# CLOSING SUBMISSIONS, NHS ENGLAND

## Module 3 of the Covid-19 Inquiry

Contents

## Introduction

1. These written submissions follow the oral submissions made on 27 November 2024. NHS England's responsibilities have been set out in evidence; it is responsible for the co-ordination of the provision of health care services in England and oversight of local commissioners and providers of those health care services. It also provides leadership and operational guidance to NHS organisations in England. When we refer to "the NHS" in these submissions without qualification, we mean to refer only to the NHS in England, since healthcare is a devolved responsibility.

2. In our oral submissions, NHS England made a number of high-level points, concerning, first, the extraordinary efforts of NHS staff in the pandemic, and the high personal cost. We noted the light shone on these costs by the Inquiry and asked it to record how magnificently staff – including outsourced workers, volunteers, and private contractors – rose to the challenge.

3. Second, we noted the context in which the NHS operated: a global pandemic of a scale and severity not seen for more than a hundred years. We noted that the NHS, led by NHS England, sought to provide as much care as possible to patients by stretching the resources it had. We noted the limits of surge capacity in a pandemic, and recognised the consequences, for patients and staff, of the severe pressures on resources.

4. We did not rehearse in those submissions, and we do not now, the evidence which the Inquiry has heard on NHS capacity and resilience, pre-pandemic: these issues have been extensively explored. Our Module 1 and Module 2 Closing Statements address similar themes.

5. Third, we noted the NHS England structures for dealing with emergencies. We set out our view that NHS England structures generally offered clear lines of accountability, an informed response and responded at pace, but we asked the Inquiry to consider what more could be done, to plan for improved structures, whether centrally, regionally or locally.

6. Fourth, we repeated that choices made during the pandemic involved grappling with dilemmas, balancing harms and weighing risks. The Inquiry has heard that there were "no good choices" during the pandemic. Repetition of the phrase does not make it any less true. The Inquiry has heard that the scenarios faced were terrifying (see the evidence of Professor Powis and Ms Pritchard, for example).[1] We gave examples of the dilemmas faced, and asked the Inquiry to recognise that these demanded that risks be balanced and weighed, usually with imperfect information but drawing on available scientific expertise. We have submitted that evaluation of those decisions now, after the event in order to learn lessons, requires an evaluation of that risk-based decision-making, rather than the framework of 'the precautionary principle', assuming that 'precautions' may be adopted with few or no downsides.

7. Fifth, we asked that the Inquiry's fact-finding about decision-making should reflect that decisions were taken at specific points in time, with time-bound knowledge. We urged the Inquiry to look at daily sitreps, data and the reasonable worst case modelling scenarios NHS England had been asked to plan for; at the resources actually available to the NHS or NHS England when decisions were made; and to consider, against that background, what the available counterfactual or alternative was that would have saved lives or served patients better. We noted how much work was done to make the best of resources in a highly imperfect situation –

whether that was on supporting the distribution of limited PPE, or using available PCR tests as best as possible. Some of this work was within our control; much was not.

8. We add, now, a reminder of the scale of the NHS: there were over 590 million contacts with patients between April 2021 to March 2022 (over 1.6 million interactions with patients within the NHS *per day*). In the same period, there were over 318 million GP appointments (almost 54% of all NHS activity). This illustrates the challenge of variation in the NHS. From a patient perspective, there are variations in experience across those many, many interactions, and patients' stories will reflect this range. For all NHS leaders it underscores the challenge of devising frameworks that set appropriate standards across the service as a whole but allow sufficient flexibility for local variation. It is not possible to legislate for every eventuality or monitor each patient or staff encounter.

9. Finally, our submissions noted the importance of not "fighting the last war" and remaining agile. In relation to lessons for the future, overarching themes and recommendations that NHS England regards as arising from the evidence include that:

- The NHS requires to build both resilience and headroom in workforce and facilities – so that in a future pandemic or times of stress it can both cope better with augmented demand and recover (which the NHS has yet to be able to do, still recovering as it is);
- The capacity, resilience, and Government ability to direct the social care system needs strengthening and reform. Limits on social care capacity have major impacts on NHS capacity, and change that will command widespread public and political support is needed. Plans across different parts of the health and care system require co-production and alignment;
- Capacity for public health community testing and effective surveillance data of community prevalence of diseases, built up during the pandemic, should not be lost;
- Whatever NHS capability is agreed, it will be finite. There should be public debate regarding the potential need for rationing in a pandemic, and, if so, triggers and balances;
- Further research on international comparisons, with a focus on 'lessons to be learnt' from the responses of other comparable countries, would be potentially valuable;
- Work should be undertaken with stakeholders, especially those representing vulnerable or marginalised groups, to agree both channels of communication in emergencies and mechanisms to balance the values of engagement, transparency against speed and practicality;
- The principles of publishing and disseminating guidance should be agreed in 'peace time', with clarity on the categories of information and who has input into it;
- Research is needed into protective equipment suitable to protect against infectious diseases, including not only studies on the efficacy of FFP3s in clinical settings but suitable alternatives including powered respirator hoods.

10. NHS England referred to recent reports about recommendations from investigations and inquiries, specifically that from HSSIB: "Recommendations but no action". We urged the Inquiry to make specific and achievable recommendations which take account of the steps or measures

already in hand. By way of illustration: NHS England has recently developed a Register of the current recommendations relating to Maternity and Neonatal Services.[2] As at 4 December 2024, there are some 717 recommendations on it, including 86 recommendations relating to the user experience.

11. These submissions address specific topics or points of challenge or disagreement. A comprehensive overview of the evidence would be impossible, not least given the constraints on length, and unhelpful. NHS England trusts that written and oral evidence will be fully considered.

12. We focus on NHS England's contribution or actions in the Relevant Period. However, at many times these submissions consider wider perspectives relating to the performance of the NHS and its many components. Assessment of NHS England's actions inevitably touches on the question of how the NHS responded to the emergency. It also reflects the fact that there are no CPs who speak directly for NHS providers in England in this Module.

13. When assessing the contribution of NHS England to the pandemic response, the Inquiry is asked to bear in mind the balance between central direction and guidance, and continued local discretion and autonomy. The extent of NHS England's powers is set out in our Corporate Witness Statement ("**CWS**").[3] There is a framework for securing the accountability of Trusts and community services which includes commissioning bodies such as local CCGs/ICBs and national regulators such as the CQC and the HSE. Although NHS England expanded data capture from NHS bodies during the pandemic, we were always conscious of the burden of those additional 'asks' – they had to be justified, and there are still areas where NHS England does not collect data: see the comments on outsourced staffing below as one example.

14. Finally, the Inquiry will explore Vaccines and Therapeutics (Module 4) and procurement of PPE (Module 5). We have said little or nothing about these here. We have not addressed social care as we know that this is an issue for Module 6.

15. Against that background, we turn to a number of the specific topics that have featured in the oral hearings in Module 3.

## Emergency Preparedness, Resilience and Response ("EPRR")

16. The Inquiry has heard much about the state of the NHS on the eve of the pandemic, not only in Module 3 but also in Module 1.[4]

17. EPRR structures were outlined at AP/1.[5] See also the scale and variety of the emergency challenges which the NHS, and NHS England's central EPRR team, face every year.[6]

18. It was never the case that NHS England's pandemic flu planning focussed on 'the management of deaths'. NHS England notes the findings of the Inquiry in Module 1, that the UK's 2011 Pandemic 'Flu Strategy "*failed adequately to consider the steps that could be taken to either mitigate or suppress the outbreak of a novel infectious disease*."[7] However, NHS planning related to the preservation of the capacity to treat patients.[8]

19. Specific issues raised in this Module include the extent of pre-pandemic surge planning, or the readiness of sectors, e.g. the primary care sector. On this, Prof Edwards suggested that primary care was overlooked by NHS England in its pandemic planning, referring to the absence of coverage of primary care in NHS England's 'Operating Framework for Managing the Response to Pandemic Influenza'.[9] However, that was a framework for how NHS England would respond

to pandemic flu, not a detailed plan for each part of the NHS. In September 2018 NHS England sponsored a primary care preparedness exercise, 'Exercise Pica', which had RCGP participation, and identified 26 "lessons".[10] NHS England developed an action plan which sought to identify the routes to implementation for each of these "lessons",[11] (e.g., developing IT capacity for remote consultations). See also the 2019 plan for digital transformation, which although in place prior to the pandemic was greatly accelerated during the pandemic.[12] An informal pandemic planning group for primary care, involving NHS England, the BMA, and RCGP, was established prior to the onset of Covid-19, although these meetings were in their infancy when the pandemic began.[13] NHS England instructed GP practices to review business continuity plans in February 2020, anticipating the impact of Covid-19.[14] NHS England primary care guidance was updated in 2022, to expand the requirements for business continuity plans.[15]

20. NHS England acknowledges that further work must be done to ensure the preparedness of primary care for a future pandemic. It is not the case, however, that primary care was an afterthought in preparedness planning prior to the Covid-19 pandemic.

21. As to wider surge planning, consideration of reduction in non-urgent elective care activity to cope with demand peaks is a standard part of winter planning. That said, it is evident that the demands of the pandemic necessitated more widespread elective cancellations, and for longer, than would normally be needed across winters.

### The development of the NHS response, from January 2020 into "Wave 1".

22. NHS England traced its actions in the early months of 2020 in its Closing Submissions in Module 2[16] and the Inquiry is referred to those submissions.

### Phases 1 – 3 letters

23. See the written and oral evidence of Ms Pritchard outlining the nature and purpose of these letters.[17]

24. It is important to recognise the number and breadth of the policies set out in the Phase 1 letter, together with the scale of the reorganisation asked. The letter is sometimes referred to as 'the hospital discharges letter', but that is a caricature of its contents.

25. Cancer screening: the Phase 1 letter instructed health systems that all cancer and other clinically urgent care should continue unaffected. However, as Ms Pritchard acknowledged, local organisations still had "*to take responsibility for the implementation locally and for interpretation locally*"; some organisations were under more pressure than others.[18] Moreover, bowel scope screening was not offered between April and June 2020; however, participation in the bowel cancer screening programme recovered to above pre-pandemic levels by July 2020.[19]

26. Prof Bhangu suggested some GPs may have thought they should reduce or stop urgent suspected cancer referrals. He suggested the NHS England letter of 19 March 2020, which instructed GPs to "*continue to refer those for suspected cancer for diagnostic tests as normal*" was not sufficiently "*accessible nor was it clear at that time*".[20] However, NHS England continued to instruct GPs to refer patients for urgent suspected cancer via standard operating procedures (from May 2020 onwards).[21] Moreover, Prof Edwards cited evidence that, once patients consulted with primary care, clinical staff "*urgently referred a similar or greater proportion of*

*patients in 2020 compared to previous years".*[22] The overall lower rate of referrals was therefore more likely attributable to changes in public behaviour.

27. NHS Confederation criticised the Phase 3 letter in this Inquiry: too soon, asking too much and demoralising for staff. However, planning for recovery from the earliest point in time is an essential task.[23] The groundwork had been laid in the Phase 2 letter. Ms Pritchard explained in oral evidence the work that was done both to develop the contents of the policy, and to engage with NHS staff.[24] Given the evidence of treatment delays following the pausing of non-urgent elective care, the need to restart these activities cannot be doubted. The Inquiry's experts noted that it was accompanied by financial incentives[25] and there was recognition of innovative practice.[26]

## Discharges from hospital

28. Returning to the beginning of Wave 1, the CWSs address delayed transfers of care and explain why a 'hospital discharge policy' was adopted by Government as one of the many measures to increase hospital capacity contained in the Phase 1 letter.[27] These discharge measures built on pre-existing measures to reduce long hospital stays, including Discharge to Assess ("D2A").[28] They were one part of a large number of measures to increase NHS capacity at a time when modelling showed that, on a RWCS, that capacity would be exceeded many, many times over.

29. Sir Chris Wormald has explained the policy's rationale, as did Dame Jenny Harries.[29] The policy developed from pre-pandemic standard practice and renewed effort was appropriate due to the crisis we faced. In effect, no one has disputed the principle that it is good to get people out of hospital quickly, once clinical (hospital) treatments are no longer needed. The measures were Government policy,[30] underpinned by crucial Government financial support. DHSC support was key, given the interrelationship with social care. The financial package meant that it was no longer necessary to determine, before discharge, who would be responsible for the costs of support (NHS or social care) and worked in tandem with the suspension of the Continuing Healthcare Framework. Thus the policy enabled the process to be neutral as to organisational responsibility for financing immediate support post discharge. It exempted local authorities from having to pay for this period and sought to maximise the individuals' independence (and therefore minimise the ongoing impact on the social care sector).

30. Ms Pritchard stated: *"… one of the things we were aware of at the time was, lots of individuals and families didn't want to be in hospital because there was …. understandable fear as well about being in a place where we were expecting an awful lot of people to arrive with this infection…".*[31] This perspective, supported by known drops in hospital attendance in Wave 1, should be set against charges of 'overhasty' discharges. (There is also concrete evidence, in Wave 2, from Bedford Hospital of an analysis of nosocomial infection in October – December 2020, including, sadly, of 3 patients who were exposed to Covid-19 whilst awaiting community transfer.)[32]

31. Testing policy as at 17 March 2020 was a product of the (very limited) availability of tests (some 3000 per day, nationwide on 11 March 2020), and was determined by PHE, approved by the Secretary of State. Only PCR tests were available, so there were delays between testing and delivery of results. Thus testing before discharge was not an available option at the outset of Wave 1. Government policy shifted as more tests became available (by 15 April 2020). By Wave

2 the situation had again changed, and additional measures were introduced by DHSC such as discharge of Covid-19 positive patients to 'designated settings'.

32. The stated aim of the measures in Wave 1 was to release 15,000 beds, as patients became fit for discharge.[33] The immediate impact was to reduce long stays significantly.[34] Although these stays then trended back upwards over time, they remained lower than before the pandemic.[35] The changes in length of stay are measurable, and a proxy for 'beds' in this context. It is more unclear if the policy met its aim of releasing 15,000 beds as so many factors were in play – not only falling bed occupancy caused by drops in the numbers attending hospital and due to the cancellation of non-urgent elective procedures, but also because some hospitals started to take measures to accelerate discharges in advance of the national policy.[36] Even in such cases, the clarity of the national policy was welcomed.[37]

33. Our understanding is that the policy's impact was variable across different Trusts, and owed much to the strength of the existing teams working to secure prompt discharge. When relationships were already in place, the policy was more effective.[38] By May 2020 c.4000 staff were freed up from not doing CHC assessments, to support discharges.[39] A paper of Feb 2021[40] suggested that "*Critically, given workforce shortages*" the D2A model was freeing up 11,000 members of staff. The NIRB report of May 2020 identified c.4000 staff freed up from not doing CHC assessments, to support discharges.[41] Given the strains on staff, this was significant.

*Discharge when this was not clinically appropriate or indicated:*

34. Whilst this has been asserted,[42] the Inquiry has not raised examples of this with NHS England. One element of the discharge measures introduced in March 2020 was a list of clinical 'reasons to reside' developed by clinicians and co-produced with the Association of Medical Royal Colleges, which should have guarded against this. A policy of discharging those who were "medically fit" was not aimed at increasing the numbers of those discharged *per se* and did not do so, but aimed to reduce the length of stay. See para 62 of NHS England's Closing Statement in Module 2.[43]

*"Overhasty" discharges*

35. NHS England acknowledges examples (e.g. by Healthwatch and the PHSO)[44] of difficulties when people were discharged without the necessary medication in place or adequate hospital discharge letters. There was, for some, a reduction in patient choice. However, the Inquiry should note that difficulties in discharge co-ordination may occur in discharging people from any acute hospital any day of the year and were not linked specifically to the changes made in the pandemic.

*The interface with social care/care in the community*

36. The issue of the organisation of support and care packages in the community is for Module 6 so we have not addressed it; but see para 29 above on the policy aims, and para 62 of our Closing Statement in Module 2[45] for the centrality of discharge to the community: 95% of patients were expected to return to their previous homes, with only 5% of discharges expected to need care in care homes for the first time.[46] These issues will be further examined in Module 6. However, it is submitted that, having regard to: (i) the RWCS modelling regarding 'overwhelm' in Wave 1; (ii) the vivid evidence of the strains actually experienced by hospitals during this period; and (iii) the risks presented by continuing stays in hospital, redoubling efforts to ensure that those who were

not in need of clinical care were discharged was a necessary and rational policy. It is not helpful to characterise it as shifting "the burden" of care to the community. This pits the two sectors against each other, when the NHS has tried to support the strengthening of the social care sector.[47] It is also because no-one, having heard about the strains on hospitals and their staff in Wave 1, could doubt the pressures that the NHS was under, too. That is not to ignore the conclusions of the High Court in the *Gardner* case; NHS England leaves this for Module 6 to explore further.

