices (along with social care facilities) to permit visits.

Decision-making on the balance of risks

4. Medicine is always about a balance of risks; the risks of treatment compared to the disease without treatment or the harms from a public health intervention compared to the harms of greater incidence of disease without that intervention. In a medical emergency these decisions become even more stark. As the Inquiry will well understand, many choices had to be made based on what was considered to be the 'least-worst' in

situations throughout the pandemic. These were always difficult decisions which had adverse consequences for some, which have been discussed during this module and throughout the inquiry.

5. It is beyond the scope of this closing submission to detail each of these decisions. The Department takes this opportunity to highlight some instances where decision-making relied on choosing the 'least-worst' option. To give one example, whilst it was vital that some elective services were stopped at the beginning of the pandemic to free up capacity for the inevitable (but difficult to predict) surge of cases from this previously unknown disease, this had a significant negative impact upon all those patients who needed treatment from these services.

6. The Inquiry heard evidence about the impact of the public health message, "Stay Home, Protect the NHS, Save Lives". This public message reflected the real worry in March 2020 that the NHS would be overwhelmed and great uncertainty about the overall effects of the disease. If the NHS had failed to function this would have led to care not being available both to those with COVID-19 and those who did not have COVID-19 but required urgent care. There was a difficult balance between making clear the dangers at an individual and societal level of COVID-19 and discouraging people with need of emergency care from coming forward. Efforts were taken to communicate that the NHS was open and that people should still go to hospital when they needed to, and this included emphasizing this message at the Downing Street press conferences. Despite this, we know that some people did not come forward even when their health required intervention, as heard by Professor Stephen Powis.

   "We saw falls in the number of admissions for a number of conditions. And of course we were very quickly on to trying to remind people that you should come but it is one of the things to reflect upon for future pandemics"[1]

7. The NHS was fragile and lacked resilience at the beginning of the pandemic. This was a result of a decade or more of chronic underinvestment in its infrastructure. As Lord Darzi's report highlights, international comparisons show that the impact on the NHS appear more severe than similar countries with available data.

8. Lord Darzi's independent investigation of the NHS in England is the first step of the current Government's mission to build a health service fit for the future. The Department has also expressed lessons in previous submissions as "the five lessons" and refers to

[1] Oral evidence of Professor Stephen Powis: [7/11/2024]: [P162, L23 – P163, L2]

them in this submission as providing a useful focus for considering the possible recommendations of this Module.

Lesson 1 – A toolkit of capabilities is more important than plans

Capabilities to develop and deploy new vaccines and therapeutics.

9. The ability to develop and deploy new vaccines and therapeutics was essential to tackle the virus and thus reduce the impact on the health system. This point was illustrated by Professor Charlotte Summers (An intensive care specialist and expert instructed by the Inquiry),

   "…the thing it's important to remember, particularly as we are talking about intensive care, is that intensive care provides supportive care for people. It is not a disease-modifying therapy in and of itself. And so, what was required was research and studies to try to find therapies, such as vaccines and drug therapies, that would change the trajectory of the pandemic whilst we were desperately trying to look after people. The RECOVERY Trial was one such thing."[2]

10. As has been explored and explained by the CMO and others, having existing research capability available to be deployed (the RECOVERY trial was a research project which used resources swung over to COVID-19 at the onset of the pandemic), as well as the ability to rapidly scale up research will be essential to any future pandemic. We heard from the CMO,

    "*Ultimately, what reduced mortality rates overall from the first wave to the second wave was research and individual clinicians learning, […] -- but then the second thing was the prevention, the vaccine in particular. Without that […] if the things like the dexamethasone treatment had been three, five months later, the mortality rate, terrible as it was, would have been even worse than that. […] The other things [social measures] are holding the line until the science does the work. And putting that absolutely central I think is important.*"[3]

11. Prior to the pandemic, the Department had invested in the UK Vaccine Network and NIHR research infrastructure which supported the development of vaccines and therapeutics. Investing in capabilities can support a response and mitigate the impact on the health system and should be central to preparation for any future pandemic.

