Witness Name: Julian Kelly
Statement No: 1
Exhibits: JK1/001 – JK1/114
Dated: 23 December 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JULIAN KELLY

CONTENTS

I, Julian Kelly, will say as follows:

Introduction

1. Responding to the pandemic has been the single biggest challenge that the NHS has faced in its history.

2. During January and February 2020, existing emergency response structures across government and NHS England were mobilised in response to Covid-19. In particular, in January 2020, the NHS England Emergency Preparedness Resilience and Response ("**EPRR**") function followed its processes for responding to an emerging threat, and on 30 January 2020 NHS England declared a Level 4 Incident. All sectors of government prioritised activities to respond to the emergency and 'normal' processes were disrupted, or adapted or new ones built to meet these challenges.

3. In response to this declaration, the role of NHS England changed as it performed its role as a Category 1 responder and co-operated and collaborated in the national effort, supporting others in their roles.

4. In terms of the scope of Module 5, NHS England generally did not procure key healthcare equipment and supplies but did procure other equipment/supplies on a national basis as set out in this statement. On a practical level, NHS England was available to provide advice, resources and information that central government could use in making procurement decisions..

5. Procurements of all key supplies and equipment were affected at the time by the fact that Covid-19 was a new, global virus and that demand for key healthcare equipment and supplies was increasing on a global basis. This led to a 'suppliers' market' as global demand outstripped the goods available and buyers sought to secure items against rapidly increasing global prices.

6. NHS England is in the process of learning lessons from the pandemic response. NHS England now has a 'disease agnostic' protracted incident plan for the NHS that builds on the pandemic learning. Lessons are shared and when implemented are often implemented across a range of responders.

Corporate witness statement

7. I have been the Chief Financial Officer for NHS England since 1 April 2019 and latterly also Deputy Chief Executive.

8. I was in post throughout the Covid-19 pandemic, an NHS England Board Member and member of National Incident Response Board ("**NIRB**"), the latter group I chaired in the absence of the COO.

9. Prior to joining NHS England, I was Director General Nuclear, leading the Defence Nuclear organisation at the Ministry of Defence. Prior to this I was Director General of Public Spending and Finance at HM Treasury and have held a number of other senior roles including with the UK Border Agency, and in the private sector.

10. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The request received on 24 May 2024 pursuant to Rule 9 of the Inquiry Rules, specifically relating to Module 5 of the Inquiry (the **"Module 5 Rule 9 Request"**) to NHS England is broad in scope and time period and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (both current and former NHS England employees) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

11. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England, references throughout to 'NHS England'[1] and 'we' represent the voice of the organisation. I have referred to all individuals (including myself) in the third person, by job title and, where appropriate, by name.

12. This corporate statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement therefore provides a 'high level account', and is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this

[1] This response represents NHS England as a legal entity prior to the merger with NHS Digital and Health Education England

statement if it was available before the deadline for its production, or if experience suggests that the Inquiry would wish to see a more detailed discussion of any particular issue.

Approach to the Module 5 Rule 9 Request

13. NHS England welcomes the chance to assist the Inquiry to understand and examine the key issues it has identified as in scope for Module 5 (and in subsequent engagements with the Inquiry team).

14. This statement is premised on the basis of the Inquiry being interested predominantly in the procurement of key health care equipment and supplies which it has listed as PPE including RPE (eye protection, face shields, fit test kits, gloves, masks (including Type IIR, FFP2 and FFP3) shoe protectors, scrubs, aprons and gowns), ventilators and oxygen, lateral flow tests and PCR tests. NHS England has therefore not provided detailed information on procurements undertaken on other goods and services, although some general information on what it did procure during this period is included.

15. We also understand that the scope of Module 5 does not extend to procurements undertaken in relation to healthcare services. Also, that procurement for supplies for the vaccination programme or the creation and running of the Nightingales are excluded on the basis that they are covered in other modules. NHS England wishes to make it clear that it did procure certain key health care equipment and supplies for these programmes but this statement does not provide information given their exclusion from the scope of Module 5.

16. This statement primarily addresses the role of 'NHS England' during the Relevant Period and its role and functions during this time. Where we encompass or address the functions or response of any of the now merged legacy bodies, we highlight this.

Outline of this corporate witness statement

17. This statement contains responses to topics and questions set out in the Module 5 Rule 9 Request. As suggested by the Inquiry, the statement adopts its own structure whilst aiming to answer the Inquiry's requests for information comprehensively.

18. The Inquiry has asked a number of questions in its Rule 9 Request to facilitate understanding and contextualise NHS England's role generally and in particular in the health procurement landscape. The Rule 9 Request also asks more specific questions about certain supplies and processes. To support reading of this statement it is structured in three parts:

a. Part 1 – provides background information on NHS England's and others' roles within the healthcare system, NHS England's role in relation to procurement generally and during the pandemic and its role in relation to procurement within the wider NHS. It also covers how NHS England worked with other bodies during the pandemic.

b. Part 2 – deals with specific matters as follows

   i. PPE

   ii. Testing

   iii. Ventilators

   iv. Oxygen

c. Part 3 – identifies lessons learned from the pandemic.

19. In order to understand how NHS England's role changed during the pandemic and the broad reasons for that change, it is helpful to understand NHS England's role pre-pandemic. This has largely been set out in NHS England's First Module 3 Statement. However, a brief summary is also set below in Section 1.

20. In this statement I have referred to NHS England, the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

21. Public Health England ("**PHE**") became the UK Health Security Agency ("**UKHSA**") in October 2021, midway through the pandemic, and is therefore referred to as PHE and UKHSA depending on the date of reference.

22. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this Statement unless otherwise stated.

23. Where this statement refers to "**NHS providers**", we are referring predominantly to providers of NHS health services unless stated otherwise.

PART 1

Section 1: Role of NHS England in Procurement

Executive Summary

24. Prior to and during the Relevant Period, NHS England was not a provider of health services, but principally a 'commissioner'[2].

25. NHS England was not responsible for the preparedness and response of the public health system, so stockpiles and community testing was not within its domain.

26. Whilst NHS England is therefore a contracting authority for the purpose of procurement law, it was not responsible for procuring key healthcare equipment and supplies during the pandemic for the NHS.

27. However, NHS England had emergency response duties and powers which enabled it to support the NHS and government to tackle supply issues and challenges. It also worked with multiple organisations and stakeholders during the Relevant Period.

28. NHS England made some purchases on a national basis in the interests of speed and to benefit the national response of dealing with Covid-19. These were exceptional spends which were necessary to support the sector and also benefitted the devolved nations.

29. This part sets out

    a. An overview of the NHS in England including key roles in relation to Module 5 including an explanation of how health services are delivered;

    b. Commissioning and contractual arrangements;

    c. NHS England's procurement obligations generally in relation to its own spend and the wider NHS;

    d. NHS England's procurement obligations during the Relevant Period in relation to its own spend and the wider NHS; and

    e. How NHS England worked with others during the Relevant Period.

Overview of the NHS in England

[2] NHS England's remit is now wider given the various mergers that have taken place.

30. In accordance with the framework established by Parliament, the NHS in England is not one organisation but an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly-funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care and community health. NHS England is part of that ecosystem and is not the same as 'the NHS in England'.

31. The NHS in England provides care free at the point of use[3]. It is funded by the tax-payer, with its budget set by HM Treasury ("**HMT**") and DHSC.

32. An explanation of some of the various bodies within the NHS in England is set out below.

NHS England

33. NHS England (formerly the NHS Commissioning Board) was legally established on 1 October 2012 and became fully operational on 1 April 2013, pursuant to the Health and Social Care Act 2012 (the "**2012 Act**") which amended the National Health Service Act 2006 (the "**2006 Act**") which remains the main piece of primary legislation governing the NHS. Annex 1 of NHS England's First Module 3 Statement provides an overview of the 2012 changes, also known as the 'Lansley Reforms'.

34. NHS England is an executive non-departmental public body sponsored by DHSC. NHS England is an Arm's Length Body as it is a public body established by statute with a degree of autonomy from SSHSC and is operationally distinct from DHSC. Before the start of each financial year, SSHSC issues an annual 'mandate' for NHS England setting out its objectives which NHS England must seek to achieve and its budget[4], which sets limits on the use of capital and revenue resources (in effect, this sets NHS England's financial allocation) (section 13A of the 2006 Act) (the "**Mandate**"). Certain resources are ringfenced by the Mandate meaning that those sums cannot be used for any other purpose, even if there is an underspend. NHS England is accountable to the SSHSC for the delivery of the Mandate.

35. NHS England is not

    a. a core political or governmental decision-making body;

    b. responsible for setting national health or public health policy; or

[3] Subject to certain mandated charges such as for prescriptions and dentistry.
[4] Budgets are no longer contained within the mandate; they are separately set out in financial directions.

c. a provider of patient services.

36. One of NHS England's core legal functions is to arrange for the provision of services for the purpose of the health service in England (section 1H (3) of the 2006 Act), a duty owed concurrently with SSHSC, and to conduct oversight of local commissioners and providers of those health care services. In other words, NHS England does not have a duty to deliver services directly to patients in its own right, but it does have a duty to ensure they are provided. Depending on the service, it may be commissioned at a national level by NHS England or (in the Relevant Period) at a local level by Clinical Commissioning Groups ("**CCGs**") (now Integrated Care Boards ("**ICBs**"). For example, NHS England contracts with certain specialised services providers for the delivery of highly specialised services (for example, certain types of transplant procedures) whilst maternity care is commissioned by CCGs (ICBs). These core functions do not however apply to that part of the health service provided in pursuance of public health functions.

37. Responsibility for public health sits with SSHSC and local authorities, and SSHSC exercised that responsibility through Public Health England ("**PHE**") (until UKHSA was established in 2021) and local Directors of Public Health jointly by local authorities. SSHSC also established 'NHS Test and Trace'. NHS bodies are those defined as such in the 2006 Act. The SSHSC can, exceptionally, describe an organisation as 'NHS' that is not an NHS body. This was the case with Test and Trace.

38. The SSHSC routinely delegates specific public health functions, such as vaccination and screening programmes, via Section 7A agreements, to NHS England on an annual basis. In the pandemic this was the mechanism by which SSHSC requested NHS England to undertake the Covid-19 vaccination programme.

39. In times of emergency, NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 meaning it has a duty to co-operate with a group of other named responders. NHS England maintains an EPRR Framework, together with several plans, not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

40. A more detailed explanation of the key individuals and key meetings relevant to the scope of Module 5 is set out within Annexes 1 – 3.

Department of Health and Social Care

41. In general, it is the responsibility of Government Departments to direct national strategy and set funding levels.

42. DHSC is responsible for setting policies that deliver the Government's strategic health objectives; and in turn for making sure the legislative, financial, and administrative frameworks are in place to deliver those policies (including the NHS Mandate). DHSC oversees the health and social care system through its agencies and public bodies, holding them to account for the implementation of agreed plans and commitments.

43. The DHSC is also responsible for social care and public health.

Public Health England

44. Public Health England ("**PHE**") was established as an Executive agency to DHSC. Its core role was to fulfil the SSHSC's statutory functions (primarily set out in sections 2A and 2B of the 2006 Act) to protect the nation's health, address health inequalities and promote the health and wellbeing of the people of England.

45. Prior to its dissolution on 1 October 2021, and the replacement of its functions primarily by the UKHSA and the Office for Health Improvement and Disparities, PHE was the body responsible for providing specialist health protection, epidemiology and microbiology services across England and collaborating with the health protection agencies (providing similar specialised services) in the devolved administrations.

46. Like PHE, the UKHSA is an Executive Agency with close ministerial oversight while still permitting "*independence in the delivery of policy advice*". As set out in the Framework Document between DHSC and the UKHSA, UKHSA "*will form an essential part of the UK's national security infrastructure, helping to protect the country from societal and economic shocks arising from pandemics and other external threats to health*", while bearing in mind that health is a devolved matter.

Regulators

47. Providers of healthcare services i.e., those that provide direct care to patients at an organisational and clinician level, are regulated by different regulators depending on their structure and the services being delivered. For the Relevant Period this included:

    a. the Care Quality Commission ("**CQC**"), the independent regulator for the quality and safety of care who oversees and inspects organisations that provide health and social care services **[JK1/001] [INQ000269886]**;

b. NHS Improvement[5] which oversaw Trusts for other matters as more fully described in Annex 1 of NHS England's First Module 3 Statement;

c. the Health and Safety Executive ("**HSE**"), the national independent regulator for health and safety in the workplace, including within health and social care settings **[JK1/002] [INQ000270069]**;

d. Medicines and Healthcare Products Regulatory Agency ("**MHRA**"), an executive agency, sponsored by DHSC, which regulates medicines, medical devices and blood components for transfusion in the UK; and

e. for clinicians themselves, the relevant healthcare professional bodies, such as the General Medical Council ("**GMC**") and the Nursing and Midwifery Council ("**NMC**").

Category of health services

48. Taxpayer-funded health services are commonly grouped into four broad categories, denoting the typical way in which a patient can experience the health system from first point of contact. These services are intended to act as an integrated system:

a. Primary care includes: general medical practice (GP), community pharmacy, primary dental care and primary optometry services. Almost all primary care providers are independent businesses operating in accordance with contracts commissioned by NHS commissioners;

b. Secondary care includes: planned (elective) care that usually takes place in a hospital (including specialised dental and ophthalmology), urgent and emergency care including 999, ambulance services, hospital emergency departments, and some mental health services. Secondary care is predominantly provided by public sector organisations such as Trusts but can also be provided by independent sector organisations under contract to the NHS;

c. Tertiary care includes: highly specialist care provided to patients who are referred from primary or secondary care services. Tertiary care includes neurosurgery, transplants, specialist stroke units and secure forensic mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations also provide this under contract to the NHS.

[5] NHS Improvement and NHS England worked together as a single organisation since 1 April 2019, to help improve care for patients and provide leadership and support to the wider NHS. NHS Improvement became part of NHS England in July 2022

Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

d. Community care includes: community nursing, community mental health services, health visiting, child health services and sexual health services. Community care is provided by a range of independent and public sector organisations. Commissioning of community care is a mixture of local authority and NHS commissioning.

Delivery of health services

49. As noted above, providers of the different groups of care range from public sector organisations e.g., NHS Trusts (established by orders of the SSHSC) and NHS Foundation Trusts (public benefit corporations),[6] to independent providers including charitable and other not-for-profit providers, and independent contractors (e.g., GP practices) including some for-profit organisations.

50. Trusts can operate multiple hospital and community sites.

51. On 31 March 2020 there were: 74 NHS Trusts, 149 Foundation Trusts, 6,771 GP practices in England. In 2019/20 there were approximately 11,800 community pharmacies in England.

52. As of 31 March 2022 there were 69 NHS Trusts, 144 NHS Foundation Trusts,[7] 6,499 GP practices, and approximately 11,500 community pharmacies in England.

53. NHS England's website publishes a provider directory.[8]

54. Independent sector providers provide services to the NHS under contract. Since 2014 they have been required to hold an NHS provider licence unless they are exempt. The NHS provider licence is used to regulate providers of NHS services and was regulated by NHS Improvement[9] during the Relevant Period. It sets out the conditions that providers of healthcare services, for the purposes of the NHS in England, must meet to help ensure that the health sector works for the benefit of patients.

55. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS

[6] The governance structure of Trusts is determined by statute.
[7] The number of Trusts varies due to NHS merger and acquisition activity.
[8] Please see https://www.england.nhs.uk/publication/nhs-provider-directory/
[9] Now NHS England following the merger between NHS England and NHS Improvement on 1 July 2022

workforce'.

56. To avoid doubt, the workforce of Trusts are not employed, or managed, by NHS England.

57. "Commissioning" is the continual process of planning, agreeing, funding and monitoring that services are delivered. For example, where NHS England commissions a service, it develops and issues a service specification, which forms part of a contract between NHS England and the relevant provider. Under this contract, the provider agrees to deliver the service in accordance with the service specification, in return for payment by NHS England.

Commissioning and contractual arrangements – general

58. There are around 4,000 commercial, procurement and supply management professionals in the NHS (including within NHS England) spending £30 billion across approximately 80,000 suppliers, including medical goods and services, office supplies, catering, cleaning and transport services.

59. During the Relevant Period, CCGs commissioned the majority of NHS services, including most hospital and ambulance services and NHS 111, whilst NHS England directly commissioned:

    a. primary care services; however, during the Relevant Period NHS England had principally delegated this role to CCGs for GP services[10]. NHS England, particularly through its regional teams, retained responsibility for commissioning dental, optometry and community pharmacy services;

    b. specialised services (often provided as part of tertiary care), which includes highly specialised services. These services, which are defined in statute, support patients with rare and complex conditions, and include services for high consequence infectious diseases ("**HCIDs**");

    c. military and veteran health services;

    d. health services that support children and adults throughout the youth justice and criminal justice systems in England;

    e. secondary care services from the Independent Sector; and

[10] By 1 April 2021 every CCG in England had these delegated responsibilities.

f. a limited number of public health services (working closely with PHE/UKHSA and DHSC) **[JK1/003] [INQ000270071]**.

60. Further details of commissioning in the context of the requirements of the 2006 Act, are set out in Annex 1 of NHS England's First Module 3 Statement.

NHS England's role in procurement for its own purchasing

61. As set out above, NHS England is a contracting authority for the purpose of the Public Contracts Regulations 2015 (the "**PCR**") and as such, is bound by them[11]. NHS England undertakes procurements for its own business and workforce needs. However, such purchasing would not generally include key healthcare equipment and supplies as NHS England does not *deliver* health services. The majority of NHS England's procurement needs relate to goods and services such as medicines (jointly with DHSC) digital services, corporate services, professional services, workforce, learning and development and communications. Details of central purchasing undertaken by NHS England are set out below at paragraphs 95 to 105.

62. As part of the Government's control of expenditure, NHS England is subject to specified expenditure controls and is bound by its standing financial instructions ("**SFIs**") (see **[JK1/004] [INQ000496973]** for those in place prior to the pandemic up to 31 August 2020)[12]. Together, these controls cover a range of expenditure categories and require proposed expenditure to be approved to secure best value for money and ensure efficiency is being maximised. For expenditure above certain thresholds in specified categories (including professional services and consultancy), onward approval is also required from DHSC and for some cases the Cabinet Office and/or HM Treasury. If the Government makes changes to these spend controls, this is communicated along with updated guidance and training, and the changes are reflected in the commercial and procurement systems to ensure the correct workflow is being followed.

63. NHS England's policy "*Tackling Fraud, Bribery & corruption: Policy & Corporate Procedures*" **[JK1/005] [INQ000496976]** sets out how NHS England tackles economic crime, provides guidance to officers (as defined within the policy as all employees of NHS England and/or any other parties who undertake business on behalf of, or representing NHS England) and sets out reporting requirements. The NHS Counter Fraud Authority, an independent special health authority, that works to identify,

[11] With effect from 1 January 2024, the PCR do not apply to procurements for certain defined health care services and NHS England instead procures using the Provider Selection Regime
[12] NHS England's SFIs were updated on 1 September 2020 to reflect the merger with NHS Improvement and again on 6 February 2023

investigate and prevent fraud and other economic crime within the NHS and wider health group, monitors NHS England's compliance with this policy. All individuals within NHS England have to declare any conflicts of interest on an annual basis which are approved by managers. These are then passed to the governance team who validate them. NHS England also has a hospitality and gifts policy.

64. NHS England also has a dedicated in-house Counter Fraud Team that investigates allegations of economic crime in the organisation.

65. NHS England's Commercial Delivery Team (previously the Procurement and Contract Management Team) supports NHS England teams (not the NHS in England) in the procurement of national clinical services, managed within its SFIs, and in line with its scheme of delegations with DHSC and in accordance with statutory and policy requirements.

NHS England's role in procurements for the wider NHS

66. As a commissioner, rather than provider, of health services, NHS England does not generally procure or purchase goods and/or services on behalf of NHS providers.

67. However, NHS England does procure national frameworks in relation to certain goods and services. Suppliers seeking a place on a procurement framework must go through a tendering process and meet certain requirements to be accepted. NHS providers can then place orders without running a lengthy, full tendering exercise and draw from the list of accredited vendors.

68. Procurement practice is again undertaken in line with the PCR and reflects policy requirements such as sustainability, prompt payment, and maximising SMEs and VCSE supply opportunities. Examples of frameworks/contracts secured by NHS England within the context of its statutory obligations are:

    a. Within the context of specialised commissioning, NHS England directly commissions 149 "Prescribed Specialised Services" within its annual budget allocation. NHS England operates at a national level to coordinate the commissioning of Prescribed Specialised Services, with regional working with healthcare providers to support delivery. The services commissioned support people with a range of rare and complex conditions and where the number of patients affected is small and the services they need are very specialist. Unlike CCGs (now ICBs) or local authorities who commission goods and services for their local populations, Specialised Commissioning focuses on purchasing

services from specific providers, irrespective of the originating population, ensuring equitable, national access to approved services and treatments. High-cost drug treatments or services are in this case inter-connected because of their bespoke nature – the drugs are developed for rare diseases in this group. Here, the medicines procurements in the sense of access arrangements by the negotiation of prices and volumes are exceptionally also part of Prescribed Specialised Services. NHS England provides reimbursement to providers who correctly use the frameworks/contracts put in place for these drugs/services.

b. NHS England procures national frameworks and contracts for the supply of high-cost drugs (including but not limited to specialised commissioning). NHS England centrally puts the arrangements in place for NHS providers to order and buy. Relatively recent examples include (i) direct-acting antivirals for the treatment of Hepatitis C; (ii) pre-exposure prophylaxis or PrEP to prevent HIV infection; and (iii) Adalimumab to treat inflammation of the joints.

c. NHS England undertakes procurements for directly commissioned services including, for example, contracts for the provision of orthodontic services.

d. Medicines Value and Access (previously the Commercial Medicines Directorate) supports patients to access the latest innovative and most clinically effective new medicines, while securing maximum value for the NHS and taxpayers. NHS England understands that medicines procurements do not fall within the scope of Module 5.

69. NHS England has been asked if it shares competence with any other body in relation to procurement within the scope of Module 5. NHS England understands that the question being asked is whether it shares responsibility with any other body in relation to its own procurements within the scope of Module 5. The answer to that question is that it does not. NHS England is responsible for its own procurements for goods and services.

Procurements and purchasing within the NHS in England

70. Purchasing and procurement decision-making falls to individual providers that are commissioned to provide health services in England, as they are separate, independent bodies. This would include decision-making around the procurement of key healthcare equipment and supplies, including in the event of a pandemic.

71. NHSE does not monitor the individual policies that Trusts put in place for dealing with conflicts of interests and tackling fraud, or their application, except where individual

cases are raised to it, for example, through whistle blowing or via Freedom To Speak Up; this is the job of Trust Boards.

72. NHS England has issued guidance on managing conflicts of interest in the NHS and this version was in effect at the time of the pandemic **[JK1/094] [INQ000533225]** but has since been updated. At the time, this guidance applied to CCGs, NHS Trusts and NHS Foundation Trusts and NHS England. Whilst the guidance confirmed that it did not apply to independent and private sector organisations, general practices, social enterprises, community pharmacies, community dental practices, optical providers or local authorities (as they are subject to different legislative and governance requirements), the boards/governing bodies of those organisations were invited to consider implementing the guidance as a means to effectively manage conflicts of interest and provide safeguards for their staff. It also confirmed that the requirements of GC27.2 of the generic NHS Standard Contract should be interpreted in that light.

73. There were also templates available to CCGs for recording conflicts of interest.[13]

74. Each NHS provider will have their own SFIs (in the case of Trusts), policies and/or procedures in relation to their own procurements and purchasing arrangements and governance arrangements (including in relation to conflicts of interest and anti-fraud policies). Such matters should be scrutinised by Trusts' own internal and external auditors and then independently by the National Audit Office. NHS England would have no knowledge of what conflicts of interest systems and policies individual Trusts would have in place in relation to procurement decisions and how they are enforced. Nor can NHS England provide any examples of NHS Trusts awarding contracts for the supply of PPE or key healthcare equipment and supplies despite the existence of a conflict of interest (regardless of whether it was declared at the time or not) because NHS England does not hold such information. Some information, such as Trusts' SFIs, may be available online but this would not be monitored by NHS England.

75. NHS providers buy the goods and services they need (including key healthcare equipment and supplies) to support service delivery to their local populations. Often these activities are facilitated by NHS Supply Chain (previously owned by DHSC, see further below at paragraphs 136 to 141).

76. Specific service contracts are mandated for use by commissioners including:

    a. the NHS Standard Contract (**[JK1/006] [INQ000113318] [JK1/007]**

[13] These can be found at NHS England » Conflicts of interest management templates

[INQ000113214], [JK1/008] [INQ000113215], [JK1/009] [INQ000113216]); and

b. specific contracts for different primary care services such as GP and optometry.

77. NHS England considers NHS trusts' procurement practices so it can understand efficiency issues, behavioural and category spend to support the NHS more widely by developing policies and guidance which drive forward the strategic direction for health in England as set out by DHSC. Additionally, NHS England also provides support to NHS trusts to enable them to improve individually and on a system-wide basis to drive efficiency savings within the system. The work undertaken to establish the National Procurement Forum, which encouraged collaboration and sharing of best practice among NHS commercial leaders, was instrumental in enabling NHS England to set up the Trust Supplier Sourcing (**"TSS"**) initiative during the pandemic (see paragraphs 221 to 227 below).

Procurement spend within the NHS in England

General

78. NHS England did not collect mandatory datasets in relation to the number of commercial, procurement and supply management professionals in the NHS in England but does hold limited data from NHS Trusts. To avoid doubt the data provided does not include organisations which were out of the scope of the annual corporate services data collection, which at the time of the data collection, included but were not limited to, CCGs, Primary Care Services, GP Practices, Commissioning Support Units ("**CSUs**"), NHS England, NHS Digital, NHSX, NHS Improvement, Health Education England ("**HEE**").

79. In summary, the number of procurement function staff working in an NHS Trust function each year is shown in the table below.

	FY2016/17	FY2017/18	FY2018/19	FY2019/20	FY2020/21	FY2021/22
Number of procurement function Full Time Equivalent ("**FTE**") staff	3,842	4,001	4,106	Not available	4,411	4,565

80. The dataset was not collected for FY2019/20 due to the impact of the pandemic.

81. The data set is not mandatory and the number of Trusts changed during the data collection periods due to mergers, acquisitions and other factors. A number of assumptions apply to this data:

a. the data collected uses full time equivalent as the count and this has therefore been provided as a proxy for the 'number'. Headcount is not collected at procurement function level in the source data.

b. the values provided in aggregate per year relate to all staff recorded in the procurement function for each year, regardless of qualifications, as this data was not collected

c. FTE values are only requested via the annual corporate services data collection where Trusts are delivering an in-house service or have a retained team to manage an outsourced service.

d. Over 70% of Trusts had an in-house service for the procurement function in FY2018/19 and this was the first year that this distinction was made in the data collection template.

e. Where a Trust has outsourced their whole or aspects of their procurement function, the data collection accounted for these costs in non-pay not in FTE as those staff are not directly working for the Trust.

Total amount spent on the procurement of key healthcare equipment and supplies

82. Each year NHS England presents "consolidated NHS provider accounts" to Parliament in accordance with the 2006 Act. These consolidate Trusts' accounts, an example has been exhibited for the Financial Year 2019/2020 here: **[JK1/010] [INQ000496979]**.

83. These published datasets provide the most consistent year on year summary for how much was spent on high level operating expenditure groups by Trusts. For example, the table below details the expenditure for supplies and services – clinical (excluding drugs costs):

Accounting Period	**Spend (£m)**
2016/2017	6,343
2017/2018	6,428
2018/2019	6,521
2019/2020	6,674

84. According to the National Audit Office ("**NAO**"), in 2019 Trusts ordered PPE to the value of £146 million, the DHSC budget for PPE in 2020/21 was £15 billion and the number of PPE items procured to manage Covid-19 between February 2020 and July 2020 was 32 billion.

NHS England's procurement obligations during the pandemic regarding its own purchasing

85. NHS England's procurement obligations for its own purchasing requirements (which would not have included key healthcare supplies and equipment[14] for the reasons set out above) did not change as a result of the pandemic. NHS England, when undertaking procurements and/or purchases at a national or regional level, was still obliged to comply with its legal obligations in relation to the 2006 Act, its specified spending controls and the PCR.