## Use of the independent sector and the Nightingale hospitals

37. Independent sector capacity played a significant role in supporting recovery, in instances such as cancer.[48]

*Nightingales*[49]

38. The Nightingales were 'a weapon of last resort' or an 'insurance policy' after the first wave – but nevertheless, when making planning decisions about them, we were "expecting to need them"[50]: "*And if we had not had this kind of facility available at that time, this Inquiry would be having a very different kind of conversation if we had ended up in that kind of scenario, where we would have been unable to treat potentially many, many thousands of patients.*"[51]

39. Suggestions that NHS England, or the army which worked with it to establish them, did not properly appreciate that Nightingales needed staff as well as beds to function, lack all credibility and should be rejected – NHS England is well aware of the staffing requirements for beds, and how those resources would have to be stretched, or new reservoirs of personnel found. The Inquiry heard from Ms Pritchard that the assurance process required sign-off of staffing plans, and that there were plans to draw on reserves such as staff from less hard-hit areas, volunteers, or those with basic medical training such as airline staff.[52] The model was far from 'conventional' hospital care – it involved huge open wards of fully ventilated Covid-19 patients, or "*unprecedented field hospitals*".[53]

40. It would have been challenging to stand up the Nightingales. It was preferable to deliver care in familiar and better supported settings, with decompression to relieve pressures where possible (and by Wave 2, the fact that "*you really would not want to ventilate patients in a field hospital*" was better appreciated[54]. But that does not mean that their construction was not justified, particularly having regard to the underlying modelling in the early stages of Wave 1, when they were conceived; and indeed many other countries adopted the same policy, as field hospitals as a 'backstop'. There is no credible evidence that the creation of the Nightingales led to a material diversion of staff resources from front-line efforts: see Prof Ball.[55]

41. NHS England recognises that Government committed large sums to Nightingales (although cost per bed was low compared to a full hospital, see[56]). The Chair referred to the merits of using settings that could be repurposed for NHS uses in the longer term, and such sites would undoubtedly be preferable; but there are, and realistically would always be, difficulties in finding vacant premises.[57] The first priority is to use existing NHS resources where possible. E.g. Birmingham QEH could expand IC bed capacity enormously at least in part because it had been built to include capacity for 100 ICU beds, of which 67 were funded at the outset of the pandemic.[58] Such headroom is an aspect of NHS resilience.

42. The Inquiry is asked to recognise that, of necessity, plans for emergency field hospital should remain a tool in the emergency response to future pandemics. As Ms Pritchard stated, she "*wouldn't want to rule that out before you knew exactly what the circumstances were of a further …pandemic. But this is a 'what's the alternative?' question. So we had done surge. This is super-surge…. And the alternative is that you do not treat people at all.*"[59]

## NHS 111

43. NHS 111 services were addressed in the fourth written statement of Prof Powis.[60] Importantly as he stated, NHS 111 is merely a number; "*there are a set of different services that can be flexed that sit behind that number*."[61] NHS 111 telephony services were commissioned by local commissioners (CCGs) during the Relevant Period, according to a national NHS England specification. ICBs now have responsibility for this commissioning.[62]

*Planning and mobilisation*

44. There were suggestions made that little or no emergency planning, including for a pandemic, had taken place in 111 services, with Prof Helen Snooks stating that preparedness had '*predominantly been placed around major incidents as opposed to a nation-wide pandemic'*. Whilst acknowledging that planning and mobilisation proved insufficient to cope with the peak demands of March 2020, it would be wrong to overlook the prior planning and the pre-existing mechanisms by which NHS 111 services could be temporarily scaled up. Mobilisation of these plans, and other steps taken, reduced at least some of the operational pressures on NHS 111 during Wave 1. NHS England also notes, as a matter of further context, that no advance planning had been done (in government) on NPIs, which was a key factor in the surge in NHS 111 calls.

45. The National Pandemic Flu Service ("NPFS") had been established after the 2009 H1N1 pandemic, as a 'dormant' capability to deploy in the event of a future ('flu) pandemic. It was intended to provide an online and telephony self-assessment service for symptomatic callers, routed through a single 111 number. Planning via the NPFS had identified a framework of suppliers ("Managed Contract Centre Services" or MCCS) with both capabilities that could be mobilised rapidly and pre-existing connectivity to the NPFS call-handling centres.[63]

46. Enabled by the 2017 NPFS Tripartite Agreement which allocated distinct roles and functions to DHSC, NHS England and PHE, the following steps were taken:

    a. From 7 February 2020, a PHE Covid-specific helpline was operational.[64] Calls to NHS 111 were routed into this. This helpline provided non-clinical advice regarding Covid-19, but it was later merged with the new clinical Covid Response Service (CRS);[65]

    b. The CRS was operational from 5 March 2020hosted and managed by the South Central Ambulance Service ("SCAS"). This provided non-clinical assessment of Covid-19 symptoms by non-clinical staff, routed via the 111 number. This service responded only to callers with Covid symptoms, so new call-handlers could be trained in a shorter period than core NHS 111 call-handlers;

    c. Additional CRS call-handler capacity was mobilised 5-17 March 2020, per the MCCS mobilisation framework. Baseline additional capacity of 750 agents was achieved in week 3, ahead of the planned 5 weeks.[66] By mid-April 2020, CRS staff grew to 5,100.[67]

47. NHS England also mobilised three clinical queues, to which callers to NHS 111 could be referred for clinical advice. This included the Covid Clinical Assessment Service (CCAS), staffed mainly by GPs and retired GPs, which was hosted by SCAS and operational from 5 March 2020.[68]

48. It has been suggested that by 26 March 2020, no attempt had been made to expand NHS 111 'core' call-handler capacity. Whilst new NHS 111 call handlers had not been onboarded at this point, due to the six weeks needed to train them (longer than CRS call-handlers), on 26 February NHS England agreed to fund additional hours for existing NHS 111 call-handlers, employed via West Midlands Ambulance Service (equivalent to 150 FTE agents). Funding for the equivalent of 117 FTE additional call-handlers was agreed in March 2020. Further, under the NPFS, NHS England had established a forecast and capacity function (FACT) within its NHS 111 cell in January 2020. Based on trends in 111 telephony demand in August 2020, additional CRS capacity was stood up on 5 October 2020. This lasted until 23 March 2021.

49. Sir Sajid Javid was asked when a further recruitment drive occurred during his term. NHS England provided additional funding to recruit NHS 111 call-handlers in summer 2021, after performance began to fall again from early 2021.[69] At this point NHS England began tracking recruitment into the NHS 111 core service. The CRS and CCAS were stood back up on 19 January 2022, for 8 days.

50. Mobilisation was accompanied by steps which aimed to route queries, where possible, to online information. On 26 February 2020 a new service was added to NHS 111 online to provide access to the latest information on Covid-19 and support the delivery of care. From 27 February 2020 onwards, nhs.uk, the NHS App and NHS 111 Telephony all directed the public to an updated NHS 111 Online service for Covid-19 concerns (this was an automated triage service), and NHS 111 Online began operating as a 24/7 service. On 10 March 2020, GP practices were advised that any patient who did not meet the case criteria for Covid-19 should be directed to information and advice online.

51. NHS England acknowledges that the additional NHS 111 capacity was insufficient to meet public demand during the first Covid-19 wave in particular. The Inquiry has heard how NHS 111 telephony services experienced a sharp, though short-lived, increase in demand in March 2020 – from around 1.5 million calls in January 2020, to over 2.5 million in March 2020. Of these, over 1.1 million calls (over 40%) were abandoned (compared to around 72,000 abandoned calls, almost 5%, in January 2020; the proportion declined back to under 5% by May 2020). It was not envisaged that the NPFS would be required to cater for such demand. However, the pandemic flu dormancy frameworks did enable NHS England, with PHE and SCAS, to rapidly commission and mobilise additional services to relieve at least some of the pressure on core NHS 111 services.

52. The Inquiry has heard that, from as early as Jan 2020, the SSHSC wanted NHS 111 to be the 'single point of contact' for members of the public experiencing Covid-19 symptoms. From February 2020, professionals in primary care and community settings were advised to instruct patients experiencing Covid-19 symptoms to call 111. National messaging advising people to stay at home will also have driven a temporary surge in demand for 111 services. This scenario was foreseen in a Covid-19 (M) meeting held on 12 March attended by the PM, SSHSC and Sir Simon Stevens, immediately before the government asked anyone experiencing Covid-19 symptoms to stay at home; it was agreed that the public should be asked to use the internet for

information, rather than calling NHS 111.[70] The record does not suggest that NHS England was asking for a delay in lockdown measures to allow for NHS 111 preparations, as Mr Hancock suggested[71] – and NHS England does not believe that it did, such measures being for Government decision-making. The discussion was about the timing of telling people to call NHS 111, and the use of the internet by the public in lieu. The aim was to reduce the risk that callers seeking general information could crowd out, and affect the triaging of, urgent calls.

53. As Dr Saleyha Ahsan noted, there were occasions when GP surgeries would refer patients to NHS 111, and NHS 111 would refer them back to their GP.[72] On 5 April 2020, after being made aware of such instances, NHS England advised GPs to avoid redirecting patients to NHS 111 if they presented to general practice after being unable to reach NHS 111. Any patient who would have normally been treated in GP or community setting should have continued to be offered these services throughout the pandemic.

54. Demand for NHS 111 telephony services has remained consistently higher than before the pandemic. Public behaviour appears to have shifted: NHS 111 now experiences a greater proportion of its calls during working hours, whereas prior to 2020 NHS 111 was predominantly an 'evening' and 'night' service. This shift has strengthened the case for a more resilient NHS 111 service. NHS England acknowledges the need for more work to consider how temporary surges in demand might be anticipated and prepared for. Preparations for future pandemics will build on the learning acquired during the Covid-19 and need to consider the extent to which services can be scaled safely.

55. The improved functionality of NHS 111 Online is a beneficial legacy of the pandemic. From February 2020, the online service began operating 24/7 and offered a dedicated site providing advice on Covid-19. Nhs.uk, the NHS App and NHS 111 telephony all directed the public to the NHS 111 Online service for Covid-19 concerns, which is likely to have alleviated pressure on telephony services. On the basis of clinical advice, a BT call filter was also switched on to direct 999 callers to NHS 111 if they had non-life-threatening Covid-19 symptoms. In the event of a future pandemic, more could be done to signpost the public to the online 111 service: it provides the same dispositions as the telephony service (as it is based on the same software), and so could reduce the need to recruit and train additional call-handlers.

*Quality, quality assurance and access*

56. The Inquiry has raised questions about the quality assurance mechanisms put in place in the CCAS. CTI put to Prof Powis concerns about safety of services.[73] Generally, the HSIB report into NHS 111 was addressed in SP/4[74] and, in response to CTI questions on governance.[75]

57. Dr Ahsan suggested 111 services were particularly challenging for non-English speakers and disabled people. However, efforts were made to make the service accessible. See SP/4 for the accessibility provisions built into NHS 111, CRS and CCAS service specifications.[76] NHS 111 Online also offered British Sign Language access, which allows patients to communicate with an NHS 111 adviser through a video consultation. Video consultations were trialled and developed as part of NHS 111 telephony during the pandemic and remain operational.

58. See SP/4[77] and the evidence of Anthony Marsh. The CWS sets out the organisation of ambulance and 999 services, which are both provided by eleven ambulance services[78] and the role of NHS England in providing national leadership and support.[79]

## Ambulance and 999 services

*Planning and early impact*

59. Services came under considerable pressure in the early stages of the pandemic, especially in the regions where Covid-19 case numbers peaked first. Prof Snooks has suggested that "*planning and preparedness was inadequate at national level for 999 or 111 services to meet operational and clinical needs during the Covid-19 pandemic*"[80] and NHS England acknowledges the evidence of Anthony Marsh, when asked whether enough was done to prevent demand outstripping capacity in 999 call handling centres, that: '*I don't believe it was*'.[81]

60. Ambulance services are Category 1 Responders[82] and ambulance trusts are subject to the EPRR duties outlined in AP/1,[83] including the need to maintain up to date plans and to train and exercise and to meet the core EPRR standards[84]. The Inquiry may consider evidence already presented as part of Module 1. Ambulance services were considered as part of Exercise Winter Willow (2007)[85], which anticipated issues such as high workload and staff sickness. The Department of Health report on the exercise stated that "*Guidance for ambulance services has been developed as part of the UK National Framework for Responding to an Influenza Pandemic*" and that "*In the circumstances that a pandemic could present, the deployment of ambulances will be focused on supporting patients in need of urgent medical treatment.*"[86] The UK National Framework for Responding to an Influenza Pandemic[87] sets out the challenges and envisaged prioritisation of "*all emergency and urgent calls, although some prioritisation and reduction in normal response time standards may become unavoidable.*"[88]. In other words, there was acceptance that it might well not be possible to flex or surge capacity to meet all increased demands. Following the development of NHS England's capabilities, ambulance services were made subject to the NHS England EPRR Core Standards, including for the need to plan and exercise for emergencies. The National Ambulance Commissioners Group (of the NHS Confederation) summarised the obligations, including the need to "*have vehicles and equipment held in reserve for a major incident... Commissioners need to build this capacity into their plans...*"[89]

61. NHS England does not accept, therefore, that the need for ambulance services to plan for emergencies, including pandemics, was overlooked prior to 2020. It is apparent, however, that the older frameworks such the UK National Framework acknowledged that services would not be able to meet all the increased demands and that prioritisation would need to take place. The Inquiry may wish to consider what further or additional capacity it is reasonable to expect ambulance services to build (by way of staffing or equipment), as part of planning for further emergencies, or what more it considers should have been done. There was much done (referenced only briefly below) to increase capacity from March 2020 onwards, as well as the deployment of mutual aid to relieve pressure. This Module has considered the steps taken to preserve capacity for the most urgent calls – e.g., the implementation of triage protocols (such as Protocol 36), and, as Prof Snooks observed, 999/ambulance response times '*remained fairly stable for the most urgent categories*'[90] , whereas by contrast for less urgent callers, '*response times increased significantly across the period, and were well outside performance targets*'.[91]

62. The steps that NHS England took to provide support, including for expansion in capacity, are set out in SP/4.[92] They include commissioning emergency and non-emergency ambulance support from St John Ambulance and the provision of further funding, from July 2021. Military Aid to Civil

Authorities ("MACA")[93] was provided by the army, co-ordinated through the NHS EPRR teams and individual ambulance services. Anthony Marsh described steps taken to increase capacity at Trust levels, such as the recruitment of additional crews and increasing the size of the fleet, the recruitment of additional 999 call handlers, "unprecedented" mutual aid for 999 services ([INQ000479041/8], including post-pandemic learning) and the use of students[94], as well as co-ordination with non-emergency patient transport service.[95] At times, there was a tension between speed of response and quality of services: see e.g. Anthony Marsh's judgement that length of training for new 999 call-handlers should not be reduced.

*Ambulance handover delays at hospitals*

63. An ongoing challenge is of ambulances and crews having to wait with patients outside of hospitals, owing to pressures within the hospital delaying safe clinical handover, preventing them from heading back out to answer further emergency calls. NHS England agrees with Anthony Marsh that "*this is an area which continues to be a significant challenge and despite people's best efforts remains the largest contributory factor undermining ambulance service performance achievement in several regions of the Country*".[96] As Anthony Marsh said, there was and is regional variation in respect of this; there was also particular pressure building up from c. July 2021 onwards.[97] NHS England made £55m of additional non-recurrent funding available to ambulance services to help them to meet extreme operational pressures brought on by the pandemic. Part of this funding was made available for extended hospital liaison officer cover (known as "HALOs") to support handover of care at the most challenged acute trusts. In September 2021, NHS England published a 10-point Urgent and Emergency Care action plan, which included "ensur[ing] that tackling ambulance handover delays is a system priority in order to reduce risk of harm to patients both in the community and delayed at hospital".

64. Recovery plans for the NHS continue to address handover and A&E delays as a key and urgent operational priority. Consideration of any suggested recommendations in this area should take account of what is underway at the moment – e.g. NHS England is working with providers to test effective approaches, such as London Ambulance Service's "Release to Rescue" model with clear steps enabling crews to complete handover at a maximum 45 minutes post-arrival.

*PPE and IPC Guidance*

65. There were concerns about the viability of central IPC guidance for the specific needs of ambulance crews, with suggestions that these were not taken account of. NHS England notes the evidence of Dr Ritchie, that there was a representative of the Ambulance Association of Chief Executives ("AACE") on the IPC Cell.[98] "*The AACE representative, similar to the other agency/organisation representatives, was responsible for communicating/forwarding any collective decisions taken by the UK IPC Cell through to their responsible lead in their own clinical governance structure. As I recall, the ambulance sector had their own IPC guidance document which was based on/aligned to the UK IPC guidance.*"[99] Anthony Marsh referred to work done by the AACE to provide specific guidance for the sector in non-clinical working areas for staff[100], and to the ability of crews to conduct dynamic risk assessments, in relation to PPE, from the outset of the pandemic. He agreed with the Chair that the terminology was not helpful to staff and that any changes would be subject to the availability of PPE, "*But the point I was making was they already did have the ability to upgrade where that equipment was available and it should have been made available*".[101]

*Triage tools and clinical prioritisation software for 999 call handling*

66. Ambulance services use two different platforms: NHS Pathways and AMPDS. Prof Snooks noted that NHS Pathways was created and is operated by the NHS; AMPDS is a commercial product.[102]

67. Professor Snooks made a number of critical observations on the use of triage tools, e.g.: "*Although triage tools performed at reasonable levels, they were less accurate in identifying calls that did and did not need immediate care than hoped. Existing inequalities related to age, sex, ethnicity and disability may have been exacerbated, although data on ethnicity and disability are often missing in the emergency prehospital setting*".[103]

68. NHS England notes that (i) triage processes reflected early lack of knowledge of Covid-19 and were revised as this was gained; (ii) changes to scripts were overseen by a senior group of *clinicians*, with a Clinical Coding Group (doctors, medical directors from ambulance services, clinical director from NHSE); (iii) whilst there were challenges in implementing many changes to the scripts, changes were necessary as the knowledge changed rapidly in the early stages of the pandemic. NHS England acknowledges that triage tools are not perfect, although this is not a problem which is unique to the pandemic; Professor Snooks cites a study dating back to 2018 as part of her observations on the "known limitations of telephone-based emergency triage tools".[104]

## Critical care surge, NHS capacity and "NHS overwhelm"

69. Surge planning for critical care needs in February / March 2020 took place in the context of RWCS modelling, which suggested that many, many patients would require ICU-type care. See for example the slide deck dated 12 March 2020, and the Module 2 evidence.[105] At this point it was uncertain how many patients would need ventilation and how quickly equipment could be sourced. But it was apparent that even the 'surged' limit of 7000 ventilated ICU beds was likely to be exceeded many times over, even applying reasonably 'favourable' assumptions on infection rates and the effects of NPIs. The surge capacity of 7,000-plus ventilated beds ("V beds") alone, when compared to the 'business as usual' capacity of c.3,500 ICU beds (including paediatric intensive care), implied specialised nursing staffing ratios of 1:2 (or more, given matters such as likely staff vacancies), which compares with the GPICS recommended level of 1:1 for the highest Level 3 intensive care. The surge capacity figure was determined by the ventilator survey rapidly obtained in late February 2020 (which confirmed estimates previously obtained in 2017 as part of part of pandemic 'flu preparations[106]).