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[2] Oral evidence of Professor Charlotte Summers and Dr Ganesh Suntharalingam: [02/10/2024]: [P45, L8-17]
[3] Oral evidence of Professor Sir Chris Whitty: [26/09/2024]: [P177, L4-18]

12. The Department's current aim in preparing for future pandemics is with the "*aim of minimising transmission and severity of illness, thereby reducing the potential burden on the healthcare system*" and the government has committed to the global 100 Day Mission to have safe and effective diagnostics, therapeutics, and vaccines in the first 100 days of a pandemic.

Procurement of PPE and the provision of other materials in respect of Infection and Prevention Control (IPC).

13. The first stage of appropriate PPE is providing specialist clinical guidance. The Department relies on technical bodies for much of the clinical advice and was not responsible for developing clinical IPC guidance for the healthcare profession. This was the role of the IPC guidance cell and at no time did the Department seek to influence the recommendations of the IPC guidance cell by way of which PPE was adequate or sufficient for which healthcare tasks.

14. The Department understood that the NHS and other healthcare bodies had instructions in place that without adequate fit testing, staff should not be deployed onto the front line of caring for those with COVID-19. It assisted NHS England (NHSE) in providing additional staff to the frontline to perform fit testing.[4]

15. The Inquiry has also heard evidence about the need for different types and shapes of PPE to fit the entirety of the healthcare workforce. In planning for future pandemics, stockpiles need to take account of the workforce of the NHS.

16. The Inquiry has heard both in Modules 1 and 3 about the stock of PPE that was kept for distribution in the case of a pandemic. The Department does not agree with the questions put which suggested that it was too slow in procuring gowns ahead of the beginning of the pandemic or that it should have had a stockpile purposed for COVID-19 (which would not have been possible). The need for the procurement of these gowns was first identified in July 2019 and the process for identifying which gowns were required was ongoing when the pandemic began.[5]

17. The procurement of PPE was constrained by global supply. Distribution of PPE was hard, and whilst the UK did not entirely run out of PPE, there were shortages in some areas and in some parts of the country, in particular between March and June 2020. The Department recognises the very real fear, anxiety, and concern of those told to reuse

[4] INQ000389241: [P84, Paragraphs 285-286]
[5] Oral evidence from Sir Christopher Wormald: [12/11/2024]: [P16, L15 – P19, L8]

gowns or that masks may not be available, particularly in the early stages of the pandemic.

18. National stocks of clinical countermeasures are maintained for a future pandemic with arrangements in place for how these would be distributed in an emergency. These clinical countermeasures include – but are not limited to – antivirals, antibiotics, ITU medicines, vaccines (when they become available), clinical consumables such as needles, hygiene consumables such as disinfectants, and, personal protective equipment (PPE), such as facemasks and respirators. However, it is also important to remember that we should not simply seek to stockpile those PPE items which were necessary for the COVID-19 pandemic as the next pandemic may look very different.

19. Instead, we must have enough PPE to cope until we can ramp up the supply chains. This will also buy time whilst more information is gathered about a particular virus and/or specific countermeasures are developed.

Lesson 2 – The underlying resilience of the system matters

Workforce

20. The Department recognises that the NHS runs with little flex in the system and that the workforce is no exception. The healthcare workforce was under significant pressure pre-pandemic and the evidence has shown that this was compounded by the impact of staff absences due to COVID-19 and Long Covid.

21. The pandemic also required the stretching of staff to patient ratios to cope with increased demand in intensive care units and this had a significant impact upon staff.[6] There was also a requirement to redeploy staff from non-COVID-19 services to high demand services where they did not always have the experience required to maintain standards of care at pre-pandemic levels. This undoubtedly contributed to the negative long-term mental and physical health impacts felt by staff across the system.

22. The redeployment of staff also led to the loss of specialist staff, such as learning disability nurses, from parts of the system which required them.[7]

23. Had there been more staff available during the pandemic and had the system not already been running at capacity without the additional strain of the pandemic, there

[6] Oral evidence from Professor Charlotte Summers and Dr Ganesh Suntharalingam: [02/10/2024]: [P58, L8 – P59, L3].
[7] Oral evidence from Ms Jackie O'sullivan: [28/10/2024]: [P83, L20 – P86, L11].

would have been less of a need for staff redeployment and less of a need to reduce some forms of elective care.