86. On 24 March 2020, NHS England's Commercial Team issued an internal document entitled "*Commercial Advice: Supporting Covid 19 Requirements*" which set out how NHS England could procure goods and services in response to the pandemic **[JK1/011] [INQ000496974]**. That document confirmed that all decisions needed to be documented with a business case provided and set out:

    a. a decision tree to be followed based on the type of goods and services required, spend levels, whether the spend was recurring, whether they were covered by existing frameworks or contract awards and factors to consider whether to run a tender or use a direct award; and

    b. guidance on the exceptional circumstances in which specific processes can be undertaken in response to Covid-19.

87. A Covid-19 Finance approvals process dated 6 April 2020 was issued **[JK/012 [INQ000496983].** Guidance from NHS England to its corporate and regional teams, CSUs and CSU transition team, on expenditure during the pandemic was also issued on 7 April 2020 **[JK1/013] [INQ000496982]** and confirmed

    "Whilst we need to respond swiftly and flexibly to support the service, we remain accountable for our spending decisions and the maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Every member of staff must continue to comply with internal policies and procedures,

[14] As defined in the Inquiry's Rule 9 Request.

where applicable statutory responsibilities and, have regard to their duties as set out in Managing Public Money and other related guidance including the SFIs, Schemes of Delegation, Standards of Business Conduct and Tackling Fraud, Bribery and Corruption: Policy and Corporate Procedures."

88. Recognising the need for procurements and spending decisions to be taken urgently, that guidance also confirmed

"The Finance & commercial business case approvals process must still be followed, but this has been temporarily amended to ensure a rapid response regarding financial approval".

89. During the pandemic, all NHS England expenditure above £25,000 (now £10,000 excluding VAT) required a business case, procurement or quotation and approval at a commercial panel within NHS England. A process was put in place to rapidly consider them.

90. For Covid-19 business cases, a short-form business case form was completed **[JK1/014] [INQ000496984]** which was firstly considered by the National Incident Team, led by the Strategic Incident Director. Once approved as Covid-19 spend, the senior finance team would, within 24 hours, either approve the case, request more information or if required, request DHSC/HMT approval. Following approval, the Commercial Panel (or Commercial Executive Group depending on value) would then test and approve that the most appropriate commercial route was being used.

91. Due to the criticality of the pandemic response, NHS England also made use of Regulation 32(2)(c) of the Public Contracts Regulations 2015 alongside PPN 01/20 to ensure urgent procurements were put in place quickly, in the vast majority of cases for non-clinical supplies contracts. However, even direct awards went through the process set out above to ensure it was properly considered and were published on Find a Tender.

92. During the pandemic, NHS England's Commercial Delivery Team continued to support business as usual activity across its corporate and national/regional services. However, priorities across the organisation shifted into focussing on NHS England's needs in responding to the pandemic. The core commercial delivery function was reduced so that resources could be diverted into other areas of critical need, including, for example, the NHS England Covid Vaccine & Flu Programme and the DHSC ventilator programme.

93. At all times, NHS England sought to comply with its statutory and regulatory obligations in relation to its purchasing during the pandemic and to enter into the contracts which secure value for money. This does not always mean the cheapest product. NHS England will consider, in its procurements, how it can secure the best value for the money it spends. It is a question of getting the correct balance between quality and price.

94. NHS England sourced goods and services set out above via various routes available to it including direct awards, call-off contracts, contract extensions and contract variations.

NHS England's role in relation to procurement for the NHS in England during the pandemic

95. As a result of a Level 4 national incident being declared by NHS England on 30 January 2020, NHS England's role changed to strategically direct the NHS operational response in line with its EPRR framework.

96. NHS England's obligations in relation to procurement for the wider NHS did not change. At no point did NHS England become responsible for procuring goods and services, including key healthcare equipment and supplies, for the NHS in England as a result of either the pandemic, the declaration of a level 4 national incident or from being a Category 1 responder.

97. However, Covid-19 imposed an unprecedented demand on healthcare systems around the world. Healthcare systems became the frontline of the pandemic response. This brought about global demand for certain items to equip the frontline response. In such exceptional circumstances, NHS England centrally procured some equipment on behalf of Trusts and DHSC as set out below both to take advantage of national buying power but ultimately because of the need for speed in getting the equipment into the country and out to providers.

CT scanners, mobile x-rays and contrast injectors

98. NHS England purchased CT scanners and related housing, mobile x-rays and contrast injectors initially via a direct award and subsequently via NHS Supply Chain. NHS England also purchased handheld ultrasound devices. A paper dated 15 April 2020 was presented to NIRB in relation to this equipment **[JK1/015][INQ000226893]**.

99. NHS England also made allocations of this equipment to the devolved nations on a fair share basis, again, because it was able to more quickly procure the goods needed at more competitive rates. This course of action required DHSC involvement because

NHS England had no power to allocate the assets outside England. A ministerial direction was sought and obtained to allow NHS England to distribute these assets.

100. Ultimately, these assets were transferred by donation to Trusts and the devolved nations.

101. Additionally, NHS England agreed with the independent sector to secure access to the fleet of mobile CT scanners in the UK (34 vehicles, of which 19 were already deployed in the NHS), and for them to be staffed 24 hours a day, seven days a week.

102. DHSC also purchased and donated to NHS England CT scanners and housing on the basis that NHS England was managing the donation of these items to NHS bodies and the devolved administrations.

Pulse oximeters

103. NHS England also supported the procurement of pulse oximeters and the development of the Covid Oximetry at home (**"CO@h"**) pathway. CO@h supported people with Covid-19 who were well enough to be at home but who were most at risk of becoming seriously unwell, helping them to self-monitor trends in oxygen saturations alongside other symptoms allowing them to get more timely hospital treatment if required.

Coveralls/Gowns

104. At the start of the pandemic, NHS England raised a purchase order on behalf of DHSC to secure contract for 50,000 medical gowns. This course of action was undertaken because the supplier had not been set up on DHSC's system whereas the supplier was known to NHS England, having supplied equipment for the Nightingale hospital so the invoice could be paid within the timescales required by the supplier to secure the order.

105. NHS England is aware that NHS England's regional team in the East of England also made a de minimus purchase of 682 coveralls in April 2020 as a contingency plan in the event mutual aid was needed by an organisation; the stock was not subsequently needed.

Working with others during the pandemic

Working with Trusts

NHS England issued guidance to support NHS providers and commissioners to free up management capacity and resources to prioritise Covid-19 preparedness and response.

106. On 2 March 2020 NHS England issued a letter: *'COVID-19 NHS preparedness and response'* **[JK1/016] [INQ000087445]**. This letter asked all NHS organisations (ie. a communication which included Trusts), amongst other things, to:

a. Ensure that procurement teams had processes in place to monitor clinical consumables (including PPE);

b. Ensure that stock levels were maintained but not stockpiled in individual organisations;

c. Review business continuity arrangements;

d. Work with local social care partners to ensure they were prepared to manage the impact of Covid-19 on their residents, including infection prevention control measures; and

e. Notify NHS England's EPRR of anything that was or may have affected service delivery.

107. Following the government announcement on 12 March 2020 of the move from the 'contain' to the 'delay' phase of the virus, NHS England sent a letter dated 17 March 2020 which requested that Trusts and other NHS bodies enact urgent measures that were considered vital to free-up the necessary capacity to cope with the incoming wave of infections and prepare the NHS for the anticipated large number of Covid-19 patients in need of respiratory support (the **Phase 1 Letter**") **[JK1/017] [INQ000087317]**. The operational aim was to expand critical care capacity to the maximum and free up at least 30,000 of England's 100,000 G&A[15] beds and supplement existing capacity by block-buying capacity from the independent sector ("**IS**"). NHS England also purchased CT scanning capacity from independent providers of mobile CT scanning services. Elective care was stood down in advance until 29 April, after which organisations were instructed to step-up non-Covid-19 urgent services as soon as possible. The letter was informed by government demand planning assumptions at the time, which indicated that at the peak of the pandemic, demand for critical care beds would significantly exceed usual and surge capacity in the NHS. Amongst other things, the letter instructed the NHS to prepare for and respond to large numbers of inpatients requiring respiratory support and confirmed that there was a dedicated line and email for local issues with PPE distribution.

[15] General and Acute

108. The Phase 1 Letter set out changes to how NHS providers would be funded, as NHS England realised that to respond quickly to the requests of NHS providers the current financial regime would need a simpler approach. NHS England, with DHSC and HMT, agreed rules and processes for how the extra costs would be claimed. In summary, this approach materially simplified the usual Trust sector financial framework. All Trusts moved to block-contracts which provided a guaranteed monthly income, based on a national methodology, to remove the need for local negotiation. A top-up mechanism was also introduced to fund NHS secondary care providers for the difference between their net cost base and their block-contract income consisting of both a projected top-up (paid in advance to fund providers for their expected level of net expenditure) and a retrospective top-up after month-end (to true up any actual spending in the month including Covid-19 costs). The additional funding required above the previously planned NHS England budget for 2020/21 would be provided by HMT (and ultimately reflected in the final NHS England Mandate/Financial Directions for 2020/21). Costs in respect of which NHS England was uncertain of at the time including temporary staffing costs to cover sickness absence, loss of income from other sources, costs of PPE (before Government confirmed that this would be covered nationally), extra cleaning and security costs.

109. Guidance entitled *"Revised arrangements for NHS contracting and payment during the Covid-19 pandemic"* was issued on 26 March 2020 **[JK1/018] [INQ000269915]** which clarified the implications for contracting between commissioners and (i) Trusts and (ii) other non-NHS providers which included confirmation that the NHS Standard Contract must be used (the shorter-form version was said to also be appropriate) for contracts with non-NHS providers.

110. On 27 March 2020, NHS England issued a process for approval of capital expenditure for NHS Trusts, Foundation Trusts and CCGs to claim Covid-19 capital expenditure **[JK1/019] [INQ000269938]**.

111. NHS England was responsible for retrospectively considering, approving and reimbursing additional funding requests from Trusts for Covid-19 specific spend. For example, this could include additional workforce spend as a result of staff needing to self-isolate.

112. As set out above, NHS England also issued guidance on financial approvals for capital expenditure and Covid-19 spend.

113. In April 2020, NHS England's Finance Covid PMO Cell set up a PPN[16] team to provide responses to enquiries from NHS providers (mainly Trusts and CCGs) following the publication of the Cabinet Office's PPN 02/20 (1 April 20 – 31 May 2020) and PPN 04/20 (1 June 2020 – 31 October 2020) on supplier relief notices. These notices set out Cabinet Office guidance on how contracting authorities could help at risk suppliers in a range of ways to ensure business and service continuity and to protect jobs. The guidance aimed to ensure suppliers were in a position to resume normal contract delivery after the pandemic. The PPN team assisted the NHS in implementing the guidance in a way that was managed and which considered value for money.

114. NHS England issued a letter on 29 April 2020 setting out the next phase of the NHS response. It removed the restriction in relation to elective care and acknowledged the increased demand for aftercare in relation to Covid-19 patients as well as support in community health, primary care and mental health. The letter also emphasised scaling up the use of technology to reduce the risk of cross infection (the "**Phase 2 Letter**") **[JK1/020][INQ000087412].**

115. A paper presented to NIRB dated 4 May 2020 **[JK1/021][INQ000226895]** provided a supply workstream update in relation to PPE, medicines, ventilators, oxygen and MDCC and non-clinical supplies and the actions being taken to address them. All workstreams were noted to have limited supplies and global supply issues.

116. Further specific examples of how NHS England worked with Trusts in relation to PPE during the pandemic are set out in Section 2 below.

Working with GP surgeries

117. The contract with a GP practice is often referred to as the GP contract. It comes in three forms known as the General Medical Services contract, the Personal Medical Services agreement and the Alternative Provider Medical Services contract.

118. At the start of the pandemic GP services were faced with urgent issues to manage including:

- how to provide safe and effective GP services to patients in the context of restrictions on movement, infection prevention measures and a drop in workforce availability;

[16] Procurement Policy Note – these are guidance documents published by the UK Government (devolved administrations also publish their own) on best practice for public procurement and which in-scope contracting authorities should have regard to them

- how to provide GP services to persons with Covid or who could have Covid; and
- addressing hesitancy of patients, or delays by patients, in seeking GP appointments due to the perceived risk of catching Covid-19 at the GP practice or the desire not to unnecessarily burden the NHS.

119. The steps taken by NHS England in the context of Module 5 were to alleviate the potential adverse impact of these issues on the capacity of GP practices to provide services.

120. NHS England assisted in the CO@h initiative as described in paragraph 103 above.

121. In the 5 March 2020 GP readiness letter **[JK1/022] [INQ000000039]**, NHS England set out that all GP practices should now change from face-to-face appointments booked online to remote triage of all incoming patient demands, inquiries and issues. The rationale was that this would minimise the risk of Covid-19 infection and onward transmission to primary care staff or other patients.

122. In March 2020, NHS England instructed GP practices to use the 'GP Connect' system to enable direct booking of GP appointments by NHS 111. By June 2020 NHS England estimated that 97% of GP practices were enabled to use GP Connect.

123. During the pandemic, NHS England's approach to enabling and facilitating the use of digital infrastructure and tools by GP practices took the form of:

    a. establishing the total triage model early in the pandemic through which GPs were to assess each patient's clinical needs by using consistent criteria, and then identifying both the appropriate health professional they needed to see and the mode of that consultation (whether by telephone, video or in-person).

    b. disseminating guidance to assist GPs in making appropriate use of technology to meet patient needs. NHS England launched the Digital First Online Consultation Framework which set out assured suppliers of technology services which local commissioners could call down upon to implement for GP practices in their area. NHS England also ran webinars to showcase and describe the functionality of the available assured products. Funding was provided to GP practices to procure from the list of assured suppliers. As outlined in a letter to GPs on 27 March 2020 **[JK1/023] [INQ000470420]** the use of those suppliers had been funded centrally by NHS England and it was for CCGs to work with their local practices to implement them; and

c. issuing alerts and updates, and providing live webinars, to all GPs and commissioners on the steps being taken to respond to the evolving nature of the pandemic, and the priorities they should focus on to provide appropriate care and treatment to patients balancing their clinical needs against the risks of transmission.

124. NHS England worked with CCGs to enable secure remote working options for GP practice staff. Equipment such as iPads, laptops, headsets, smartcards and VPN tokens (to ensure patient confidentiality) were made available to those working from home. By June 2020, NHS England estimated that over 40,000 laptops and 19,000 smartcard readers had been deployed via local IT service providers to support remote working across general practice since March 2020.

125. The Phase 2 Letter required GP practices to continue to triage patient contacts and to use online consultation so that patients could be directed to the most appropriate member of the practice team straight away, demand could be prioritised based on clinical need and greater convenience for patients could be maintained.

126. NHS England's letter to all GP practices on 9 July 2020 **[JK1/025] [INQ000051183]** stated:

"*All practices must now also deliver face to face care, where clinically appropriate. It should be clear to patients that all practice premises are open to provide care, with adjustments to the mode of delivery. No practice should be communicating to patients that their premises are closed. Nor should they be redirecting patients to other parts of the system, except where clinically assessed as appropriate.*"

127. On 9 November 2020, NHS England announced the creation of the General Practice Covid Capacity Expansion Fund with £150 million of revenue being allocated to CCGs for general practice for the purpose of supporting the expansion of general practice capacity to the end of March 2021 **[JK1/024] [INQ000058907]**. The announcement also stated that a digital suppliers framework was to be made available to assist GP workforce deployment by matching sessional capacity to local demand.

128. NHS England also worked with GP practices in relation to the Covid-19 vaccination programme, which is outside the scope of Module 5.

Government departments including the Cabinet Office and DHSC

129. At an operational level, NHS England worked with the Government and DHSC through some aligned cells in order to support the system-wide pandemic response. These cells

consisted of multi-organisational teams, led by, and subject to the governance and decision-making processes of Government departments (see paragraphs 32 to 41 of Annex 3).

130. Alongside other agencies, NHS England provided additional staff capacity and an operational perspective.

131. On 12 March 2020, the Prime Minister as well as senior No.10, Cabinet Office, DHSC and NHS officials met to review and agree measures to be taken by the NHS to seek to accommodate the expected influx of emergency Covid-19 patients (known as a 'Resilience Meeting'). The meetings discussed stopping non-urgent operations, reducing hospital long stays and faster hospital discharge, use of the independent sector, and funding for social care providers. They also covered intensive care units and general hospital bed capacity, procurement of equipment including ventilators and oxygen supply, and workforce issues.

132. DHSC established its own "battle plan" in March 2020 to organise six key workstreams (resilience for the NHS and adult social care, supply of key products and equipment, testing, technology accelerating new interventions, social distancing and shielding). Representatives from NHS England worked with DHSC within these workstreams via informal arrangements where staffing resource was supplied as part of the "all hands on deck" approach. Within the supply workstream (which subsequently became the supply and distribution of key products), there were 4 sub-categories namely (i) PPE (SRO Jonathan Marron of DHSC) (ii) medicines (SRO Steve Oldfield of DHSC) (iii) tests (SRO Steve Oldfield) and (iv) oxygen & ventilation and medical devices & clinical consumables (SRO Emily Lawson, NHS England's CCO). Each SRO reported into the Cabinet Office/No.10.

133. The Commercial and Procurement Cell ("**CPC**") which had previously been established within DHSC in February 2019 to manage the EU Exit transition period was subsequently key in supporting the response to PPE and other supply disruptions during Covid-19 (and other supply disruption incidents). The CPC was part of the National Supply Disruption Response ("**NSDR**") centre established by DHSC. The CPC assisted organisations in ensuring that there was continuity of supply of PPE and non-clinical goods and services ("**NCGS**"). For example, the NSDR hotline (see paragraphs 209 and 211 below) was set up for providers who had an urgent requirement for PPE. The Government's PPE Plan published on 10 April 2020 (the "**PPE Plan**") **[JK1/026] [INQ000050008]** confirmed

"The NSDR operates a 24/7 helpline for providers who have an urgent requirement (such as requiring stock in less than 72 hours) for PPE, which they have been unable to secure through their business-as-usual channels."

134. A lot of work had already been done in relation to the overall NHS supply chain in preparation for a no deal EU Exit. As such, in January and February 2020, and following on from the planning lessons arising in Operation Yellowhammer, NHS England was able to adapt the structures that it had previously established to manage potential supply issues for EU Exit to deal with some of the emerging challenges of the Covid-19 pandemic. NHS England set up a funded workstream within the CPC with a team to support the co-ordination of emergency distribution of PPE and data analysis The CPC linked with DHSC's NSDR Centre to create infrastructure to support the response. This allowed NHS England to understand the "demand signal" from the NHS (ie. how much PPE the NHS would need).

135. NHS England's CCO assisted the Cabinet Office and DHSC in relation to ventilators, procurement of PPE and the creation of the parallel supply chain as described further below in Sections 2 and 4.

NHS Supply Chain/SCCL[17]

136. NHS Supply Chain, originally hosted within DHSC itself, is a trading name and was created in 2006 to provide the NHS with goods. Today, 'NHS Supply Chain' (not NHS England) manages the sourcing, delivery and supply of healthcare products, services and food for NHS trusts and healthcare organisations across England and Wales.

137. NHS England's CCO worked with NHS Supply Chain in relation to her role in assisting the Cabinet Office and DHSC with the parallel supply chain for PPE (see from paragraphs 214 to 215 below).

138. Supply Chain Coordination Limited ("**SCCL**") is the legal body and management function for the NHS Supply Chain operating model. SCCL is a limited company which was set up in 2018 by DHSC as sole shareholder to manage NHS Supply Chain. At that time and during the pandemic, it operated as a small management function and outsourced the procurement of goods and services through 11 specialist buying functions called "towers". By way of example, three of those towers provided different types of PPE. SCCL, whilst established as a limited company, is classified to the public sector pursuant to Office of National Statistics rules and so is bound by the PCR.

[17] Please note that SSCL and NHS Supply Chain are used interchangeably in this statement

139. SCCL also operated a logistics service whereby it contracts with a third party logistics provider to deliver products to Trusts. During the pandemic, Unipart Logistics was the provider of logistics services to NHS Supply Chain which included delivering all aspects of the logistics service, from inventory management to delivery.

140. SCCL's aim is to deliver savings to the NHS primarily via economies of scale. At the time of the pandemic, the NAO report on *"The supply of personal protective equipment (PPE) during the COVID-19 pandemic"* confirmed that nine PPE products were provided by 24 suppliers under SCCL frameworks **[JK1/027] [INQ000145895]**.

141. In 2018, DHSC announced that it intended to transfer its' shareholding in SCCL to NHS England. To plan for this, in July 2019, the then National Director for Transformation and Corporate Operations (who then became the CCO) at NHS England and the then Director of Provider Transformation at NHS England, joined the SCCL Board. This also coincided with NHS England's planned establishment of a new directorate, to formally commence on 1 April 2020, and an executive post of CCO, to focus on addressing commercial challenges and efficiency initiatives for the NHS. This transfer was delayed due to the pandemic.

142. Minutes of NHS England's board meeting approving the transfer of ownership of SCCL to NHS England, which took effect on 1 October 2021, are attached **[JK1/028] [INQ000496981]**.

Ministry of Defence (MoD)

143. Working with the Ministry of Defence ("**MoD**") and partners, the EPRR team reorganised structures to respond to a protracted event and as a result developed daily (initially) meeting groups: Tactical Fusion, Strategic Fusion, NIRB and respective sub-groups. These groups made changes over time to the way in which NHS England delivered its functions.

144. NHS England worked with the MoD in relation to ventilators as set out further below from paragraph 297.

145. NHS England's CCO also supported DHSC and the Cabinet Office in the creation of the Parallel Supply Chain which involved working with the MoD as further set out at paragraph 214 below.

146. NHS England representatives would have also been involved in a number of convened meetings where MoD representatives would also have been in attendance. Examples include the UK Senior Clinicians Group.

NHS Commissioning Support Units ("CSUs")

147. NHS England oversees the five CSUs which operate across the whole country, providing support to several types of organisation including CCGs (now ICBs), local authorities and non-NHS bodies. CSUs deliver a range of support services that have been independently assessed to ensure that the NHS receives the benefits of scale, including clinical procurement services, business intelligence services and human resources. CSUs support with national and regional procurements. This is managed in accordance with NHS England policies, standing financial instructions and contractual arrangements using standard contract terms for clinical or non-clinical goods and services. The CSU staff group are employed by the NHS Business Services Authority.

148. Although operationally distinct, and in governance terms a 'hosted body' in NHS England's governance framework, CSUs do not have separate legal personality, and are legally part of NHS England. CSU activities are included in NHS England's Annual Report and Accounts except where otherwise indicated.

149. NHS England's CSU Transition Team provides assurance in relation to CSU liabilities to the NHS England Board and provides development support to CSUs to ensure they can become and remain successful, viable units.

*The Chief Medical Officer ("**CMO**")*

150. The establishment of NHS England posed the question as to which former DHSC roles could or should be moved or replicated in NHS England to ensure that the identified functions of NHS England could be carried out efficiently.

151. Two critical roles, which were reviewed and recreated in NHS England, were the senior clinical leadership roles of the National Medical Director ("**NMD**") and the Chief Nursing Officer (**"CNO"**) (see paragraphs 156 to 175 below).

152. Senior medical leadership is required throughout the English health system:

    a. within DHSC, the Office of the Chief Medical Officer (**"CMO"**) exists to provide the Government with advice on medical and public health matters; and

    b. every Trust is legally required to appoint a medical director as part of its governance structure.

153. Consequently, the role of a National Medical Director was created; in effect the 'Chief' NHS Medical Director who was to be operationally facing, not primarily an adviser to

the Government.

154. The National Medical Director works solely for NHS England. England is unique among the four nations in having both a CMO and a National Medical Director; in the devolved administrations the roles are essentially combined.

155. The CMO's UK Senior Clinicians Group was established in February 2020 as a forum at which senior UK clinicians involved in pandemic management could discuss predominantly clinical issues relating to Covid-19. It was not a decision-making group. Meetings were chaired by the CMO or an appropriate deputy and involved all the Deputy Chief Medical Officers ("**DCMO**s"), Chief Medical Officers, DCMOs and clinical advisors from all four nations, UK CNOs, and representatives from GCSA, HEE, Scottish Government, Public Health Scotland, NICE, Ministry of Defence, and DHSC as well as NHS England.

*The CNO and the Office of the CNO ("**OCNO**")*

156. The CNO for England is employed by NHS England but is also an adviser to DHSC, Government and the wider NHS on nursing and midwifery related issues.

157. Within NHS England the CNO is an executive director who leads the Nursing Directorate (or OCNO). The CNO is responsible for the delivery of national programmes and policy areas that typically have a strong focus on nursing and midwifery. The CNO also provides the nursing perspective and input into a wide range of clinical and operational issues that are the responsibility of other senior colleagues. The CNO's core accountabilities and deliverables are exhibited at **[JK1/029] [INQ000421176].**

158. The CNO role has the additional dimension of being the professional lead for the nursing and midwifery professions in the NHS in England, who make up the largest group of the total NHS workforce. The CNO is accountable for providing clinical and professional leadership for all nurses and midwives in England. Public health nurses were the responsibility of PHE/UKHSA's Chief Nurse until 16 November 2023, when the CNO assumed professional leadership for this group of nurses.

159. The CNO does not have responsibility for the procurement of healthcare related equipment and supplies nor for deciding on the type of PPE to be used by healthcare workers. The CNO's IPC role (and that of NHS England) in relation to PPE was to promote the consistent implementation of the recommendations in the UK IPC Guidance published by PHE in the NHS.

160. Through the CNO's professional leadership role during the Relevant Period, she was made aware of frontline concerns. As such, whilst the CNO and her team escalated concerns (for example around supplies and fit testing) and led on projects, she was not involved with the mechanics of procurement or the technical specifications of PPE (which would be a matter for HSE) or medical devices (which would be a matter for the MHRA).

161. The CNO is supported by four deputy CNOs (**"DCNO"**) within NHS England who provide senior leadership and support on specific areas. The CNO is also supported by the Chief Midwifery Officer (**"CMidO"**) and NHS England's Director for People and Communities. The structure of the Nursing Directorate is set out at Annex 2.

162. The CNO works closely with NHS England's seven regional teams through their regional Chief Nurses. Typically, one of the roles of regional Chief Nurses is to manage relationships with lead nurses in Integrated Care Systems, which include Trusts, who are responsible for leadership of nurses and midwives within their own organisations. The CNO has no line management responsibilities in relation to nurses, midwives and/or nursing associates at Trusts or independent sector organisations (at any level).

163. The role of CNO does not have a public health emergency role when compared to, for example, the Accountable Emergency Officer role within NHS England which is typically undertaken by NHS England's Chief Operating Officer. However, as with all NHS England executive directors, and the organisation as a whole, the CNO's focus turned to supporting the management of the pandemic as new priorities rapidly emerged.

Government Engagement

164. CNOs in the devolved administrations have a similar professional leadership role. Prior to the pandemic, the CNO formally met with their UK and Republic of Ireland CNO colleagues on a quarterly basis to discuss issues relating to our professions, covering matters within our own areas of responsibility as well as international and UK and ROI-wide nursing matters. Each meeting was chaired by the host CNO in rotation.

165. As the pandemic developed, the CNO met with the CNOs for the devolved nations to discuss urgent issues more frequently. These meetings covered a wide range of issues, including IPC measures, guidance and PPE supply.

Stakeholder engagement

166. Over the course of the pandemic, the CNO engaged with a wide range of external

organisations. Most prominent among these were the representative bodies for the nursing and midwifery workforces, the Royal College of Nursing (**"RCN"**) and Royal College of Midwives (**"RCM"**) and the regulatory body for nursing and midwifery, the National Midwifery Council ("**NMC**").

167. The CNO also regularly engaged with trade unions, for example Unison, as well as the medical Royal Colleges, particularly the Royal College of Obstetricians and Gynaecologists (**"RCOG"**). The CNO did not engage with the Health and Care Professions Council as their primary relationship would be with the Chief Allied Health Professions Officer, who provides professional leadership for allied health professionals.

168. The CNO's engagement that was relevant to PPE was with the RCN and specifically related to the shortage guidance (see from paragraph 18 of Annex 4).

169. The CNO's engagement with trade unions such as Unison and Unite were mainly focused on issues relating to the steps taken to increase workforce capacity. However, the CNO also engaged with them on issues such as IPC and PPE for NHS staff.

Frontline engagement

170. Prior to the pandemic the CNO had in place a number of structures and meetings to discuss nursing and midwifery issues face to face with colleagues in NHS organisations. These were enhanced through the pandemic and new structures were also created to ensure that an even wider range of voices were heard. For example, the CNO had an established weekly CNO calls on Fridays involving their senior leadership team, senior nurses from HEE, PHE and regional Chief Nurses.