70. It was apparent that after reaching 7000 'V' patients and the national 'fail' point, very difficult care decisions would be necessary and invoke triage by resource – or worse. New capacity needed to be created, at speed. The extension of the critical care footprint and the development of extended care for those who were likely to need ICU-type care and respiratory support in V, O and O+ beds outside of ICU settings, as well as the new requirements for staff to work in extended teams (see below) reflected these urgent imperatives.[107] They also drove matters such as the pausing of non-urgent elective surgery and other treatment. There was, at the time, a consensus that such measures were needed – see the signatories to the letter of 25 March 2020 on critical care nursing redeployment.[108] The Inquiry is asked to accept that necessity.

71. Reference has been made to nursing staff ratios 'diluted to 1:6'. As Prof Ball stated, this *"is not strictly true. I think it's actually the skill mix that changed rather than the ratio, so there was one-to-one nursing on ITU but the skill mix changed, so we would usually have an intensive-care-trained nurse per patient – they weren't always intensive-care-trained nurses but they were overseen at a kind of pod level of four by at least one intensive-care-trained nurse*".[109] The national guidance of 25 March 2020 envisaged one specialist ITU nurse caring for a maximum of six patients, but only in the event of ICU capacity quadrupling (or a maximum of 2 patients if capacity doubled, or 4 patients if trebled). Critically, each specialist nurse would be supported by a team of non-specialist nurses and support workers.[110] From 10 December 2020, staffing ratios were tightened: the ratio of specialist ICU nurses per patient should not have exceeded 1:2, unless local and regional mutual aid options had been exhausted and escalated appropriately.[111]

*Surging capacity to care for the seriously ill*

72. Care for seriously ill Covid patients who needed respiratory support was necessarily extended beyond the usual ICU footprint. The work done to facilitate and support this centrally – including work on estates, equipment such as ventilators, CPAP, ECMO and haemodialysis machines, as well as oxygen and medicine supplies – is detailed in the CWS.[112] It was for Trusts to work out how they could best deploy available staff (including returnees), building on their knowledge of local conditions; but central guidance addressed support such as training. Support was provided by employers: see e.g. Prof Ball.[113] There was reassurance from professional regulators that staff working outside of their normal areas of specialism would not face disciplinary action.[114]

73. Numbers of those cared for is shown in graphs in AP/2.[115] The data covers all forms of beds giving respiratory support, whether within or outside the previous ICU footprint, which in practical terms became almost irrelevant at the peak times of Waves 1 and 2.

74. Arrangements for Wave 1 were built upon in Wave 2, by which time lessons had been built into the planning for Winter 2020/21, including the issue of the National Service Model for Adult Critical Care Transfer Services.[116] However, the Inquiry will be aware that Wave 2 was, in many respects, worse than Wave 1.[117]

*Impact on staff*

75. There has been extensive impact evidence relating to the trauma or 'moral injury' to staff, required to work under conditions of extreme stress as a result, and NHSE supports the Inquiry's efforts to investigate and record this. Much evidence, e.g. that from Prof Fong based on his site visits for NHS England, was compelling. Whilst the evidence has focussed much on ICU staff, there were many other areas under stress, whether areas directly impacted by Covid-19 care needs (resuscitation wards) or other areas of non-Covid care where staff numbers were affected by redeployment, illness etc. Prof Powis also made the comparative point, on the moral injury that would have been caused by adopting triage systems: *"I should also say, and you heard this very graphically from Professor Fong, if the NHS had got to the point where it was completely overwhelmed, it would have been even worse. The moral injury would have been, you know, orders of greater magnitude. But having said that, even what we had to deal with had a huge impact on staff."*[118]

76. Many efforts to support staff were made, with NHS England seeking to supplement or underpin what was first an employer responsibility (legally, and because employers are best placed to

know and respond to staff needs). By way of examples only, see (i) recommendations for refresher training on respiratory care in the letter of 17 March 2020;[119] (ii) evidence of Prof Powis[120]; (iii) evidence from the ICU experts, who noted that NHS England "*should be recognised*" for "*providing training packages for unfamiliar devices*"[121]; and (iv) the Professional Nurse Advocate ("PNA") programme, which started as a critical care project but was expanded to all nursing staff.[122]

*Data collection and knowledge of strain*

77. NHS England collected data on "available beds" through its sitreps.[123] Data from sitreps, sometimes imperfect as it was submitted daily[124] was supplemented by intelligence from regional teams and other forms of NHS England engagement with colleagues such as webinars; the peer visits system described by Prof Fong; and CRITCON declarations (which had a deliberate element of subjectivity in them), as well as the 'front line' knowledge gained from staff working shifts (see the evidence of Dame Ruth May). NHS England asks the Inquiry to reject the suggestion that it had inadequate knowledge of system strains, or was overly reliant on quantitative data. See Prof Powis on the sitrep data, including the evidence that the list of missing Trusts was "*usually small, often none, and typically I think less than five*".[125] Ms Pritchard responded thus to the suggestion that NHSE was over-reliant on data and did not understand frontline pressures:

> *I don't agree. Throughout the whole pandemic there was a combination of information that we were relying on, data was – it was part – it was an important part but it certainly wasn't all of it. So Professor Fong went out to do those visits partly at the request of my colleagues in the EPR team because they valued so highly that firsthand feedback.*[126]

*Data burden*

78. There have been criticisms of the burden of data collection, particularly for overstretched Trusts or services. However, not only did NHS England carefully consider the necessity of its 'asks' (it sought only what was needed for operational purposes[127]), but the Inquiry heard criticisms in Module 2 from Government and its agencies regarding the lack of NHS data – NHS England was responding to new demands. Further, it took steps to reduce the number of 'business as usual' demands, to balance the load (see the Wave 1 letter).[128] The ultimate end goal would be to reach a position where data can be extracted directly from patient record systems, without requiring additional returns; but that will require additional technical infrastructure.[129]

*Reporting of hospital capacity and strains*

79. The Inquiry has extensive evidence of how capacity was reported within NHS England, and whether baseline capacity was as well reported, or understood, as 'surge' figures. How this was understood may be broken down by audiences:

    a. Within NHS England: NHS England does not understand there to have been any suggestion that the data, and the difference between surge and baseline capacity, was not understood within the organisation. This was not suggested by the ICU Experts.[130]

    b. Within Government: NHS England cannot assess how its information was understood by everyone in government, but it rejects the suggestion that its reporting of strain was inadequate. The decision-making context was of government decisions driven by a wish

to ensure that the NHS was not overwhelmed, implying careful scrutiny of pressures and performance. In Wave 1, the difference between baseline and surge capacity was at the heart of modelling and the work to surge.[131] More generally, Ms Pritchard stated, referring to the accounts that Prof Fong was bringing back to NHS England: *"Similarly, I have to say I was in the room with very senior politicians relaying exactly those kinds of stories and describing in a way that I think was very clear – in fact we've got notes I know were released to another module of the Cabinet Office discussions and meetings Covid-O in January '21, where some of the language there clearly says that we were very clear about the state of pressure in the NHS and that was widely understood and well understood."*[132] She was referring to the minutes of the Covid-O Minutes of 12 January 2021,[133] where this was set out.

c. By the Public. The ICU experts drew attention to newspaper articles which used data from the NHS England database to argue that there was spare hospital capacity. But Ms Pritchard explained how journalists were "*invited to film in our critical care units and in our hospitals, to try to help the public understand what staff – what extraordinary lengths staff were going to*", as well as the work done through (e.g.) press conferences to knock down inaccuracies[134]. For the future, she acknowledged that putting in "*both a baseline and a surge probably makes that clearer*".[135] The personal accounts from journalists "*actually going and spending time in units*" would be more powerful[136].

## Outcomes

80. The Inquiry has investigated the impact on patient care and patient outcomes. The Inquiry's expert Prof Summers was clear that stretching the staff ratio impacted on the quality of care, and both the experts and Prof Fong described how the care provided by ICU specialists, for whom attention to detail is key, was 'diluted' during times of pressure.

81. The fullest data on outcomes has been provided by ICNARC research. This research was based on data collected through the Case Mix Programme, participation in which is required by the NHS England Service Specification for Adult Critical Care[137]. NHS England comments that, first, the data does not necessary reflect outcomes for critically ill patients being managed in 'surge' beds outside of intensive care units (Prof Rowan noted that the inclusion of such surge 'intensive care' beds was not consistently reported[138]). Hearing of "*a great number of people being treated outside of critical care who would normally be treated within it*"[139] (as it was put to Ms Pritchard) cannot be a full measure of how effective the delivery of treatment was; especially as experience emerged that mechanical ventilation was not the most effective treatment for Covid-19. Second, as Ms Pritchard stated:

> *"What I think the data tells us from ICNARC – I've looked carefully at what Professor Rowan and Dr Matteo have said, and I think they're right to be cautious about drawing conclusions, and certainly they're right, clearly, not to dismiss any of that data and what it might tell us, but in terms of being able to draw a direct causality I think I would share their view that we'd have to be careful about jumping to conclusions, and clearly there's a need, I guess, to understand a bit more about what the therapeutic options around vaccination, dexamethasone, other forms of oxygen, allowed to happen outside of that traditional ICU space, which also feeds into this."*[140]

82. That said, it is right that critical care and specialist staff ratios were stretched and care 'diluted', to maintain access for as many patients as possible. Given the context, it is perhaps noteworthy that ICNARC did not find worsened outcomes for Covid-19 patients in Wave 1 as well. However, it is acknowledged that their conclusions were that outcomes in ICU did suffer for non-Covid patients in Wave 1 and all ICU patients in Wave 2. It is noteworthy that the published ICNARC paper noted similar a similar pattern for Covid-19 patients in US hospitals - including the fact that strains were worse in Wave 2.[141]

*Rationing and 'overwhelm'*

83. The language of 'overwhelm' was derived from the central government discussions and priorities discussed in Module 2, when the Inquiry heard that it was a central government objective not to allow the NHS to be overwhelmed. In addition, as we commented in our Closing Submissions for Module 2 "*Predicting the exact point at which the NHS could no longer treat all patients was complex, and understandably some witnesses have struggled to articulate what terms such as "overwhelmed" meant.*"[142] It was generally used with regards to the NHS's continuing ability to admit patients needing hospital care, and critical care in particular. Thus, discussion did not generally reference the fact that at least parts of the NHS experienced short-term operational pressures that exceeded capacity (e.g. in NHS 111 services in mid-March 2020, see the discussion of demand and its drivers, including Government communications on calling NHS 111, at paras 51-52 above). The word was not generally used to refer to the capacity pressures affecting recovery: waiting lists for many elective procedures grew substantially, and continue to exceed 18-week referral-to-treat targets.

84. Considering hospital beds, clearly many staff felt seriously overwhelmed at times of acute pressure, and this reflected the stresses of the demands on them as well as the underlying issue of whether beds were available to admit new patients. The fact that local capacity was, at times, exhausted has led to questions about the usefulness of the term 'overwhelm' and its focus, for centrally-based decision-makers, on the system as a whole.

85. To an extent, this is a question of language: had the term 'overwhelm' been used more widely to describe local pressures, some other term would have been needed to describe the national picture. Furthermore, it was important throughout to stress that the NHS remained 'open for business' and for the treatment of non-Covid-19 patients.

86. NHS England data and evidence to the Inquiry on the CRITCON declarations vividly shows the pressures that local Trusts were under, at peak times. There were, however, only a handful of CRITCON 4 declarations. There were only 22 days in which units declared CRITCON 4 (around 2.6% of the 850 days of the Relevant Period), with no more than one trust declaring CRITCON 4 at any one time; for context, England has over 200 NHS critical care units. At least 4 CRITCON 4 declarations, covering 7 days, appear to have been made in error.[143] The perspective of NHS England was that:

> *".... we were aware nationally of where we were reaching that point of, you know, absolutely maximum capacity locally. Such that there was an ability then to relie[ve] local pressure either through that local transfer or further afield. Or indeed moving equipment, moving staff, you know, to support those places that were really under maximum pressure. Such that we never got to the point nationally where, if you like, the philosophy that we always had in the*

*NHS through all of the pandemic, which was we try to treat every patient to the best possible – within available resources, such that that became impossible and we were then talking about, you know, systematic limiting of access to treatment.*

*That does not mean, though, that it did not feel completely overwhelming to staff at this time in those places, and it does not mean that the kind of care that was being provided was anything like normal. And it also, you know, doesn't mean that this looked like, sort of, you know, in any way how you would think of as our sort of normal way of providing critical care services in particular."* [144].

87. The evidence of the Intensive Care Society (Dr Mathieu) was that: *"Intensive care is not restricted by cost or resources. It is for the most critically ill patients in the UK and therefore there is, and remained throughout the Covid-19 pandemic, access for all that required it."*[145] Spotlight Trust evidence too was generally to the effect that, despite extreme pressures, these Trusts did not reach the point of rationing by resources across their estates including in CC areas.[146] In addition:

    a. King George Hospital BHRUT's evidence explicitly makes the point that data for ICU admissions cannot be examined in isolation, with the shifting footprint of non-invasive care needing to be taken into account:

    *"The criteria for admitting patients to the critical care area did change, but this was purely down to the treatment which the hospital could provide in other clinical areas; particularly by the second wave… Hypoxic patients, who could be treated with NIV and CPAP, were treated on the respiratory ward and this increased Critical Care capacity to treat the more unwell patients. It is noteworthy that, pre-pandemic, this was already standard practice in some hospitals."*[147]

    b. University Hospitals Leicester NHS Trust[148] noted that:

    *"A retrospective data collection of decision making of all referrals to ICU at the Hospital was made during the first wave of the pandemic …. The conclusions were that there was no identifiable change in ICU admission decisions."*

88. The 'outlier' was, perhaps, Medway Maritime Hospital which spoke of "rationing", particularly in Wave 2, and reported using the Clinical Frailty Score to assist in escalation decisions in both Waves 1 and 2.[149] The use of a Frailty Score does not, per se, indicate the rationing of resources; it is a tool to understand the potential benefits of treatment (see the evidence of Bradford Royal Infirmary on the use of Clinical Frailty Scores).[150]

89. Against the hospital evidence has been set ICNARC's findings and the Inquiry's own Escalation of Care Survey. On this, NHS England has noted the small sample size and the confirmation bias risks implicit in the survey methodology (particularly the use of 'snowballing'). That said, it acknowledges (as did Sir Chris Whitty) that in times of pressure including Winter, there will be an element of decision-making that reflects the treatment resources available to clinicians – although that should also reflect the decompression and mutual aid options. It also acknowledges ICNARC's evidence that, during the peaks of the first two Covid-19 waves, there was a decrease in the proportion of patients admitted to critical care for reasons other than Covid-19, who were aged 75 or older, or (for non-elective admissions) had prior dependencies or advanced chronic conditions.[151] However, as Prof Rowan noted, that data was not

contextualised by any understanding of which patients were getting to hospital in the first instance (and who might then have been eligible for referral to critical care), so it cannot be relied upon to infer that ICU 'rationing' occurred.[152] NHS England recognises that categorical statements such as "*everyone who needed to be treated in a critical care bed had been given a critical care bed*" may properly be tempered by the caution of the ICU experts, who felt unable to draw any conclusions from the available data, as to whether informal triage-by-resource did or did not occur.[153]

### A clinical prioritisation tool

90. Prof Powis explained the difficulties of developing a prioritisation tool at speed, in a pandemic, with no patient or public engagement.[154] NHS England submitted in oral closing that although some doctors sought such a tool, if deployed it would have removed choices from doctors and provoked understandable resistance. In its oral closing submissions, the Disability Charities Consortium set out four conditions to be met if such a tool was to be used. The Inquiry may feel that those conditions – important as they would be to future debate – illustrate the many problems of deploying a tool in the midst of a pandemic.

91. The publication of a tool could well have had unintended consequences, including exacerbating patient reluctance to go to hospital – this was a real concern when the Sunday Times published an article in October 2020, arguing that there had been rationing of care for the elderly. It was important that NHS England's response to the article[155] reiterated that the NHS remained open for all. Further, as Prof Powis stated with regards to the decision not to release the tool that had been developed: *"I had a fear that if it was released it might be used when it was not needed to be used."*[156] Prof Simon Ball similarly noted the need to "*be careful at which point you kind of change – unknown to yourself change people's attitudes ... so we were quite careful not to and to emphasise that we will come to that and deal with it as and when it is necessary. Fortunately it wasn't ...*".[157]

92. To avoid these unintended consequences, NHS England worked tirelessly to ensure that there was no need for systematic rationing guidance. In oral closing, NHS England asked whether a national stakeholder debate should now occur. NHS England asks the Inquiry to note that this is an example of an issue which is not merely 'health-related.' Not only would it require cross-government input into a debate, but it would require planning and exercising for implementation – forecasting the kind of public disquiet which could reasonably arise should individuals be turned back from hospitals, even on the basis of agreed criteria.

### Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPRs)

93. This topic was addressed in the CWS[158] and in Dame Ruth May's evidence.[159]

94. The nature of CPR is set out at SP/3,[160] and in the oral evidence of the Inquiry's Intensive Care experts on 9 October 2024.[161] It is an intrusive and physically demanding treatment option. There was pre-existing guidance about decision-making, before the pandemic.[162] The Inquiry has heard from its experts about how such discussions were conducted, both before the pandemic and how practice had to be adapted in the pandemic (see the expert oral evidence – including as to just how difficult this was, both for families and healthcare staff, when families had not been at the bedside prior to conversations held remotely).[163]

95. In early April 2020, reports emerged of the inappropriate or 'blanket' use of DNACPRs.[164] The CU experts had no personal knowledge of such notices being imposed, in their own settings of intensive care, where discussion of options was part and parcel of normal care. They surmised that problems might have been more likely in settings where these discussions were less normal, and discussed the importance of training in these conversations, out of 'stressed' situations. This may help to answer the question as to why the problem emerged despite long-standing guidance. Prof Powis also described the possibility of confusion arising from the NICE Clinical Frailty Score[165] and the final CQC Report analysed the reasons why poor practice occurred.[166]

96. The written evidence confirms that there was a rapid response by system leaders to the issues of 'blanket' or inappropriate DNACPRs, with a letter sent out on 3 April 2020[167] and on 7 April 2020 by Prof Steve Powis and Dame Ruth May.[168] See also Dame Ruth May's evidence.[169]

97. The Inquiry is asked to scrutinise with care any evidence of a continued or ongoing problem in decision-making despite this response; it is limited. For example, the PHSO's Inquiry statement was put in questions to the CMO, with assertions that there were more issues in September 2020,[170] but the PHSO statement refers to examples from March-April 2020.[171] Dame Ruth May was questioned on the premise that the issue had been raised again in September 2020[172], but in fact her statement (para 367) referred to an anonymous survey of nursing staff working in care homes that was published in September 2020,[173] but which had been carried out in May and June 2020, i.e., in relation to events early in the pandemic.[174] The majority of respondents said there had been no issues; 39 responded that Covid had been "*a positive focus for change and discussion of practice or ceiling or types of care.*" [175] 16 reported negative experiences, without giving details of dates or whether/how the problem had been addressed. The CQC Interim Report published in November 2020, stated: "*There was a quick response from multiple agencies following which there was no evidence that it has persisted as widespread problem*".[176] Care must be taken in interpreting evidence of continuing poor practice, and there is some evidence of good practice.

98. The CQC Interim Report recommended that: "*Some "wrong" DNACPRs may have remained in place so care providers should check and discuss them with patients to achieve assurance decisions were appropriately made.*"

99. The full CQC report on decision making at earlier stages in pandemic was published in March 2021.[177] It reported variable experiences of involvement in conversations about DNACPR, noting that conversations took place under stress. It criticised communication, governance and practice across the system. It made a series of recommendations, one of which designated NHS England as a lead body (jointly with DHSC) for developing "*A consistent approach to advance care planning".* NHS England's implementation of the recommendation is set out in SP/3.[178] It resulted in the publication of a comprehensive Advance Care Planning document ("the Universal Principles") in partnership with 27 other national bodies. This was a broad statement of principles rather than a specific document to record the implementation of such principles (as the ReSPECT tool does). Prof Powis provided his views on whether the ReSPECT tool should be the standardised form mandated for use, rather than allowing some local flexibility.[179]

100. There have been calls for an audit of records to identify problematic 'pandemic' DNACPRs. The CQC's Interim Report recommended that care providers should check and discuss them with

patients to make sure decisions were appropriate. In March 2021 the CQC did not call for a further audit. Prof Powis explained that in September 2020, NHS England incentivised GPs, via the QOF framework, to review the care of those on their lists with learning disabilities and autism, including a review of any DNACPRs; but that work had to be paused when GPs' work was again reprioritised as a result of the pandemic, including the vaccines drive.[180] This is an example of how priorities, or finite resources, had to be ordered to meet multiple demands. Similar issues would arise if the exercise were to be contemplated now, particularly if it extended beyond a review of GP records (GPs have identified patient lists, and study of hospital records would be much more complicated, given how patients enter hospital for finite episodes of care and events since any in-patient episode may not be clear from hospital records). NHS England suggests that it may be more fruitful and productive to focus on better training on Advance Care Planning, for the future.[181]

101. Prof Powis noted the overall lesson, that *"I think we need to be aware that this is a potential issue going into a next pandemic... I don't think that guidance necessarily needed to change. But we need to be aware that in times of emergency and stress it may be used in a way that wasn't anticipated..."*[182]

## Pulse oximetry

102. This topic was addressed in the CWS[183] and, briefly, by Prof Powis in oral evidence.[184]

*Usage*

103. Pulse Oximeters were used (i) in hospital, including ICUs, where they would be part of a wider suite of monitoring measures for patients; (ii) as part of the "Covid Oximetry at Home" (CO@h) programme introduced to detect silent hypoxia; and (iii) as part of the Covid Virtual Ward pathway rolled out from early 2021, under clinical supervision. SP/4 notes that patients in CO@h were advised to take baselines and to observe trends, rather than to rely on 'absolute' numbers.[185]

*Concerns about oximeters and darker skin tones*

104. Concerns about oximeters' accuracy for more darkly pigmented skin were raised in an article published in the BMJ on 21 December 2020, itself based on an article in the New England Journal of Medicine.[186] It has been suggested that the failure either to ensure the safety of these devices for all races, or the failure to pay attention to this issue until December 2020, is an example of systemic racism. NHS England agrees that this issue should be carefully scrutinised. The Inquiry will wish to consider:

    a. The fact that all devices were meant to conform to ISO standards requiring them to be accurate to +/- 2-3% in all skin colours.[187] That such a standard was set implies that regulatory authorities were not blind to the issue of accuracy with all skin colours;

    b. The quality of the evidence suggesting inaccurate results, prior to 2020. Prof Powis noted that there were concerns about the methodology of the original/early articles[188] – this is likely to have affected any clinical response in, for example, the ICU clinical community which used oximeters extensively;

    c. That, as the MHRA guidance of 26 March 2021 notes,[189] there are a number of factors which can impact on results, including nail polish, tattoos and also low perfusion rates (it

was this that led to a pause in procurement in May 2020 to ensure oximeters would be safe for care homes). Hence the need for clinical supervision, etc.

*Response to concerns from NHS England*

105. The Inquiry noted, during the evidence of Prof Powis, that on 23 December 2020, NHS England published a CO@h operational update, responding to the concerns raised by the BMJ article. The steps taken in response were set out in SP/4.[190]

*Evidence of harm*

106. There has been concern that inaccuracies in oximetry readings may have led to patient harm (see, for example, the statement by Sir Sajid Javid to the Andrew Marr show about "possible" harm, although he added that he was not in possession of "the full facts").[191] However:

    a. In the hospital and ICU settings, oximeters are only one means of clinical oversight;

    b. There were pilot projects undertaken when CO@h was rolled out: a pilot project in Slough focussed on a group, 50.2% of which was drawn from BAME patients. The outcomes were positive.[192]

    c. There has been evaluation of the CO@h programme.[193] Whilst studies have shown "mixed results" in reducing mortality/readmissions etc, results were not poorer for those with darker skins; "none have shown harm".[194]

107. When Professor Powis gave evidence, he summarised the position as "*I don't believe we have seen any adverse outcomes*", despite the evaluations commissioned.[195] On this, see for example (i) the Frimley Health and Care evaluation of 26 March 2021[196] and (ii) the Whitehead Report (11 March 2024)[197]. But NHS England recognises that the absence of evidence is not definitive. Rather, it looks forward to studying the NIHR evaluation of the research in this area, believing that it will demonstrate the importance of high-quality research in an area of public importance.

108. NHS England has continuing concern that important and valid discussion about the accuracy of pulse oximeters and a drive for improvement should not ignore the risks of deterring people from using them. Improvement is vital but: *"NHS England were, and are, of the view that a far greater risk is occasioned by people not coming forward for pulse oximetry. Although imperfect, pulse oximeters were an important tool used through the pandemic in identifying silent hypoxia, supported by proper guidance*."[198]

## Infection Prevention and Control ("IPC")

109. IPC measures have rightly been considered in detail by the Inquiry in this module and NHS England will welcome the Inquiry's findings and learning on this complex topic. NHS England nevertheless supports the observation made by the Association of Royal Medical Colleges, that the Inquiry must "*seek to avoid inappropriate retrospective judgments. It must, surely, primarily be about learning lessons and should provide practical recommendations for the future to minimise harm in a future pandemic or emergency.*"[199]

110. This is an area where there have been intemperate and abusive comments on social media and personal attacks made against individuals who stepped up to work tirelessly on this issue in unprecedented circumstances. As the WHO have recognised, the debate on this topic was

sometimes polarised, negative, over-simplistic and hampered constructive scientific discussion.[200] NHS England rejects any suggestion of bad faith or dishonesty on the part of those involved in IPC Guidance, or the suggestion that actions were driven by defensiveness rather than science and asks that the Inquiry explicitly does the same.

111. The Inquiry has heard evidence requesting greater clarity within IPC guidance and related documents and of a relative lack of research on the relationship between science and practicalities of IPC. NHS England has established mechanisms to support the development and review of the NIPCM England, including the Clinical Oversight Group, which is independently chaired and includes stakeholders from across the healthcare system. In advance of any interim report on Module 3, the Clinical Oversight Group will be reviewing the National IPC Manual ("NIPCM") for England, taking into account scientific advice, new research, evidence before the inquiry and with input from stakeholders,[201].

112. The topic of IPC guidance and controls is addressed in detail in the CWS of Prof Stephen Powis,[202] as well as the written and oral evidence provided by Dr Lisa Ritchie and Dame Ruth May,[203] which the Inquiry is invited to study.

*Routes of transmission*

113. NHS England was and is not responsible for scientific advice on the nature of the Covid-19 or other viruses, or for determining the mode of transmission of the virus (and nor was the IPC Cell). Rather, NHS England took advice from PHE (now UKHSA), as well as SAGE and NERVTAG and others on such matters. NHS England's role is to provide operational guidance based on that advice. During the Relevant Period that advice was that SARS-CoV-2 was predominantly spread by droplets other than in defined circumstances (i.e. AGPs). This was consistent with the international position advanced by the WHO.[204]

114. At the start of the pandemic there were three established modes of transmission in which a respiratory virus could spread: aerosol, droplet and contact (including fomite).

115. When Covid-19 was designated as an "airborne HCID", it was on the basis that it was a virus transmitted by respiratory droplets and/or aerosols, in addition to contact routes of transmission. The HCID classification did not determine the route of transmission other than it was transmitted "via the air". As the Inquiry has heard, HCID classification requires specific PPE regardless of the mode of transmission. SARS and MERS (airborne HCIDs) and Ebola (a contact HCID) all require the use of FFP3 masks, because they are HCIDs. As Prof Sir Christopher Whitty stated in Module 1 "*...Ebola, just to be clear, is actually a touch-based disease, it's not airborne or respiratory by route. That's an important point. So were I sitting next to someone who had Ebola, I would be much less concerned than if it was an airborne or respiratory infection*." [205]

116. Thus, FFP3 masking for HCIDs is not predicated on whether the virus transmits via aerosols or even the airborne HCID classification. SARS and MERS require FFP3 masks *because* they are designated as HCIDs. Although the example of SARS was much cited, the SARS experience was that FFP3 masks were not needed throughout an entire hospital, as confirmed by Professor Susan Hopkins:

> "*the majority of evidence from the SARS epidemic from 2003 was that the majority transmission was through droplet and, actually, it was from the SARS epidemic that occurred that the idea of aerosolise – generating procedures actually came to the fore, predominantly*

*because the people who had not – had just worn no face masks or only fluid-resistant surgical masks were transmitted in healthcare, having performed a procedure, an aerosol-generating procedure. If those people were in – doing other forms of healthcare, so normal healthcare routine delivery, without FFP3s, we didn't see transmissions. Transmissions occurred at those AGP moments."*[206]

117. Once Covid-19 was declassified, what was known about similar viruses, such as SARS, was the starting point for understanding transmission.

118. NHS England recognises that the declassification of Covid-19, and subsequent changes to the IPC Guidance to reflect the fact that Covid-19 was no longer a HCID, may have felt like protection was being taken away from staff. In a future pandemic, how this is communicated to frontline healthcare workers should be given explicit consideration.

119. NHS England also recognises that, there was, and remains, inconsistency in the use of terms to describe the modes of transmission, especially when considering the language around 'airborne' transmission. The WHO has undertaken considerable work on this and recommended use of the phrase "through the air" be adopted consistently and internationally. The WHO highlights the complexity of transmission-based precautions. Factors such as the transmissibility of the infectious agent, the type of procedure being performed, and the care environment must all be considered when determining appropriate IPC measures.[207] NHS England considers that the dichotomy around droplets and aerosols is unhelpful, going forward.

*Transmission within a hospital setting*

120. Hospital teams are well-versed in managing healthcare associated infection ("HCAI") and outbreak response through established IPC measures, which are integral to their 'business as usual' operations.[208] Transmission within hospital settings can occur through various routes, including: patient to patient; patient to staff; staff to staff; and visitors to staff or patient pathways. Effective precautions must account for the transmissibility of the disease, adherence to IPC protocols, and the resilience and adaptability of the estate – many NHS hospitals are older facilities with large open wards which create a higher risk for HCAIs compared to hospitals with more single rooms, or enhanced ventilation systems. A further challenge with Covid-19 was the high rate of community transmission - when community transmission levels rose, there was a corresponding increase in HCAIs within hospital settings.[209]

121. Shin, Gould and Warne suggest that estimates of HCAI range between 5-20% of all cases identified in acute hospitals.[210] They also note that "*it is not possible to reliably demonstrate at scale the proportion of Covid-19 infections in HCWs that were acquired in healthcare settings, as opposed to the community.*"[211]

122. Whilst the Inquiry has heard limited evidence on the work undertaken in hospital and other settings, steps were taken to modify the estate and to implement IPC measures by reorganising hospitals, including one way systems, cohorting of patients, hot/cold wards, with regular reviews and further reorganisations as the evidence changed. These changes may have been less obvious to front line staff but represented a significant amount of work on IPC. So too, were there regular reviews and outbreak management to identify local issues and to continually improve the IPC measures.

*The Hierarchy of Controls*

123. IPC is an integral part of health care practice, routinely implemented by healthcare workers to prevent and manage infection. Hospitals and other healthcare providers employ dedicated IPC and estates specialists who support the development of and implement protective measures based on organisation-wide and individualised risk assessments. Whilst the establishment of the IPC Cell introduced a new level of coordination, IPC measures themselves were already well-established to address a wide range of infections, albeit with a greater focus on Covid-19 during the pandemic.

124. Fundamentally, IPC is managed through a balance of risk in which employers are required to:

- carry out risk assessments as required under regulation 6 of The Control of Substances Hazardous to Health Regulations 2002 ("COSHH") taking into account both organisational and individual circumstances; and
- ensure that "*the exposure of his employees to substances hazardous to health is either prevented or, where this is not reasonably practicable, adequately controlled*".

125. Where it is not reasonably practicable to prevent exposure, employers are required to apply protection measures appropriate to the activity and consistent with a risk assessment in accordance with the established principles of the Hierarchy of Controls ("**HoC**"), set out in regulation 7 of the COSHH,[212] and explained in the statements of Richard Brunt and Prof Powis.[213] The HSE is responsible for compliance with COSHH.

*Ventilation*

126. Ventilation is an engineering control within the HoC and an important part of business-as-usual IPC. The age and variety of the NHS estate present challenges for ventilation. Whilst HEPA filters may be effective (depending on the volume of the area being filtered), application to the healthcare setting requires appropriate risk assessment for patient safety, e.g. for power loading, trip hazards and ligature risks.[214]

127. In its 'Lessons Learned' report NHS England stated:[215]

> "*[v]entilation was, and still is, vital in the management of Covid-19, particularly where the risk of airborne transmission is higher such as when aerosol generating procedures are being undertaken. NHSE worked with industry experts and DHSC to develop comprehensive advice and guidance on the legal requirements, design implications, maintenance and operation of specialised ventilation in healthcare premises. This guidance was updated during the pandemic to ensure adequate procedures such as lamina flow and air changes are in place for certain environments.*"

128. NHS England notes the recommendations of Prof Beggs regarding ventilation;[216] he suggests that ventilation guidance is outdated. However, as set out in SP/5:[217] (i) ventilation guidance for the NHS was updated (and checked against learning from Covid-19) in 2021;[218] Prof Noakes and Prof Beggs contributed to this document; and (ii) two new guidance notes were published in 2023, covering the application of ultraviolet devices for air cleaning in healthcare spaces and the application of HEPA filter devices for air cleaning in healthcare spaces. Currently, no further updates are anticipated other than as part of the usual update programme. But should NHS England's review of the NIPCM or advice from public health bodies regarding the science require changes, these will be made.