24. The system cannot run without staff and Lord Darzi's recent report highlights the importance of addressing the low levels of staff engagement post-pandemic. The Department recognises the importance of delivering on the '*NHS Long Term Workforce Plan'* and the NHS must seek to be a service which has sufficient levels of staff of a high quality.

NHS estate

25. There had been chronic underinvestment in the NHS estate for a significant period of time prior to the pandemic. The NHS entered the pandemic with too many old hospitals without single occupancy rooms, buildings with poor ventilation and a lack of space to operate social distancing in a way required during the pandemic.

26. The Government recognises the need for increased capital investment in estate and the Chancellor's announcements in Phase 1 of the Spending Review includes over £1 billion to tackle dangerous reinforced autoclaved aerated concrete and essential maintenance, safety and upgrades across the NHS estate. It will also include £1.5 billion for new surgical hubs, diagnostic scanners, beds, and equipment. This will create a more resilient NHS estate.

Lesson 3 – The ability to scale up in the first few months is essential

27. As was stated by nearly every expert and individual who came to give evidence, the better the state of the system prior to the pandemic, the better it can cope with shocks and use spare capacity. Investment in the system is therefore essential in "peacetime".

28. There was a need to scale up capacity very rapidly at the start of the pandemic, and the lack of this ability to scale up was one of the main learnings from the early part of the pandemic. If investment or industrial capacity is not there before an emergency, it is difficult to make up for that lack during the early stages of one. To cope with projected increases in demand, the Department worked with NHSE to scale up capacity as quickly as possible. This included ramping up bed capacity within hospitals by enhancing discharge policy and expanding critical care capacity by converting beds in surgery recovery wards to critical care beds. This was further supported by converting beds on general wards to high intensity care beds to provide capacity for treating COVID-19 patients.

29. The Department also worked with NHSE to provide the logistics and financing to set up the Nightingale hospitals. Whilst the Nightingales were not required to function at their initial planned capacity, this was in part because of the effectiveness of other measures including non-pharmaceutical interventions, and the evolutions in clinical practice in respect of COVID-19 (explained more fully in chapter 10 of the Technical Report).[8]

30. The Department understands that acute bed capacity cannot be used to its full effect without the workforce to staff it. Whilst local NHS Trusts are responsible for the operational running and organisation of individual units, and the redeployment of staff to meet demand during the pandemic was carried out by NHSE, the Department worked with NHSE and other Government bodies to put in place policies in respect of pay, pensions and other financial issues to help increase the availability of staff. This included changing the rules for registration of clinical professionals with regulators to enable additional staff to be deployed and to work with NHSE to support staff health and wellbeing.

31. As submitted in the Department's opening submission to this module,

"*There was also an immediate need for increased mechanical ventilators at the beginning of the pandemic. In response, the Department worked with NHSE under the National Covid Oxygen, Ventilation, Medical Devices & Clinical Consumables (O2VMD&CC) programme to increase the purchasing of ventilators on the market for use in the NHS. In addition to ventilators, this programme focused on the whole system required to maintain the critical care ventilated beds to NHS clinical standards".* [9]

32. The Department has learnt valuable lessons about seeking to deliver specialist equipment rapidly and the need to have solutions ready even if they are ultimately not needed.

33. The ability to surge capacity is a crucial part of a pandemic response and must be considered alongside the underlying resilience of the system. A more resilient health system, running with more flex capacity during "normal" times, will provide time at the onset of a pandemic before the system's capacity needs to be ramped up.

34. However, surge capacity is not only relevant for pandemic preparedness, but also an important issue for the NHS every winter. As such, the 10 Year Health Plan will set out

[8] INQ000101642
[9] INQ000502161: [P5, Paragraph 21b]

the path to delivering the shift in care "from hospital to community". As more patients are treated in the community, there will be more capacity available for peak periods.