171. During the early stages of the pandemic the CNO established an informal strategic advisory group consisting of some of the most experienced and senior Chief Nurses from NHS organisations across England. These meetings were used to seek views and feedback on a range of operational issues including IPC and PPE availability.

172. On 6 May 2020, and following approval of its terms of reference at NIRB on 29 April, these meetings became a formal bi-weekly group: the NHS Directors of Nursing Strategic Advisory Group (**"CNO SAG"**) **[JK1/030] [INQ000087544]**.

173. The CNO SAG meant that the CNO was connected to, and received valuable input from, senior nurses in the NHS to help ensure that their work and any subsequent decisions reflected the experience of frontline staff. For example universal mask wearing in healthcare settings in June 2020 **[JK1/031] [INQ000477788]**.

174. In addition to the CNO's involvement and that of the NHS England's NMD, other senior national leaders joined webinars which focused on specific issues. For example, PHE's Deputy Director of the National Infection Service joined on 8 April 2020 for a webinar on UK IPC Guidance, where issues around implementation of IPC guidance and supplies of PPE were shared and discussed. The feedback from senior nurses and medics via these webinars was important in ensuring that national guidance took into account operational issues and supported implementation.

175. An existing group which provided the CNO with valuable input during the pandemic was the CNO and CMidO Black and Minority Ethnic Strategic Advisory Group (**"CNO BME SAG"**). This group had existed for a number of years, giving a voice to Black and ethnic minority NHS nurses and midwives.

Chief Scientific Adviser and other government medical advisers

176. To the best of its knowledge, NHS England did not work with the Chief Scientific Adviser or any other government medical advisers in relation to matters falling within the scope of Module 5.

Social Care Sector

177. NHS England is not responsible for social care in England since it does not fall within the scope of its statutory remit.

178. However, via the CO@h programme, pulse oximeters were made available to care homes for those eligible within the pathway.

179. Additionally, in December 2020, with the support of the CNO, and as outlined in DHSC's "*Adult social care: our COVID-19 winter plan 2020 to 2021*" (published on 18 September 2020), DHSC established the post of the Chief Nurse for Adult Social Care to provide social care nursing leadership at DHSC. This post was originally created on an interim basis for nine months before becoming a substantive role for a period of three years from September 2021. The CNO maintains a close working relationship with the Chief Nurse for Adult Social Care to support consistent leadership across all areas of nursing in England. The Chief Nurse for Adult Social Care reports to DHSC's Director General of Adult Social Care with a professional line to the CNO.

Community Care Sector

180. As set out above, community care includes community nursing, community mental health services, health visiting, child health services and sexual health services.

Community care is provided by a range of independent and public sector organisations with commissioning being a mixture of local authority and NHS commissioning.

181. The CO@h programme was rolled out within the community care sector for those eligible within the pathway.

182. NHS England's CCO also worked closely with DHSC and others in relation to procuring PPE for this sector as set out further in paragraphs 215 to 217 below.

183. NHS England also issued system wide guidance to this sector in relation to services commissioned by it.

Devolved administrations and the NHS in devolved nations

184. NHS England has no statutory remit in relation to the provision of health care services in the devolved nations. Health is also a devolved matter. But there were many ways in which the four nations joined up or co-ordinated their approaches.

185. Pre-pandemic, the CNO attended regular meetings with the CNOs of devolved administrations as set out above, and NHS England's NMD from time to time would meet with CMOs from devolved administrations individually or collectively, including within the CMO's UK Senior Clinicians Group.

186. NHS England's CEO met with four nations counterparts during the pandemic on an ad-hoc basis.

187. NHS England officials also met with CMOs on an ad-hoc basis when required, for example:

    a. NHS England's NMD met with Scotland's CMO on 7 February 2020;

    b. NHS England's Strategic Incident Director attended a meeting with the CMO discussing the definitions of "Covid cases", definition agreed across four nation CMOs; and

    c. NHS England officials attended Senior Clinicians Health Care Workers Testing Sub Group with UK CMOs in May 2020.

188. Further examples of NHS England's interactions with the devolved administrations include:

    a. Updates via the Critical Care Capacity Panel ("**CCCP**"), which also considers approaches from the devolved administrations for data-sharing or co-operation

[JK1/032] [INQ000087493];

b. The CCCP was also informed by information covering the devolved administrations. For example, the CCCP received the ICNARC (Intensive Care National Audit and Research Centre) report on Covid-19 in critical care at meetings which included the position in England, Wales and Northern Ireland **[JK1/033] [INQ000087506]**; and

c. Mutual aid:

i. Five English Ambulance Services took Scottish Ambulance Service Calls; whilst all ambulance services in the UK have well established buddy arrangements for dealing with spikes in 999 calls, these new arrangements, which were overseen by the National Ambulance Co-ordination Centre, built upon those existing arrangements and strengthened them further **[JK1/034] [INQ000087484];** and

ii. Discussions took place at CCCP and Strategic Fusion regarding Northern Ireland **[JK1/035] [INQ000087510]; [JK1/036] [INQ000087511] [JK1/037] [INQ000087515]; [JK1/038] [INQ000087516].**

189. There was a well-established relationship between the EPRR teams across the four nations and NHS England has a "*Four Nations Operational Group*" which meets monthly to work in a collaborative manner, to share good practice and intelligence in relation to all matters concerning health and social care resilience. During Covid-19 the regular engagement meetings were suspended but the four nations continued to meet via monthly DHSC coordination meetings, and there was informal contact between NHS England and Wales and NHS England and Scotland at various times during the pandemic including the UK Senior Clinicians Group.

190. Additionally, NHS England engaged with the devolved administrations in relation to oxygen and ventilator issues as set out further below in Sections 2,4 and 5.

PART 2

Section 2: Personal Protective Equipment ("PPE")

Personal Protective Equipment

Executive Summary

192. Whilst DHSC led on both the procurement and supply of PPE to the healthcare system, NHS England played an important role in supporting partners, ensuring that DHSC understood the demand signal for PPE within the NHS and in turn, where PPE needed to be distributed.

193. This section of the statement sets out NHS England's position on the following:

    a. The roles of the relevant bodies responsible for issuing PPE specifications and guidance;

    b. How PPE procurement and supply was co-ordinated;

    c. How the original structures in place for the provision of PPE adapted and changed in order to deal with the exponential increase in demand for certain types of PPE;

    d. How PPE was supplied to the NHS;

    e. Issues arising with the supply/provision of PPE;

    f. Fit-testing for certain types of PPE; and

    g. The High Priority Lane ("**HPL**").

PPE Specifications and Guidance

194. Technical specifications for PPE are overseen by:

    a. HSE in relation to equipment meant to protect the provider of services (including healthcare); and

    b. MHRA in relation to items which fall into the definition of a medical device. MHRA regulation also oversees supply chain security for the relevant items.

195. These bodies supported the national effort more generally e.g., by being involved in assessing the fitness for purpose of items of PPE entering the country and ensuring its

compliance with regulatory requirements. DHSC put in place processes to ensure that all items of PPE complied with UK regulatory requirements. For example:

a. On 30 March 2020 the Cabinet Office and DHSC published all the technical specifications on its website entitled "*Guidance: Technical Specifications for personal protective equipment (PPE)*" with an overarching narrative setting out the purpose of the page as being to provide documents for new suppliers and manufacturers when they are using the tendering process for the supply or manufacture of PPE to ensure that those parties understood the regulatory requirements and that all products must comply with the stated standards, legislation and/or directives. This webpage, available on the Gov.UK website, was updated regularly between March 2020 and throughout the pandemic until 14 February 2022 and was ultimately withdrawn on 3 March 2023.

b. In July 2020 a document called "*Information on Specific Products and Quality Assurance*" **[JK1/039][INQ000330876]** was produced and provided for NHS England regions to use as required in relation to specific products so that they could explain and give confidence to Trusts on quality control issues. It described the assurance processes in place for releasing PPE stock into the supply chain and the content was based on questions that had been raised previously, for example:

    i. concerns regarding latex labelling (which turned out to be incorrect); and

    ii. questions on shelf-life extension of masks such as Cardinal FFP3 respirators which were part of the PIPP stockpile had been submitted for 3 year accelerated shelf-life testing in February 2020) **[JK1/095] [INQ000533226] [JK1/096] [INQ000533227]**.

    The document was agreed by DHSC with input from HSE, MHRA and NHS England, but to NHS England's knowledge, it was not formally published.

196. NHS England supported the processes put in place by DHSC to ensure PPE purchased was to the right standard. However, it was not NHS England's role to determine, or endorse, those standards and it did not make decisions about what PPE to purchase.

197. The inquiry has asked what NHS England's stance was in relation to IPC guidance on aerosol generating procedures and whether this changed. The majority of the UK IPC guidance was produced with the assistance of the UK IPC Cell (see paragraph 36 of

Annex 3). NHS England supported the UK IPC Guidance, which was published by PHE (now UKHSA), including that on aerosol generating procedures. Implementation of such guidance including the AGP list[18] was a local matter for individual Trusts.

198. A timeline of IPC guidance is set out at Annex 4 to provide context for the work undertaken in procuring PPE during the Relevant Period[19] as the requirements set out in IPC guidance influenced the procurement decisions taken during the Relevant Period.

PPE supply and co-ordination

199. On 27 January 2020, in expectation of a pandemic requiring PPE measures, NHS England's National Director for Emergency Planning and Incident Response approached DHSC to discuss concerns regarding the PPE stockpile **[JK1/040][INQ000330791] [JK1/041][INQ000330792] [JK1/042][INQ000330793] [JK1/043][INQ000330794] [JK1/044][INQ000330795].** NHS England had sourced an estimate of PPE use per patient based on Covid-19 being classified as an HCID and had requested that DHSC maintained the EU Exit PPE stockpile that had been accumulated. NHS England's National Director for Emergency Planning and Incident Response also requested that DHSC, NHS Supply Chain and NERVTAG provide further advice on PPE and that the NHS service specification should be changed from pandemic flu to Covid-19. NHS England's primary care team was also exploring with GP practices what PPE stock they held and how it was sourced. Further work was undertaken by DHSC and NHS Supply Chain on modelling (NHS England shared its estimates with SAGE) and supply and demand for PPE during this time.

200. On 30 January 2020, NHS England's Incident Management Team requested the convening of a Supply Chain Cell to manage product supply issues as part of the response to the emerging Covid-19 situation and preparations in the UK. The Supply Chain Cell involved key stakeholders from DHSC, NHS England, Public Health England, NHS Supply Chain, MHRA and devolved administration counterparts and met for the first time on 3 February 2020. The Supply Chain Cell considered product already within the NHS Supply Chain network to support "business as usual" supply, stockpiles put in place for EU Exit and the stock held within Pandemic Influenza Preparedness Programme (**"PIPP"**) stockpiles.

---

[18] The AGP list is a list of procedures which have an increased risk of aerosol generation associated with them.

[19] NHS England understands that Module 3 will examine IPC, the recommendations within the IPC guidance and the roles and responsibilities of those in the UK IPC Cell.

201. Around this time, at a very early stage of the pandemic and before Wave 1 had taken hold, NHS England was aware of concerns regarding PPE shortages. The IMT also noted that the PHE modelling on the Wuhan outbreak may only represent 5% of cases. On 2 February 2020, for example, NHS England's IMT received an informal suggestion of PPE shortages in an ICU in the North West via an email from a clinical director in NHS England. No specificity was provided in the email about the extent of the shortages; just that stock levels appeared low and there seemed to be a lack of adequate eye protection to prevent corneal transmission **[JK1/045] [INQ000409918].** NHS England escalated this matter to DHSC during a routine call and DHSC's, Head of the Procurement agreed to investigate any reports of shortages. Alongside this, NHS England sought further information from its Regional Team in relation to the products which were reportedly in short supply, which included what action had been taken to address any shortages and whether mutual aid had been sought.

202. At that time, NHS England was engaging with DHSC and NHS Supply Chain about the stockpiles of PPE and consumables held for pandemic influenza and EU Exit and had also asked Trusts to undertake an assurance process resulting in the IMT report of 1 February 2020 confirming *"[g]enerally adequate supplies of PPE reported, organisations reporting deficiencies to be followed up by regions"* **[JK1/046] [INQ000409919].** On 11 February 2020, as part of a longer letter from DHSC to NHS customers about measures the Government was taking in response to the outbreak and requesting some precautionary actions, DHSC asked them to monitor orders carefully and consider demand management plans in the event of excessive or unusual ordering patterns and to inform the DHSC of the outcomes of supply chain risk assessments **[JK1/047][INQ000049357]**.

203. NHS England had a key role in communicating information to the system, such as what actions organisations should take and how providers should access PPE. As set out above at paragraph 106, on 2 March 2020 NHS England issued a letter to the NHS system: '*Covid-19 NHS preparedness and response*' setting out steps to take to get prepared for the pandemic **[JK1/016] [INQ000087445].**

204. On 10 March 2020, NHS England's CEO asked NHS England's CCO to investigate issues arising with PPE and discuss these with DHSC. He was concerned that Trusts were raising issues with supply from SCCL that were not being addressed rapidly enough. There were concerns that SCCL had not been fully fulfilling orders and/or orders not arriving on time. The CCO was well-placed to have these discussions given that she held a place on the SCCL board. The CCO raised the matter with SCCL's

CEO and the Chair that same week. The matter was subsequently raised during a meeting the CCO attended with Government ministers in the Cabinet Office on 17 March 2020.

205. The NAO report confirms that on 28 February 2020, PPE from the PIPP stockpile was distributed to Trusts and on 3 March it was distributed to primary care **[JK1/027][INQ000226897]**.

206. A NIRB briefing on 13 March 2020 **[JK1/048] [INQ000330804]** on the supply of PPE confirmed that new structures were being put in place with NHS England and DHSC. It also confirmed that PIPP stock was being released to alleviate pressure and that there would be a focus on developing specifications to enable UK manufacturing of PPE.

Distribution

207. Immediately after the above meeting with Government ministers, NHS England's CCO and a member of the Cabinet Office contacted Unipart Logistics, the company that SCCL used for its logistics provision, to ascertain capacity and to explain that it would need to significantly increase the throughput of its logistics. Within 24 hours, Unipart confirmed that it had already upscaled staffing in its logistics centres and did not have the capacity to expand further. In parallel, it had become clear from the work undertaken to date that SCCL's 'just in case' stockpiles, infrastructure and processes were insufficiently equipped to meet the unprecedented PPE demand pressures, primarily because SCCL had not been established for this purpose.

208. NHS England's CCO suggested that military support would be needed to review the logistical capacity issues and this was accepted.

209. Difficulties of distribution were a direct and unavoidable consequence of a constrained national supply because limited aggregate availability inevitably meant little or no local buffer stock to ensure ward level availability.

210. In the meantime, following the announcement made by the Government of the move from the 'contain' to the 'delay' phase of the virus (on 12 March 2020), NHS England wrote to the NHS system on 17 March 2020 setting out next steps in the Covid-19 response **[JK1/017][INQ000087317]**. As set out below, the letter instructed the NHS to prepare for and respond to large numbers of in-patients requiring respiratory support and confirmed that there was a dedicated line and email for local issues with PPE distribution. This dedicated line ("**NSDR hotline**") was set up by DHSC's NSDR centre, which had already undertaken work to prepare for potential supply disruptions

emanating from a possible no deal EU Exit. The unit was staffed largely by NHS England staff and contractors. The letter included the following comment:

"In respect of PPE, the DHSC procurement team reports that nationally there is currently adequate national supply in line with PHE recommended usage, and the pandemic influenza stockpile has now been released to us. However locally distribution issues are being reported."

211. In evidence to the Health and Social Care Committee that same day (17 March 2020), NHS England's COO recognised that there had been local distribution problems which meant that "we do not necessarily have the kit in the right place". However, she confirmed that the NSDR hotline had been set up so that if people had local issues and required an immediate response, they had a channel of communication to make an urgent request and stock could be moved to where it was needed. She also confirmed that "*this is something that has a very high level of continual focus…*". In the same Committee meeting NHS England's CEO stated:

"…nationally the Department of Health and Social Care procurement team has sufficient for the PPE that we are going to need over the coming weeks, but there is a distributional issue around the country and we are going to need more of it. Let us be clear that this is a challenge facing every country. A lot of the Chinese supply for some of the more basic items has been disrupted, so we are going to need to ramp up production for gowns in particular, and some of the face masks. This is not a flash in the pan. As we know, it is not something that is just going to be resolved in a fortnight or a month; the coronavirus pandemic is going to be with us for months to come, so we are going to have to ramp up domestic production of those items as well. It is a combination. Have we got aggregate supply now? We are being advised yes. Do we need to improve distribution to every part of the service? We think so, hence the approach that Amanda set out. Will we need more stock over the coming months? Yes, we will."

212. NHS England's Strategic Incident Director also confirmed at the Health and Social Care Select Committee that they had been assured that the stock was there for the coming weeks, and a distribution model was going into place.

213. NHS England sent a further letter **[JK1/049] [INQ000330809]** to the NHS system on 20 March 2020 setting out in a single document the key information the system needed to know about the distribution and use of PPE.

214. Military support was subsequently secured at strategic level. Over the course of the weekend of 21-22 March 2020 the military identified that a separate logistics solution would be required to deal with increased demand and distribution of PPE to the 232 NHS Trusts in the system. The Parallel Supply Chain was established by DHSC in late March 2020 with support from the armed forces who assumed responsibility for logistics, sourcing, and delivery of PPE. It included at maximum a team of around 450 staff to find and buy PPE plus a new distribution system. It performed five key functions: to plan, source, make, order and deliver. It developed mechanisms to support adult social care providers, who were not customers of SCCL, supplementing the supply going from the pandemic stockpile via their usual wholesalers, as well as other institutions who did not have a dedicated supply chain, such as hospices.

215. Between the SCCL supply chain and the Parallel Supply Chain, there developed a need to support over 34,000 customers, including Trusts, primary and community care providers (i.e., GPs, pharmacists, dentists etc).

216. From 21 March the Army offered service personnel to help to manage and offload supplies in some NHS settings, helping to distribute and deliver urgent PPE to the frontline.

217. A press release by NHS England on 23 March 2020 noted the scale of the operation to ensure the steady distribution of PPE:

    a. On Thursday 19 March 2020 (in just one day) 2.6 million face masks and 10,000 sanitisers went to Trusts in London.

    b. Over the previous three days (Friday, Saturday and Sunday) more than 200 organisations, including all NHS hospitals, received facemasks and PPE along with ambulance Trusts and other NHS organisations.

    c. Every GP practice, dental practice and community pharmacy had received a PPE delivery.

Supply

218. To inform the purchasing of PPE, as well as to achieve the most effective and efficient method of distribution, DHSC and others, including NHS England in its supporting role, needed to know how much PPE local organisations held in stock to inform the demand signal for PPE. Initially, no national body held this information.

219. Throughout February and March 2020, NHS England worked on national and regional projections of PPE demand based only on direct Covid-19 care in the acute sector.[20] NHS England's CCO initially engaged McKinsey for 10 days on pro-bono basis to assist with this task before DHSC subsequently contracted with McKinsey to build on NHS England's data, to develop a demand model; McKinsey developed the modelling to include non-Covid-19 demand. NHS England's role was to provide advice and ensure that demand signals (data on bed occupancy, covid admissions and associated scenarios) was made available to the modellers. This was used, along with patient numbers and growth rates of inpatients, to estimate needs and to inform the usage projections used for distribution. That model was in place by early April and was further developed by creating an inventory data collection system. This was piloted and developed with a few Trusts and then rolled out nationally during May 2020. To ensure this would be helpful to Trusts as opposed to a resource-intensive cost on their time, the tool was designed to benefit Trusts locally as well as the national effort. The benefits to Trusts included the ability to manage stocks locally, as they were able to see that a nearby Trust had some of what they were lacking.[21] Over May, June, and July much effort went into aligning systems so that this model could also factor in projected stock arrivals into the UK. In the interim this data was collated manually from various systems and presented at the distribution meetings.[22]

220. DHSC used information from NHS England's modelling as set out above, which enabled a shift in the way PPE was distributed to Trusts from a "pull" to a "push" system. This meant that DHSC "pushed" PPE to providers based on the expected number of patients, bed capacity, etc. This reduced the load on Trusts regarding the need to predict and order against their needs. It also simplified the distribution system and provided insight into purchasing needs.[23]

221. In addition to the work undertaken by the Parallel Supply Chain to source PPE, on 29 April 2020, the TSS delivered a complementary approach to procure PPE via local suppliers at Trust level. This was the product of a joint effort with a combined team of Trust procurement teams supported by NHS England teams, the central PPE buying

---

[20] Early modelling, from February onwards, was based on reasonable worst-case scenarios for the virus, from SAGE, and an understanding of how much PPE would be required in those scenarios. These estimates were not forecasts but deliberately high sided, assuming high levels of Covid-19 activity, full compliance with IPC guidance and, implicitly, that all demand for PPE would be supplied through central procurement.

[21] As data collection of local stocks became available, models of actual usage and demand were developed. NHS England had no direct involvement in these.

[22] The model was developed using a spreadsheet but later moved to NHS Foundry.

[23] The model was later supported on the NHS Foundry platform.

team and DHSC. A copy of the initial email to trust leads, together with governance and process maps, is attached at **[JK1/097] [INQ000533237] [JK1/098] [INQ000533238] [JK1/099] [INQ000533239] [JK1/100] [INQ000533240] [JK1/101] [INQ000533241] [JK1/102] [INQ000533242] [JK1/103] [INQ000533243].**

222. The aim of the TSS was to co-ordinate supply leads, help boost national supply levels, stop Trusts and central buying teams from competing with each other in the PPE market and to bring one voice to supplier negotiations. The TSS did not procure anything nor did it purchase anything, nor did it have any budget to do so. The TSS was set up in order to filter the flow of potential leads before passing opportunities which were deemed credible, on to the Central Buying Team in DHSC for them to then follow their own processes to determine whether to proceed with a purchase. This was needed as some suppliers were contacting every Trust asking whether they wanted to purchase PPE so the TSS was a way of stopping that practice and streamlining potential opportunities to forward on for urgently needed supplies.

223. A lead Trust and head of procurement was identified for 12 categories of PPE but with gowns being split between two leads (creating 13 leads in total) as follows:

PPE Category	**Region**	**Trust**
Apron	Midlands	University Hospital of North Midlands
Eye Protector	North East and Yorkshire	Calderdale and Huddersfield NHS Foundation Trust
Face masks FFP2	Midlands	University Hospitals Birmingham NHS Foundation Trust
Face masks FFP3	South East	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Face mask II	North East and Yorkshire	Sheffield Teaching Hospitals
Face masks IIR	South West	University Hospitals Plymouth
Fit Test (full kits)	East	Nottingham University Hospitals NHS Trust

Fit Test (solutions)	North East and Yorkshire	The Newcastle upon Tyne Hospitals NHS Foundation Trust
General Purpose Detergent	East	Mid and South Essex University Hospitals
Gloves	London	Royal Free London NHS Foundation Trust
Gowns	North West	Liverpool University Hospitals NHS Foundation Trust
Gowns	London	Guy's and St Thomas' NHS Foundation Trust
Hand hygiene	North East and Yorkshire	Rotherham Doncaster and South Humber NHS Foundation Trust

224. Initially, the list also included body bags and clinical waste bags. Generic mailboxes were created to filter the flow of leads between the lead Trust, technical assurance team and DHSC. The TSS team established a working target of managing leads and progressing them to the point they could be sent to the Central Buying team in DHSC within 48 hours. To be clear, no referrals were made to the high priority lane from this process; all leads were referred to the Central Buying team in DHSC.

225. Each trust worked with a clinical colleague and received training on quality checks via the Cabinet Office. There was no counter-fraud checking and there was a light touch due diligence and quality check which comprised of a checklist to ensure the documentation that DHSC would need had been provided by the buyer. No technical assurance was signed off by the TSS.

226. The TSS had a weekly meeting chaired by NHS England's then Director of Procurement Transformation and Commercial Delivery and included the 13 Heads of Procurement at each of the lead Trusts and others including two representatives from the Cabinet Office. The TSS would discuss a dashboard of information including the current prices of various items of PPE, what was needed and the types of prices being paid at that time. TSS sitreps were also provided for the daily PPE morning call which set out the day's focus and asks for the management forum **[JK1/104] [INQ000497443].**

227. The TSS was stood down on 26 June 2020 following instruction from DHSC. In the time the TSS had been in service, the team had dealt with 303 leads across 12 categories of PPE of which 7 resulted in the issuance of purchase orders by DHSC. The TSS was not a decision-maker in terms of buying PPE, which ultimately rested with DHSC.

228. During this time, DHSC and NHS England realised that many Trusts, having been concerned that they would not have sufficient PPE for their staff, had started to procure their own PPE stocks by sourcing their own supplies, rather than going through SCCL or a wholesaler. Some Trusts were also doing both: i.e., sourcing PPE directly and ordering PPE through SCCL. This meant that effectively the NHS system was inadvertently competing with itself on price due to the global demand for PPE. In order to address this, on 1 May 2020 **[JK1/050][INQ000226899]**, the CCO and DHSC's Director General, PPE and Public Health, DHSC SRO for PPE Policy, sent a joint letter to Trust Chief Financial Officers and regional directors explaining the efforts being undertaken to procure new supplies. The letter highlighted that it was vital that the Government procured certain items, including PPE, mechanical ventilators, Bilevel Positive Airway Pressure ("**BiPAP**")/non-invasive ventilation ("**NIV**") ventilators, Continuous Positive Airway Pressure ("**CPAP**") devices and oxygen concentrators, nationally rather than individual NHS organisations competing with each other for the same supplies.

229. In May 2020 a comprehensive PPE Sourcing Strategy was produced by the Cabinet Office with input and support from NHS England's CCO and other NHS England and DHSC staff **[JK1/051] [INQ000330862]**.

230. NHS England separately took the initiative to consider if and how PPE could be reused. At the end of May 2020 (and separate to the shortage guidance see from paragraph 18 of Annex 4), NHS England set up a pilot for reusable gowns with several Trusts (a May 2021 update on reusable gowns in the NHS and a case study are exhibited at **[JK1/113] [INQ000533230] and [JK1/114] [INQ000533229])**. The CCO provided guidance on the approach and style of documentation. The Decision Making Committee (part of the DHSC PPE Cell) also played a role to agree an approach to reuse and a separate working group included PHE.

231. On 12 October 2020, the CCO gave oral evidence at the Public Accounts Committee hearing on the supply of ventilators and also covered questions around PPE.

232. In her evidence **[JK1/052][INQ000087462]**, the CCO explained that the focus of the PPE strategy was on building up sufficient supplies for the winter. By that time, for most

items, there was already four months of supply either in the country or with UK-based manufacturers. She confirmed that she was '99%' sure that that would be the case for all items by the beginning of November 2020. Work was being done with Trusts to make sure that they did not just have a set of items, but particular items that were actually required. She also explained that they were continuing to develop the PPE portal (which by that time had been established for PPE requirements) so that smaller volume users such as GPs and smaller social care homes could order exactly what they needed via the portal.

233. At that Committee, the CCO also confirmed that a register of prices was kept by the DHSC PPE cell in order to track market prices. This was particularly important in relation to stock which the UK did not manufacture, such as gloves.

PPE supply concerns

234. On 19 February 2020, while Covid was still classified as an HCID, the NHS Supply Chain noted that demand for FFP3 masks was three times greater than their stock and that there were supplier problems with manufacturers in China **[JK1/053][INQ000330797][JK1/054][INQ000330798].** This prompted an action for all other stock lines to be reviewed.

235. Other concerns around PPE supply included:

    a. the issue of the re-labelling of PPE: this was raised by the Health and Social Care Committee on 17 March 2020 and related to PIPP stock (as opposed to new stock supplied through NHS Supply Chain or Parallel Supply Chain). An example regarding GP surgeries was used: 20 areas were sent batches of masks that said, "Best before 2016" and a sticker had been put over saying "Best before 2021". The quality of the protective equipment being sent out to healthcare settings was therefore of concern. In response, NHS England's Strategic Incident Director said:

    "We are fully aware of those. They came from one of the stocks that I talked about, and they went through a quality assurance test for health safety. The reason they were rebadged is that it was appropriate. They were tested to ensure that they are of current standard."; and

    b. concerns regarding the quality of certain masks: around 28 May 2020 an alert on Cardinal Type IIR masks with flaking nose strip was issued **[JK1/105] [INQ000533236]**. The MHRA arranged for masks to be tested with the

manufacturer and confirmed on 19 June that the results of the testing showed that majority of the batches tested had the nose flaking issue, and therefore a recall might be required. On 27 June an Important Customer Alert was cascaded to Regional Teams, Trusts, LRFs and wholesalers **[JK1/106] [INQ000533235]** as well as being made available on the PPE Portal for social care and primary care providers. Following further discussion and SSHSC approval, a medical device alert was released on 20 July 2020 to instruct the destruction of affected lots **[JK1/107] [INQ000533228].**

236. Some of the first items distributed by the military over the weekend of 21 March 2020 were FFP3 masks in an attempt to try to relieve some of the pressure.