*Masks*

129. A primary focus for the Inquiry has been the use of masks, specifically the use of FFP3 and FRSM masks. Whilst instinctively it may appear that PPE should be the most important element of IPC, without the full suite of IPC measures (including social distancing, cohorting and testing) masks alone would not be effective, compared to being used alongside other measures. FFP3 masks are not a panacea or "magic bullet". They have downsides; the efficacy of PPE, and specifically FFP3 masks, is dependent on correct doffing and donning (including fit testing) and can provide a false sense of security. Disposable "FFP" masks must ensure that the user has a tight seal to ensure the intended level of protection.[219] Fit testing is a legal requirement under health and safety law, and an employer's responsibility. A user will then "fit check" a mask which has been previously fit tested every time that it is worn. Although FFP3 masks appear more robust, without fit testing they cannot be used as respiratory protective equipment. When NHS England became aware of reports of organisations only undertaking fit checking of new masks instead of fit testing, it wrote to the system reminding them of their health and safety duties.[220] Fit testing is not the only issue with disposable FFP masks; for example, if manufacturers' guidance is not observed regarding recommended wear time or they are not discarded in certain circumstances (e.g., if they become damp), or if staff are not sufficiently training in how to use masks, their effectiveness is also reduced.[221]

130. Fit testing is not straightforward. Failures can occur for several reasons including glasses, facial hair and facial shape[222] – as FEMHO noted, the masks used "*were largely based on the Sheffield man face, a standard white male face shape that did not reflect the diversity of the healthcare workforce*". When re-procurement proposals were developed for the pandemic 'flu stockpiles in 2015, there was a requirement for diverse masks to be supplied; so the reasons for the failure to secure diverse supplies might further be explored by the Inquiry in Module 5.[223]

131. Feedback regarding fit testing issues with certain ethnic groups resulted in the CNO's team leading a fit testing quality improvement project.[224] This project highlighted the need to ensure a range of masks in different shapes and sizes were available.[225] However, disposable masks would still not be appropriate for all users. As set out by Shin, Gould and Warne "*[s]ome staff had beards for religious reasons and could not shave these. It is impossible to achieve a satisfactory FFP3, half face or full-face respirator seal in the presence of a beard. The beard allows leakage of air between the mask and the face and prevents an effective seal.*"[226] Staff in this position should not be asked to remove their beards but should be provided with alternatives or redeployed. There are also alternatives to disposable FFP3 masks which should be used if an individual is unable to wear a disposable mask, including powered hoods which do not have the fit testing issues of disposable FFP3 masks;[227] Professor Ball, for example, described how in his Trust, if "*you were not able to work with a mask then you were provided with a hood*".[228] If no alternative to a disposable FFP3 mask is available, the individual should be re-deployed to an area where such a mask is not required.

132. When thinking about FFP3 masks, it is necessary to consider the balance of harms involved in their use, particularly for extended periods beyond which they were designed to be worn – they were not intended to be worn for multiple hours at a time. The harms include physical discomfort e.g. pressure sores, as well as dehydration. Harms can impact compliance levels,[229] as well as risks to clinical decision making and patients. The Inquiry has heard the impact on

communication with patients when masks are worn (e.g., on patients with dementia or who are hard of hearing). This effect can be mitigated through the use of powered hoods. Whilst many advocate for greater use of FFP3 masks, NHS England was also lobbied to reduce mask wearing.[230]

133. It remains NHS England's perspective that whilst masks are important, they are but one part of a comprehensive set of measures to limit (by prevention and control) the spread of infection. IPC strategies encompass multiple measures including environmental engineering, administrative policies, vaccination programmes, surface decontamination, patient cohorting, testing and tracing, and (in the case of Covid-19) non-pharmaceutical interventions. A comprehensive approach aligned to the HoC that balances these measures is critical to reducing the risk of transmission effectively. Masks for healthcare workers needs to be seen within this hierarchy of measures, particularly as masks have multiple points of failure (which is why they are a final step if the threat cannot be sufficiently eliminated/mitigated).

134. The Inquiry has heard that FRSMs are not PPE. Technically this is correct, because they are medical devices; however, the use of FRSM as part of universal masking reduced overall infection[231] rates and they form a useful part of a package of IPC measures used to protect healthcare workers on a daily basis.

135. There has been discussion of whether, even now, there should be more widespread use of disposable FFP3 masks within hospitals (see, for example, the submissions of Clinically Vulnerable Families). For the reasons set out above, the operational impact would need to be fully considered. NHS England's perspective is that widespread long-term use of disposable FFP3 masks is impractical, given the fit testing issues and other harms affecting compliance, etc. Instead there should be further research into alternatives, including the potential of powered hoods.

*UK IPC Guidance and local implementation*

136. The BMA stated that: "*ageing estates meant that infection control measures could not always be fully implemented. Witnesses described working in unsuitable spaces with large open bays and inability to distance between beds, a lack of side-room capacity to isolate patients and a lack of ventilation*".[232] There were widespread variations across the estate and local risk assessment was essential – IPC guidance could not replace (or act as a derogation from) employers' duties under COSHH. IPC guidance had always to be implemented subject to local risk assessment; both organisationally, based on the estate and what measures could be taken, and for individual staff members. Additional risk assessment would be required for those at high risk from Covid-19 complications in the same way as occupational health risk assessments would be carried out pre-pandemic. IPC guidance did not prevent any organisation using different masks where a risk assessment considered this necessary.[233] By June 2020 there was rising demand for FFP3 as a result of staff risk assessments.[234]

*The IPC Cell*

137. The UK-wide IPC Cell was a new structure which developed to work collaboratively across the Four Nations. The IPC Cell brought together IPC leads (with different qualifications) of the NHS (for operational input) and public health bodies (for scientific input) from the Four Nations to produce guidance. It has been suggested in evidence that additional scientific expertise should

have been present on the IPC Cell. Although this expertise was available within existing groups such as SAGE and NERVTAG, NHS England recognises the importance of reviewing the structure and composition of IPC advisory groups for future pandemics. Consideration should be given not only to embedding scientific expertise more directly within an IPC cell but also to whether an alternative structure or model might better address the integration of science, policy, and practical implementation.

138. The Inquiry has heard a number of conflicting views regarding the ultimate responsibility for the IPC guidance. As Dr Lisa Ritchie stated,[235] organisation roles and responsibilities were not as clear as they could have been – but this was not due to mal-intent and is a lesson which has been learned. To quote Sir Chris Whitty "*I don't think the people involved were exactly clear, although they were all trying to do their bit -- this was not an abrogation of responsibility*".[236] Clearer arrangements on roles and responsibilities in relation to guidance production were agreed during the pandemic.[237] Since the end of the Relevant Period, further arrangements have been agreed between DHSC, NHS England and UKHSA. These are being reviewed (December 2024) for updating in early 2025 as appropriate.[238]

139. However, whilst more than one view has been expressed on where the responsibility for final sign-off lay, in practice this did not affect what had been agreed in terms of the contents of the IPC documents. These were agreed through discussion and consensus, after considering a wide range of views including outcomes from SAGE, NERVTAG and ARHAI. It is clear that no guidance would have been issued which did not have PHE/UKHSA approval regarding e.g. the position on the mode transmission (i.e., the science). In practice, any concerns regarding the accuracy or appropriateness of the guidance could have been escalated – whether to SROs within an organisation (NHS England, PHE) etc; or the CNOs who spoke frequently. Dame Ruth May (Dr Ritchie's SRO) stated: "*So my role was to question, to challenge, to ask "Have the IPC cell reviewed and considered the latest evidence", and I've done that a number of times during the relevant period. As all UK CNOs did, we all collectively and individually would always challenge…*"[239]

140. The Inquiry has heard assertions or criticisms regarding how consensus decisions were reached within the IPC Cell.[240] It would be fundamentally incorrect to suggest or conclude that decisions were made by a small number of members or that others were excluded. IPC Cell members actively participated in meetings, engaging in discussions encompassing a range of perspectives before reaching a consensus opinion. This, as set out in the oral evidence of Prof Susan Hopkins, is contrary to 'groupthink'. Whilst there were no formal votes, the IPC Cell Chairs[241] would summarise the consensus reached at the end of the meeting, to ensure a shared understanding and to enable challenge. Minutes were also circulated to attendees, and could have been queried if incorrect. Some issues were escalated to the Senior Clinicians' Group, who could flag any concerns if perspectives were being wrongly ignored. Neither the IPC Cell nor any of its Chairs could compel any of the Four Nations to adopt the guidance produced – instead the consensus views reached by the Cell were adopted at the discretion of each nation.[242]

141. The IPC Cell was accused of a lack of transparency for not publishing its minutes and membership. NHS England disclosed the IPC Cell minutes to the Inquiry in January 2024. The Inquiry has considered only limited examples in the hearings and is invited to read the full

minutes. The minutes were not previously published as historically NHS England internal cells have not routinely published minutes (although subject to the Freedom of Information Act 2000).[243]

142. The Inquiry has heard that PHE highlighted the increased transmissibility of the Alpha variant in December 2020 but confirmed that the mode of transmission had not changed.[244] This is the reason why IPC guidance remained substantially unchanged during this period. During IPC Cell meetings in December 2020, concerns raised by PHE members about the Alpha variant were discussed, but ultimately the agreed position was that no changes to recommended mask use were made. PHE were also having these discussions internally and carried out further reviews of the evidence. As Professor Hopkins noted:[245]

> "*I would highlight from this is this is views being expressed to bring consensus to discussion. It is also views that were then brought back into PHE to discuss further, and the decision at that was to go and further review the evidence to decide whether the evidence was strong enough to do that.*" She further confirmed that: "*FFP3s were one part of the control measures that, in this scenario, that it was a reasonable thing to propose but it was not the only view that was expressed, either in PHE or in other organisations.*"

143. It would be unfair, and unjustified by the evidence, to suggest that the consensus arrived at by the Cell was based on defensiveness, or an unwillingness to shift position; or that individuals were forcing their views on others.

144. Risk assessment remained: *"[r]educing transmission requires the risk from all activities to be assessed for all areas, and the hierarchy of control should be used to identify appropriate controls with "elimination", "substitution", "engineering controls" and "administrative controls" considered (including in combination to build strength in depth) before PPE or RPE is considered"*.[246] So when an unacceptable level of risk remained (i.e., consistent with the HoC and health and safety obligations), RPE should have been considered.[247] By October 2021, the PHE-convened Respiratory Panel found that "*that all types of face coverings are, to some extent, effective in reducing transmission of SARS-CoV-2 in both healthcare and public, community settings – this is through a combination of source control and protection to the wearer*".[248] The same Panel found that:

> *"the evidence to date suggests that the modes of transmission of VOCs [variants of concern] has not changed compared to other variants, so it is expected that the same infection prevention and control measures should be appropriate, including ventilation, hand hygiene, face coverings and, in high risk settings, respiratory personal protective equipment PPE (medium confidence)."* [249]

145. The Inquiry heard suggestions that the IPC Guidance recommended particular types of face masks based on supply constraints.[250] This was directly rejected by Dr Ritchie and is rejected by NHS England. Rather, the IPC Guidance was produced on the basis of what was understood about Covid-19 at the time, not whether there were sufficient stocks of the recommended PPE. This is demonstrated not only by Dr Ritchie's evidence, but by what has become known as the "shortage guidance", published by PHE on 17 April 2020. This guidance was not endorsed by the IPC Cell or the CNO – derogations from recommendations in the event of shortages were a matter for HSE's approval. The separation of functions was preserved.

*Support for implementation*

146. To support the implementation of IPC guidance, on 28 April 2020 NHS England published checklists for Trusts and produced a compendium of documents and training resources. Throughout the pandemic the IPC Cell provided direct support to NHS Trusts and other healthcare providers to support implementation and help manage outbreaks. In the time available, this has only briefly been explored in oral evidence but was addressed (by way of examples) in Prof Powis statement *e.g. webinars, 10 Key Actions on IPC, Every Action Counts*.[251]

147. The Inquiry has heard criticism of guidance being issued on a Friday, which made implementation over the weekend difficult. Some guidance was issued on a Friday, particularly in the early stages of the pandemic, but the majority of IPC guidance was not.[252] As Prof Ball noted, this may (partly) have been an issue of perception of those under considerable strain.[253] Whilst it is always a balancing act, if new or updated guidance needs to be issued, the day of the week cannot be a constraining factor in a pandemic. As Prof Hopkins noted on 6 March 2020: "*Not ideal that it goes up Friday but needs must*".[254]

*Guidance – observations*

148. Whilst the IPC guidance has been heavily challenged by some, NHS England submits that it was a reasonable and expert-led response to the scientific evidence presented to the IPC Cell over the Relevant Period. Local risk assessment allowed for the greater use of FFP3 masks if deemed appropriate; given the challenges to staff and patients presented by their use in clinical (as opposed to laboratory) conditions, NHS England is not persuaded that, in particular, general or more widespread use of FFP3 masks should have been recommended (or mandated). This perspective is supported by the views of Senior Clinicians including the CMO England, Prof Chris Whitty, and Prof Susan Hopkins of PHE, both at the time and in their evidence to the Inquiry.[255]

149. How better to engage with staff and win 'hearts and minds' in a future pandemic is something NHS England will explore, based on the evidence put before, and recommendations of, the Inquiry. It is acknowledged that perceptions of the Covid-19 IPC guidance may have influenced trust in the NIPCM, as indicated by concerns raised by some stakeholders, and the topic of a review is addressed above. In addition, NHS England has noted the need for further research, both into the effective use of FFP masks in clinical conditions (risks and benefits), and into alternatives such as, but not limited to, powered hoods. Such research offers the best opportunity for improvement, before another pandemic.

## PPE and risk assessments for staff

*PPE*

150. Responsibility for procuring PPE, in 'peacetime' and in relation to the pandemic 'flu stockpile (managed by PHE) was addressed in SP/3.[256] NHS England has explained the efforts made to assist DHSC and its partners with understanding the "demand signal" from the NHS and the distribution of PPE to the healthcare system.[257]

*Staff risk assessments*

151. The aim of staff risk assessments is to secure a safe system of work; they served a wider purpose than assessing PPE needs alone, but it is convenient to consider the topic here. The extensive work undertaken by NHS England to ensure that risks assessments of staff were carried out by employers following, in particular, the emerging evidence of particular risks posed to BAME staff was covered extensively by NHS England in evidence:[258]

    - 24 April 2020: discussion at NIRB, Action Plan;
    - 29 April 2020: CEO and COO wrote to the NHS – recommendation to assess staff potentially at higher risk, including BAME staff;
    - 30 April 2020: publication of the first version of the Risk Assessment Guidance, which was updated over time – carrying out a risk assessment was advised for all vulnerable staff including those from a BAME background, advice on actions which employers could take to keep staff safe;
    - 12 May 2020: independent publication, supported by NHS England, of "Risk Reduction Framework for NHS Staff at risk of Covid-19 infection";
    - 6 July 2020, formal establishment of the Risk Assessment Delivery Unit (RADU). This was designed to press for proper implementation (see the fuller account of its work,[259] including the evidence of implementation of the assessments. "Completion" of an assessment was defined as reaching agreement on the steps to be taken as the result of the assessment, i.e., it was not enough merely to have been assessed).

152. NHS England submits that the evidence of Prof Powis, that NHS England "*acted quickly, particularly when we started to understand the risk profile of Covid, particularly amongst colleagues from our BAME community*"[260] should be accepted. He was speaking of the initial guidance upon risk assessments, and then noted that this had had to be followed up with monitoring of implementation.

153. Evidence of engagement with staff groups, e.g., by the CNO, the CEO (Lord Stevens) and the Chief People Officer has also been set out.

*Outsourced staff*

154. The Inquiry heard evidence that staff working in outsourced positions were less likely to be offered risk assessments, had greater difficulties in securing PPE and felt that they were more likely to be deployed to high risk areas, or had no adjustments made for their risk factors. Staff whose positions were insecure or who received low wages were also more vulnerable.

155. The guidance on risk assessments to NHS employers stated that "staff" should be offered risk assessments and reasonable adjustments made.[261] The particular risk to BAME staff was flagged and the role of line managers as well as unions was stressed. Whilst in this document, for example, there was no direct discussion of outsourced staff, NHS England was not blind to the issue of staff who were not directly engaged by NHS Trusts when seeking to ensure that risks assessments were conducted for all. Thus, the presentation from our Chief People Officer to NIRB on 22 May 2020 which outlined the measures being taken, stated:[262]

*"We are encouraging all organisations to deploy a comprehensive education programme focusing on social distancing, hand hygiene and PPE. This programme should reach the whole workforce, including lower grades where BAME staff are overrepresented.*

***Alongside this, we are engaging with HEE, IPC Cell and HR Directors to develop a central communications programme that helps to reach Agency staff, support services and ancillary workforce - understanding that traditional learning tools such as e-learning may need to be modified to achieve penetration."*** (bold added).

156. The report back to NIRB on 19 June 2020 from the London and East of England regions also shows that steps were being taken to engage with outsourced workers, referring to "*National contact with independent employing agencies to encourage consistent approach. (London's bank suppliers have well engaged to established [sic] NHS consistent process).*"[263]

157. It is fair to say that measurement of compliance, when rolled out as part of the concerns about securing risk assessments, was based on the NHS Electronic Staff Record, which records directly employed NHS staff only. It was nevertheless expected that outsourced workers should receive risk assessments. On 6 July 2020, as part of the establishment of the Risk Assessment Delivery Unit and the exercise of data capture for staff, the expectations were set out *"The total workforce numbers should be taken from staff in post within the Electronic Staff Record (ESR). We accept that within some providers bank/agency and contracting staff are not included with the data from ESR,* ***and we expect that groups are either offered assessments by NHS organisations or assurance of risk assessment compliance should be sought from any contractor."***[264] Prof Powis stated in evidence that his view was that all who worked for "the NHS community" should be included in the risk assessment process.[265]

158. Ms Pritchard acknowledged in oral evidence that on reflection, NHS England should have been clearer about the expectation that guidance needed to apply equally to outsourced staff.[266] Although the local employer is responsible, in a pandemic situation there is probably a need for greater clarity of expectations. This was one of the "*points of learning I would take into a future pandemic.*"[267]

159. That said, it is ultimately for local employers to make outsourced staff feel a valued member of the team, as a matter of good practice and law.[268] Ms Pritchard made it clear that that she had seen good examples of this (and see the reference to the work of London Bank agencies, above). The TUC submitted orally that the indirectly employed workforce is a 'blind spot' for those responsible for the services these workers deliver. It noted that NHS England does not hold any data on outsourced staff and that indirectly employed workers are not accounted for in the workforce plans or race equality strategies. Greater visibility and oversight of the indirect workforce must therefore be achieved in advance of a future pandemic, it submitted.