Lesson 4 – Diagnostics and data are essential

Diagnostics

35. The Department recognises that it did not have the manufacturing capacity nor laboratory space available to increase the number of tests available to a sufficient level in March and April 2020.

36. In relation to the impact on the NHS, a significant issue was the limitation this placed on the ability to test NHS staff. As Professor Sir Chris Whitty told the Inquiry, this limited testing capacity, combined with the limitations of PCR tests, meant that it "*wasn't a practical reality*" to implement asymptomatic testing across patient facing staff until late 2020.[10]

37. Today there is capacity for around 10,000 tests per day – a key capability we have added to our pandemic preparedness 'toolkit'. However, a recommendation which the Department would identify for any future pandemic is to have the ability to scale up testing rapidly.

Data

38. Having robust data enables evidence-based decision-making and the "QCOVID" model demonstrates just one way in which data was used effectively during the pandemic to estimate the cumulative effect of different risk factors associated with COVID-19 mortality.

39. However, whilst the Department would highlight that the UK has some of the most extensive health data in the world, there are significant operational and societal barriers to these data being integrated or used as effectively as they could be.

40. These barriers include concerns about the privacy of data and its usage, as well as poor interoperability between NHS and other care sector data platforms, evidence of which was given during this module by a variety of individuals. This makes it difficult to share data in ways that are useful in planning services and developing interventions. These limiting factors were of particular concern during the development of the shielding programme as NHS Digital was required to use multiple datasets to identify those who were clinically extremely vulnerable and clinically vulnerable.

[10] Oral evidence from Professor Sir Chris Whitty: [26/09/2024]: [P225, L17 – P226, L1].

41. As a result, the National Audit Office's report "*Protecting and supporting the clinically extremely vulnerable during lockdown*" recommended that the Department should "*ensure that healthcare data systems allow easy, but secure, access to healthcare data*".[11] There is significant work underway in this complex space. For example, the NHS's "Federated Data Platform" aims to improve this by connecting disparate IT systems across health and care.[12,13]

42. Data flows must be improved in "peace time" and there is a lot of work to be done to ensure the NHS can make use of digital technologies. The Government's proposal is that the health system must tilt towards technology with a shift from "analogue to digital" to create a more modern NHS. The path to achieve this will be set out in the upcoming 10-Year Health Plan.[14]

Lesson 5 – prepare for future threats not just for COVID-19

43. As outlined in previous closing submissions, pandemic preparedness should not seek to prepare only for the pandemic which has just happened; instead, pandemic plans need to take account of and be responsive to all the modes of transmission of communicable disease pandemics or major epidemics which could in the future occur, namely respiratory, touch, oral, sexual/blood and vector. There may also be different levels of mortality and age structure of severe disease in future pandemics.

44. As explained in the Department's module 3 lessons learned statement,

    "*For the NHS this means being properly equipped to deal with all routes of disease transmission, including those, such as Ebola, which are touch-based and present particular challenges in a healthcare setting, whilst also being supported by the development and deployment of Infection Prevention and Control (IPC) guidance documents and measures*." [15]

Tackling health inequalities and supporting the vulnerable

45. In addition to the five lessons outlined above, the Department is committed to tackling health inequalities.

46. The pandemic further exposed the health inequalities which exist in this country and it was clear early on in the pandemic that COVID-19 did not affect all population groups

[11] INQ000059879
[12] Oral evidence from Sir Christopher Wormald: [12/11/2024]: [P58, L15 – P59, L3].
[13] NHS England » NHS Federated Data Platform
[14] The Department will submit the 10-Year Health Plan to the Inquiry upon its publication.
[15] INQ000473872: [P22, Paragraph 57 – P24, Paragraph 60]

equally. The Department sought to address these throughout the pandemic and has continued to learn lessons since.[16] As such, the CMO commissioned research rapidly to investigate the extent that ethnicity impacted upon the risk and outcomes of COVID-19. This research was led by Professor Kevin Fenton who was instrumental in ensuring the findings were considered in decision-making at local levels.[17]