237. As the number of patients with Covid-19 in hospitals increased through March and early April 2020, there were increasing reports from frontline staff of PPE supply shortages. At this same time, the CNO (due to their professional leadership role for nurses and midwives) received feedback from the frontline which was generally focused on supply issues and the impact of shortages of PPE on staff, which caused significant concern. These concerns were discussed at the Senior Clinicians' Group on 9 April 2020. This was at a time when the pandemic was rapidly developing – there were increased hospital admissions and PPE supplies were decreasing. PHE's Deputy Director of the National Infection Service was tasked with drafting guidance on steps to be taken during PPE shortages **[JK1/055] [INQ000489981] [JK1/056] [INQ000489980] [JK1/057] [INQ000477783]**. This draft was prepared on 12 April and the CNO led an urgent discussion with Regional Chief Nurses and Trust DoNs regarding gown use in advance of a specially convened meeting of the Senior Clinicians' Group on that same day.

238. The UK IPC Cell, NHS England's Head of IPC and the CNO could not endorse the proposals. PHE were formally informed of this by the DCNO for Patient Safety and Innovation on 14 April 2020, which confirmed that these were matters for HSE **[JK1/057] [INQ000477783] [JK1/055] [INQ000489981] [JK1/056][INQ000489980].**

239. On 17 April 2020, PHE published a version of this guidance: "*Considerations for acute personal protective equipment shortages*", which advised continued use of masks and re-use of PPE due to potential shortages as part of preparations for a reasonable worst-case scenario.

240. In an emergency, it is normal to look ahead. There was also considered to be a need to prepare for the worst-case scenario in case PPE shortages became so acute that there

was not enough supply for the NHS. The shortages guidance was withdrawn on 9 September 2020 by PHE on the basis that it was not required. Whilst those involved in publishing the guidance felt it necessary to publish it to provide organisations with essential advice in the event that the worst-case scenario of national shortages materialised, and recognising that the tighter national supply becomes, the more difficult it will be to ensure even distribution, publishing the guidance sent a negative signal about stock availability. In addition, although national and Trust level supply was sufficient, some organisations have multiple sites and departments/locations and so delivery to all those individual sites may have been incomplete. For instance, some community Trusts, mental health Trusts and ambulance Trusts have 100+ locations. In hindsight, the guidance would therefore have been more useful for that particular cohort of providers than for general distribution.

241. Around the time that the shortage guidance was published by PHE:

    a. the Government started to secure additional PPE stock; and

    b. through joint work across the UK CNOs, the CNO was also able to agree with the CNO for Northern Ireland to receive 25,000 gowns from their stockpile under mutual aid arrangements to relieve the acute shortage, as Northern Ireland had greater availability at that point. These gowns were received on 18 April 2020.

Fit-testing

242. During the Relevant Period, there were reports concerning both improper safety procedures and FFP3 masks not fitting Black, Asian and minority ethnic staff (for example due to religious beards, which would prevent a seal).

243. Respiratory Protective Equipment (or "**RPE**") such as FFP2 or FFP3 respirators come in different shapes and sizes. There are also alternatives to disposable RPE such as powered hoods. Each time a new style, size or brand of FFP3 is provided to an individual it must be fit tested.

244. Fit testing is a legal requirement and must be carried out by a competent individual to ensure that specific masks are safe for the individual user before they can be used. Fit testing must be carried out every time a new size, shape or brand of FFP3 is provided to a use. Fit checking, however, is typically undertaken by the user every time that they use an FFP3 mask for which they have already been fit tested – it is not a substitute for fit testing **[JK1/058][INQ000330850]**.

245. NHS England's NMD and the CNO wrote to Trusts jointly on 24 April 2020 in response to reports of organisations only undertaking "fit checking" of new masks instead of fit testing.

246. Due to its many links to the frontline, the CNO BME SAG was involved in raising the issue of the disproportionate impact of Covid-19 on staff and patients from Black, Asian and ethnic minorities in April 2020. This feedback played an important role in prompting the work of NHS England and PHE regarding fit testing. On 10 June 2020, the CNO BME SAG shared a summary report with the CNO which provided the first feedback on issues for specific ethnic groups and individuals with the fit testing of FFP3 respirators.

247. Building on the evidence provided by the CNO BME SAG, a project was launched in June 2020 led by the DCNO for Patient Safety and Innovation, which gathered evidence and data from over 5,000 participants across 35 Trusts from a range of backgrounds **[JK1/059] [INQ000477789] [JK1/060] [INQ000477790].** This work provided the evidence base for a quality improvement programme, which worked with 11 Trusts to gather learning and embed best practice across all healthcare settings.

248. The learning from this work along with a fit-testing algorithm was published by NHS England on 29 October 2020 for use by healthcare organisations. This outlined the process for fit testing, which included ensuring that a range of masks were available, results were recorded, and re-testing was undertaken when masks or the wearer's circumstances changed **[JK1/061] [INQ000330889] [JK1/062] [INQ000330961].**

249. The CNO communicated this work to nursing and medical leaders via the fortnightly calls that that they jointly led with NHS England's NMD. The Nursing Directorate also ensured that this work was shared with others involved in PPE purchasing decisions to ensure the appropriate range and variety of PPE was procured.

PPE procurement by Trusts

250. Trusts are responsible for the procurement of goods and services they use. To the extent Trusts sought to procure their own PPE during the Relevant Period this would have been in accordance with their internal policies and relevant legislation. Any issues regarding fraud would have been considered locally through Trust audit arrangements including through reports to the NHS Counter Fraud Authority.

251. NHS England does not hold data on the quantity of PPE purchased by all Trusts during the Relevant Period. However, NHS England is aware that Trusts did purchase their

own PPE and some of these costs were reimbursed **[JK1/063] [INQ000496977] [JK1/064] [INQ000269945].**

252. There were, however, arrangements which came to the attention of NHS England's Regional teams. For example, on 12/13 April 2020, the Whittington Health NHS Trust confirmed that they had a lead for a manufacturer of gowns/coveralls in Cyprus. There were 2 million disposable coveralls available which were in Johannesburg and there were 1 million disposable gowns available near Ankara. This offer was escalated to National Team who confirmed that they were happy for the Trust to proceed as long as there was confirmation that the items were fluid-repellent and that the product specifications met the National standards. The London Region requested someone from Cabinet Office to prepare documentation and legal resource to advise on setting up escrow in Cyprus.

253. Trusts will have in place processes and procedures to monitor supplies using their internal systems including risk management systems such as Datix which could show shortages of equipment.

254. Trusts would have had links to NHS England's regional teams and escalated concerns over shortages or quality concerns. There would have been defined routes of escalation depending on the concern. For example:

    a. in the Midlands Region if a Trust escalated a shortage concern there was a defined process to follow, which included checking if the Trust had sought mutual aid from neighbouring organisations in the first instance, considering if the product shortage was known to the Region and reviewing review the activity data for that Trust to understand if the request for additional supplies was reasonable based on the patient number and service pressures in that Trust.

    b. In London from 23 March 2020, the London Covid-19 Supply Chain Cell team met virtually with Trust procurement leads on a daily basis (at peak this was held 7 days a week) to discuss the stock levels of key PPE items across Trusts in London as well as supply and demand levels.

255. Concerns regarding quality issues, for example, PPE being received marked as 'not fit for medical use' were escalated to the national NHS supplies group for investigation through the daily calls. CAS alerts were also sent via the CAS alerting system in respect of quality issues (see for example **[JK1/065] [INQ000081415]).**

256. Where Trusts had identified they had an excess of PPE, Trusts would contact Regional Incident Coordinator Centres or appropriate Cells to inform the Region that they had 'spare' equipment. Trusts also shared 'excess' PPE by way of mutual aid across regions. For example:

    a. On 30 March 2020, the East of England Region created a mutual aid store at its Regional Head Office. This allowed for redistribution of PPE across NHS organisations.

    b. On 10 April 2020, the East of England Region received 2,000 gowns from London (mutual aid basis): 375 were delivered to James Paget University NHS Foundation Trust, 600 to Mid and South Essex NHS Foundation Trust and 495 to West Hertfordshire Hospital NHS Foundation Trust.

257. NHS England is aware that local companies made contact with Trusts regarding the donation of items. For example, in 2020 a local South West company approached the South West Supplies Cell in relation to offers of PPE donations or improvised PPE. The Supplies Cell were not in a position to procure any stock and so they were put in touch with Trust procurement teams who would then be responsible for their own procurement decisions.

258. Storage of PPE received by Trusts either through national procurement or local Trust arrangements would typically be a matter for Trust estate teams. PPE distributed via national procurements would have been stored in hubs pending distribution, however, once distributed Trusts would need to manage their stock. As far as NHS England is aware the decisions by some Trusts to enter into agreements for additional warehousing and offsite storage were done at a local and system level. Some Integrated Care Systems used storage made available via the Local Resilience Forums, Fire Stations, and local authority provisions such as sports centres during the early stages of the pandemic.

High Priority Lane ("HPL")

259. NHS England was not involved in the creation, introduction or operation of the HPL. However, as explained in paragraphs 129 to 135, NHS England worked closely with DHSC and provided additional staff capacity to DHSC to assist DHSC with its response to the pandemic. In particular, NHS England's CCO worked closely with DHSC in setting up the Parallel Supply Chain (see paragraph 214 above) and was formally seconded to DHSC to assist with supply issues from 20 March 2020, although she had been working closely with DHSC in the earlier stages of the pandemic. NHS England's

CCO has set out her knowledge of the HPL and her involvement in the initial development of the HPL in her personal witness statement.

260. NHS England is aware that individuals within NHS England forwarded suppliers' details across to the HPL. To the best of NHS England's knowledge, this was because NHS England personnel were receiving many emails and offers of help from multiple suppliers and contacts and this was a way of sharing information about potential suppliers' offers of help with those who were working on obtaining PPE. The sourcing and supply of PPE was DHSC's responsibility so contacts were being passed to the appropriate people for further follow-up and scrutiny. Evidence relating to specific referrals to the HPL which have been attributed to individuals from NHS England (as identified in the table on gov.uk) is contained in the relevant personal witness statements for those individuals.

Reflections on PPE supply, demand and distribution

261. Extraordinary steps were required to ensure that all NHS sites had access to sufficient PPE. The collaboration with stakeholders and other public bodies in the commercial supply chain area is, from NHS England's perspective, an example of how effectively NHS England worked with everyone across Government, including the army, to rapidly put in place complex structures, process, and connections to address emerging supply issues urgently. This meant NHS England providing support for issues even if those issues were not NHS England's responsibility.

262. Whilst DHSC confirmed that the UK did not run out of PPE, the NAO noted that:

The NHS provider organisations we spoke to told us that, while they were concerned about the low stocks of PPE, they were always able to get what they needed in time. However, this was not the experience reported by many front-line workers. Feedback from care workers, doctors and nurses show that significant numbers of them considered that they were not adequately protected during the height of the first wave of the pandemic.

263. Going forward there needs to be contingency planning, stock management, supply chain resilience and forecasting in preparation for future pandemics. The alignment of NHS Supply Chain with NHS England and the creation of a Central Commercial Function ("**CCF**") in NHS England offers further opportunities to ensure suppliers are held to account, markets are sufficiently diverse and robust, and that mechanisms are in place to avoid patient harm and delays in treatment where supplies are disrupted in future (see paragraphs 355 to 359 and 388 to 400 respectively below).

Section 3: Testing

264. During the Relevant Period NHS England did not engage in the procurement of test kits and was not otherwise directly involved in the procurement of test kits for use by staff, patients or the public – this was primarily led by PHE and NHS Test & Trace.

265. During the Relevant Period, Covid-19 testing was led by PHE (now UKHSA) and DHSC. In support of that effort, NHS England stood up its NHS Testing Cell, which in collaboration with PHE contributed to part of Pillar 1 of the DHSC national testing programme. This involved scaling up swab testing for those with a medical need and, where possible, the most critical key workers as identified by DHSC.

266. During the pandemic, the NHS Testing Cell was tasked by DHSC with coordinating:

    a. The NHS RT-PCR1 testing programme, which included high throughput and rapid turnaround testing;

    b. The serology testing programme for NHS patients, as clinically required, and serology testing for social care;

    c. Testing of known variants of concern initially in collaboration with PHE and subsequently by NHS laboratories; and

    d. Lateral flow device ("**LFD**") testing programme for asymptomatic staff and other NHS uses.

267. NHS England did play a role in assisting PHE and NHS Test & Trace in connection with the initial distribution of LFDs. When LFDs were first rolled out NHS England supported PHE in connection with the distribution of the test kits to the NHS, by assisting PHE in determining the correct number of test kits to be distributed to local NHS organisations and by coordinating the distribution of test kits to primary care staff (GPs, dentists, pharmacists optometrists) via Primary Care Support England (PCSE), the existing provider of logistical and support services to primary care service, alongside PCSE's existing delivery portfolio for consumables **[JK1/066] [INQ000496978]**.

268. Once a national distribution system for LFDs was established (both for the public and NHS organisations), NHS England stood down its coordinating role.

Section 4: Ventilators

269. NHS England was not responsible for the sourcing and procuring of ventilators (or their associated consumables). That responsibility lay with DHSC as did the management of the commercial relationships with suppliers and manufacturers except in relation to the Cabinet Office's 'ventilator challenge' which the Cabinet Office oversaw. NHS England was responsible for the allocation of ventilators within England.

270. The following paragraphs explain the different types of ventilators, demand modelling, the role of NHS England in the procurement of ventilators and whether any quality issues arose with the ventilators procured.

Introduction

271. Ventilators are machines that assist or replace a patient's breathing by moving pressurised air with adjustable concentrations of oxygen in and out of the lungs. Patients with Covid-19 who are admitted to hospital often have problems breathing. If their blood oxygen level is low, the hospital may provide:

    a. standard oxygen therapy using a loose-fitting face mask - the patient is awake and is breathing on their own;

    b. non-invasive ventilation ("**NIV**") - the patient is awake and breathing on their own with either:

        i. a CPAP machine, i.e., the patient wears a tight-fitting face mask or helmet which increases the amount of oxygen in the air the patient breathes and the ventilator positive pressure helps keep the patient's lungs inflated - used in patients who are awake and in whom maintaining safe oxygen levels are the main breathing issue; or

        ii. a BiPAP machine - similar to a CPAP machine but a more sophisticated ventilator allowing for different air pressures when breathing in and out – used in patients who are awake and for whom maintaining safe oxygen levels and treating / preventing rising carbon-dioxide levels is required;

    c. high-flow nasal oxygen which is administered via cannulae placed into the nostrils and provides high flow, humidified and heated oxygen at high concentrations, and a small amount of CPAP;

    d. mechanical ventilation ("**MV**") – the term invasive or intermittent positive pressure

ventilators ("**IPPV**") is often used interchangeably here. Mechanical ventilators are used to treat the most severe type of respiratory failure, in which patients are anaesthetised and a breathing tube (endotracheal tube) is placed into the windpipe; this tube is then connected to a mechanical ventilator which provides intermittent positive pressure ventilation. Initially, the patient's own breathing efforts, and cough reflexes, are stopped using drugs, the patient is sedated and not conscious. After a period of days or weeks, if the patient continues to require MV, a tracheostomy tube may be placed directly through the neck, into the trachea, in a procedure done at the bedside in critical care, or the operating theatre. After this, a patient may be taken off sedative drugs, woken up, and the process of 'weaning off' the ventilator can continue. MVs are used in different forms – for example, anaesthetic MV machines are used to keep patients asleep in the operating theatre. These are usually used where a patient has healthy lungs and only requires ventilation for a maximum of 16 hours. They are not as sophisticated as other MVs. Transport ventilators, which are usually quite limited in function, are designed to be portable and used for transporting patients around or between hospitals. Some critical care MVs can also provide CPAP and NIV to awake patients via masks or helmets.

272. Ventilators require a supply of oxygen. Each model of ventilator also requires specific consumable products often specific to the manufacturer and model such as filters and tubes as well as connectors to power outlets and oxygen supply outlets.

Modelling ventilator demand

273. This section considers the modelling of demand for ventilators and how estimates of the number of ventilated beds that could be needed were revised over the course of the pandemic. It sets out how NHS England fed into the modelling scenarios at that time which in turn fed into modelling of the number of ventilated beds that could be needed.

274. NHS England's modelling, as opposed to modelling conducted by others for the UK Government, was for the development of planning scenarios in relation to the capacity of the NHS in England. It did not have a role in modelling demand for ventilator use in Scotland, Wales or Northern Ireland.

275. Modelling projected demand for ventilators was key to assessing whether enough ventilators would be available. NHS England was responsible for the development of planning scenarios in relation to NHS capacity. NHS scenarios were reviewed regularly within the multi-disciplinary NHS England Modelling Cell. Modelled scenarios provide

outlines of possible future developments but are subject to assumptions, inputs and caveats.

276. On the direction of the Government, NHS England's modelling was based on the Reasonable Worst-Case Scenarios ("**RWCS**"). These were developed by the Scientific Advisory Group for Emergencies ("**SAGE**"), the Scientific Pandemic Influenza Group on Modelling ("**SPI-M-O**") which was a sub-group of SAGE that gave expert advice to the UK Government on Covid-19 based on infectious disease modelling and epidemiology, and the UK academic modelling Groups (Imperial, Oxford and the London School of Hygiene and Tropical Medicine). NHS England usually used assumptions received via SPI-M-O but on occasion used those directly received from Imperial.

277. SPI-M-O's function was to feed into central government. NHS England was not represented at most of the early SPI-M-O meetings although NHS England's NMD began attending from 25 February 2020. NHS England therefore developed its own modelling for NHS operational planning and delivery purposes.

278. On 5 February 2020, NHS England's Strategic Incident Director attended a Cabinet Office Briefing Room meeting in which RWCS planning was presented and which he subsequently shared within NHS England to add to its capacity modelling.

279. In early February 2020, early indications were emerging from China which gave a first indication of the possible unmitigated impact. Early model parameters on infection, hospitalisation and ventilated bed rates translated to an estimated peak demand for ventilated beds of 59,000.

280. At its 20 February 2020 meeting, SAGE raised an action for NHS England to provide SPI-M-O with a list of criteria used for NHS planning and from 25 February 2020, NHS England began attending SAGE meetings.

281. More information was being received about the impact of social distancing in Hong Kong, Wuhan and Singapore which fed into the SPI-M-O modelling. A new RWCS was agreed by SAGE at their 27 February 2020 meeting and confirmed/refined on 1 March 2020 during a workshop involving members of SAGE and SPI-MO, with analysts from DHSC and NHS England in attendance. The intention was to test whether the view held at that time emerging from modelling, that the NHS would not have enough capacity was justified. The new RWCS translated into a peak demand of 90,000 ventilated beds.

282. On 17 March 2020, new evidence from SPI-M-O gave a lower overall hospitalisation rate but with a higher proportion of those requiring mechanical ventilation. Models were

beginning to emerge that estimated more systematically the impact of different mitigations. With no mitigations, this model had a peak demand for ventilated beds of 138,000. The output also included a run, including 75% compliance with social distancing, which reduced the estimated peak demand for ventilated beds to 2,400-11,300, depending on what other mitigations were implemented alongside it. The main planning scenario at the time was the Imperial-modelled RWCS with a combination of the following mitigations: home isolation, household quarantine and wider social distancing. This scenario was associated with peak demand for ventilated beds of 11,300.

283. On 23 March 2020, cases were rising rapidly and Imperial provided updated advice on the two-week lag of mitigations on hospitalisation rates. Based on this, NHS England issued a set of regional scenarios that were calibrated to give a doubling of hospitalisations every three days between 23 March and 5 April 2020, before gradually merging with the detailed runs from Imperial, based on different levels of compliance with social distancing. The modelled levels of compliance all had peak demand for ventilated beds of around 17,500 in mid-April 2020, driven by infection growth before lockdown was announced, but then had very different rates of decrease. For the end of April, the models predicted demand of between 6,300 and 11,700.

284. A briefing to NHS England's Chief Executive as preparation for a meeting with the Prime Minister on 23 March 2020 included the estimated number of patients in London requiring mechanical ventilation against the NHS surge capacity, with the former increasingly rising above the latter from that date **[JK1/067] [INQ000087334]**, **[JK1/068] [INQ000087335]**, and **[JK1/069] [INQ000087336]**.

285. On 31 March 2020, two scenarios of future infection growth were provided by Imperial and via the SAGE secretariat labelled "Good compliance" and "Poor compliance", with reference to adherence to social distancing rules. By early April 2020, NHS providers had reported a reasonable time-series of daily situation reports (the Daily NHS Provider SitRep or **"SitRep"**), allowing model outputs constrained to these levels. These showed that concerns of an initial period of three-day doubling were abating. When fitted to the SitRep data up to 1 April 2020, the latest good compliance scenario had a peak in the second week of April 2020 of 2,200 ventilated beds. The poor compliance scenario had a peak of around 4,000 ventilated beds in early May.

286. By late April 2020 comparisons between the SitRep data and planning lines showed the SitRep data trend falling between the good and poor compliance curves. An updated set of planning curves based on a 'blended curve' were produced and shared with NHS

Regions on 1 May 2020 to support local planning. The blended curve combined and fitted the Imperial good and poor compliance scenarios to SitRep data.

287. Modelling of NHS capacity, including in relation to ventilated beds, continued after May 2020 although by that time supply of ventilators was not an issue. In July 2020, the Cabinet Office commissioned three variants of new RWCSs from SPI-M-O. NHS England collaborated with the Oxford Big Data Institute Pathogen Dynamics Group to develop the Oxford Simulator to produce modelling based on the Cabinet Office RWCSs which was submitted to SPI-M-O. From July 2020, NHS England developed capability to use the Oxford Simulator in its own modelling, calibrated by the SitReps and specific assumptions. During the autumn of 2020, NHS England's modelling assumed a lower proportion of those hospitalised with Covid-19 needing a ventilated bed. Into 2021, NHS modelling began including the impact of the vaccination roll-out.

NHS England's role in procuring ventilators

288. As set out above, NHS England had no role in relation to procuring ventilators but did assist in sharing information about its own modelling of capacity in order to inform decisions being taken by the UK Government on the numbers of additional ventilators needed. NHS England's CCO also assisted DHSC by working in its ventilator supply team, as set out below.

289. In early March 2020, NHS England's Chief Executive asked NHS England's CCO to look at the supply position relating to ventilators to ensure NHS needs were being communicated effectively to DHSC. The CCO spoke with Chris Stirling who led the DHSC ventilator supply team acting under Steve Oldfield. There had been meetings for several weeks prior to this discussing supply of ventilators (among others). The day after speaking with Chris Stirling, NHS England's CCO joined the 8am team meetings. Those meeting were attended by the ventilator supply team and by those within DHSC working on oxygen supply. The latest demand modelling for ventilated beds was also discussed along with timings of deliveries of additional ventilators into the country.

290. When the CCO joined the ventilator supply team, it was clear that they had been working and were continuing to work to procure additional ventilators at a time when there was unprecedented global demand. China was a manufacturing hub for ventilators and most of the world was trying to place orders and secure supplies from Chinese manufacturers.

291. On the ground, DHSC's ventilator supply team, including NHS England's CCO, operated as one. NHS England's CCO subsequently became the SRO for the Oxygen

Supply and Distribution Cell.

292. As was the case with PPE, to ensure that decisions taken by NHS England's CCO in relation to ventilator procurement remained in line with organisational responsibilities, the CCO acted under the same secondment agreement between NHS England and DHSC as set out at paragraph 259 above.

293. In addition to the activities of NHS England's CCO, from 2 March 2020, NHS England's National Clinical Director for Critical and Perioperative Care, in response to a request from NHS England's National Director for Emergency Planning and Incident Response, began assisting the DHSC's ventilator procurement team by providing clinical advice on the suitability of ventilators that DHSC had identified as possible supplies.

NHS England's role in the allocation of ventilators

294. We set out a brief overview of the process of allocation of ventilators once they arrived at the warehouse. This provides context to the following section on issues arising with use of procured ventilators.

295. The allocation process was based on the following three principles:

    a. all nationally procured ventilators would be held centrally by NHS England and would be distributed and redistributed as required between hospitals and regions;

    b. the base allocation per English region and devolved nations would be based on an objective number of ventilators per million population; and

    c. stock that arrived first would be deployed to the areas with most immediate need as judged by actual data on patient numbers.

296. NHS England had approximately 3-4 days' lead time knowing how much new ventilator stock would arrive into the country. From 17 March 2020 onwards, DHSC circulated (including to NHS England) the Oxygen and Ventilation Situation Report **[JK1/070] [INQ000087358] and [JK1/071] [INQ000087359]** - a spreadsheet updated daily setting out updates on various workstreams relating to ventilator procurement, including conventional procurement (new deals with suppliers, manufacturers and intermediaries), the Cabinet Office's ventilator challenge, ventilator consumables and the "PO to Ward" process (how to allocate procured ventilators and manage Trust engagement processes).

297. On arrival into the country, new stock was transported to a warehouse in the Midlands,

MoD Donnington, that had been rented by DHSC from the Army. Large scale distributions of ventilators began from the start of April with the military assisting with the transportation from the warehouse to hospitals around the country once decisions were made on allocation.

298. The intention was that ventilators newly arrived at the warehouse would be opened, inspected and consumables would be added so that a full package of machine, tubes, masks and anything else needed could be distributed to hospitals. But due to the way the warehouse worked, consumables were not stored in the same place as the ventilators and recipients of ventilators received the consumables separately.

299. On 25 March 2020, NHS England issued a letter to Trusts **[JK1/072] [INQ000513772]** indicating that as newly procured ventilators became available, NHS England would coordinate distribution via regional teams who would work with local health systems. It was reiterated that NHS England would deploy the devices to areas with the most immediate need, on a fair share basis relative to patient ventilation need.

300. NHS England established the National Ventilation Allocation Programme ("**NVAP**") on 2 April 2020 with representation from the regions. Meetings were initially held daily (seven days per week) to challenge, review and allocate equipment where required, based on urgent clinical need. A system of gathering and recording data was put in place which, by mid-April, led to a complete map of institutions using oxygen across the country, which assisted with the allocation of ventilators to Trusts.

301. The allocation process included an assessment at regional and Trust level of existing patients, Covid-19 infection growth rates, and the equipment already in place. Representation from all regions had a positive effect – there were examples of regions whose Trusts had less urgent need for ventilators agreeing that the available equipment should go to Trusts in other regions instead. Frequency of calls and meetings of the NVAP changed over the subsequent 18 months based on Covid-19 prevalence rates.

302. In relation to whether all NHS patients who needed a ventilator were able to get access to one, on 8 April 2020 a communication from NHS England's COO to Regional Directors stated "*The numbers also suggest that we will also have enough physical ventilators and associated equipment and supplies in the country*" **[JK1/073] [INQ000087383]**, **[JK1/074] [INQ000087384]**, **[JK1/075] [INQ000087385] and [JK1/76] [INQ000087386]**.

303. By the end of June 2020, around 24,000 ventilators were available. The successful

ventilator challenge produced high numbers of new ventilators. On 29 July 2020, members of NHS England's NIRB considered a report on the proposed approach to strategic allocation of ventilators and associated equipment to regions. The reported stated "*We do not believe that availability of ventilation equipment will be a constraining factor in any future surge response*". NIRB resolved to approve the proposed allocations **[JK1/077] [INQ000087448].** By 3 August 2020, around 30,000 ventilators were available.

304. NHS England is not aware of any point when a patient who needed a ventilator was unable to get one because an appropriate ventilator was not available. Allocation of a ventilator to a patient is a clinical decision; NHS England is not able to comment on whether individual clinicians changed their normal practice as a result of current or anticipated pressures of the pandemic.

Escalation procedure

305. A standard operating protocol (version circulated on 3 April 2020 is set out in **[JK1/078] [INQ000496986]**) was developed for Trusts to escalate any issues with ventilator supply.

306. The first step was for the Trust to report a problem. Local solutions (such as mutual aid – provision of equipment from one neighbouring Trust to another) needed to have been exhausted before the matter was escalated to regional level. Considerable mutual aid occurred at local level.