160. The Inquiry should note, in relation to possible recommendations, that it would be a large piece of work to collect data on outsourced staff as well as NHS employees, and further thought would need to be given to the purpose and future uses of such data capture, outside of the pandemic. There are a substantial variety of staff working on NHS premises, including not merely bank or agency clinical staff, cleaners and porters but estates operatives, caterers and the employees of franchises (sometime major chains such as M & S). Catering services, for example, may be provided by large chains and staff deployed flexibly. Whilst contracts can have regard to equality

metrics, still shifting the primary responsibility for matters such as racial equality strategies directly onto the NHS would require careful consideration.].

### Visiting guidance and palliative care

161. There is evidence on this topic in the SP/3[269] and RM/1;[270] it was addressed in evidence by Dame Ruth May on 17 September 2024, and Professor Powis on 7 and 11 November 2024.

*The overall balance*

162. NHS England recognised the significant impact visiting policies had on patients, families and the NHS workers involved. However, "*These difficult decisions were made with overall patient safety at their heart*".[271] Or as Prof Ball stated "*It's an incredibly difficult balance to get right, if I'm honest*".[272] Infection risk from visitors was a reality; there are examples in the Spotlight Trust evidence of visiting being the source of Covid-19 infections in hospital. A balance had to be struck, with broad rules or restrictions subject to necessary exceptions. The balancing act was made exceptionally difficult not only by the range of important interests affected but also by the shifting nature of the viral threat and the variety within local NHS estates or NHS services. It was also an area on which NHS England faced a learning curve, visiting guidance having previously been a matter for local judgement.

163. NHS England submits that the Inquiry's IPC experts (Dr Shin, Professor Gould and Dr Warne) fairly concluded that:

> "8.22 *Overall, taking into account the exceptions made for special circumstances like end-of-life care, maternity services, patients with cognitive impairment or additional care needs, and paediatrics and the fact that visiting guidance evolved to be more flexible over time, we believe a reasonable balance was struck, but with variation in local practice that contributed to differing experience. It is unlikely any iteration of visiting guidance would satisfy all relevant stakeholders who have very different priorities and responsibilities."*
>
> In oral evidence, Dr Shin said that "*some form of control was reasonable, logical and I think the right – probably the right decision*".[273]

164. That said, NHS England witnesses recognised the challenge of publishing guidance for the first time, and that, as a learning point, particular aspects of the guidance could have been clarified more quickly. For example, Prof Powis was asked if he thought that it was "*an error in the initial guidance when it was published on 25 March not to have permitted expressly visiting for people with dementia, learning disabilities or autism*". He noted that "*this was new territory for us … And so there was inevitably a learning curve for us in terms of providing guidance. So, on reflection, I think it is possible that we should have done -- made that clearer earlier."* After discussing the example of clarification of the status of faith leaders, he continued:

> *"… that was I think part of our learning process in producing guidance in an area that we had not previously had experience… we fully recognise as NHS England, getting that balance right was really difficult. But we wanted to be as flexible as we could and increasingly flexible as we learnt more, as we were able to put in more measures to protect staff, to protect patients and visitors. And there were areas such as end-of-life care and birthing and labour, in particular, where we, from the outset, were clear that we wanted to*

*make exceptionality. But I think you have raised a good point and I think as part of our reflective process, then, that is something that we would think about."*[274]

165. Dame Ruth May made similar points and, in particular, that she had not anticipated that the guidance on allowing partners to be present in labour (which was allowed throughout) would be implemented by drawing a distinction between active labour and non-active labour.[275] Areas of consensus have developed regarding the need to take particular account of the needs of particular groups, especially the disabled and others needing support as a result of mental impairments; and the need for psychological support to be available to pregnant woman and those who had recently given birth. The pain of restrictions for families facing the death of their loved ones has also been a repeated theme in impact and other evidence. Visiting at the end of life was always permitted but it is apparent how very difficult that was in practice, especially when families had not previously been able to visit a ward.

166. However, it will be important to avoid rigid prescriptions for the future. Whilst the Inquiry may reinforce the importance of taking account of the psychological harm caused by unduly restrictive visiting rules, decisions in any future pandemic would need to be guided by the scale of the risk posed, including by viruses with a higher infection fatality rate, or the difficulty of supplying sufficient and effective PPE to visitors. Depending on the circumstances, such concerns could even extend to those who should normally be considered as part of the patient's care and support team. Flexibility has to be retained.[276]

167. NHS England submits that allowing discretion to local providers of services, within an overall framework of principles, is likely to remain both necessary and appropriate. Local estates varied in their ability to (e.g.) segregate streams of visitors or to maintain social distancing. Spotlight Trusts noted the need for flexibility and described careful local decision-making.[277] When there was variation as a result of local decision-making, given such scrutiny it would not be fair to describe the result as a "postcode lottery". Rather, the challenge is to better communicate the reasons for variations.

*Engagement with the public and stakeholders*

168. The Disabilities Charities Consortium submitted that there had been a failure to take "modest practicable steps" to consult with disabled people, with communications revised "only after the event" and after they had led to adverse consequences.[278]

169. Initial guidance issued on 16 March 2020 envisaged a number of reasons for "essential" visits, including support for the patient. The removal of a number of those exceptions on 25 March 2020 followed the announcement of the national lockdown and was taken at a time when little was known about the virus. Restrictions were revised on 8 April 2020 to allow for greater support those with disabilities, and again on 5 June.[279] NHS England has clarified that there was no consultation conducted with disability advocacy groups between 8 April 2020 and the updated version of 5 June 2020 – however, the guidance did take into account representations received from such groups, about the terms being unduly restrictive (and fortnightly webinars with third sector organisations including those representing those with disabilities and learning difficulties started on 25 March 2020).[280] The Reasonable Adjustment Flag that will, when fully implemented from December 2025, support staff with information about patients' needs and help in considering the adjustments needed for them, including with respect to visitors.[281]

170. NHS England submitted in its oral closing submissions that weight should be given to the fact that guidance was not set in stone but was subject to review and revision. This is not to undermine the experiences of those who suffered as a result of (e.g.) the most restrictive rules, from 25 March – 8 April, but there was an emphasis on learning fast.

*The maternity journey*

171. Oral submissions from the 13 Pregnancy and Babies Organisations included that it was "acknowledged too late" that partners and supporters of a birthing woman "are not visitors but partners in care".[282] Partners were always allowed in during active labour, but the wider principle was acknowledged in the NHSE guidance on maternity services of 14 December 2020; this was preceded by the RCOG Guidance of 8 September 2020 which drew a distinction between birth partners and visitors, with birth partners being those identified as those nominated by the woman to accompany her during labour.[283]

172. Restrictions prior to active labour, for neonatal care, and antenatal scans were singled out for criticism. Prof Powis stated that "*So our reflection, I think, would be that we could have been clearer, and I think this is a lesson for next time, if there is a next time, in making those distinctions as to who is part of the healthcare support team if you wish, faith leaders, carers, birthing partners, and who is a visitor. And I think you saw that in the guidance as we iterated it, but I absolutely agree that one of the reflections that we would have coming out is to do that sooner and be clearer.*"[284] See also the evidence of Ruth May, who accepted that Maternity guidance could have been more specific earlier, but also made the point that increased testing available earlier would have affected the way visiting guidance was drafted (i.e., that it was easier to be less restrictive as time went on).[285] That there was understandable caution in the early days, and concerns about the particular vulnerability of babies, was accepted by Jenny Ward in evidence.[286]

173. It was also said that the "visiting restrictions did not reflect robust science" as they did not fall into the remit of the IPC cell. Work on Visiting Guidance drew on "*the specific clinical expertise of the then CMidO and NCD for Maternity and Women's Health to work with the Royal Colleges on an agreed position. … The wider visiting guidance …. was overseen by the Clinical Cell".*[287] Finally, it was said that it made no sense not to treat partners as part of a single unit, on the basis that this would not increase infection risks. However, not all birthing partners will reside at the same address, and professionals such as sonographers, for example, expressed worries about the numbers of people attending in small confined spaces. Throughout the pandemic, there were frequently issues about where to draw lines in situations where clear brightline distinctions were not possible – yet increases in numbers did carry increased risks.

*Palliative and End of Life care*

174. When questioning Prof Powis, CTI contrasted para 233 of SP/3, on the adequacy of capacity for end-of-life care in hospital, with the statement of Dr Cox of the Association of Palliative Medicine.[288] NHS England notes the context, that the passage in SP/3 quoted related to the availability of a hospital bed for end of life care. It was not a statement on the wider pressures on palliative care teams who, as Prof Powis acknowledged, were placed under considerable pressure, caring for many more patients than would normally be expected.[289] Prof Powis further acknowledged the issue of the losses implicit in the delivery of care remotely for patients

reaching the end of their life in the community, and the impact of visiting restrictions in hospital.[290] NHS England has explained what it did to support the sector, including helping to secure additional funding for hospices.[291]

*Recommendations and the future*

175. For the future, recognition of the probable need to issue visiting guidance will be factored into pandemic planning. As noted above, this was a new role for NHS England, and recognising this need as part of planning would reduce the burden of a 'standing start'. Please see the comments on areas for change at paragraph 9 above.

## Primary Care and Community Services

176. Primary care was covered in the CWS.[292] Pandemic planning for primary care is covered above; remote consultations, support for GPs, and community pharmacies are covered below.

*Digital infrastructure*

177. As the country moved into lockdown in March 2020, NHS England instructed GPs to move to a 'total triage' access model, whereby patients were triaged, and where possible managed, via telephone, video, or online consultation technology.[293] Face-to-face consultations were offered where clinically necessary. Since January 2019, plans had been in place to roll out online consultation systems in general practice; around 50% of GP practices had already implemented an online consultation system by March 2020. The pandemic necessitated a more urgent shift to online consultations. NHS England undertook a rapid procurement exercise and funded online consultation systems for those commissioners and providers who had not yet implemented them.[294] NHS England also provided additional operational guidance to support practices to implement online consultation systems.[295] 96% of GP practices were able to offer video or online consultations by 30 April 2020.[296] NHS England does not seek to minimise the strains caused by the need to accelerate the shift to online consulting – and work is ongoing to improve digital infrastructure in primary care – but the quick roll-out of remote consultations has been positively recognised by NHS Providers.[297] NHS England agrees with Prof Banfield (BMA) that the shift to remote working was a success, helping to maximise a limited workforce and allowing those who had to isolate to work remotely if well enough.[298]

*Digital inequalities and the quality of remote care*

178. GPs could not have safely maintained the volume of appointments they delivered during the pandemic, without the rapid shift to remote care. For some patients – for example, those with mobility problems, or those in full-time work – the availability of online consultations has improved their access to GP services. However, online consulting was less accessible for some patients: e.g. those who experienced difficulties using phones or computers, who had sensory impairments, who were vulnerable, or those with learning disabilities. Some clinicians felt less able to identify symptoms, or diagnose illness, via online platforms – although deaths or serious harms associated with remote encounters in primary care are extremely rare.[299]

179. These issues were recognised before the onset of the pandemic. In July 2019, NHS Digital (as it then was) published a revised "Digital inclusion guide for health and social care".[300] NHS England's 19 March 2020 instruction to GPs to adopt a 'total triage' access model required them communicate with patients via telephone, if those patients could not use online or video

platforms.[301] Prof Adrian Edwards acknowledged that an understanding of digital exclusion was 'factored into' early NHS England guidance documents:[302] for example, on 29 May 2020, NHS England published "Principles of safe video consulting in general practice during COVID-19" jointly with the RCGP.[303] The Phase 3 Letter of 31 July 2020 again emphasised the need for GP practices to consider the accessibility of digital services".[304]

180. NHS England agrees that more research is needed to understand the effectiveness of strategies to tackle digital inequalities, and that healthcare staff may benefit from more formal training to deliver remote care safely and inclusively.[305] It continues to work to mitigate against digital exclusion: Prof Edwards acknowledged the 2023 NHS England 'top tips' to support digital inclusion in general practice, for example[306]. Prof Banfield emphasised the need for healthcare services to ask patients themselves about how they prefer to access health services.[307] From May 2021, as lockdown restrictions eased, NHS England required GP practices to take account of patient preferences' regarding how they accessed care.[308]

*Public messaging and support for GPs*

181. It has been suggested that, following the first Covid wave, there was a '*shift in the media narrative*' towards '*blame towards GPs for a perceived lack of face-to-face appointments*' and that this prompted increased levels of abuse and harassment of GP practice staff.[309] It was said that not enough was done by the government or by central NHS bodies to counter this. Criticism has been directed specifically at NHS England's press release of 14 September 2020, reminding GP practices of the need to make clear to patients that they could still see their GP in person if appropriate. Some felt this encouraged a false perception that GPs were not making themselves sufficiently available for face-to-face appointments.[310] NHS England's aim was to address legitimate concerns that some patients were not accessing healthcare services – either because of fears about contracting Covid-19 or of overwhelming NHS services, or owing to a misperception that GPs were not 'open' following the shift to remote triage. There were also legitimate concerns that a small proportion of GP practices had stopped providing face-to-face care even when it was clinically necessary.[311] There was never any intention (in that press release or at any other time) to fuel public dissatisfaction with GPs, and NHS England does not consider that it has been demonstrated that any of its public messaging had that effect.

182. NHS England published guidance for GPs on how to communicate with patients about how to safely access general practice, which was updated as guidance on face-to-face consultations changed.[312] NHS England's Medical Director for Primary Care appeared on the Prime Minister's televised daily Covid-19 briefing on 6 May 2020, to support the message that GP practices remained open for business. NHS England also ran the 'Help Us, Help You' campaign[313] and worked with the BMA and RCGP on communications around GP access, face-to-face care and abuse of staff. On 14 October 2021, NHS England published a plan – with the involvement of the Secretary of State and DHSC – to improve GP access and to support GP staff, committing to a 'zero-tolerance' campaign against abuse of staff and providing £5 million for upgrades to GP practice security measures.[314]

183. NHS England recognises the additional pressures placed on general practice during the pandemic, including delivering the Covid-19 vaccine and identifying and supporting clinically extremely vulnerable patients. NHS England took steps to free up GP capacity during the pandemic, including offering income protection on various elements of the GP contract.[315] Prof

Banfield said the easing of contractual requirements afforded GPs 'greater autonomy, flexibility and freedom to act in the best interests of their patients' during the pandemic.[316]

*Community Pharmacy*

184. The Inquiry has heard evidence in relation to community pharmacists. This is a sector in which providers vary in scale, from small businesses to large chains. The provision of NHS services is accompanied by commercial trading. The role of NHS England in supporting community pharmacists, in the specific context of medicines supply, was addressed by Prof Powis.[317]

185. The main criticism from CPs representing pharmacists was that they felt undervalued, with the examples of lack of access to PPE and the initial failure to include them in the NHS Coronavirus Life Assurance scheme given as examples. NHS England was not responsible, prior to the pandemic, for securing access to PPE for pharmacists. Specific criticism was directed at pharmacists being given later access to the PPE portal. This was a partnership between the DHSC, NHS Supply Chain (at the time, a DHSC body[318]) and other logistical partners. In SP/4, NHS England noted that pharmacies, alongside a wide range of other bodies, were able to access the portal by June 2020.[319] The topic of the Life Assurance Scheme was not covered by NHS England's CWS; it was (rightly) not asked about it as it had no role in the scheme, negotiated between the DHSC and HMT;- NHS England was simply not consulted.

186. NHS England notes the evidence given by Mr Hancock that there was a "lack of enthusiasm" on its part for supporting community pharmacists and the suggestion that they were "the last thing on the list". NHS England strongly disagrees. It would point to the rapid use of community pharmacies in vaccine role out and the pharmacy contract framework that was agreed in 2021.[320] NHS England values community pharmacists as an integral part of the primary care system. Community pharmacy was included as part of the work done to support the risk assessment of staff, conducted across primary care settings.[321]

## Shielding

187. NHS England's involvement in the Shielding programme was addressed in written evidence and is not further addressed here.

## Long Covid

188. Long Covid is addressed Prof Powis' written and oral evidence.[322]

*Early recognition of Long Covid and the establishment of specialist services*

189. A common theme among those who have suffered from Long Covid was scepticism, disbelief, and delays in diagnosis from medical professionals, especially in the earlier parts of the pandemic: i.e. medical professionals were not sufficiently aware of Long Covid.

190. Sir Chris Whitty accepted that the fact that viral infections may have long-term consequences is not a new phenomenon and is predictable; but he noted that the nature and scale of those consequences are not predictable.[323] It is also predictable that if people are seriously ill and admitted to ICU, some will have long term consequences. But NHS England would add that the early history of recognition of Covid-related symptoms for those who had not been admitted to hospital was complicated by the dearth of testing and clarity on who had had Covid-19.

191. In terms of the early response from clinicians to patients reporting symptoms, Prof Powis' evidence was that "*I agree that at [early stages of the pandemic] it's maybe not surprising that all clinicians didn't have the information they needed, but I absolutely understood the frustration of those who were suffering with Long Covid.*"[324]

192. In oral evidence Sir Chris Whitty stated: *"And I think we probably should have been swifter off the mark in spotting Long Covid as it emerged, although I think we were relatively quick and it wasn't obvious we could have done something different as a result because of the way – the main thing we could do at the beginning, before we understood it slightly better, was to reduce the amount of Covid. If you don't get Covid, you don't get Long Covid."* [325] NHS England's M2 Long Covid Supplemental Statement also noted the importance of reducing infection rates.[326] It continued*: "It would not have been possible to foresee the specific constellation of features of Long COVID, nor could its incidence have been predicted at the start of the pandemic.*"[327] There needs to be some definition of the problem in order to develop treatment services; hence, for example, the need for NICE to produce a case definition.