47. Additionally, following this research, the NIHR conducted studies to better understand the drivers of the disproportionate impacts of COVID-19 on high-risk groups.[18]

48. Furthermore, as part of the work to seek to identify how the structures and systems of medical devices and products are tested and based upon one ethnicity, the NHS recognised that pulse oximetry was not as accurate for those with darker skin tones – as was the case in other devices who use light-based tools. That is why the Department has accepted the recommendations from the March 2024 Independent Report "*Equity in medical devices*".[19] Significant work has already been undertaken in this field, for example, the Medicines and Healthcare products Regulatory Arm (MHRA) now requests that approval applications for new medical devices describe how they will address bias.[20,21]

49. The Department's view remains that while pandemic planning needs to take account of all health inequalities, tackling and reducing health inequalities cannot and should not be done only when the country is responding to a pandemic. Instead, the government and society should consider how best to improve the underlying health of the population and address health inequalities in "normal times", so that when a pandemic emerges the whole population is as resilient as possible.

50. To this end, the Government has set out the required shift from "sickness to prevention" in the health and care system which will involve addressing population health and health inequalities. The Government's vision for health and the path to deliver this shift will be set out in the upcoming 10 Year Health Plan.

DNACPRs

51. The use of 'Do Not Attempt Cardiopulmonary Resuscitation' orders has been explored in the Module 3 hearings and the Department's evidence is that it did not issue any

[16] INQ000473872: [P2, Paragraph 5 & P41, Paragraph 109]
[17] INQ000176354
[18] INQ000410237: [P51, Paragraph 4.62]
[19] INQ000468614
[20] Oral evidence from Sir Christopher Wormald: [12/11/2024]: [P50, L14 – P54 – L1]
[21] INQ000389241: [P39, Paragraph 129 – P41, Paragraph 133]

directions to the clinical workforce to use DNACPRs.[22,23] There should never have been the issue of blanket DNACPRs.

52. In response to concerns about inappropriate and blanket use of DNACPRs, the Department commissioned the CQC to conduct a review of DNACPR decisions during the COVID-19 pandemic in October 2020.[24]

53. CQC's final report included a number of recommendations to be taken forward and significant work has been carried out in this area.[25] A Ministerial Oversight Group was set up and published a set of "Universal Principles for Advanced Care Planning' with a coalition of partners. The joint nature of this publication "demonstrates the commitment that all of the partner organisations have to implementing clear and consistent best practice across all settings so that everyone gets the personal care they deserve".[26]

Conclusion

54. As outlined above, learning lessons on responding to the pandemic has been a priority for the Department. In addition, the Department would again point the Inquiry to the Technical Report from the UK Chief Medical Officers (CMOs), Government Chief Scientific Adviser (GCSA), UK Deputy CMOs (DCMOs), NHS England (NHSE) National Medical Director, and the UK Health Security Agency (UKHSA) Chief Executive which covers the lessons to be learnt for the future.[8]

55. Module 3 was focused on the impact of the pandemic on the health system and necessarily explored the state of the NHS pre- and post-pandemic. Understanding the lasting impact of the pandemic and ensuring the system is able to operate at peak performance is of the upmost importance to the Government.

56. The Government will set out a way forward in the forthcoming 10 Year Health Plan. This will include laying out the path to deliver three shifts across the health system: "hospital to community", "sickness to prevention", and "analogue to digital". The 3 big shifts will be our key principles for reform and will revolutionise the way people manage their health and access care. Our reforms will also shift the NHS away from late diagnosis and

[22] INQ000389241: [P17, Paragraph 56 – P24, Paragraph 79]
[23] Oral evidence of Sir Christopher Wormald: [12/11/2024]: [P62, L9 – 24]
[24] INQ000389241: [P19, Paragraph 65]
[25] INQ000235492
[26] INQ000339327

treatment to a model where more services are delivered in local communities and illnesses are prevented in the first place.[27]

[27] Department of Health and Social Care's Press Release - "Government issues rallying cry to the nation to help fix NHS" (21 October 2024).