307. Once escalated to regional level, regional teams would consider if an intra-regional solution was available before considering involving adjacent regions. If still unresolved, the matter was escalated to national level. A senior decision-maker within the national incident coordination team would consider the issue and if considered appropriate, a recommendation would be made to the next NVAP which included senior clinicians. A consensus approval was secured and the central warehouse was instructed to deliver the stock to the Trust site.

Ventilator issues

308. Technical checks on specifications of ventilators and compliance with regulatory requirements issued by MHRA was part of the process of procurement. On arrival at the warehouse, ventilators were again checked from a technical specification perspective.

309. As indicated earlier, NHS England's National Director for Emergency Planning and

Incident Response, began assisting the DHSC's ventilator procurement team by providing clinical advice on the suitability of ventilators that DHSC had identified as possible supplies. This was a clinical review of the suitability of devices which were already on NHS procurement frameworks lists, and other device lists provided by DHSC through their engagement with sales teams internationally. It was a clinical review of the suitability of the devices on these lists for use in the pandemic, given the available information about the disease, and projections of demand. No indication was provided to NHS England's National Director for Emergency Planning and Incident Response that the list of devices were 'recommendations' for devices to be procured and the National Director was not part of any other types of review or due diligence carried out on the devices. The expected output was a recommendation (as set out below) back to the DHSC team.

310. This clinical review involved categorising devices (according to whether they provided IPPV, NIV or other respiratory support, and for which age groups), and evaluating the potential for them being used to treat Covid-19 patients. The information provided was usually from open sources such as marketing materials from manufacturers' websites or Instructions for Use. The clinical review could not involve putting the devices to actual use, as the devices had not been bought. If it was identified at any stage that a device did not have a 'CE' mark, the MHRA were involved, and the devices would be required to go through their 'exceptional use' process. NHS England's National Director for Emergency Planning and Incident Response provided a "go/no-go" recommendation to the commercial team on procurement. This recommendation was relevant only to the clinical review, i.e. an indication that it was considered that the device was clinically appropriate or not, based on the materials reviewed. A "go" recommendation was therefore a recommendation that the device could proceed to the next review or due diligence stage. A "no go" recommendation was a recommendation that it should not proceed. All "go/no-go" recommendations were based on clinical grounds and with no consideration of commercial factors. The ultimate decision on whether to contract with a particular supplier was made by the DHSC team responsible for that particular product.

311. A batch of ventilators sourced from China, Aeonmed 510S Shangri-La ventilators, was sent, very soon after landing in the country, to Birmingham which was experiencing capacity pressures. NHS England's National Director for Emergency Planning and Incident Response had been asked to carry out the clinical review of the device prior to procurement, as one device on the list of devices provided by DHSC colleagues as described earlier. The National Director had not been part of any other review or due

diligence undertaken on the device before then. The documents considered for the clinical review were those that were publicly available or had been provided by the device's manufacturer. A "go" recommendation (relating to the clinical review only) was given to the relevant DHSC team. Procurement was approved on 18 March 2020 and devices arrived in the UK in early April 2020. The ventilators were accompanied by consumables including tubing connecting the ventilator to the oxygen outlets on the wall. The quick turnaround time did not allow for the usual comprehensive checks on accompanying consumables. This was made clear to the recipient Trust but it wanted them sent as soon as possible. On arrival it was discovered that the tubing was not compatible with the UK oxygen wall sockets. After discussion with the national clinical director relating to ventilators from the same manufacturer, it was recommended that these ventilators were withdrawn from use with outstanding orders of ventilators from this manufacturer cancelled.

312. The issue had been communicated to NHS England's National Director for Emergency Planning and Incident Response by one of the seven NHS England regional medical directors. NHS England regional medical directors typically work within their given NHS England regions, and engage with the wider NHS system on their patch. They are not medical directors within individual NHS Trusts; during Covid they had multiple roles, which included supporting coordination within and between regions of care and resources (including people and equipment). Where the allocation process indicated that a particular Trust needed ventilators, neither the regional medical directors nor local Trust leaders could specify the make or model of ventilator they would like. Allocation was a fair system based on clinical need, demands of patient care and the available devices within the warehouse.

313. Checks were subsequently carried out on the actual devices prior to Trust allocation. This was an additional check added once procured ventilators had arrived at Donnington for allocation. It was separate to, and much later in the procurement process, than the clinical reviews provided prior to any buying decision. As ventilators had not been procured at the clinical review stage, it was not possible to check whether a ventilator actually worked in accordance with its specification. Most ventilators procured were manufactured overseas so unless a device was already familiar to UK clinicians, the initial clinical review was entirely dependent on the quality of information provided by manufacturers.

314. On 31 March 2020, two Trusts in the Black Country, Dudley and Wolverhampton, reported that they had run out of CPAP machines **[JK1/079] [INQ000087372]**. NHS

England, after confirming that non-invasive ventilator equipment was acceptable, liaised with the Cabinet Office to arrange for a delivery from the central stock held at the warehouse at MoD Donnington. The military were to locate the devices and send to the Trusts that evening.

315. On 1 April 2020, NIRB was provided with an update on ventilator capacity and the ongoing work to address concerns and requests that had been raised by regional teams **[JK1/080] [INQ000087376]**. Over the following days, more NIVs were delivered with 253 mechanical ventilators being delivered to five Trusts in the Midlands area on or around 4 April 2020 **[JK1/081] [INQ000087375]**. These were ventilators from the same manufacturer as those referred to above in relation to Birmingham which were subsequently subject to a recommendation to be withdrawn from use.

Section 5: Oxygen

Introduction

316. The supply of bulk liquid oxygen itself was less of a concern during the pandemic as national control of Bulk Oxygen Infrastructure Projects was put in place across the industry oxygen suppliers (BOC, Air Products & Air Liquide) by DHSC, cognisant of devolved administrations' use of these suppliers. This was to ensure that engineering capacity, bulk oxygen equipment, bottled oxygen and liquid oxygen distribution were focussed on the delivery of projects and services that most effectively met the needs of the Level 4 incident, including for Nightingale Hospitals and the emergency response more broadly.

317. NHS England is not aware of any procurement issues that arose in relation to the supply of oxygen to the NHS system during the pandemic.

318. NHS England undertook considerable work throughout the pandemic in relation to oxygen supply in terms of getting the oxygen to patients from the oxygen tanks. However, this was not a procurement issue but NHS England assisting primarily, on managing and improving the infrastructure across the NHS for delivering oxygen to patients. This included a rolling package of funded capital works for NHS Trusts but also provided regional and national oversight in managing critical incidents affecting oxygen supply. To be clear, there were no procurement supply issues in relation to the supply of oxygen during the Relevant Period. In fact, the UK generally makes more oxygen than it needs.

319. As a result of the nature of Covid-19, and initial treatments, oxygen supply was identified early in the pandemic as presenting a particular risk. There was a concern that demand for oxygen would far exceed previous oxygen usage and supply norms, such that it would place existing infrastructure under unprecedented pressure.

320. NHS hospitals typically use bulk liquid supply of oxygen through piped systems, delivered through a Vacuum Insulated Evaporator (or **"VIE"** system). The VIE turns the liquid oxygen into gas, and then pumps up through the hospital's pipework to the areas they need to draw on it. Those systems usually operate at around 40% of their maximum capacity. They are generally reliable, using simple mechanical engineering. They also have a secondary system for back-up which is in line with the normal 40% operating capacity of the primary system.

321. All NHS providers must comply with the Health Technical Memorandum (HTM) 02-01) Medical Gas Pipeline Systems', which is mandatory guidance that was issued by DHSC in May 2006. That guidance deals with:

    a. design, installation, validation and verification of systems;

    b. management of medical gas pipeline systems; and

    c. dental compressed air and vacuum systems.

322. Compliance with this guidance is not monitored centrally as Trusts are locally responsible for its implementation; there are not sufficient resources available to monitor centrally. Through the NHS Premises Assurance Model (NHS PAM), NHS organisations provide assurance regarding their medical gas systems. This is a self-certification process, and therefore, limited as certification will be generally undertaken by those who have implemented the system.

323. There are no direct penalties for non-compliance with this guidance. Compliance with guidance issued by the NHS Estates Division is referenced by the CQC under Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as relevant guidance.[24] In addition, non-compliance can be considered in legal proceedings as evidence of failure to provide a safe environment for patients, visitors and staff.

324. Due to the age and condition of some hospitals (one in eight are older than the NHS and 30% are more than 50 years old), their pipework presented problems for them in terms of being able to deliver oxygen across their site to full capacity. Further, it became apparent during the pandemic that a significant number of hospital sites which reported issues or concerns in relation to their oxygen supply had not fully implemented and assured compliance with the 2006 guidance – particularly in terms of maintaining infrastructure and establishing local governance arrangements for medical gas safety. Hospitals and Trusts were often able to resolve any concerns or incidents directly with regional teams or with commercial suppliers. The central NHS England team was notified of some incidents, typically via regional teams, and normally only where the problem was significant enough to require NHS England's central team to intervene (principal examples of which are outlined further below). Consequently, not all local incidents or concerns have been documented centrally.

[24] It is listed within a section dealing more generally with the Health technical memoranda series - including Policies and principles of healthcare engineering (HTM 00) (Department of Health, 2014).

325. As a result, and as set out further below, there was considerable activity to monitor and respond to oxygen-related incidents throughout the pandemic. This included a frontloaded programme of work to identify and support priority oxygen infrastructure projects during Wave 1, when the demand for oxygen therapy was significantly less than in Wave 2. Those efforts were significant in creating additional capacity across the NHS.

The National Oxygen Infrastructure Programme

326. The National Oxygen Infrastructure Programme ("**NOIP**") was established in March 2020 as a sub-cell of the Oxygen and Ventilation National Covid-19 Cell (operated by DHSC and described below). The NOIP team was a multi-agency forum that worked 'virtually' and collaboratively – working across organisational and commercial boundaries - to assess system impact, intelligence and determine national, regional and local Trust medical oxygen requirements. Further detail regarding the NOIP's terms of scope can be found in its project initiation document. A key role was to support allocation of funding for works improvements (**[JK1/082] [INQ000270013]**).

327. In early March 2020, an urgent national data collection across all acute Trusts in England was initiated, to understand their oxygen infrastructure and bed capacity that was capable of delivering bed-head piped medical oxygen supply. Oxygen capability was constrained by a number of factors:

    a. vessel size;

    b. evaporator capacity;

    c. controls capacity; and

    d. distribution pipework within a hospital (pipe diameter and configuration).

328. NHS England also made arrangements for all Trusts to be fitted with gauges which monitored their oxygen consumption, which provided real-time feedback on how they were tracking against overall oxygen capacity. Where capacity was identified as a concern for a particular Trust then this informed decisions to prioritise funding through the capital works programme described below.

329. With this information, multi-disciplinary regional teams (estates, emergency planners and clinicians) undertook surge planning exercises to explore how bed capacity could be increased. Where critical resilience issues were identified, these were collaboratively addressed as urgent priorities.

330. With only limited capacity in the works supply chain, and the allocated initial budget of £20m assigned by HMT, the NOIP team carried out further analysis which detailed all Trust proposed oxygen infrastructure projects, and the beds that could be created by them. This data was presented back to regions who prioritised the schemes based on their surge capacity modelling exercises.

331. Following prioritisation into 'waves', the NOIP team worked across the health system and the works supply chain to establish the scope of the required projects and the specific work that would be required. This initial work identified 59 projects in four prioritised sequential waves, for example:

    a. the oxygenation of existing beds;

    b. the refurbishment/recommissioning of existing capacity; and

    c. the fit out of new beds introduced specifically in response to the pandemic.

332. The prioritised project list was shared with supply chain partners with the intention of establishing the efficacy of the proposals with Trusts and what alternative schemes could be developed to provide the same outcomes, without using limited and scarce oxygen resources whilst working within the allocated budget. The shortlist of initial urgent projects included the Nightingale hospitals.

333. The first phase of these projects delivered oxygen to over 3,000 additional beds at acute hospitals in just over four weeks (compared with a 'normal' 16 weeks) with a further 1,547 in various stages of completion.

334. Following the completion of the planning phase of the first wave oxygen projects, preparations commenced for a second wave of projects. Each regional team was asked to reconfirm its priorities for the second Wave 2 schemes. Final submissions were received from those teams by 24 April 2020.

335. The NOIP team then considered the newly identified second wave Trusts that had been given priority status by the regional teams, which then proceeded as Wave 2a. The remaining second wave Trusts were then planned in as Wave 2b subject to supplier resources (albeit Wave 2b was subsequently redefined as Waves 3 and 4).

336. By May 2021 NHS England had concluded most of the Wave 1, Wave 2, Wave 3 and Wave 4 projects (seven projects remained, that were programmed to complete prior to the end of July 2021). The Wave 5 pipeline projects were reconfirmed with regions, and

handed over to the suppliers to assist in their work planning and prioritisation for the future.

337. In addition to the NOIP, which provided national oversight and coordination, regions developed their own cells to respond to incidents reported to them by local Trusts. NOIP supported these cells and other frequent queries.

338. Broadly speaking, the NOIP was effective in mitigating oxygen supply incidents throughout its existence.

339. The NOIP identified a number of lessons learned when reflecting on its work which can be summarised as follows:

    a. Trusts which had fully followed the DHSC guidance referenced above, to include implementation of a local and effective multidisciplinary medical gases safety committee, did not suffer issues during the pandemic;

    b. relatedly, there was a need to review and more broadly reinforce that guidance to ensure that Trusts were aware of its requirements;

    c. further evaluation of, and investment in, Trust pipework systems was, and is, required;

    d. business continuity plans related to oxygen supply should be updated to include surge planning;

    e. a need to expand the medical gas specialist workforce;

    f. similarly a need to invest in the most oxygen efficient medical equipment as well as systemwide deployment of new flow monitoring technology;

    g. ward-level housekeeping and practice makes a huge difference to the efficacy of oxygen supply; and

    h. a need for improved governance and assurance, to include building on the identified benefits of multi-disciplinary working between technical/engineering and clinical experts (particularly through medical gases safety committees).

340. In respect of modelling oxygen supply and medical gas pipelines, NHS England provided data to, and inputted into the mechanics of, the DHSC's Oxygen Stress Test Model in late 2021. DHSC will be best placed to explain in more detail but at a high level, this was a model designed to stress test peak oxygen flow rate as a percentage

of VIE capacity. It took into account the oxygen supplier-reported capacity of the installed VIEs. A Sitrep was developed as part of the Foundry data system which provided a daily "hotlist" of sites where oxygen flow rate exceeded 60% of capacity. These sites were contacted by the NHS England Oxygen team to determine if there was an issue and if so, how the NHS England team could assist.

Oxygen incidents

341. There were several incidents relating to oxygen supply which arose during the pandemic of which NHS England is aware but none related to the procurement or supply of oxygen. Rather such incidents arose from transporting the liquid oxygen from tanks to the bedside of the patient due to issues around the increased use of oxygen and/or the nature and/or age of the infrastructure in place at the relevant premises. NHS England is not aware of any incidents that arose in respect of portable oxygen supplies or medical gas pipeline systems due to procurement issues with the supply of oxygen.

342. NHS England issued several communications early in the pandemic in relation to oxygen, both in light of the general known issues relating to oxygen supply and in light of learning from specific incidents (as set out above, those incidents did not relate to procurement issues with the supply of oxygen). In particular:

    a. a letter and guidance to CEOs, Medical Directors, Critical Care Directors and respiratory/acute medicine directors on 31 March 2020 outlining urgent actions which should be taken to mitigate risks posed by increased demand for oxygen. The distribution was also effected through a number of other methods, including existing online platforms which bring together NHS estates professionals and also through circulation to engineering professionals;

    b. a systemwide alert on 6 April 2020 via the CAS. This provided guidance on safely managing oxygen systems to achieve maximum sustainable flow, and the process for responding to, and escalating, concerns or defects in equipment; and

    c. a further systemwide letter on 12 April 2020 issued jointly by NHS England's Strategic Incident Director and CCO. This also outlined the steps which Trusts should implement to avoid placing unnecessary demand or pressure on the supply chain. Queries or escalations were to be addressed through regional delivery teams, who in turn would prioritise requests with regional and national estates teams (**[JK1/083] [INQ000226892]**).

PART 3

Section 6: Lessons Learned

Introduction

343. Given the complexity of the health system, reflecting on how improvements can be made to (i) respond to any future response; or (ii) the resilience of the healthcare sector, presents similar complications. There are currently multiple policies and plans being enacted by the NHS, the last and current Governments and health Arms' Length Bodies, that build on learning to date.

344. Whilst the procurement of key healthcare equipment and supplies was not NHS England's responsibility, NHS England worked closely with key stakeholders and organisations as part of the "all hands on deck" approach, to support the system in getting PPE and other items of equipment and supplies to where it was in most need as quickly as possible.

345. Likewise, the pattern of government decision-making during the pandemic was overall supportive of funding the NHS' additional resource needs that arose as a result of its response to the pandemic. This in turn allowed NHS England to quickly arrange for funding to be allocated where it was required within the NHS in England to respond to the pandemic.

Identifying lessons learned

346. The NHS had been moving to greater system collaboration prior to the pandemic, which further supported collaborative working during the pandemic, and was later cemented through the Health and Care Act 2022.

347. Throughout the pandemic, individuals, teams, networks and NHS England have continuously conducted different types of reviews at different levels both formal and informal. Lessons have been identified and learned in different time horizons, in different forums and at operational, tactical, and strategic levels.

NHS England's Lessons Learned Report

348. NHS England's report "*Lessons from NHS England and Improvement's response to the pandemic*" **[JK1/084] [INQ000226890]** brought together information and lessons gathered during 2022.

349. The report adopts both a chronological and thematic approach and was produced as an

initial attempt to identify lessons at a particular point in time. NHS England recognises that its reflections may not be representative of how others have reflected upon the events of the pandemic; and that others may have identified other important lessons that are not addressed in the report.

350. The report is exhibited in full alongside this statement, and has also been made available to other Modules, so is not reproduced here. The report considers issues that arose in both primary and secondary care and addresses learning in relation to health inequalities. Lessons 62 and 63 (Resourcing protracted incidents) and 64 (Continuity of Supply) within the report relate to resourcing and continuity of supply which are relevant to Module 5. Some additional reflections are set out below.

351. Following the report, an action plan has been produced to take forward its recommendations, along with arrangements to oversee and monitor implementation.

Examples of work undertaken within NHS England

(i) Strategic framework for NHS Commercial ("NHS Commercial Framework")

352. NHS England's first ever commercial framework for the NHS commercial sector **("NHS Commercial Framework")** was published in November 2023 and updated on 18 December 2023 **[JK1/108] [INQ000533233]**. The NHS Commercial Framework sets out a strategic direction across key commercial capabilities in managing key supply markets and suppliers, commercial arrangements with suppliers, as well as looking at unnecessary cost and waste, and missed opportunities to drive additional value and leverage scale. The NHS Commercial Framework states that it will also make it easier for suppliers to work with the NHS so they can deliver innovative solutions to meet NHS priorities for patients and staff.

353. The NHS Commercial Framework is focussed on themes which include attracting the best talent, to use data strategically and drive greater transparency, to use its position to work with supply markets to deliver innovation and wider social values and economic benefits through procurement. One of its strategic outcomes is to embed a resilient commercial and supply chain operating model.

354. One of the actions set out in the NHS Commercial Framework is to implement NHS-wide supply risk management as follows:

"We will implement an NHS-wide approach to supply risk management and resilience. COVID-19 exposed the importance of near real-time insights into supply risks and proactive management of supply disruption across global healthcare supply markets.

This will include:

- *comprehensive risk analysis using leading commercial intelligence platforms combined with insight and intelligence from stakeholders across the NHS;*
- *a co-ordinated approach to resilience, involving key partners including NHS Supply Chain, to provide a national approach to continuity planning*
- *a co-ordinated approach to managing and mitigating emerging issues to achieve best outcomes, particularly those risks that impact on patient care*
- *ensuring that future national category development focuses on opportunities to improve both value and system resilience."*

(ii) The Central Commercial Function ("CCF")

355. NHS England's Commercial Directorate launched the CCF in 2022 to oversee and set the strategic direction of NHS procurement and supply chain activity for the NHS. This was in response to engagement with commercial and frontline delivery teams across the NHS and suppliers that identified the requirement for greater oversight and guidance, and more clearly defined services to support NHS Commercial activities through a unified commercial community.

356. The CCF comprises a team of commercial experts delivering 7 services for the wider NHS commercial community and is not confined to pandemic planning. The services are at different stages of maturity with some being new or in development.

357. NHS England's Board Paper of 7 July 2022 **[JK1/109] [INQ000533231]** set out what the CCF will deliver and how.

358. Specifically in relation to supply chain and resilience issues, which is one of the 7 services, the website states

"A resilient supply chain is vital in ensuring that our frontline teams have the resources they need. The central commercial function manages our strategically important supplier relationships, so that we can rapidly respond to supply chain challenges."

359. Within CCF, a Continuity of Supply team will oversee supplier resilience and plans, which will be managed through operational governance and provision of guidance, tools and best practice. The team will also identify areas of risk and variation to supply continuity across key categories and use data and insight to horizon scan global risks and solutions to protect onward supply. This work is also important in the context of

pandemic planning in that it will work on supply chain resilience and develop further its insight and intelligence so that it can respond quickly to potential supply disruptions in those markets important to the NHS.

Additional learning relating to Module 5

360. From NHS England's perspective, we have highlighted below some areas where further improvements may be possible going forward in relation to the matters being considered by the Inquiry within the scope of Module 5.

(i) Planning and preparation

361. Planning and preparation in advance is clearly necessary to be able to respond quickly to emergencies such as those encountered during the pandemic. For example, having an outline plan already established to deal with potential supply chain issues including the rapid mobilisation of deliveries of critical healthcare equipment and supplies (should this be necessary), would have been helpful in dealing with logistical issues that arose with deliveries of PPE to the NHS at the outset of the pandemic.

362. For example, the advanced planning and preparation that took place for the UK's exit from the EU enabled the NSDR hotline to be set up quickly to deal with PPE issues as set out above.

363. NHS England's Framework for managing the response to pandemic diseases **[JK1/110] [INQ000474402]** confirms that Supply Chain and Estates would be a cell included in an example structure of a regional incident management team.

(ii) The ability to centrally procure when a Level 4 incident is declared

364. NHS England considers that it should have the ability to rapidly centrally procure when a Level 4 incident is declared, to be used in prescribed circumstances. NHS England considers that being able to rapidly centrally procure is critical in order to respond to situations like those which arose during the pandemic, to harness the national buying power of the NHS and draw on wider expertise of the Government. NHS England would be able to assess whether the need to centrally procure was required or not and would be able to use such powers if necessary.

365. NHS England could purchase key healthcare equipment and supplies for the whole system as it has visibility and the intelligence to be able to do so. During a Level 4 incident, NHS England would be able to understand the demand signal better than any other organisation and can allocate based on need and criticality. NHS England has

significant experience in dealing with stock issues when they arise and using data (which we can obtain from NHS Supply Chain, our own data sources and/or the regions) to understand where stock is held, what the burn rates are and how to allocate appropriately within the system. NHS England holds the relationships with suppliers and has the clinical expertise available to understand what products should be purchased, and crucially, to what specification.

366. Purchasing would need to stay with DHSC meaning that price assurance processes would be required in order approve buying decisions and spend.

367. This suggestion arises from lessons learned early in the pandemic where there were examples of Trusts competing with each other for the same supplies[25]. This required a national response and culminated in the letter that was issued on 1 May 2020 **[JK1/050][INQ000226899]** as set out in paragraph 228 above to ensure that certain items were purchased nationally.

(iii) Data collection

368. At the time, the lack of data and transparency available nationally, to inform purchasing decisions in the initial stages of the pandemic, proved to be problematic. Every Trust and CCG is a separate legal entity and generally was not required to share granular detail of its stock with NHS England. NHS England was obliged to have regard to regulatory burdens and approaches data collections purposively. However, during the pandemic, it was vital to the national response to understand what stock organisations held and what their requirements were. This meant having to compile data to ensure stock was delivered to where it was needed and required NHS providers to share their own data to do so. Given NHS England was not the buyer or supplier of PPE, it held no information about usage or stocks of PPE held in trusts at the start of the pandemic. SCCL also had historically, not needed this information, and Trusts often had not needed detailed information as PPE was a low cost, commodity item that could in normal course of business, be ordered overnight when needed. The PPE cell therefore did not know, other than from the previous pattern of Trusts orders to SCCL pre pandemic, what demand might be expected. As outlined above, NHS England's CCO commissioned McKinsey to

[25] The National Audit Report "The Supply of Personal protective Equipment (PPE) during the COVID-19 pandemic" INQ000145895 noted at para 3.9 "This followed an instruction from the Department and NHSE&I that (to prevent competition between NHS bodies increasing prices) trusts should only buy PPE from "new, small, local suppliers". Additionally, the Witness Statement of Paul Webster on behalf of SCCL gave some examples of issues they faced including Trusts placing surge orders out of line with actual need; and where products were subject to demand management, some Trusts would try to get around this by ordering from multiple different requisition points within the Trust.

model the expected demand based on IPC guidance as to what PPE should be worn in different situations and by which staff, with respect to the current incidence and growth rate of covid cases in a Trust. This model was tested with clinical and other staff to ensure it was practical, and then tested in practice to see how close it got to what hospitals said they needed. Over time this demand model was also expanded to cover social care, hospices, primary care (with substantially less detail) and some other users. The model was in place by early April and was further developed by including inventory data from Trusts from May 2020 and stock data. Over May, June and July much effort went into aligning systems so that this model could also work from projected stock arrivals into the UK. In the interim, this data was collated manually from various systems and presented at the distribution meetings.

369. There is now greater transparency across Trusts in England via NHS England's Spend Comparison Service, a platform introduced in August 2019 and refreshed in May 2023, which enables NHS procurement teams to compare price and spend data, helping to identify potential savings, leverage the market and collaborate to purchase goods and services. Nearly all Trusts now submit data monthly in arrears, which should ensure that more accurate information is available on the national picture of Trust purchasing. Data could also be requested more quickly and more regularly (and for a number of Trusts there is now a direct feed from their accounts) should this be needed for the purpose of responding to future emergencies.

370. NHS England and Trusts are also moving to the Federated Data Platform to bring about more collaboration and data together across the NHS.

(iv) Building resilience

(a) Supply chain issues

371. The supply chain in the NHS is highly complex, providing millions of commodities, consumables, bespoke equipment, medicines, and devices to hospitals, general practices and other healthcare facilities, as well as directly to healthcare professionals and patients at home in every part of the country.

372. Prior to the pandemic, the majority of PPE globally was purchased from China. As the pandemic unfolded, global demand increased resulting in dependency predominantly on China and Chinese suppliers for these items.

373. Given the market conditions at the time, negotiating contract terms with suppliers and/or intermediaries was extremely challenging. The contract terms were often onerous

requiring large deposits before any order could be confirmed. Building better resilience into the supply chain could potentially remove and/or mitigate the need to enter into such contracts, thereby delivering better value for money during times of emergency.

374. The UK had no or very limited manufacturing capability in producing items that became critically important, including PPE. Had the UK been able to rely on domestic manufacturers for its own PPE requirements, this would have given it an advantage in being able to source and supply such items more reliably and quickly. Future pandemics are undoubtedly going to face similar issues and NHS England notes that others have suggested that manufacturing capacity within the UK should be reviewed together with other contingencies to mitigate supply disruptions, including, for example, whether the stockpile should be increased and expanded to cover additional pandemic types to ensure the right balance of stockpiling with technology development and the potential cost of expired equipment.

375. NHS England considers that there should be a risk exercise undertaken by the UK government on a range of critical supply areas which is regularly updated. The Cabinet Office undertook this task during the pandemic and NHS England believes that maintaining this for major risk areas (including, for example, PPE and medicines) as well as there being a regular consultation on where the major risks are, would enable timely discussions on how such risks could be removed, reduced or mitigated in order to build more resilience into the national supply chain.

376. Similarly, NHS England considers that the healthcare sector should risk assess their own supply chains and highlight instances where they are reliant on a single supplier and take steps to inject more resilience into their supply chain.

(b) Becoming brand agnostic and stripping back specifications to those required

377. Some NHS providers make purchasing decisions via NHS Supply Chain's catalogue of supplies and/or their own supply chain networks based on preferred brands and/or on the basis that some of their clinicians are only trained on one particular type or brand of equipment. In order to support increased competition between suppliers, enhance value for money, support business continuity and increase supply chain resilience, the NHS needs to become better at being brand agnostic.