193. Prof Powis noted that he, along with others, became concerned about reports of symptoms "*as we came out of wave 1 and into the summer of July 2020*".[328] It is submitted that, objectively, there was a rapid response by the NHS in England to that evidence of need; services were developed from July 2020 onwards. The initial online offering, in July 2020, offered validation of the issues and should have been an effective answer to any scepticism displayed by clinicians. Prof Powis said: "*... in my view we acted very quickly in terms of our response to Long Covid, and I absolutely acknowledge that from the perspective of those with Long Covid, it is never fast enough"* ... [but] *"we had 69 clinics by December* [2020] *which I think was faster than just about every country in the world.*"[329]

194. Specific evidence on the content of NHS website, in relation to Covid-19 symptoms, is contained in SP/5.[330]

*Challenges in consistency and access*

195. The challenges with regards to securing equal access to these new services was outlined by the Inquiry's experts. NHS England acknowledges these strains. For example, its Lessons Learnt report: *"115. Although good progress has been made on the actions set out in the 10-point plan, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups."* [331] These issues are not unique to England (see the evidence of the situation in the Devolved Nations). Unfortunately, the challenges faced are part of a wider picture of increased demand for healthcare services attributable to the pandemic, set against finite or reduced resources (e.g. staffing) during the Relevant Period. Increased demand for mental health services is another example where it is hard to meet demand or ensure equal access to services.

196. Whilst there has been unease about the transfer of centrally- funded Long Covid services to ICBs from April 2024, the position reflects the fact that Long-Covid clinics are not defined as a specialised service[332] which NHS England must commission directly. ICBs must still commission against NHS England frameworks. Prof Powis explained that NHS England is *"currently undertaking a stocktake of the existing service, so that we have a better sense of where those services are*[333] He suggested that there could be merit, over time, in Long Covid services being

incorporated into wider, post-viral treatment clinics. This would help to consolidate expertise and build resilience. NHS England would be happy to provide the Inquiry with the outcome of this stocktake and details of any further policy developments in this sphere. It is submitted that such consideration of how Long-Covid services can best be developed is likely to be a more fruitful way forward than (for example) recommendations about earmarked funding for Long-Covid. Without in any way seeking to diminish the importance of these services, the issue of regional variations in services is common, and the case for earmarked funding could be made by virtually every clinical grouping across the country.

*Data, coding and Long Covid in healthcare workers*

197. The NHS (and NHS England) collects data on sickness rates and the reasons for it amongst the NHS workforce, but to date sickness coding for Long-Covid does not exist, so it is not specifically recorded as a reason for absence. Ms Pritchard stated that this would be a "*fairly obvious things for us to try and build into the next iteration of ESR*" [i.e. the Electronic Staff Record].[334]

198. Data is collected about those accessing Long-Covid clinics. As noted by Prof Powis, "*The Long Covid registry data includes information on the number and proportion of adults accessing Long Covid services for the first time who are employed by the NHS.*"[335] The stocktake referred to above will consider whether Long Covid services data currently being collected is sufficient.

## Inequalities

199. NHS England recognises the vital importance of breaking down barriers to healthcare, and of supporting all who work within the NHS to feel valued by the NHS community, and to be able to reach their full potential.

200. Inequalities exist in many forms. There are many protected characteristics; and many others, patients and staff, will have illness or vulnerabilities (including Long-Covid) which do not attract the public sector equality duties but nevertheless require recognition and appropriate treatment by the NHS. Many aspects of these important topics have been mentioned in the course of the submissions above, but further comments below address patient care and staff experience.

*Patient care and health inequalities*

201. The social determinants of health and the impact of social deprivation and related issues, including the effects of racism in society, were set out in the M1 Expert Report from Professors Bambra and Marmot.[336] They are largely outside of the direct control of the NHS. The authors of the report made the point that since NHS healthcare is free at the point of use, "*by and large, the majority of the inequalities in health that we see are not attributable to inequalities in access to care*."[337]

202. But the NHS seeks to secure equal access to its healthcare service and reduce health inequalities; and it is accepted that there are barriers to access, including with regards to the fair allocation of resources - one example is the uneven provision of GP services. Equally, the NACR Quality and Outcomes Report 2022 on cardiac rehabilitation services noted how the majority of patients benefitting came from urban, rather than rural areas.[338] There are also inequities and distortions in the provision of care itself, with the issue about inaccuracies in pulse oximeters for patients with darker skin tones being an example of this. All these dimensions

represent complex, long-term challenges for the NHS, with work both preceding the pandemic[339] and continuing after it.

203. The complexities of issues relating to the exclusion or marginalised of the vulnerable were illustrated by Prof Powis when speaking of remote consultations and digital exclusion. Pointing out that strategies to implement remote consultations pre-dated the pandemic, he continued "*So that is a concern in pandemic times and outside of pandemic times, that we don't digitally exclude individuals ... So it's very much on our minds. But, equally, I have always felt that the use of digital technology can be a benefit for more vulnerable groups because actually coming to hospital can be quite a challenge ...*" [340]

204. During the pandemic, the NHS continued to provide care that was free at the point of use, and the continued offer of services – including treatment for Covid-19, which affected those from a BAME background,[341] or with disabilities, disproportionately – was one means of mitigating health inequalities. There were also severe challenges, as noted in (e.g.) the Inquiry's expert reports. These included the exacerbation of health inequalities across a number of the services studied by the Inquiry. NHSE's response to these challenges was multifaceted and included:

    a. In relation to maternity services, the communications work that was part of the "Help us to Help You" campaign. It aimed to support pregnant Black and Asian women who were particularly at risk;[342]

    b. The NHS Cancer Programme monitored and published regular data on the recovery of cancer services broken down by age, gender, ethnicity and deprivation, to monitor health inequalities. The data suggested that initially those most at risk of Covid-19 had been slower to return to services (as measured by GP urgent referrals). But these effects were no longer significant/discernible or were below pre-Covid levels by Quarter 1 of 2022/23;[343]

    c. In Mental Health services, the Equality and Health Inequalities Impact Assessment for secondary care to mitigate adverse impacts of video consultations, for adults and then children and young persons;[344]

    d. The Vaccines Equality Tool encouraged equal uptake of vaccines in all communities – to be explored further in Module 4.[345]

205. SP/5 contains information on steps taken to improve data collection and dissemination across the NHS in relation to disability, and continuing work.

206. NHS England accepts that the overall effect of the pandemic has been to exacerbate health inequalities and outcomes.[346] Restrictions or delays in accessing NHS services risk further entrenching these divisions. NHS England, supported by the analysis and insights from organisations including the NHS Race and Health Observatory[347] will continue to focus on addressing health inequalities as part of the ongoing NHS recovery (as discussed further below).

*The NHS workforce and racial injustice*

207. The second dimension of health inequalities concerns the NHS in England as an employer (the largest employer in England), and specifically the issue of racial discrimination and inequality within the NHS. There are about 200 nationalities employed in the NHS today, with staff from a

BAME background making up over 20% of the NHS workforce. Those members of staff are also more likely to have experienced inequalities in their lives which may impact on overall health.[348]

208. Risk assessments are addressed above. As Prof Powis stated:

> *"So of course the intent of the risk assessments that were undertaken was to identify those that were at the highest risk and working in the highest risk circumstances and, where appropriate, provide redeployment. That was the intent. That was the purpose of this exercise. And I'm sure that happened in many, many cases but it may not have happened everywhere. This, of course, is a responsibility for local organisations, with NHS England, NHS employers and others providing the guidance and the tools to do it.*
>
> *We did see in the staff survey, again, as I've mentioned, reporting from over the period October 2020 that in the round staff felt their health and well-being was more supported compared to previous, although that dropped off again the year after. And I think do think one of the lessons perhaps for us specifically is around, in a future pandemic, understanding more the impact of those assessments at local level as well as just whether they were undertaken."*[349]

209. Support to staff is dealt with generally by Prof Powis[350] and by Dame Ruth May; the contents are not repeated.[351] There were concerted efforts to engage with staff groups representing frontline staff most at risk in the pandemic, through a range of mechanisms.[352] Dame Ruth's statement details the steps that were taken as a result of engagement.[353] The value of some of this work has been acknowledged in evidence, e.g. by Mr Fernando of the Filipino Nurses UK Association, speaking of Dame Ruth May and Ms Coghill's[354] engagement with the Association. NHS England submits that the focus on these actions, their intent and their outputs, in terms of the work on staff risks assessments for example, are such that it would not be fair to describe them as "*tokenistic*".[355]

210. As a long-term contribution, NHS England also highlights the establishment of the NHS Observatory on 30 May 2020. It had been planned prior to the pandemic, but the plans were not shelved. The differences between it and NHS England on the manner on which it announced its concerns about pulse oximetry in December 2020 highlights the independence of the Observatory.

211. In relation to NHS leadership and training, Prof Powis acknowledged the need for NHS leaders to be more representative of NHS staff and of the communities that they serve.[356] He noted that some progress is being made and that "*We at NHS England are working hard to rectify that, to support people, to mentor people, to get into a position where they're in those senior roles and I know many organisations across the NHS are doing something similar."* This is built into WRES.[357] WRES reports are publicly available, the most recent being from 2023,[358] and contain important information to challenge the NHS and to spur change, on standards such as the relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants.

212. Staff insecurity, particularly in outsourced roles, and that outsourced workers are disproportionately more likely to be migrants and/or from BAME backgrounds, was highlighted.[359] Professor Sir Chris Whitty stressed the importance of safe places of work for all, and that there was work to be done on securing adequate training for those who performed key

roles but were not patient facing. He added: "*I worried throughout the pandemic as to whether we were dealing with the financial situation of people who were not on an employed basis. Permanently employed basis was optimal.*"[360] He acknowledged that this was a topic for further consideration in advance of any future pandemic. NHS England agrees.

213. There was criticism of the lack of NHS or NHS England data on ethnicity and race. Ethnicity is captured in the NHS Electronic Staff Record. The system for capture of this information in the case of staff deaths was addressed by Prof Powis.[361] Prof Powis further noted that ethnicity data for NHS staff deaths would be collected in a similar manner, in the event of a future emergency.[362]

214. None of these observations, illustrating aspects of the pandemic response, are intended to deny that more needs to be done. Thus the Impact Assessment[363] described the limitations of health and wellbeing initiatives for BAME staff, for example.[364] In particular, NHS England acknowledges:

    a. The serious nature of the evidence that staff from BAME backgrounds were discriminated against in the pandemic, in terms of matters such as access to adequate and suitable PPE or deployment to more risky positions.

    b. The disadvantages suffered by those whose employment was precarious, and the fact that they were more likely to come from minority groups.

    c. The ongoing issues relating to the fair and equal treatment of staff in the NHS, tracked by data such as that captured in WRES.

215. All of these issues represent not only injustices but were, and remain, deeply corrosive of staff trust. Speaking of such matters, Prof Powis stated *"I should emphasise it is of highest importance for us in NHS England that we address this."*[365]

216. Experiences of ethnic minority staff, and staff from disadvantaged backgrounds, during the Covid-19 pandemic prompted NHS England to publish the 'NHS equality, diversity, and inclusion plan' in 2023. The plan defined six 'high impact actions' which NHS employers could take to address the impacts of discrimination and bias in the workplace. Annual WRES and Workforce Disability Equality Standard ("WDES") reports continue to promote targeted, organisation-specific actions to help improve the experiences of staff from ethnic minorities or with disabilities.

## Conclusion

217. NHS England hopes that these observations have been helpful and looks forward to the Inquiry's Report.

NHS ENGLAND

20 December 2024

ENDNOTES

[1] Professor Powis said "*Frankly, I was personally terrified, terrified that the NHS was going to be overwhelmed and doctors were going to be placed in a position, and other clinicians, where they would not be able to make the professional judgment that they usually make in terms of treatments and escalation.*" [28/89/25].
[2] Available at https://www.matneo-recommendations.nhs.uk/home
[3] AP/1 paras 61-93. Witness statements of NHS England Module 3 evidence from Amanda Pritchard, Professor Stephen Powis, and Dame Ruth May have been referred to by initials and statement number (e.g., AP/1 being Ms Pritchard's first witness statement).
[4] See AP/1 INQ000409250 at Section 1, as well as the M1 statement INQ000177805.
[5] AP/1, paras 104-172.
[6] AP/1, Annex 5.
[7] Module 1 Report, paras 4.14 and 4.16.
[8] See the NHS England Pandemic Flu Plan INQ000113189/7-8. This sets out objectives, including to provide treatment and care to patients in the pandemic; to maintain business as usual as much as possible, and to minimise, as much as possible, the impact of the pandemic.
[9] Prof Edwards report para 58 INQ000113189.
[10] INQ000113205, para 152 of AP/1.
[11] INQ000113308.
[12] SP/4, para 344.
[13] INQ000339027/2 para 6, RCGP Statement.
[14] INQ000470668/18.
[15] AP/1 para 119.
[16] INQ000399545 paras 12-19
[17] AP/2 at para 130 and 29/71/17-87/7
[18] 29/85/2.
[19] SP/4 paras 1318-1325; 1347.
[20] 24/9/3-11/5.
[21] See for example INQ000470533/25.
[22] INQ000474283/183.
[23] See the NHS England Pandemic Flu Plan INQ000113189/17, which sets out the need to plan for recovery from an early stage.
[24] 29/90/23-94/4.
[25] 24/65/4-64.
[26] INQ000474244/6-7.
[27] AP/2 paras 328-330 and 530-600, SP/4 paras 112-116 (as well in M2 INQ000116811 paras 133, 181-194, 213 and Lord Stevens' personal statement INQ000280647 paras 31-33).
[28] AP/2 para 533.
[29] INQ000144792, at paras 37 and 170-171, and INQ000489907, at paras 5.10-5.15.
[30] See the details set out at para 31 of INQ000280647 (Witness statement of Lord Stevens, Module 2). HMT advised the Chancellor on 9 March 2021 that the policy represented the best value for money of all the capacity options INQ000412069/3.
[31] 29/74/18.
[32] INQ000477436, paras 86-87.
[33] AP/2 para 349a and b.
[34] See paper to NIRB of 1 May 2020 INQ00027009/3-6.
[35] INQ000270006/17 and 28, paper of 21 Feb 2021.
[36] QEH Hospital, Birmingham INQ000477597, para 72; Bradford Royal Infirmary INQ000421793, para 79; Gloucester Hospitals NHS FT INQ000477448, para 36.
[37] INQ000477597 at para 76.
[38] INQ000270006/4.
[39] INQ000270099/3.
[40] INQ000270006/25.
[41] INQ000270099/3.
[42] INQ000376769, witness statement of Matthew Fowler, para 21.
[43] INQ000399545, para 62.
[44] INQ000381156/6, witness statement of Louise Ansari para 13; INQ000251928/20-21, witness statement of Rob Behrens, para 9.
[45] INQ000399545, para 62.
[46] We observed: "*For the figure of 5% who were expected to be unable to return to their homes and might need a commissioned bed for ongoing care, including in a care home, see para 2.5 (p7) of the Covid-19 Hospital Discharge Service Requirements, 19 March 2020 [INQ000049702].*"
[47] See for example the evidence of Dr Prentice on behalf of NHS England in Module 1: INQ0001777805 at paras 302, 303.
[48] See AP/2 paras 1145-1233, page 286-312, and oral evidence of Prof Powis 28/158/13 - 28/159/7.

[49] See AP/2 INQ000409251 paras 1033-1144, page 259-285 and Ms Pritchard oral evidence 29/122/17-29/130/2.
[50] 29/122/23.
[51] 29/123/7-12.
[52] 29/125/19 - 29/127/21.
[53] 29/122/20.
[54] 29/133/4-5.
[55] 28/13/17-22.
[56] 29/129/7-19.
[57] 29/128/16 – 29/129/6.
[58] Professor Ball's evidence at 28/2/8.
[59] 29/128/7-15.
[60] SP/4, paras 712-836.
[61] 28/138/20
[62] SP/4, para 717
[63] SP/4, para 737-751
[64] SP/4, para 743-751
[65] 8/11/24
[66] SP/4 para 746-748
[67] SP/4 para 751
[68] SP/4 para 749
[69] SP/4 para 786
[70] INQ000056221 para 10 - 13("*The public announcement would also need to contain a clear direction for people at home not to call NHS 111 unless their symptoms were serious.*")
[71] 36/89/8
[72] 39/62/10
[73] 28/146/14
[74] SP/4 at paras 828-832.
[75] 28/145/2-28/150/6
[76] SP/4 at paras 811-814.
[77] SP/4 at paras 567-711.
[78] SP/4 para 569.
[79] SP/4 para 572.
[80] INQ000474285/10 para 23.
[81] 14/46/2.
[82] AP/1, para 114
[83] AP/1, page 28.
[84] INQ000113227.
[85] INQ000178125.
[86] INQ000198729/16.
[87] INQ000146032
[88] INQ000146032/110.
[89] INQ000114246.
[90] INQ000114246/25 para 79.
[91] INQ000114246/30 para 84.
[92] SP/4 paras 707, 710.
[93] SP/4 para 684
[94] 14/37/15-14/41/4.
[95] 14/42/6-22.
[96] 14/93/1.
[97] 14/36/13.
[98] INQ000421939/36, para 134.
[99] INQ000421939/36, footnote 8.
[100] 14/87/43-14/87/44
[101] 14/87/17 - 14/93/8
[102] 23/106/11-23/106/13
[103] INQ000474285/25 para 78
[104] INQ000474285/24 para 70
[105] INQ000087305
[106] 29/133/4-17.
[107] SP/2 para 477 onwards.
[108] INQ000270082.
[109] 28/6/11-18.
[110] INQ000227427 (letter from CNOs of the Four Nations, CEO of the NMC and RCN outlining the need for team working, 25/03/20); this was supported by a Speciality Guide for the Critical Care Workforce. See

INQ000421219 and RM/1 at para 171: "*In theory, this meant that to ensure as many patients with Covid 19 as possible could receive critical care at times when units were under extreme pressure in terms of demand, units could implement a ratio of up to one trained critical care nurse for six level 3 patients, with support from four other registered nurses and a further team of four HCSWs.*" See also "Advice on acute sector workforce models during Covid-19" INQ000269986/9-010

[111] INQ000269986

[112] Paragraphs 720 to 827 of AP/2 and paragraphs 274 to 332 of SP/3.