378. Providers who have been trained on only one type or brand of equipment should be trained to work on at least one other. Trusts should work collaboratively to share training and learning and/or work with other brands and manufacturers in order to be more resilient in the event of supply changes/disruption.

379. Additionally, Trusts need to focus on what their essential specifications are for the items they purchase. During the pandemic, it became increasingly important for purchasing decisions to be taken based on the essential specifications needed for a particular piece of equipment as opposed to purchasing decisions based on equipment with "nice to have" items. An example of this could be seen with hospital beds purchases for the Nightingales project where the original specification provided was several pages long and included requirements including under bed lighting. The specifications needed to be stripped back to the core requirements which needed clinical involvement to ensure that the beds purchased were fit for purpose and included all essential elements but were stripped of unnecessary extras. NHS England considers that a review on specifications for healthcare supplies and equipment would be prudent and should be carried out by Trusts so they are buying only what is really needed, rather than paying extra for things that they do not.

(c) Review of social care

380. NHS England recognised the pressures on social care, prior to the pandemic. It commented publicly on the need for social care funding increases and structural review. There has always been an interdependency, with hospital beds and resources closely affected by the availability of social care in the community, whether at home or in residential care. There is also an NHS contribution to social care budgets. Although the issue of social care during the pandemic is a matter for a later module, we would suggest that resilience and capacity issues in social care are national issues which must be addressed from the centre alongside individual local authorities, or indeed individual care providers. We endorse the calls for action in this area, even if we understand that the Inquiry may not have heard sufficient evidence to call for specific solutions.

(d) Resilience within the NHS estate

381. The NHS estate is the largest and most complicated in the UK, encompassing some 17,000 buildings. The current age profile of the NHS estate varies significantly: 12% of the total estate pre-dates the founding of the NHS in 1948, around 17% is over 60 years old, and around 44% is between 30 and 60 years old.

382. A well-maintained estate that is fit-for-purpose improves the efficiency and capacity of a healthcare system. The age and design of the NHS estate means a lack of flexibility into surge response is 'baked in'. Annually published data on the estate demonstrates some of the risks associated with an aging estate and need for investment **([JK1/085] [INQ000148443])**.

383. Specifically in relation to Covid-19, the condition and layout of the available infrastructure of healthcare settings (in particular for hospitals) was and remains a constraining factor when implementing new IPC guidance i.e., separating Covid-19 and non-Covid-19 patients and distancing between beds. Single-occupancy rooms, as opposed to communal wards, ease separation of non-Covid-19 and Covid-19 patients. In Covid-19 wards, even if a bed is unoccupied, it would need to be regarded as 'occupied' and unavailable to a non-Covid-19 patient.

384. The impact of the NHS estate on the pandemic response was also seen in the capacity of the piped oxygen supply system in many hospitals during the pandemic. This required emergency mitigating actions to increase the total number of oxygen capable beds.

385. Capital funding fell by 19% in real-terms between 2013/14 and 2016/17, before beginning to rise again, only exceeding 2013/14 levels in 2018/19. Capital spend per worker in NHS trusts was estimated to be 17% lower in 2017/18 than in 2010/11 (**[JK1/086] [INQ000148430]**). During this period, the size of the maintenance backlog was growing year on year, and by 2019/20 it stood at £9bn, larger than the total capital budget.

386. Since 2010, the UK has had a lower level of capital investment in health care compared with the EU14 countries for which data is available. Between 2010 and 2019, average health capital investment in the UK was £5.8bn a year. If the UK had matched the EU14 countries' average investment in health capital (as a share of GDP), the UK would have invested £33bn more between 2010 and 2019 (around 55% higher than actual investment during that period).

387. The requirement for significant capital investment in the NHS was recognised by the previous Government prior to the pandemic, as set out in the Health Infrastructure Plan of September 2019 (**[JK1/087] [INQ000148431]**), which included the "*40 new hospital*" building project.

(v) NHS Supply Chain/SCCL

388. As set out above, many healthcare providers operate "just in time" approaches to supply, i.e. not maintaining large stocks of what they need but relying on regular and routine deliveries matched to need. Similarly, the NHS Supply Chain model buys from wholesalers rather than directly from suppliers/manufacturers. Whilst this approach is entirely standard and satisfactory during "business as usual" times and provides value for money, it proved to be inadequate to respond to the scale of demand required to

respond to the pandemic. Ordering consumables through intermediaries meant that delivery dates into the UK were often unknown, arrived late or were incomplete.

389. The distribution model was also not able to expand sufficiently quickly to meet increased demand. A model originally designed to supply 232 Trusts and 1700 sites was asked to support over 34,000 customers. Consequently, the Parallel (PPE) Supply Chain was established by DHSC in March 2020 to source additional supplies of PPE directly with suppliers, predominantly from China, rather than via wholesalers given the uncertainty.

390. NHS Supply Chain is a valuable organisation providing a central procurement function which harnesses the buying power of the NHS for the benefit of the NHS. NHS Supply Chain seeks to bring savings to the NHS by having frameworks in place which have clear specifications on products needed within the NHS and to deliver a commercial route to market.

391. However, NHS Supply Chain continues to face challenges in securing a greater collective buying power as some Trusts prefer to buy via other routes. Investment is required to increase SCCL's physical capacity. On 12 January 2024, the National Audit Office published a report entitled "*NHS Supply Chain and efficiencies in procurement*" **[JK1/111] [INQ000533232]** identified a number of ongoing challenges including late deliveries, confusion around savings figures, below target levels of satisfaction with its services, a need to make the ordering process easier.

392. NHS England has been working with NHS Supply Chain to address these concerns within the confines of its own funding settlement and the need to balance competing demand for NHS funding. SCCL has redesigned its operating model which went live on 1 August 2023 and has embarked on a transformation programme to upgrade key legacy IT systems to improve resilience, reduce manual workarounds, enable cost savings and reduce risk of error across the organisation.

393. SCCL remains a company separate from NHS England but is now more strategically and operationally aligned to ensure consistency of actions between the two organisations. There is an annual process in place through which NHS England critically reviews and works with NHS Supply Chain to develop and agree its business plan and revenue and capital funding requests for the following year. The annual plan and budget are approved by NHS England's Board which has to consider all demands for NHS funding from its allocated budget. NHS England also holds quarterly Accountability meetings chaired by its CCO to track performance against the business plan via a set of KPIs as well as receiving updates on key activities such as the

transformation and modernisation plans. NHS England also has a shareholder director on NHS Supply Chain's Board. There are also monthly finance and operations meetings, fortnightly meetings between NHS England's CCO and NHS Supply Chain's CEO and updates to NHS England's Board at least twice per year.

394. In relation to the "tower" model as set out in paragraph 138 above, NHS Supply Chain has now brought the procurement of medical, clinical and consumables into a within NHS Supply Chain in order to drive further efficiencies.

395. Further work is being undertaken with NHS Supply Chain in the context of the NHS Commercial Framework to manage the sourcing and supply of a core range of standard commodities (to be known as the NHS Core List) on behalf of all NHS providers to achieve high levels of compliance, cost containment and supply resilience.

396. Aligning with the priorities set out by NHS England, NHS Supply Chain is starting to work on the deployment of In-Trust Inventory Management Systems by using inventory management and point of care solutions to connect the NHS and increase visibility of where inventory sits in the supply chain. The initial scope will provide the solution to 20 NHS Trusts over a two year period with six of those Trusts having now gone live with the system. It will allow NHS Supply Chain to leverage a system-wide view to optimise visibility on national stock demand and consumption to improve supply chain resilience while supporting upstream supplier stock management and demand planning as well as enable national initiatives across Scan4Safety and GS1 standards adoption.

397. NHS England updated the Public Accounts Committee on 5 December 2024 by letter **[JK1/112] [INQ000533234]** to confirm the position with regards to NHS Supply Chain's current business case for its next phase of transformation.

398. Some of SCCL's deliverables include developing the pandemic response plan and developing its future supply chain offer to embed resilience across the supply chain. In any future pandemic, SCCL would continue to play a key role (as it did in the Covid-19 pandemic) in ensuring the availability and delivery of key healthcare supplies to healthcare providers. Given that DHSC is responsible for determining the levels of stock required in the future for pandemic preparedness, SCCL will also maintain the required levels of stock levels as agreed with UK Health Security Agency and funded separately.

399. SCCL will also be able to explain to the Inquiry the steps it has and will be taking to build its supply chain resilience but one further example is that it has invested in a major distribution centre in North West England to support 115 Trusts, which is three times

larger than the facility it replaced.

400. Some Trusts have also taken steps to increase their own warehouse capacity to hold larger quantities of stock.

Statement of Truth

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

Signed	**Personal Data**	**Position or office held**	**Chief Financial Officer**
Print Full Name	**Julian Kelly**	**Date**	**23/12/2024**

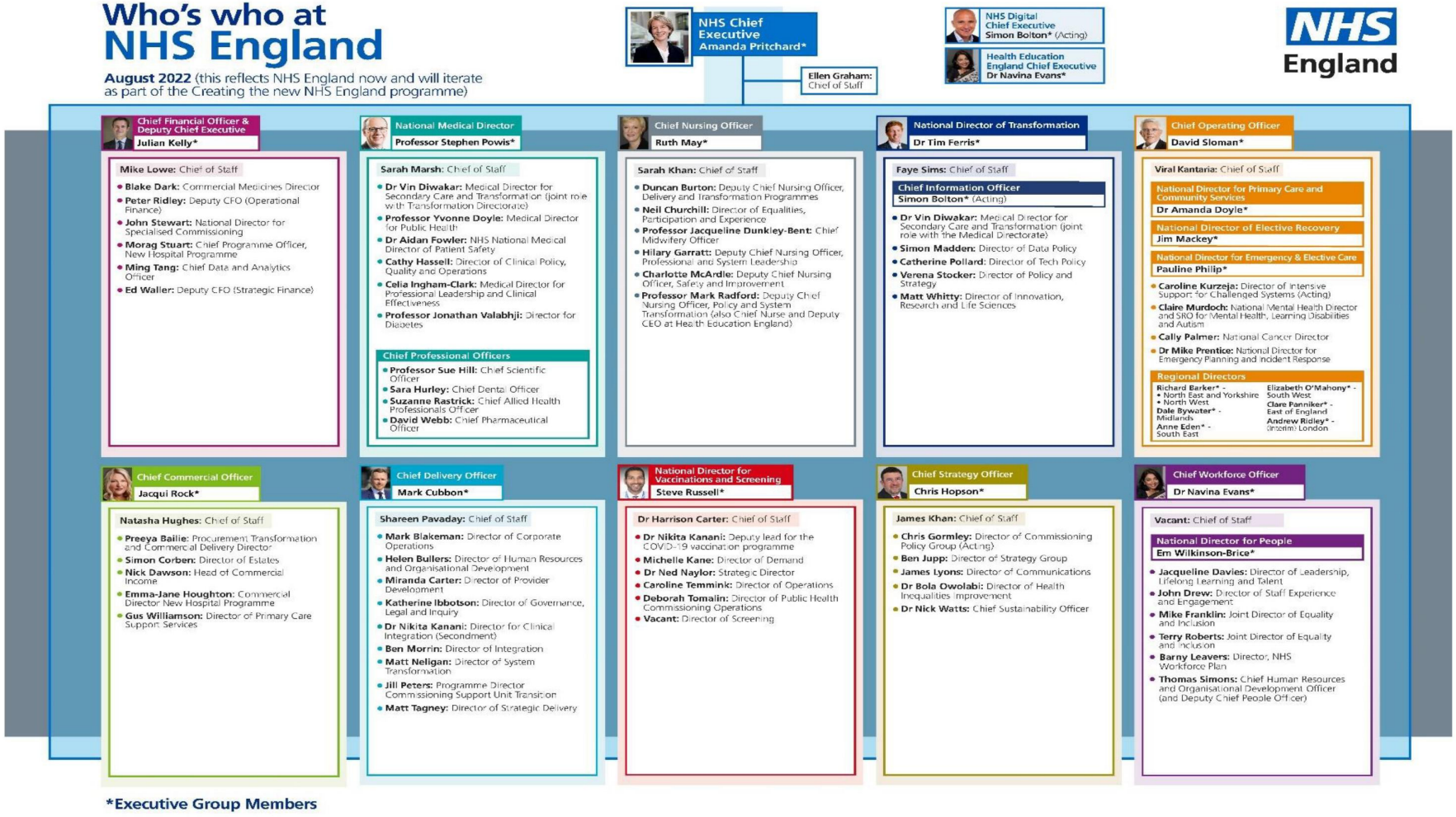
Annex 1 – Key individuals

Key Individual	Dates	Attendance at Key Meetings
Chief Executive Officer		
Lord Simon Stevens	1 April – 31 July 2021	• Prime Minister & SSHSC COVID 19 Meetings subsequently "Dashboard Meetings" • GCSA, CMO, NHSE CEO & PHE Meetings • Quad Meetings or "NHS Weekly" • Daily catch ups with No.10 Downing Street
Amanda Pritchard	1 August 2021 – to date	
Chief Operating Officer		
Amanda Pritchard	1 August 2021 – 31 July 2021	• Chair of NIRB • Accountable Emergency Officer for Covid-19 – reported to NHSE Executive Group and NHSE and NHSI boards with monthly updates on the work of NIRB • Covid-19 Operations Committee • Prime Minister's Covid-19 Dashboard Meetings • Quad Meetings or "NHS Weekly" (until August 2021) • Daily catch-ups with No.10 Downing Street (Malcolm Reid)
Mark Cubbon (interim)	1 August 2021 – 13 December 2021	
David Sloman	14 December 2021 – August 2023	
Jim Mackay (interim)	August 2023 – November 2023	
Doctor Dame Emily Lawson	November 2023 – to date	
National Strategic Incident Director		

Professor Sir Keith Willett	January 2020 – 4 July 2021	• National Incident Response Board
Mike Prentice (Deputy)	February 2020 – April 2022	
Chief Financial Officer		
Julian Kelly	1 April 2019 – to date	• Chaired National Incident Response Board in COO absence • Quad Meetings or "NHS Weekly" from August 2021 • Cross System Efficiency and Finance Board • Capital Delivery Portfolio Board
Chief Commercial Officer		
Doctor Dame Emily Lawson	1 February 2020 – 5 July 2021	
Blake Dark (interim)	6 July 2021 – 31 December 2021	
Jacqui Rock	1 January 2022 – to date	
Chief Nursing Officer		
Dame Ruth May	7 January 2019 – 24 July 2024	• UK Senior Clinicians Group (along with the CNO's from the other 3 nations) • Co-Chair of the Hospital-Onset Covid-19 (HOCI) Working Group • '4 CNO & NMC' meetings • Covid-19 Operations Committee (as required) • Daily Test and Trace meetings
National Medical Director		
Professor Sir Stephen Powis	30 January 2019 – to date	• Chaired National Incident Response Board in COO absence • Covid-19 Operations Committee • Prime Minister 'Covid-19 dashboard' meetings • SAGE

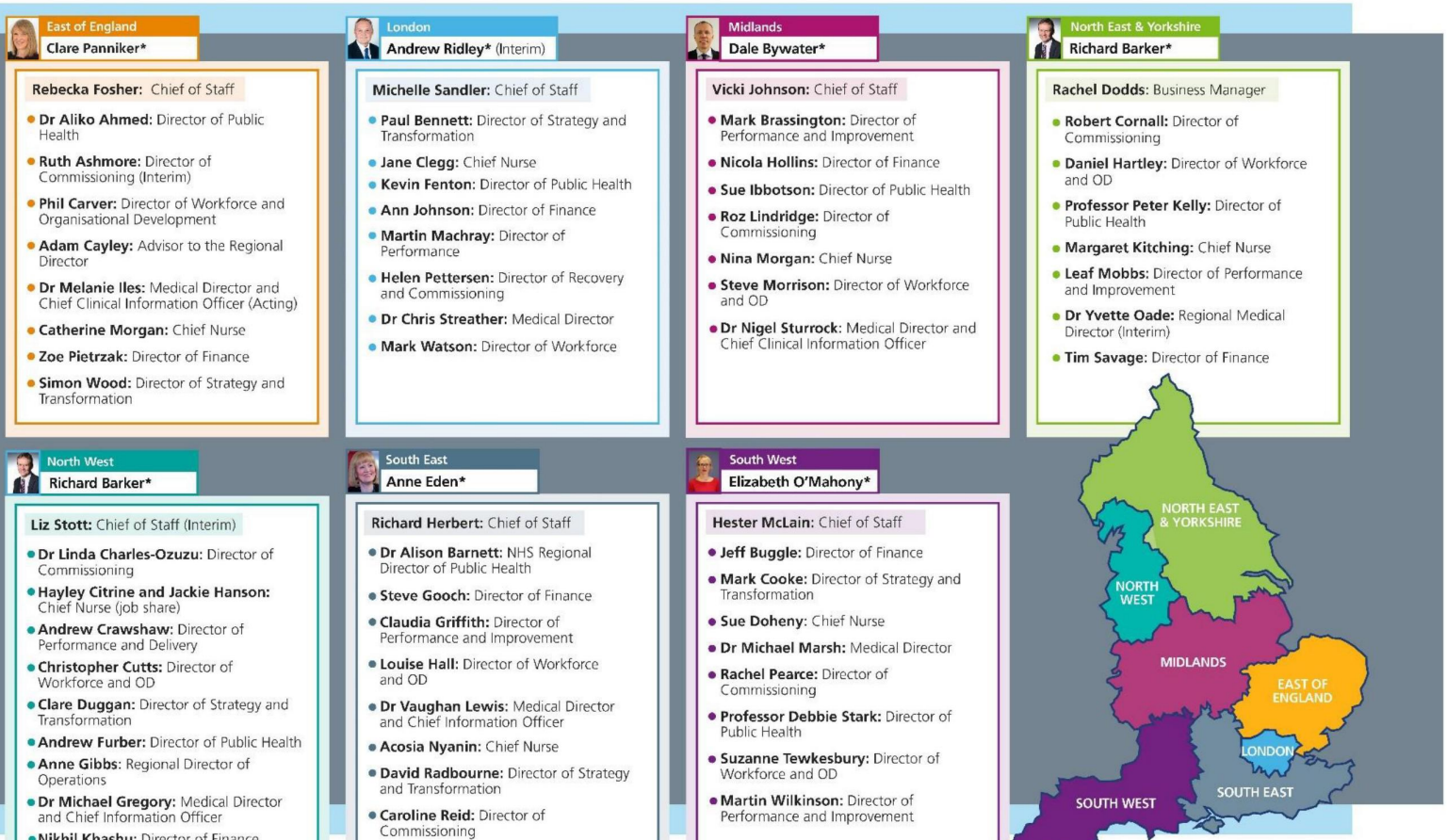
		• Joint Biosecurity Centre Local Action Committee (Gold) meeting with SSHSC (also known as DHSC Gold) • Joint Biosecurity Centre Silver meetings (also known as DHSC Silver)
Chief People Officer		
Prerana Issar	1 April 2019 – 15 December 2019	
Professor Em Wilkinson-Brice (interim)	16 December 2019 – to date	

Annex 2 – Organisational structures of NHS England



NHS England regional teams

NHS England



East of England
Clare Panniker*

Rebecka Fosher: Chief of Staff

- **Dr Aliko Ahmed:** Director of Public Health
- **Ruth Ashmore:** Director of Commissioning (Interim)
- **Phil Carver:** Director of Workforce and Organisational Development
- **Adam Cayley:** Advisor to the Regional Director
- **Dr Melanie Iles:** Medical Director and Chief Clinical Information Officer (Acting)
- **Catherine Morgan:** Chief Nurse
- **Zoe Pietrzak:** Director of Finance
- **Simon Wood:** Director of Strategy and Transformation

London
Andrew Ridley* (Interim)

Michelle Sandler: Chief of Staff

- **Paul Bennett:** Director of Strategy and Transformation
- **Jane Clegg:** Chief Nurse
- **Kevin Fenton:** Director of Public Health
- **Ann Johnson:** Director of Finance
- **Martin Machray:** Director of Performance
- **Helen Pettersen:** Director of Recovery and Commissioning
- **Dr Chris Streather:** Medical Director
- **Mark Watson:** Director of Workforce

Midlands
Dale Bywater*

Vicki Johnson: Chief of Staff

- **Mark Brassington:** Director of Performance and Improvement
- **Nicola Hollins:** Director of Finance
- **Sue Ibbotson:** Director of Public Health
- **Roz Lindridge:** Director of Commissioning
- **Nina Morgan:** Chief Nurse
- **Steve Morrison:** Director of Workforce and OD
- **Dr Nigel Sturrock:** Medical Director and Chief Clinical Information Officer

North East & Yorkshire
Richard Barker*

Rachel Dodds: Business Manager

- **Robert Cornall:** Director of Commissioning
- **Daniel Hartley:** Director of Workforce and OD
- **Professor Peter Kelly:** Director of Public Health
- **Margaret Kitching:** Chief Nurse
- **Leaf Mobbs:** Director of Performance and Improvement
- **Dr Yvette Oade:** Regional Medical Director (Interim)
- **Tim Savage:** Director of Finance

North West
Richard Barker*

Liz Stott: Chief of Staff (Interim)

- **Dr Linda Charles-Ozuzu:** Director of Commissioning
- **Hayley Citrine and Jackie Hanson:** Chief Nurse (job share)
- **Andrew Crawshaw:** Director of Performance and Delivery
- **Christopher Cutts:** Director of Workforce and OD
- **Clare Duggan:** Director of Strategy and Transformation
- **Andrew Furber:** Director of Public Health
- **Anne Gibbs:** Regional Director of Operations
- **Dr Michael Gregory:** Medical Director and Chief Information Officer
- **Nikhil Khashu:** Director of Finance

South East
Anne Eden*

Richard Herbert: Chief of Staff

- **Dr Alison Barnett:** NHS Regional Director of Public Health
- **Steve Gooch:** Director of Finance
- **Claudia Griffith:** Director of Performance and Improvement
- **Louise Hall:** Director of Workforce and OD
- **Dr Vaughan Lewis:** Medical Director and Chief Information Officer
- **Acosia Nyanin:** Chief Nurse
- **David Radbourne:** Director of Strategy and Transformation
- **Caroline Reid:** Director of Commissioning

South West
Elizabeth O'Mahony*

Hester McLain: Chief of Staff

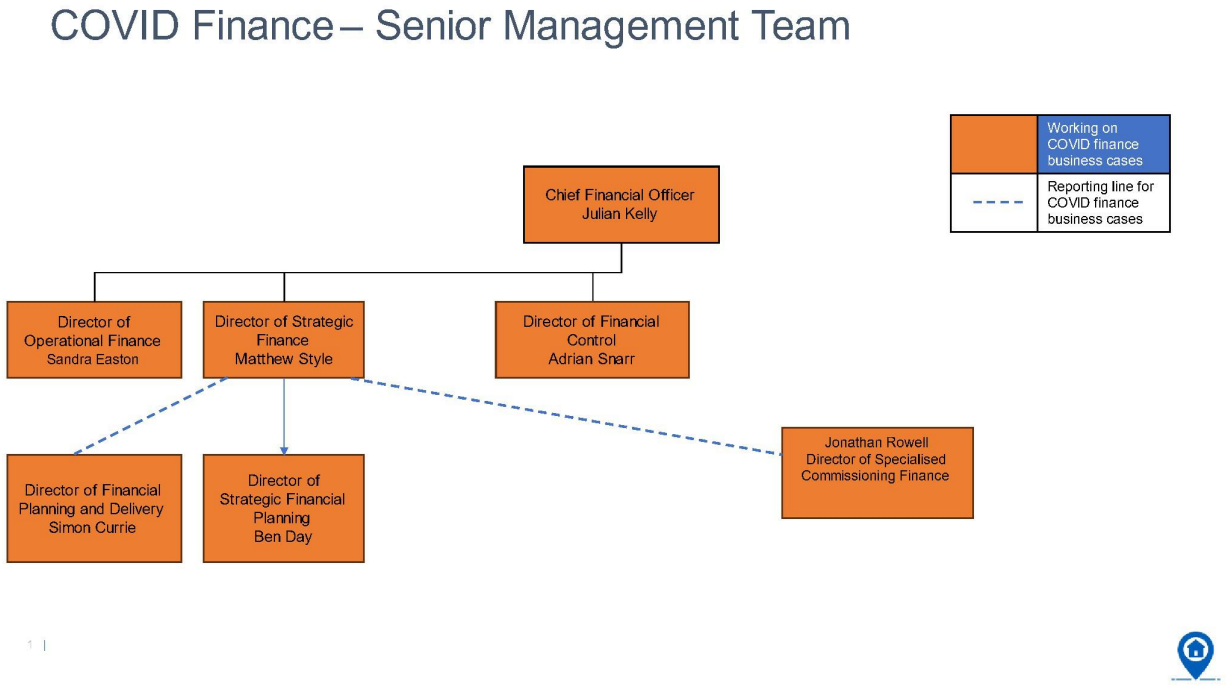
- **Jeff Buggle:** Director of Finance
- **Mark Cooke:** Director of Strategy and Transformation
- **Sue Doheny:** Chief Nurse
- **Dr Michael Marsh:** Medical Director
- **Rachel Pearce:** Director of Commissioning
- **Professor Debbie Stark:** Director of Public Health
- **Suzanne Tewkesbury:** Director of Workforce and OD
- **Martin Wilkinson:** Director of Performance and Improvement

*Executive Group Members

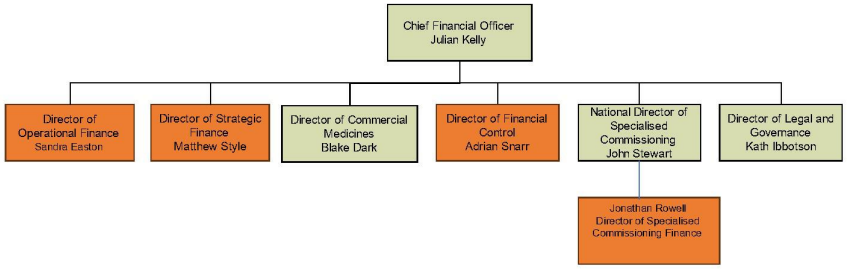
The teams primarily responsible for dealing with approval of revenue business cases within NHS England for its own spend were the finance and commercial teams. Organograms for both teams are set out below.

Finance

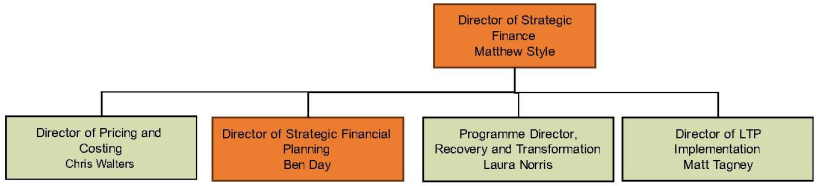
The following organisation charts show the arrangement of the Finance team for Covid-19 matters together with the "business as usual" reporting lines.



National Finance – Senior Management Team



Strategic Finance – Senior Management Team

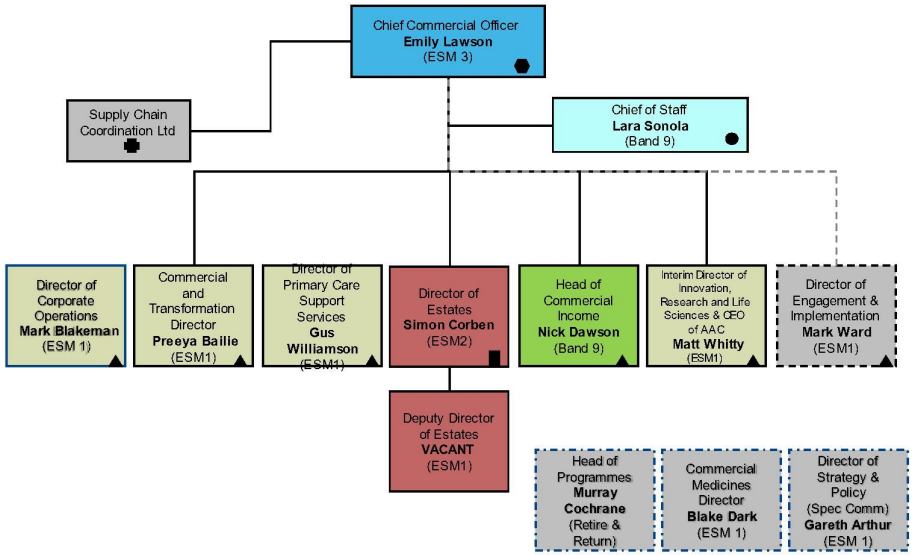


Operational Finance – Senior Management Team

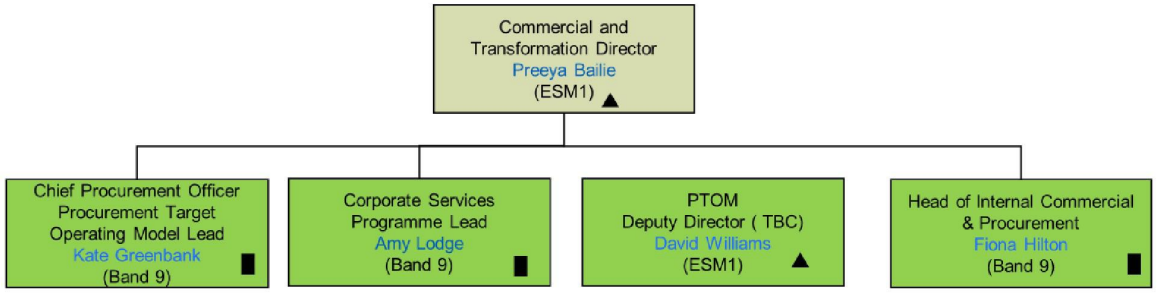
Commercial

The following organisation charts show the arrangement of the Commercial Directorate reporting lines during the pandemic and the current structure.

Commercial Senior Leadership Team

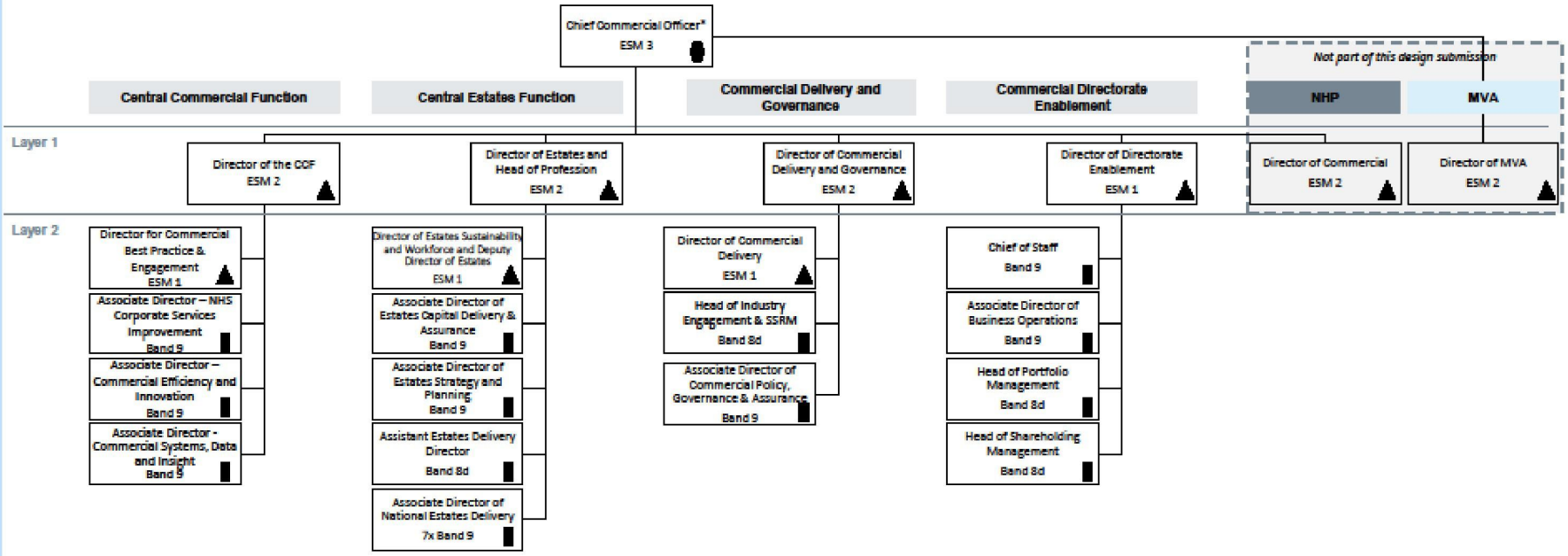


Transformation and Commercial Delivery



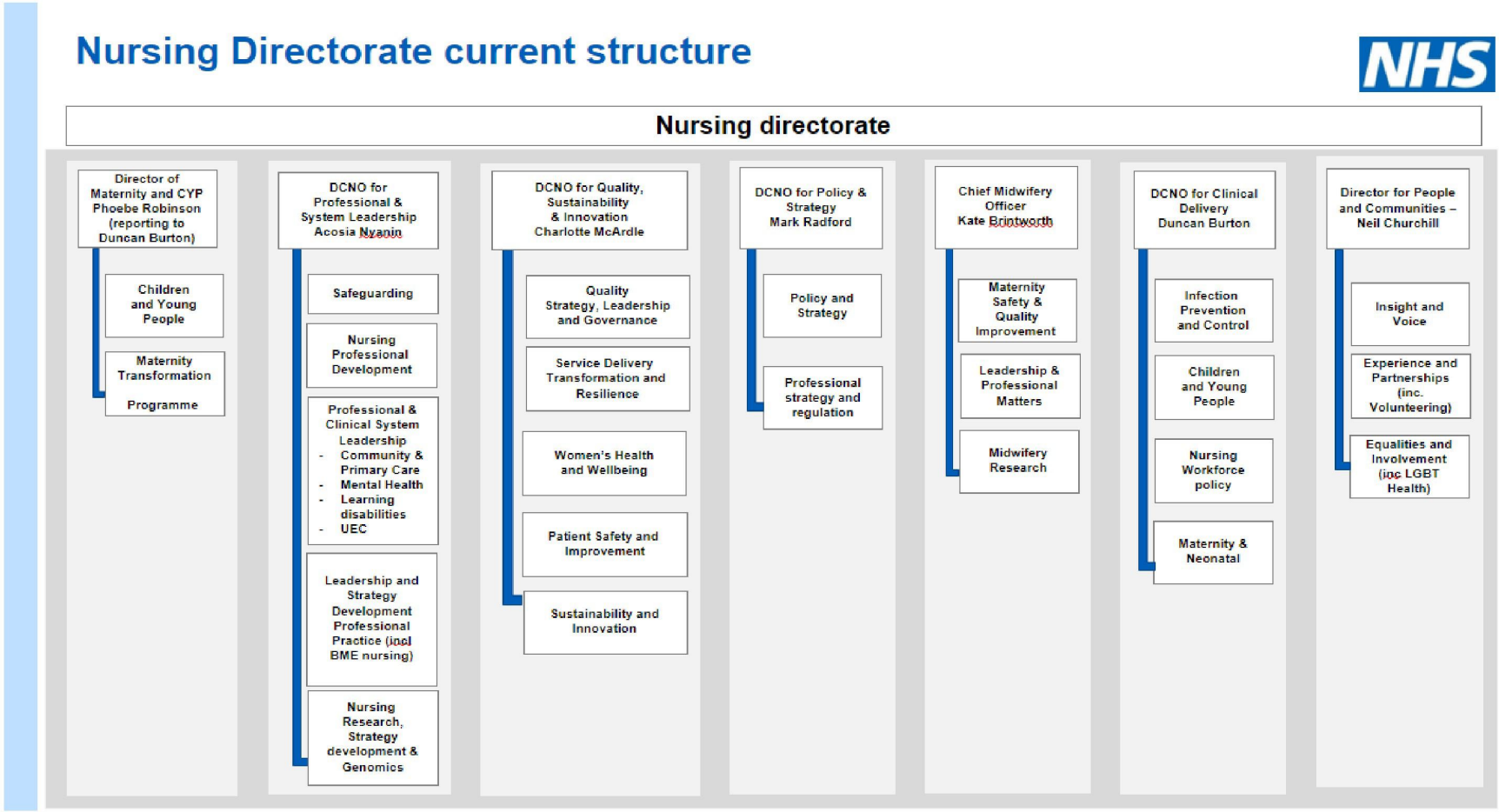
Senior Leadership Team (N-2)

The Commercial Directorate is a highly professional and accredited commercial and estates organisation, operating in a lean organisational structural environment and requires a certain seniority, qualification, and experience to lead through matrix across the NHS system. To allow NHSE to fulfil its commercial and estate statutory duties and responsibilities.

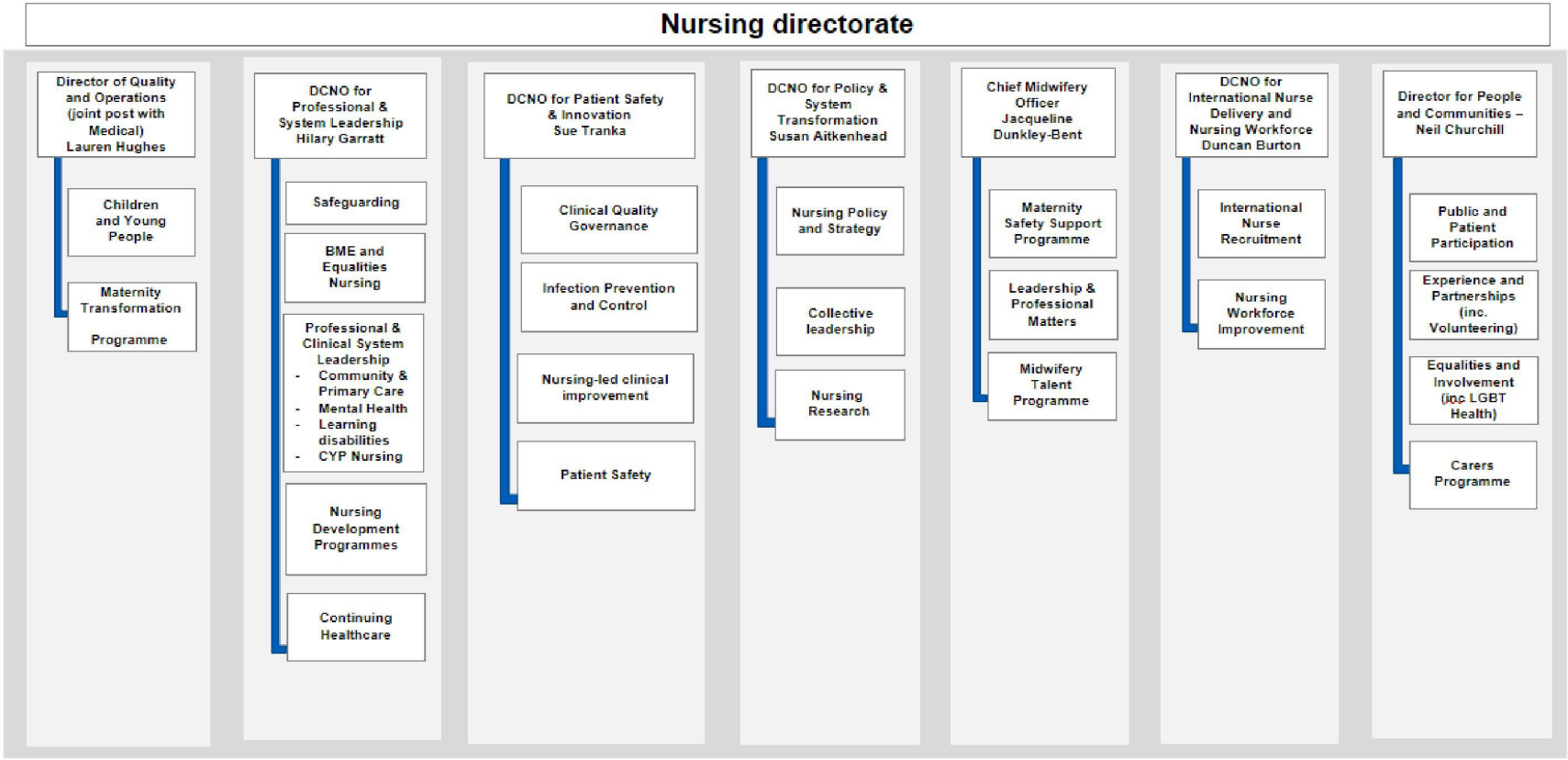


*ESM3 excluded from figures, as part of ExCo headcount

Nursing Directorate structure



Nursing Directorate 1 April 2020



Annex 3 – Key meetings in the context of Module 5

1. Many of the key meetings relating to procurement would not have been minuted by NHS England as other key stakeholders were leading on them. In line with the "all hands on deck" approach to the pandemic, NHS England staff worked with other key stakeholders in relation to aspects of procurement, despite this not being NHS England's responsibility. Insofar as NHS England would have been updated on issues around procurement issues, the main meetings are set out below.

Internal meetings

NHS England's Board

2. Updates would be given at Board meetings regarding the state of readiness and incidents since the previous update.

Incident Management Team ("IMT")

3. The IMT was activated on 21 January 2020 in response to early signs of the global spread of Covid-19 under NHS England's Strategic Incident Director and, National Director for Emergency Planning and Incident Response. On 22 January 2020, NHS England's Strategic Incident Director formally commenced his role as NHS England's Strategic Incident Director for Covid-19. Steven Groves was appointed as Incident Director. The National Incident Management Team (IMT(N)) and the Incident Co-ordination Centre (ICO(N)) were formally established.

4. IMT meetings commenced from 21 January 2020 and were attended initially by the Medical Director for EPRR, the Director for EPRR, the Head of EPRR, EPRR (National), Regional Heads of EPRR, National Communications Response, Specialised Commissioning, IPC Leads, NHS 111 Lead and HCID-A Network Lead. Meetings were initially scheduled to take place twice daily, seven days per week until September 2020 when it moved to five days per week (Monday – Friday). In May 2021, meetings were held five days per week with a further meeting on Saturdays by exception.

5. With the first patients identified in late January, NHS England declared a level 4 incident on 30 January 2020. Following this the EPRR team worked to establish a cell structure enhanced by the 'pillar' system. Operational tasks included increasing the number of available oxygen supplies and ventilators, supporting the creation of additional capacity (including Nightingale facilities) and providing quarantine facilities –

initially in the form of HCID units and latterly to support returnees from Wuhan, China and the Diamond Princess.

6. The IMT was responsible for:

   a. Receiving daily operational status updates from Regional Incident Directors and the national workstreams covering:

      i. Operational assessments of the last and next 24 hours;

      ii. Operational assessments of the next 48 hours;

      iii. Risks and mitigations; and

      iv. Issues and resource requests.

   b. Acting as the national first escalation point for the regions and national workstreams;

   c. Providing response to regional concerns where appropriate;

   d. Providing strategic and operational support and guidance to the regions and national workstreams;

   e. Disseminating key strategic and operational messages from National Strategic and Tactical Fusion to the regions and national workstreams;

   f. Escalating key tactical/operational messages to National Strategic and Tactical Fusion;

   g. Disseminating the NHS COO's daily message to the regions and national workstreams.

7. The IMT was chaired by the Deputy Incident Director (National), and in his absence, the Duty Incident Coordination Centre Manager.

NHS England's Covid-19 National Incident Response Board ("NIRB")

8. NHS England and NHS Improvement each established a group known as NIRB which met in common to support the discharge of each organisation's respective duties and powers and their combined responsibilities by setting the strategic direction and providing oversight of NHS England and NHS Improvement's response to the Covid-19 incident.

9. The duties of NIRB were (in summary) to:

   a. set the strategic direction and provide oversight of the NHS England response to the incident;

   b. work in partnership with other originations (e.g. DHSC & PHE) to protect the public and minimise health impact;

   c. agree the approach to the implementation of national response measures and related key communications activity;

   d. determine the redeployment and/or reallocation of NHS England resource to support NHS operational readiness and the response to the incident based on the Government's cross-departmental strategy and priorities, making recommendations to the NHS England Boards where a proposal has a material impact on staff, the public and/or patients, or where a decision is considered to be contentious and/or repercussive;

   e. provide oversight and challenge to NHS England operations;

   f. review key risks and issues escalated to NIRB; and

   g. ensure appropriate arrangements were established at the appropriate time to manage recovery work.

10. NIRB approved the evolving iterations of the Covid-19 operating model (as evidenced through the revised iterations of incident governance diagram and cell structures that were presented to NIRB), as well as being the central link between the response and the NHS England executive Group and NHS England Board.

11. Additionally, there were lines of communication through to NIRB via the Chair of each of Tactical Fusion and Strategic Fusion. It is also worth highlighting that the Incident Response Team (National) reported key updates on issues through to Tactical Fusion, and then as required, back to NIRB.

12. In November 2020, the duties of NIRB were amended also to support the implementation of nationally agreed strategies and programmes and oversee delivery of these. To do this, NIRB would:

   a. Monitor in-year delivery and take action to ensure finance, performance, workforce and quality objectives are achieved;

b. Consider and agree the approach to implementation for national response measures and related key communications activity, and associated targets for regional and local response, and monitor delivery of these;

c. Consider the redeployment and/or reallocation of NHS England resource to support NHS operational readiness and the response to Covid-19 based on the Government's cross-departmental strategy and priorities and in the context of delivery of NHS Long Term Plan programmes, the NHS People Plan and EU Exit programme, making recommendations to the NHS Executive Group and NHS England and NHS Improvement Boards if required; and

d. Review key programme risks and any issues escalated to the Covid-19 Board and, where necessary, determine appropriate action to mitigate these and resolve any barriers to progress.

13. NIRB was chaired by NHS England's COO, and in her absence, the NMD, Chief Finance Officer or Strategic Incident Director.

14. NIRB was re-established upon the move back to a Level 4 incident in November 2020.

15. NIRB was stood down on 31 July 2021 and the Operational Response and Delivery Group (OpReD) went live on 1 August 2021 to support the move to the recovery phase of the pandemic.

16. The COO as the Accountable Emergency Officer for Covid-19 was responsible for ensuring that updates on the work of NIRB were reported to the NHS England Executive Group and the Boards of NHS England and NHS Improvement monthly, and more frequently as required.

17. From 18 February 2020, NIRB met three times per week (Mondays, Wednesdays and Fridays) until November 2020, where it became weekly with further meetings as needed.

Tactical Fusion

18. Tactical Fusion was established to support the national response from 14 April 2020 as the IMT and NIRB needed to be supplemented.

19. Tactical Fusion was responsible for:

a. Providing daily operational status updates from Cells and Operational Functions covering:

i. Current operational assessments;

ii. Forward look on operational matters for the next 48 hours - 14 days;

iii. Horizon scan to identify issues needing early action 2 weeks+;

iv. Support and/or guidance required; and

v. Potential risks, issues and mitigations.

b. Providing response to regional concerns raised at daily IMT where appropriate;

c. Providing situational awareness to attendees of wider strategic focus from Strategic Fusion and National Incident Response Board (NIRB);

d. Cohering and co-ordinating cross cell activity at the tactical level;

e. Providing a platform for escalation of issues;

f. Fusing the national tactical operating picture, collating key points to update at the Strategic Fusion meeting;

g. Facilitating information flow across the system to contribute to situational awareness;

h. Identifying areas for Contingency Cell support and provide advice and guidance;

i. Providing direction, guidance and prioritisation for ongoing work; and

j. Feeding into the NHS COO's end of day report with key topics arising.

20. Tactical Fusion was chaired by the Incident Director (National) and, in his absence, the Deputy Incident Director (National).

21. From 21 January 2020, meetings were held seven days per week until September 2020 when it moved to five days per week (Monday – Friday). In May 2021, meetings were held five days per week with a further meeting on Saturdays by exception.

Strategic Fusion

22. Strategic Fusion was established to support the national response from 14 April 2020 as the IMT and NIRB needed to be supplemented.

23. The role of Strategic Fusion was to support the cohesive delivery of nationally-agreed strategies and programmes, including NHS England's response to the Covid-19

pandemic and recovery towards the goals set out in the Long Term Plan and other commitments, and the Strategic Fusion Delivery Group by:

a. Reviewing and seeking to resolve issues escalated to the Group from the Tactical Fusion Delivery Group or other routes and, where necessary, escalate these to the Operational Response and Delivery Group;

b. Sharing information around key areas of interdependency to support alignment in planning and delivery;

c. Agreeing national strategic key lines and actions on urgent priorities and issues;

d. Receiving regular updates on the latest situation with regard to Covid-19 and NHS recovery from the pandemic to ensure common situational awareness at a strategic / executive level;

e. Considering communications prioritisation; and

f. Feeding into summary reporting documents with key topics arising as required.

24. Strategic Fusion was chaired by the National Director for Emergency Planning and Incident Response as Strategic Incident Director (or in his absence by the Incident Director (National) or Deputy Strategic Incident Directors). From June 2021 as the incident moved into a recovery phase it was co-chaired by Director for Long Term Plan Delivery and Deputy COO.

25. From 14 April 2020, meetings were held at 11:00-12:00, five to seven times per week (Monday-Friday) plus weekends as required.

Commercial Executive Group ("CEG") and Commercial Strategy Panel ("Panel")

26. CEG and Panel are responsible for ensuring that commercial strategies for non-clinical expenditure and specified clinical activity are undertaken in accordance with the statutory framework and/or with a robust understanding of risks and issues arising, maximising sustainability and ensuring best value for money. CEG and Panel are mandatory meetings to ensure compliance with the Cabinet Office Minimum Standards for the grants award process.

27. CEG and Panel also challenge and assure expenditure which is subject to central Government efficiency controls prior to this being submitted for DHSC and other external approvals.

NHS England cells

28. NHS England established a cell structure to respond to the pandemic – each cell responded to a particular operational issue with a defined task and team allocated. Early cells that were established included IPC, 111 and Supply Chain.

NHS England IPC Cell

29. The IPC cell was initially established as part of NHS England's emergency response structure in January 2020. This is not to be confused with the "UK IPC Cell" (discussed in more detail from paragraph 36 below).

30. As well as their work as part of the IPC Cell, the IPC team in NHS England's Nursing Directorate, led work to support the NHS in England with operational IPC issues, including the production of tools and operational guidance to support the implementation of Covid-19 UK IPC guidance and manage nosocomial infections in the NHS.

31. At a regional level, in the early part of the pandemic, each NHS England regional team built a regional IPC team (sometimes referred to as a cell). These teams/cells worked with Trusts to support implementation and best practice for IPC measures, along with supporting the handling of any outbreak issues, linking with Regional Chief Nurses and Medical Directors as appropriate but they were not involved in setting policy.

Operational working between NHS England and Government

Aligned cells

32. At an operational level, NHS England and Government worked together through aligned 'cells'. These cells consisted of multi-organisational efforts led by other Government departments, reflecting the fact that policy responsibilities sit outside of NHS England. The aligned cells were:

    a. Volunteering (vulnerable individuals & group support) (DCSM, DHSC, MHCLG and NHS England);

    b. Outbreak management (PHE led);

    c. Testing (Test and Trace and NHS England);

    d. PPE (DHSC and NHS England) **[JK1/088] [INQ000496980];**

    e. Shielding Vulnerable individuals & Groups (MHCLG and NHS England);

f. Medicine (DHSC and NHS England); and

g. Vaccine Delivery and Screening (part of Vaccine Deployment Programmes with DHSC, HEE, MHRA and Devolved Administrations).

33. At NHS England National Level:

a. testing cell colleagues attended NHS England Strategic Fusion and Tactical Fusion meetings and regular attendance at the National Test and Trace Programme's Programme Board and other meetings as requested by DHSC colleagues, especially during the period when testing capacity was being rapidly increased over the summer/autumn of 2020; (e.g. testing cell);

b. At a regional level, the IPC team links with Regional Chief Nurses for IPC related issues and with Regional Medical Directors as appropriate. Each region has a regional IPC team who work with Trusts to support implementation and best practice, along with supporting the handling of any outbreak issues.

34. At national/Department level:

a. working closely with other organisations' cells e.g. the NHS England testing cell worked in close collaboration with the PHE testing cell to support the coordination of efforts to significantly expand testing capacity accessible to NHS patients and staff, underneath the overall lead of DHSC. This relationship was maintained throughout the Covid-19 testing response; and

b. NHS England representatives attending (in various capacities) cross-government structures with decision making powers such as the Health Ministerial Implementation Group (e.g. in relation to the shielding programme).

Infection Prevention and Control and Four Nations

35. Prior to the pandemic, NHS England was responsible for supporting individual Trusts to deliver high quality Infection Prevention and Control (**"IPC"**) practice as part of delivering high quality, safe care in accordance with the contemporaneous PHE guidance. In relation to the pandemic, each of the Devolved Administrations operated a similar cell structure to provide IPC support/response as per their country's EPRR.

36. The UK IPC Cell brought together the IPC leads of the NHS and public health bodies from the four nations, reflecting the collaborative approach taken and promoted by the UK CMOs and CNOs, working across national and organisational boundaries during the

pandemic. Terms of reference for the Cell are exhibited at: **[JK1/089][INQ000489995] [JK1/090][INQ000489996] [JK1/091][INQ000348137] [JK1/092][INQ000489988] [JK1/093][INQ000416768]**.

37. The membership of the UK IPC Cell sought to provide a UK-wide consensus view on issues relating to IPC measures, including the practicalities of the use of PPE including RPE. The CCO was not a member of the UK IPC Cell, however, they would meet regularly with the DCNO for Patient Safety & Innovation.

38. The Cell was not a decision making body. The 'decisions' of the Cell were recommendations based on the combined expertise of the members. Following a decision by the Cell, each national representative organisation was accountable to and responsible for their own governance structures in terms of decision making regarding the content of the IPC guidance or their nation, i.e., the individuals representing the each of the four nations, would forward any collective decisions taken by the UK IPC Cell through to the responsible lead in their own national clinical governance structure, usually either their CNO or CMO, for approval.

39. NHS England continued with its operational IPC responsibilities for England, which included developing strategies to support the wider system to implement the UK IPC Guidance. This included publishing supporting material, amongst a range of supportive measures developed and offered by the organisation.

40. At a regional level, the IPC team links with Regional Chief Nurses for IPC related issues and with Regional Medical Directors as appropriate. Each region has a regional IPC team who work with Trusts to support implementation and best practice, along with supporting the handling of any outbreak issues.

41. As this Cell grew out of the NHS England cell structure, NHS England's IPC team hosted and administered the meetings, including organising meetings and recording actions.

External meetings

42. A summary of the meetings regularly attended by NHS England representatives is provided below. A broad overview of the intended purpose is provided where possible and not all would have related to procurement issues. In addition to the regular meetings outlined below, NHS England representatives engaged with ministers and Government colleagues at various levels on a daily basis, and illustrations of these interactions are also set out below.

43. From 21 March 2020 there were very regular, often daily, meetings attended by the Prime Minister, senior Cabinet Office officials, the SSHSC and other senior Cabinet Ministers, the Chief Medical Officer, the Government Chief Scientific Adviser and NHS England's CEO to brief the Prime Minister on latest developments. These meetings subsequently became the 'dashboard' meetings (described below).

44. NHS England representatives also attended various meetings as required including Quad meetings (described below), ad-hoc Officials meetings, cross-government Situation update meetings, Covid-19 Healthcare Ministerial Implementation Group meetings, Covid-19 meetings with the Prime Minister, COBR(O) and COBR(M) meetings. The focus of these meetings from the perspective of NHS England was generally to relay information about NHS capacity and receive information about Government decisions on next steps. On occasions, work and/or updates were commissioned from NHS England in advance of these meetings around NHS capacity to inform discussions and decision-making:

Supply Chain Co-ordination Limited

45. SCCL is the legal body and management function for the NHS Supply Chain operating model. SCCL was set up in 2018 by DHSC to manage the NHS Supply Chain.

46. Ownership of SCCL transferred from DHSC to NHS England on 1 October 2021 but it operates as a separate legal entity.

Covid 19 Operations Committee

47. Chaired by the Prime Minister with attendees from cabinet and cross-Government departments. NHS England attendees included the NMD, COO and the CNO (when invited to discuss specific issues related to her portfolio).

SSHSC Covid-19 meetings

48. These meetings were held several times per week from 4 February 2020 to 19 March 2020 with the SSHSC. DHSC and PHE officials, and the NHS England CEO, were invited. This meeting series was superseded by a daily catch up with the Prime Minister and the SSHSC.

Prime Minister and SSHSC Covid-19 meetings

49. Hosted by the Prime Minister, these meetings were held daily from 21 March 2020 to 15 May 2020. The SSHSC was invited, alongside a range of Government

departments. The NHS England CEO was invited. This meeting series was superseded by regular meetings to discuss the 'Covid-19 dashboard', which started on 1 June 2020.