[113] Spotlight Trust at paras 84 – 86 INQ000477597.

[114] AP/2, paras 624, 963-964.

[115] AP/2, paras 482-483.

[116] AP/2 para 489.

[117] AP/2 paras 488 – 512

[118] 28/180/8-14.

[119] See also AP/2 para 833 (Dec 2020 learning).

[120] Both in SP/3 at paras 756 to 801 and orally 28/182/22-28/183/20.

[121] Transcript 15/99/4-5.

[122] RM/1, paras 180-189.

[123] E.g., the example at INQ000087382 which is appended to a letter dated 31 March 2020 and is the version which came into force on 2 April 2020; or the granular dashboard shown in evidence on 7/11/24: INQ000485652.

[124] 28/73/5-28/74/12 and 28/78/8-25.

[125] 28/79/17-21.

[126] 29/113/6-12; also see 29/109/21-29/110/9.

[127] 28/68/16-28/69/4.

[128] INQ000087317/2.

[129] 28/80/17-28/81/8.

[130] INQ000474255/23 para 35; 15/64/11-22.

[131] INQ000087305.

[132] 29/113/12-21; 29/116/12-29/117/19.

[133] INQ000092217.

[134] 29/109/21-29/110/9.

[135] 29/117/9-10.

[136] 29/117/17.

[137] INQ000480139/1-2, para 2.1.

[138] 14/140/7-14.

[139] 29/110/23-24.

[140] 29/111/12-24.

[141] INQ000250242.

[142] INQ000399545/15-16, para 24

[143] INQ000497473/3-4, paras 4-7.

[144] 29/108/10-29/109/6.

[145] INQ000472300/14, para 42.

[146] See (in England): Maidstone & Tunbridge Wells INQ000490123 at para 41; Queen Elizabeth Hospital, Birmingham INQ000477597]at para 191; Barts Health NHS Trust INQ000471161 (paras 72, 187 – 188); Manchester University Hospitals NHS Foundation Trust INQ000478213, para 298; Cumberland Infirmary Carlisle INQ000471398, paras 130 – 131; South Warwickshire University NHS Foundation Trust INQ000472879, paras 199 – 200; Royal Cornwall Hospitals NHS Trust INQ000474039, paras 210 – 215; Bedford Hospital INQ000474436, paras 124 – 145; West Hertfordshire Teaching Hospitals NHS Trust INQ000477511, para 74; King George Hospital BHRUT INQ000477351 paras 232 – 234; Lewisham and Greenwich NHS Trust INQ000474214, paras 6.46 – 6.47; Gloucester Hospitals NHS Foundation Trust INQ000477448, para 147; Bradford Royal Infirmary INQ000421793, para 382 – 386; University Hospitals Leicester NHS Trust INQ000474221, paras 176, 180.

[147] INQ000477351/52-53 paras 232-234.

[148] INQ000474221/39,40 paras 176, 180.

[149] INQ000474217/44-45 paras 37.14, 38.1.

[150] INQ000421793/75-76 paras 382-386.

[151] INQ000480139/10-11 para 7.6.

[152] 15/7/13-15/8/8.

[153] 19/104/24-109/16.

[154] 28/91/22-93/24

[155] INQ000087543.

[156] 28/90/23.

[157] 28/18/12.

[158] SP/3 paras 47, 182-213, page 262-267 (Annex); SP/4 paras 439-45, and in oral evidence 28/98/8-108/1.

[159] INQ000479043 paras 263-268.

[160] SP/3 para 182.
[161] 19/10/9 onwards.
[162] SP/3 paras 187-190.
[163] 18/32/12-34/14.
[164] For example, Dame Ruth May recalls the issue being raised directly with her by the media in a No. 10 press briefing on 3 April 2020: INQ00047904 para 364.
[165]28/100/20 – 25/102/15
[166] INQ000235492/41.
[167] INQ000216427.
[168] INQ000192705.
[169] INQ000479043, paras 363-368. (SP/3 Appendix 1 provides a list of all the guidance issued; see also paras 191 – 214)
[170] 12/200/12-202/3.
[171] INQ000251928 paras 3.3(a)-(c).
[172] 6/77/14.
[173] INQ000421184.
[174] INQ000421184/4.
[175] INQ000421184/16.
[176] INQ000235491.
[177] INQ000235492.
[178] SP/3 paras 205-212 (especially paras 206 and 207, pp 59-60).
[179] 28/107/8.
[180] SP/3 para 201, transcript 28/104/8.
[181] See too the observations of Prof Wylie 20/30/15-20/31/21.
[182] 29/27/1.
[183] SP/4 at Section 3.2, paras 884-1016.
[184] From 28/130/2.
[185] SP/4 para 899, 903, 970 – 975.
[186] SP/4 para 979.
[187] SP/4 paras 894, 966.
[188] 28/133/10-136/2.
[189] SP/4 para 968.
[190] SP/4 paras 979-1010.
[191] INQ000509890,
[192] See SP/4 paras 928-930 and para 977 in particular.
[193] See SP/4 paras 942-948, and 950-961 on governance and evaluation.
[194] 28/137/20.
[195] 28/133/10.
[196] INQ000470534.
[197] INQ000438237.
[198] SP/4 para 1009.
[199] Closing statement on behalf of Academy of Medical Royal Colleges, 40/89/20
[200] https://www.who.int/director-general/speeches/detail/who-director-general-s-remarks-at-the-launch-of-the-through-the-air-transmission-report---18-april-2024 (Copy can be supplied); WHO presentation at the launch of INQ000492325.
[201] Rules of engagement will apply (as they do in other stakeholder forms), which will include a code of conduct regarding behaviour. Those who seek to engage in abuse behaviour including personal attacks will not be permitted to remain on stakeholder groups. NHS England notes the comments by the Director General when launching the April 2024 Through the Air Transmission report that the debate was sometimes polarised, negative, over-simplistic and hampered constructive discussion: a copy of which will be provided to the Inquiry.
[202] SP/4, Section 3 paras 333-596.
[203] INQ000421939 and 5/62/12 and INQ000479043 paras 222-307.
[204] As clarified to the Chair during Dr Ritchie's evidence, the position of the WHO remains that whilst aerosol is a route, it is not the dominant route – 5/90/14 5/91/5.
[205] Module 1 8/126/23 – 8/127/3.
[206] 7/77/23 – 7/78/10.
[207] This is addressed in the WHO "Through the Air transmission report" dated 18 April 2024 INQ000492325.
[208] 28/124/1.
[209] 28/125/3.
[210] INQ000474282/111 at para 11.17.
[211] INQ000474282/117 at para 11.32.
[212] The regulation sets out steps which should be taken together with an order of priority.
[213] Brunt: INQ000421939/17-18; : SP/3 paras 335-339; Dr Ritchie INQ000347822 para 49 and para 356.
[214] SP/5, paras 37 – 45.

[215] INQ000226890.
[216] INQ000474276/113-114 recommendations vii and ix.
[217] INQ000474664.
[218] HTM 03-01: Specialised ventilation for healthcare premises INQ000130579.
[219] INQ000474282/29-30; INQ000492301; INQ000130552; INQ000330824.
[220] INQ000330850.
[221] The Inquiry has heard evidence from Professor Susan Hopkins regarding the real-world differences between FRSMs and FFP3 masks (7/91/8). Whist FFP3 masks are used by some staff routinely, many staff would not have been used to these masks or been fit tested for them previously thus decreasing their potential efficiency.
[222] INQ000474282/31 see paras 1.71-1.75 and INQ000347822 at para 312.
[223] NHS England understands that the re-procurement exercise did not take place; but the Business Case for the planned replacement in 2016 (dated 28/10/2015 at INQ000101067 from Module 1) includes the provision that suppliers "would be required to bid with a range of shape/style/size/fit ... that it can demonstrate (in accordance with good industry practice) will fit the maximum possible face shapes".
[224] INQ000479043/16-17 and /57.
[225] Issues regarding the diversity of PIPP stockpile should be further explored as part of Module 5.
[226] INQ000474282/31 see para 1.72.
[227] 28/27/167.
[228] 28/50/9.
[229] INQ000474282/78-79;12/137-12/140, 12/141-12/144, 12/125-12/148, 12/149-12/152; and 7/89-7/96.
[230] The Smile Free Campaign contacted NHS England expressing opposition to universal masking in the NHS including a letter stated to signed by over 2,000 healthcare workers, over 181 scientists and more than 6,500 patients/members of the public who agreed with their campaign.
[231] INQ000330923 and the RM/1 at para 307.
[232] 40/25/6.
[233] See for example INQ000348359/17 (dated 27 April 2020), which states "*Please note that this guidance is of a general nature and that an employer should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work etc. Act 1974*".
[234] INQ000339237/11.
[235] INQ000421939/37.
[236] 12/146/9-12/146/12.
[237] INQ000416768 and INQ000421939/38.
[238] INQ000421847.
[239] 6/7/20-24.
[240] 40/154/24-40/155/3.
[241] Chaired by Dr Ritchie (NHS England) June 2020 until 31 March 2021 and thereafter by Dr Eleri Davies (PHW).
[242] Individuals representing each of the four nations, national agencies or organisations, would forward any collective decisions taken by the UK IPC Cell through to the responsible lead in their own national clinical governance structure. See the evidence of Northern Ireland, Professor Charlotte McArdle 7/10/18-24.
[243] 3/79/11-3/80/7.
[244] INQ000408934/2; Professor Susan Hopkins' evidence to the Inquiry set out how the evidence base regarding the mode of transmission evolved.
[245] 7/139/25-7/140/5; 7/141/23-7/142/1.
[246] INQ000075022.
[247] Ibid: "*If an unacceptable risk of transmission remains after rigorous application of the hierarchy of control it may be necessary to consider the extended use of RPE for patient care in specific situations.*"
[248] INQ000120671.
[249] The report also states *"epidemiological evidence (usually of low or very low certainty) from SARS-CoV-2 and other respiratory viruses suggests that, in healthcare settings, N95 respirators (or equivalent) may be more effective than surgical masks in reducing the risk of infection in the mask wearer (low confidence); and evidence, mainly from laboratory studies, suggests that face coverings should be well-fitted and cover the mouth and nose to increase effectiveness (as fit is a limiting factor in the overall mask protective efficiency independently of the filtration efficiency of its fabric) (high confidence)."*
[250]Ms Imrie stated that supply was a consideration which was "discussed numerous times across the course of the pandemic" [26/150/11-13]; see also the evidence of Mr. Hancock at 36/111/5. The fact that supply was considered throughout the pandemic, does not mean that those drawing up the IPC guidance considered supply in making their recommendations. Mr Hancock acknowledged that his evidence was based on impression, second hand and not within his direct knowledge 36/111/20.
[251] INQ000330890 (paras 428-466) e.g. webinars (437) and 10 Key Actions on IPC, para 457, Every Action Counts (para 462). See also paras 437, 440, 459. See Dr Ritchie INQ000421939, paras 164-166.
[252] Around a third of the guidance was issued on a Friday and this was typically early during the pandemic.
[253] Evidence of Prof Simon Ball 28/25/4-8.
[254] INQ000381163/4.

[255] 12/140/14-12/145/17 and 7/82/18-7/87/24.
[256] SP/3 Section 3 (paras 340 – 350, paras 514 – 536).
[257] SP/3, para 528.
[258] SP/3: para 811 onwards.
[259] Set out at SP/3 paras 822 – 835.
[260] 28/171/21-23.
[261] For example, INQ000331022 – 30 April 2020.
[262] INQ000330971.
[263] INQ000330949/7.
[264] INQ000330873; see also SP/3 at para 823.
[265] 28/172/11-13.
[266] 29/192/16-20.
[267] 29/192/25-29/193/1.
[268] Health and Safety at Work Act, s3.
[269] SP/3, paras 678-702.
[270] RM/1, at paras 349-361.
[271] SP/3 para 702.
[272] 28/38/16-40/21.
[273] 8/121/13-15.
[274] 28/115/2-116/1.
[275] 6/71/19-76/15, in particular 6/73/6-12.
[276] Paragraph 221 of the Inquiry's Expert Report, INQ000474255_0084, acknowledges the need for continued variations in guidance, as well as for allowing discretion to local providers.
[277] See for example INQ000477597/50 (para 165) and INQ000421793/69 (para 351).
[278] 40/209/20-22.
[279] See SP/3, paras 689-691.
[280] SP/5, para 13.
[281] SP/5, para 17.
[282] 40/162/22.
[283] INQ000280496/4.
[284] 28/119/20.
[285] 6/71/17-76/15; 6/88/24-6/90/13.
[286] 16/14/53-54.
[287] RM/1, paras 350 -351.
[288] 28/108/5.
[289] 28/109/18-111/11.
[290] SP/3, para 240.
[291] AP/2 para 186.
[292] SP/4, section 2.1.
[293] INQ000087325.
[294] SP/4 paras 344, 373-382.
[295] INQ000470428, INQ000470438.
[296] SP/4 para 384.
[297] Saffron Cordery statement INQ000401270/50 para 191.
[298] INQ000477304, para 485.
[299] Report of Prof Adrian Edwards, INQ000474283/39, para 120.
[300] INQ000470387.
[301] INQ000087325/12.
[302] Oral evidence of Prof Adrian Edwards 9/32/15-33/22.
[303] INQ000470458.
[304] INQ000051407.
[305] Report of Prof Adrian Edwards, INQ000474283/93, para 324.
[306] Report of Prof Adrian Edwards, INQ000474283/42, para 136.
[307] 20/111/8.
[308] INQ000470533/8.
[309] INQ000339027/19-20, paras 97-100.
[310] https://www.pulsetoday.co.uk/resource/politics/in-full-nhs-englands-press-release-about-face-to-face-gp-consultations/
[311] See SP/4 paras 552-553.
[312] INQ000485255.
[313] See SP/4, paras 314-328 on public messaging.
[314] INQ000391358, paras 5, 50-53.
[315] See further SP/4 para 429-435, 471-472.
[316] INQ000477304, para 488.
[317] SP/3, paras 322-331.

[318] SP/3, paras 531-534.
[319] SP/4, para 569.
[320] https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/ (publicly available); this commits almost £13 billion to community pharmacy through its contractual framework, with a commitment to spend £2.592 billion over five years from 2019-2024. The significant investment recognised the contribution that community pharmacy has committed to making towards the delivery of the NHS Long Term Plan, and, in line with the GP contract, providing 5-year stability and reassurance to community pharmacy, enabling long term business decisions.
[321] See for example INQ000330885 especially pages 6-7.
[322] SP/4, para 1017 and from 28/163/12.
[323] INQ000410237/63, paras 4.106-4.107.
[324] 28/165/3.
[325] 12/24/17.
[326] INQ000232195, para 7.
[327] INQ000232195/4.
[328] 28/164/15.
[329] 28/164/9-167/2.
[330] SP/5, from para 22.
[331] INQ000226890/50.
[332] Schedule 4, NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.
[333] 28/168/8.
[334] 29/173/24.
[335] SP/5, at para 10.
[336] INQ000195843.
[337] M1 Hearing Day 4/5/8-24.
[338] SP/4 para 1626.
[339] See for example paras 67-69 of INQ000195843 (Bambra/Marmot).
[340] 28/156/12-22.
[341] NHS England uses this term in these Submissions as a shorthand. It is very conscious of the fact that, as set out in paragraph 1256 of SP/4 that the term 'Black, Asian and Minority Ethnic' denotes a number of strikingly different ethnic, cultural and religious groups, with different concerns and support needs. But it has been necessary to generalise in these submissions.
[342] SP/4 paras 1250-1252, see also targeted actions set out at SP/4 paras 1254-1256.
[343] SP/4 para 1378.
[344] SP/4 para 1752.
[345] Discussed in AP/2, para 411 and SP/4, para 1909.
[346] SP/4 para 1928.
[347] SP/4 para 1929.
[348] SP/3 at para 804.
[349] 29/23/16-29/24/10.
[350] Section 4 of SP/3 (para 802 - 845).
[351] INQ000479043 at paras 179-189.
[352] See the evidence of Dame Ruth May INQ000479043 at paras 59, 60 and 207-217, as well as Professor Powis at 29/18/19-29/19/24.
[353] See for example INQ000479043, paras 212-213.
[354] Yvonne Coghill was then the Vice President of the Royal College of Nursing and National Director of the NHS Workforce Race Equality Standard. The acknowledgment that "*Mr Fernando attributes much support to Ms Coghill and Ms May*" is contained in the statement on behalf of FEMHO, INQ000399526 para 19.
[355] FEMHO statement at INQ000399526 para 73- 78.
[356] 29/21/23-29/22/14.
[357] SP/4 at paras 243-244. It was Ms Coghill, the-then Director of the WRES Implementation Team on 7 April 2020, who first raised the disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities in the context of reported staff deaths with Dame Ruth May on 7 April 2020 (Statement of Ruth May, para 209).
[358] https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/
[359] For example, by the impact evidence of 9 October 2024. The witness believed that she worked for a private hospital 18/9/5, but the points were still of general relevance.
[360] 12/181/8-12.
[361] SP/3, paras 875-892 and SP/5, paras 30-31.
[362] SP/5 INQ000474664, para 31.
[363] Summarised at paras 836-840 of SP/3.
[364] Professor Thomas, on behalf of FEMHO, asked Professor Powis whether support initiatives for BAME staff were evaluated for their effectiveness 29/21/4-8. This is an example of such evaluation.

[365] 29/23/2-4.