Prime Minister 'Covid-19 dashboard' meetings

50. Hosted by the Prime Minister, meeting attendees included SSHSC, HMT and the Chancellor. NHS England attendees included the CEO, COO and NMD.

Daily catch-ups with No. 10 Downing Street (Malcolm Reid)

51. Daily calls were established with NHS England's Director, Office of the NHS Chairs, CEO and COO, Malcolm Reid (No. 10 Downing Street), Natasha Price (DHSC) and Ed Middleton (DHSC) to discuss priority tasks. The meetings started on 17 March 2020 and were held daily Monday to Friday where possible. The meetings ended on 17 April 2020.

Daily Test and Trace meetings with SSHSC

52. Meetings organised by Dido Harding as the interim CEO of Test and Trace to consider a range of test and trace and related general healthcare matters. NHS England attendees initially included its CNO and her deputy, who were invited in June/July 2020, and later the National Director for Emergency Planning and Incident Response.

UK Senior Clinicians Group

53. Established in February 2020 as a forum at which senior UK clinicians involved in pandemic management could discuss predominantly clinical issues relating to Covid-19. It was not a decision-making group. Meetings were chaired by the CMO or an appropriate deputy and involved all the Deputy Chief Medical Officers ("**DCMO**s"), Chief Medical Officers, DCMOs and clinical advisors from all four nations, UK CNOs, and representatives from GCSA, HEE, Scottish Government, Public Health Scotland, NICE, Ministry of Defence, and DHSC as well as NHS England.

The Scientific Advisory Group for Emergencies ("SAGE")

54. SAGE meetings were convened in January 2020 by the Government Chief Scientific Advisor (**"GCSA"**) and is convened to provide scientific advice to support decision-making in the Cabinet Office Briefing Room (**"COBR"**) in the event of a national emergency. It is intended as an advisory group limited to scientific matters and its members vary from meeting to meeting. NHS England did not begin to attend these

meetings until 'SAGE 10' (25 February 2020) with NHS England's NMD attending regularly, and intermittent attendance from other NHS England colleagues. The primary purpose for NHS England attendance was to support in providing NHS specific information as necessary.

SPI-M-O Group

55. This group gave expert advice to DHSC and the wider UK Government on scientific matters relating to an influenza pandemic or other emerging infectious disease threats. NHS England was not a regular attendee but was occasionally invited.

Hospital-Onset Covid-19 (HOCI) Working Group

56. This sub-group was commissioned by SAGE on the 3rd April 2020 and initially jointly chaired by NHS England (CNO) and PHE (Sharon Peacock), but by 15 April, Sharon Peacock had passed joint chairing duties to NHS England's National Clinical Director for IPC. This group focused on hospital onset Covid-19 infection / nosocomial infections, and its purpose was to provide thought leadership, direction to analysis and precipitate policy change and interventions that lead to a rapid and sustained reduction in the rate of HOCI. Information from this group fed into groups such as SAGE and supported NHS England's operational response. Members included several NHS England attendees, PHE/UKHSA, NHS National Services Scotland, Public Health Wales, Northern Ireland Executive and several university academics. It is no longer a government sub-group and is now an advisory group within NHS England.

'4CNO & NMC' meetings

57. Chaired by the UK CNOs on a rotating basis and with the NMC as secretariat, these meetings were established specifically to respond to the pandemic and were focused on the nursing response – returners and student deployment. Some of these meetings also included Unite and Unison when these issues required wider engagement and input. Members included CNO's from all four UK nations, including the CNO for NHS England and NMC members. During the response, these meetings included discussions around student fees, registration and impact on pension of returning retirees. Regular meetings with the NMC ceased after wave 1, but the 4 CNOs continued to meet regularly throughout and still meet on a fortnightly basis.

Joint Biosecurity Centre Local Action Committee (Gold) meeting with SSHSC (also known as DHSC Gold)

58. The Joint Biosecurity Centre was established in May 2020 by SSHSC as part of the Test and Trace service to help inform actions on testing, contact tracing and local outbreak management in England, and to advise on Covid-19 alert levels and inbound international health risks. Membership included PHE, ONS, academic institutions and private industry. Regular NHS England attendees included NHS England's NMD, CNO and Strategic Incident Director. The Chief Executive did not attend.

Joint Biosecurity Centre Silver meetings (also known as DHSC Silver)

59. Chaired by the Chief Medical Officer, Joint Biosecurity Centre Silver addressed issues of concerns raised at Joint Biosecurity Centre Bronze meetings, to be escalated to Gold as necessary. NHS England's NMD, CNO and the National Director of EPRR/National Director for Emergency Planning and Incident Response attended on behalf of NHS England. The weekly silver meetings were to discuss the latest Covid issues covering a wide range from epidemiology, projections, outbreaks and modelling. The silver meeting fed into the gold meeting and the papers were usually identical.

GCSA, CMO, NHS England CEO and PHE meetings

60. These weekly meetings pre-dated the Covid-19 pandemic as a healthcare-specific communication and information-sharing tool. Meeting attendees included Sir Patrick Vallance, Prof. Chris Whitty and PHE representatives alongside NHS England's CEO. These meetings remained broad in purpose during the pandemic response.

Quad meetings (also referred to as "NHS Weekly")

61. These weekly meetings (normally Monday morning) were held between the SSHSC, Minister of State for Health (MSH), Permanent Secretary of DHSC and typically the Chief Executive of NHS England (CEO) and COO of NHS England. Following the change in NHS England's CEO in August 2021, the CFO attended instead of the COO. The meetings pre-dated the pandemic and continued throughout. They were relatively informal discussions covering a broad variety of different topics, rather than a formal decision-making forum. Key points from these meetings were noted by SSHSC's private office and shared with attendees. While some limited opportunity to comment on the notes of the meeting was afforded to NHS England, the notes of the meeting were never formally agreed by the attendees.

DHSC tripartite 'Daily Coordination' calls

62. Established by DHSC on 20 January 2020, the Director and/or Deputy Director of EPRR(N) attended these calls on behalf of NHS England.

PHE Strategic Response Group

63. The PHE Strategic Response Group is a PHE-led group which NHS England attended on at least one occasion. It is NHS England's understanding that the role of the group was to support the SD in their role of cross Government liaison and communication, including supporting the tripartite arrangements in place with DHSC and NHS England.

The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG)

64. This is a DHSC expert committee which advises the CMO (and through the CMO, it advises ministers, DHSC and other government departments). Membership includes a range of clinicians and academics. Dr Lisa Ritchie, who became NHS England's Head of IPC on 1 April 2020, was a member of NERVTAG before this appointment and continued in this role through 2020. The Deputy Head of EPRR for NHS England's London Region was a member of NERVTAG throughout the pandemic.

Daily Finance meetings

65. The daily finance meetings begun on 16 March 2020 and were a daily check-in between senior finance representatives from NHS England, DHSC and HMT to discuss emerging issues and developing policy. This was not a decision-making group nor did it have a core membership. The meeting series ended in June 2020.

Cross-System Efficiency and Finance Board

66. This is a regular meeting organised by the Finance Directorate in DHSC. The NHS England CFO and Finance staff were invited to the series. The meetings focused on the NHS financial position, financial frameworks as required and the outcomes of the finances (i.e. NHS' performance). The series pre-dated Covid-19 and continued throughout.

Capital Delivery Portfolio Board

67. This is a monthly meeting organised by the Portfolio Directorate in DHSC. The NHS England CFO and finance staff were invited to the series. The meeting focussed on capital projects. The series pre-dated Covid-19 and continued throughout.

Monthly Finance meeting

68. This is a monthly meeting organised by DHSC and including MS(H). The NHS England CFO was invited. The meeting series was requested by MS(H) upon entering his post with the intention of providing an informal brief on the latest financial position and an opportunity for an open discussion on any current pressing issues. These meetings were not formal accountability discussions. The request for the series pre-dated Covid-19.

Annex 4 – IPC guidance updates during the Relevant Period

1. This Annex outlines the most significant Covid-19 IPC guidance updates published by PHE, covering the period January 2020 until May 2022. It briefly details the changes made in each new version and sets out the extent of NHS England's involvement in any changes. When NHS England was involved in guidance, this was as a member of the UK IPC Cell.

2. Guidance for NHS staff on the use of masks was covered in the IPC and PPE guidance published from early 2020 until May 2022.

Timeline of guidance

3. On 10 January 2020, PHE first published "*Wuhan novel coronavirus (WN-CoV) infection prevention and control guidance*". This guidance was based on the initial management of Covid-19 as an HCID. With the requisite PPE requirements (FFP3 respirators, masks, gloves, gowns, and eye protection) and use of specialist HCID isolation facilities for patients in line with HCID protocols. NHS England was not involved in this publication.

4. On 28 January 2020, NERVTAG concluded that the current PPE recommendations for pandemic flu were acceptable for use, should there be evidence of sustained community transmission in the UK, with FFP3 respirators reserved for ICU settings and AGPs, and FRSMs used in normal ward settings.

5. On 3 February 2020 PHE drafted and published a revised version of IPC guidance titled *"Novel coronavirus (2019-nCoV): infection prevention and control (UK IPC Guidance)"*. The UK IPC Cell advised on new content regarding PPE.

6. On 14 February PHE published a revised version of the *"2020 Novel coronavirus (2019-nCoV): infection prevention and control (UK IPC Guidance)"*. This included additional PPE requirements for people entering areas where suspected cases were being isolated. NHS England was not involved in this publication.

7. On 19 February 2020 PHE published a revised version of the *"2020 Novel coronavirus (2019-nCoV): infection prevention and control (UK IPC Guidance)"*. This included PPE donning and doffing posters. The UK IPC Cell advised on the new content, and it received sign off from the CMO.

8. On 6 March 2020, a revised version of the UK IPC guidance was published by PHE. This version of the guidance signalled a move away from managing SARS-CoV-2 as

an HCID following emerging evidence and recommended the use of RPE by staff only when AGPs were being undertaken or when providing care in high-risk areas such as ICUs. FRSMs were recommended for use on wards where Covid-19 patients were being treated. PHE drafted and changed the guidance which was approved by NERVTAG. The UK IPC Cell was involved in advising PHE on the operational implications of their decisions to make these changes to the IPC guidance.

9. On 13 March 2020 PHE published a revised version of the UK IPC guidance. The updated guidance removed disposable gowns as a requirement for all staff in high-risk units where AGPs were being conducted (they remained a requirement for staff undertaking the AGPs). Operational details arising from this change were discussed at the UK IPC Cell, but NHS England had no involvement in approving the document.

10. On 23 March 2020, PHE published a document titled *"Covid-19: PPE guidance for Aerosol Generating Procedures"*. This document outlined the recommended PPE to be used by healthcare workers delivering or assisting with an AGP, including in Intensive Care Units or the hot zone of an Emergency Department, reflecting the higher risk of transmission associated with these settings and procedures. Operational details of these requirements were discussed by the UK IPC Cell.

11. This document was followed the next day by further guidance published for staff working in hospitals, primary care, ambulance Trusts, community care settings and care homes. The operational details of this guidance were discussed at the UK IPC Cell. The document outlines the recommended PPE to be used by healthcare workers within one metre of a patient with possible or confirmed Covid-19 (but not carrying out an AGP).

12. On 27 March 2020, PHE published a revised version of UK IPC Guidance, adding a list of AGPs to the Guidance. NHS England was not involved in the production of the AGP list.

13. On 28 March 2020, NHS England's NMD, the Medical Director and Director of Health Protection at PHE and the Chair of the Academy of Medical Royal Colleges sent a joint letter to Chief Executives of all Trusts, CCG Accountable Officers, GP practices and Primary Care Networks and providers of community health services. The letter set out the PPE recommendations for high-risk procedures and other settings as outlined in the latest UK IPC Guidance.

14. On 2 April 2020, PHE published a revised version of the UK IPC Guidance which included four tables describing PPE use across different clinical scenarios and settings. Other changes outlined in this publication were advice on sessional PPE use and reusable PPE; changes in physical distance; advice on washing forearms if exposed; and advice on acceptable respirators. A wide range of stakeholders endorsed the four tables, including the UK IPC Cell, NHS England, the Royal College of Nursing, the Academy of Medical Royal Colleges, and senior clinicians. The revised guidance received final sign off from the UK CMOs.[26]

15. On 3 April 2020 PHE published the *"Covid-19: PPE guidance"*. This guidance recommended the reuse of specific items of PPE (respirators, eye and face protection) with advice on suitable decontamination arrangements (obtained from the manufacturer). It also recommended FRSMs and eye protection use for a session of work, rather than a single patient or resident contact and gowns used for a session of work in higher risk areas (rather than single use). The UK IPC Cell advised on the practical implications of these proposals in different healthcare settings but were not involved in approving this guidance.

16. During late March 2020, work was conducted by PHE working with IPC experts on Covid-19 specific PPE guidance which was subsequently published by PHE on 10 April 2020 entitled *"Coronavirus (Covid-19): personal protective equipment (PPE) hub"*.

17. On 12 April 2020, PHE published a revised version of its *"Covid-19: PPE guidance"*. This included additional information about using disposable fluid repellent coveralls and PPE requirements for ambulance staff when conveying patients into high-risk areas. The UK IPC Cell advised on the practical implications of these proposals in different healthcare settings.

18. Around this time, as has been reported by the NAO, whilst the UK did not run out of PPE overall, supply was very low at points. NHS England was particularly aware of a low supply of gowns in early April. The UK CMO discussed gowns supply with the NMD and then more widely with other CMOs and CNOs on 12 April 2020. Following this, and in needing to plan with precautions for ongoing possible shortages, on 17 April 2020 PHE published a document to be used in the event of shortages entitled *"Considerations for acute personal protective equipment shortages".*

[26] Covid-19 Guidance for infection prevention and control in healthcare settings

19. The rationale for the guidance was that there was a need to prepare for the worst-case scenario in case PPE shortages became so acute that there was not enough supply for the NHS. The shortages guidance was withdrawn on 9 September 2020 by PHE on the basis that it was not required. Whilst those involved in publishing the guidance felt it necessary to publish it to provide organisations with essential advice in the event that the worst-case scenario of national shortages materialised, and recognising that the tighter national supply becomes, the more difficult it will be to ensure even distribution, publishing the guidance sent a negative signal about stock availability. In addition, although national and Trust level supply was sufficient, some organisations have multiple sites and departments/locations and so delivery to all those individual sites may have been incomplete. For instance, some community Trusts, mental health Trusts and ambulance Trusts have 100+ locations. In hindsight, the guidance would therefore have been more useful for that particular cohort of providers than for general distribution.

20. To support the implementation of PHE's UK IPC guidance, on 28 April 2020 NHS England published checklists for Trusts and produced a compendium of documents and training resources. The checklist tool was designed to be an 'aide memoire' to ensure that the PHE Covid-19 guidance was being implemented appropriately within healthcare settings. Relevant existing documents and training resources were also placed in an easy to access format.

21. On 3 May 2020, PHE published a revised version of the *"Covid-19: PPE guidance"*. This included confirmation that the HSE had examined the use of FFP2 respirators as an alternative to FRSMs in nonsurgical settings and that an FFP2 worn without a face fit-test would offer protection similar to the levels from a surgical face mask. The guidance noted that this was a pragmatic approach for times of severe shortages of RPE. NHS England was not involved in this update.

22. On 18 May 2020, PHE published an updated version of the UK IPC Guidance. This contained more information and advice on adherence to social distancing and improving ventilation, along with a reduction in the movement of staff between care pathways. Around this time, PHE brought the IPC and PPE guidance together into a single publication suite.

23. Parallel to this, on 7 May 2020 the CNO in her role as HOCI WG co-chair commissioned the UK IPC Cell to produce a gap analysis of the current guidance and to present any proposed changes to PHE for inclusion in the guidance. The HOCI WG had identified several hospital environmental IPC risks and PHE had asked for a gap

analysis to be conducted of this work against the existing IPC guidance. The UK IPC Cell and HOCI WG completed their gap analysis and made joint recommendations to amend aspects of the guidance accordingly. PHE approved the recommendations for inclusion in the next revised publication (18 June 2020).

24. On 21 May 2020 PHE published a revised version of the UK IPC Guidance. This advised that FFP2 and N95 respirators could be used for some AGPs if FFP3 respirators were not available.

25. On 12 June 2020, NHS England and PHE both published guidance on the wearing of facemasks for hospital staff and face coverings for visitors, following the announcement of this measure by the SSHSC on 5 June 2020.

26. On 15 June 2020 PHE published a revised version of the UK IPC Guidance, drafted by PHE in conjunction with the UK IPC Cell. It included new operational guidance for the NHS in England which advised on the introduction of universal mask wearing for NHS staff and masks/face coverings for visitors and patients in healthcare settings. NHS England was involved in the development of this guidance as a result of the commissions from the CNO and PHE to the UK IPC Cell and the HOCI WG.

27. On 18 June 2020 PHE published a revised version of the UK IPC Guidance. This update aligned the list of AGPs with the list published by Health Protection Scotland on 12 May 2020. NHS England, working as part of the UK IPC Cell, had raised this inconsistency with PHE who then amended the guidance following external expert advice.

28. Over the course of June and July 2020 there were limited further updates to the UK IPC Guidance. These included changes in masking policy for healthcare settings and changes in testing as testing became more widely available. Over this period, the number of Covid-19 infections had remained low and social restrictions were being eased across the country. For healthcare, this meant that a greater emphasis was placed on treating patients whose procedures had been delayed during Wave 1 of the pandemic.

29. The reduction in infections and the refocus on treating the backlog of non-Covid-19 patients necessitated a revised version of the UK IPC Guidance. This focused on the operational implementation of IPC measures in a range of scenarios. During this period, the UK IPC Cell took on a greater role in supporting PHE by preparing drafts for the UK IPC Guidance. PHE advised on scientific developments, checked draft

guidance with wider guidance to ensure consistency, provided final approval and published the guidance. PHE, with ultimate responsibility for the guidance, had discretion (which it exercised) to change guidance to its satisfaction.

30. PHE published a revised version of the UK IPC Guidance *"Guidance for the remobilisation of services within health and care settings: Infection prevention and control recommendations"* on 21 August 2020. This version included measures to support the safe restoration of elective services through the introduction of three clinical pathways reflecting a patient's Covid-19 status (high, medium and low risk, sometimes known as red/amber/green pathways), as well as reiterating physical distancing, hand and environmental hygiene. The guidance also minimised sessional use of single use PPE items with this only applying to extended use of facemasks for healthcare workers, as per the guidance which was published on 15 June. NHS England was involved in this update as part of the UK IPC Cell which led on the drafting and development of this document. The document was approved by UK health bodies and then provided to PHE, who gave final approval and published the document. Unlike previous iterations of the UK IPC Guidance, this version did not apply to social care settings in England. DHSC produced separate guidance for social care. This separate arrangement continued for the remainder of the pandemic.

31. On 20 October 2020, PHE published a revised version of the UK IPC Guidance. This version included the addition of a dental appendix. The UK IPC Cell worked on the drafting and development of this appendix with dental colleagues from NHS England. PHE approved and published the document.

32. In the winter of 2020, as the second wave of Covid-19 continued to grow with increases in community Covid-19 incidence and resultant rises in the number of Covid-19 admissions to hospital, work was undertaken to determine what further action could reduce the risk of nosocomial infections. This was the focus of discussions with Trust leaders. It included a webinar on Sunday 8 November 2020. Following these discussions, NHS England published its 10 Key Actions on IPC and testing on 17 November 2020. This advised Trusts on the implementation of the UK IPC guidance, particularly: regular inpatient testing, minimising patient movement within healthcare settings and staff maintaining social distancing outside clinical areas. This operational guidance was amended on 23 December 2020 to further strengthen advice around minimising the movement of patients with Covid-19 within hospital settings.

33. PHE published an updated version of the UK IPC Guidance, entitled *"Covid-19: Guidance for maintaining services within health and care settings: Infection prevention*

and control recommendations" on 21 January 2021. This guidance took into account the latest research on the Alpha variant. Its main recommendations remained largely unchanged, save for the minimising of sessional use of PPE and the inclusion of specific annexes to support implementation of IPC measures in dentistry and mental health/learning disability settings. As per the process established over summer 2020, the UK IPC Cell worked on the drafting and development of this new version of the guidance. PHE then reviewed the document for final consideration and publication.

34. On 1 June 2021, PHE published a revised version of the UK IPC Guidance titled *"Covid-19: Guidance for maintaining services within health and care settings (UK IPC Guidance)"*. This update added requirements on local risk assessments and information around use of respiratory protective equipment and valved respirators. The UK IPC Cell worked on the drafting and development of this amendment following a commission from SAGE to the HOCI WG and EMG to assess the evidence of transmission of SARS-CoV-2.

35. In June 2021, UKHSA were commissioned by the SSHSC to produce distinct IPC guidance to support the restoration of NHS services in England, specifically elective services. This guidance was separate from but consistent with the wider UK IPC Guidance. NHS England provided advice to PHE regarding the areas of clinical practice which it felt could benefit from changes to IPC guidance.

36. PHE published three short thematic guidance documents to support the safe restoration of NHS elective services on 27 September 2021 recommending that physical distancing be reduced from 2m to previous levels in low-risk pathways (i.e., non-Covid-19) subject to a series of conditions and wider local risk assessments. It also recommended that the pre-elective patient testing protocols could be replaced by an on the day lateral flow device test for specific patient groups, and that enhanced cleaning procedures were no longer required in low-risk areas. A further recommendation aimed at supporting a more flexible approach to patient consultations in primary care and general practice was added in October 2021. NHS England were involved in providing further information to PHE on the clinical areas which would benefit in productivity from changes to IPC guidance, including bed number reductions due to physical distancing and patient self-isolation prior to elective procedures. This guidance was drafted and published by PHE.

37. On 22 November 2021, the *"Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 (UK IPC Guidance)"* set out the removal of enhanced IPC measures for all non-

respiratory patients. The key changes introduced included (1) the removal of the three Covid-19 specific care pathways (high, medium and low risk), with their replacement by locally defined care pathways; (2) physical distancing to be at least 1m (in line with pre-pandemic guidance) apart from for infectious disease patients; and (3) the continuation of universal mask wearing and screening/triaging/testing for Covid-19 over the winter 2021-22. The UK IPC Cell worked on the drafting and development of this new version of the guidance. This was passed to UKHSA (formerly PHE) for final consideration and publication.

38. This version of the UK IPC Guidance was subject to constant review as the Omicron variant of Covid-19 became dominant from late 2021 onwards. However, as time progressed it became more evident that Omicron was leading to lower morbidity and mortality compared with previous variants. The number of patients in hospital with Covid-19 where it was not their primary diagnosis began to exceed those patients who had been admitted because of Covid-19, and the number of Covid-19 patients in intensive care units was much lower than in previous waves of infection.

39. In December 2021, the four UK CNOs formally commissioned the UK IPC Cell to review the evidence on modes of transmission in light of the emergence of Omicron variant. A further evidence review was undertaken, which reaffirmed the position of the current guidance but proposed that the section on risk assessment based on the hierarchy of controls be made more prominent in the guidance under the 'main messages' section. A consensus statement outlining this position was drafted by the UK IPC Cell and agreed by all four UK CNOs and CMOs, as well as UKHSA, and was published on 8 December 2021 with the UK IPC Guidance being updated to incorporate this statement on 17 December 2021.

40. In January 2022, the IPC guidance was updated to ensure that healthcare workers understood that use of RPE should be informed by a dynamic risk assessment, and that if deemed necessary RPE should be available to them. This decision must be based on residual risk following application of the hierarchy of controls i.e., healthcare worker preference should not be a deciding factor.

41. On 14 April 2022 NHS England published the National IPC Manual ("**NIPCM**") for England.

42. The NIPCM states it should be adopted as guidance in NHS settings or settings where NHS services are delivered, and the principles should be applied in all healthcare

settings. The NIPCM aims to ensure a consistent approach to IPC, aligning to other devolved nations IPC manuals.

43. Version 2 of the NIPCM was published in June 2022 and a further updated version was published in September 2022.

44. On 27 May 2022 the UKHSA archived the *"Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 (UK IPC Guidance)"* and replaced it with Covid-19 pathogen specific advice for healthcare. This advice complemented the NIPCM. The UK IPC Cell was asked by UKHSA to confirm that they were content with their plans to stand the IPC guidance down. This signalled a definitive move towards treating Covid-19 as one of many infectious respiratory diseases experienced in the UK. This was reinforced in August 2022 by UKHSA's revised guidance to test only symptomatic patients.

45. On 1 June 2022, NHS England wrote to NHS organisations to provide clarity on the issue of universal mask-wearing in healthcare settings, which was part of the UKHSA-published IPC Guidance archived at the end of May 2022. This letter outlined the scenarios where healthcare workers and patients should wear masks (i.e., supporting local decisions based on local prevalence and risk assessments).

46. During the Relevant Period there had been anecdotal evidence that healthcare workers were being denied the use of RPE locally unless performing AGPs. NHS England's was not, however, aware that NHS staff may have been threatened with disciplinary action if they raised concerns regarding PPE shortage of the quality of PPE that they were provided with.

Annex 5 – Select Committee activity during the pandemic

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
17 March 2020	Lord Simon Stevens (Chief Executive Officer, NHS England), Amanda Pritchard (Chief Operating Officer, NHS England), Professor Keith Willett (Director for Acute Care, NHS England) and Sir Stephen Powis (NMD, NHS England) gave oral evidence at the Health and Social Care Committee hearing on **Management of Coronavirus outbreak.**	This inquiry considered the management of Covid-19 by the Government and its agencies. NHS England, the DHSC and the Government Office for Science were included amongst witnesses who gave oral evidence to the Inquiry.	The Health and Social Care Committee did not publish a report into this Inquiry.
08 April 2020	Sir Stephen Powis (NMD, NHS England) gave oral evidence at the Science and Technology Committee hearing on the **UK response to Covid-19: use of scientific advice**	This Inquiry considered the place of UK research, science and technology in the national and global pandemic response, and what lessons should be learned for the future. NHS England was included amongst witnesses who gave oral evidence to the Inquiry.	The Government's response to the Committee's recommendations was published in May 2021 and sets out which recommendations have been accepted. Recommendations cover: expert advice and Government decision-making, activation and operation of SAGE, transparency and

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
			communication, nature of scientific advice to Government, and application of science expertise. There were no direct recommendations to NHS England. However, NHS England and NHSx are directly mentioned within the response to a recommendation requiring DHSC to set out in an action plan what efforts have been made, and will be made during the pandemic, to address the poor data access issues raised by the scientific community and SAGE and its sub-groups. There are a number of recommendations and responses that reference NHS Test and Trace. The NHSx project came to an end in February 2022.
01 May 2020	Dame Cally Palmer (National Cancer Director, NHS England) and Claire Murdoch (National Mental Health Director, NHS England) gave oral evidence at the Health	*See entry for 30 June 2020.*	*See entry for 30 June 2020.*

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	and Social Care Committee hearing on **Delivering core services during the pandemic and beyond.** *(First session: see second oral evidence session on 30 June 2020).*		
22 May 2020	Lord Simon Stevens (Chief Executive Officer, NHS England), Julian Kelly (Chief Finance Officer, NHS England) & Stephen Powis (NMD, NHS England) gave oral evidence at the Public Accounts Committee hearing on **NHS capital expenditure and financial management.**	This Committee questioned officials from the DHSC and NHS England on capital expenditure in the NHS and considers findings of the National Audit Office's (NAO) investigation into NHS financial management and sustainability (published 5 February 2020, as referenced in the Government response).	The Government's response to the Committee's recommendations was published in September 2020 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. This includes the response to a recommendation that DHSC should review the effectiveness of having a separate body overseeing the planning and supply of the NHS's future workforce. NHS England should work with HEE to evaluate how workforce planning can be improved including the integration of training and education funding models with service planning and delivery in order to overcome

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
			persistent challenges. HEE is due to merge with NHS England from April 2023.
10 June 2020	Claire Murdoch (National Mental Health Director, NHS England and Chief Executive Officer, Central and North West London NHS Foundation Trust) gave oral evidence at the Lords Public Services Committee hearing on **Public Services: Lessons from Coronavirus**	This Committee was established by the Lords Public Services Committee to examine what the experience of the coronavirus outbreak can tell us about the future role, priorities and shape of public services.	The Government responded to the Committee's recommendations in February 2021, and set out which recommendations have been accepted. A number of recommendations were made to Government that involved the NHS working with the Government and others on certain matters related to topics of health.
22 June 2020	Lord Simon Stevens (Chief Executive Officer, NHS England), Amanda Pritchard (Chief Operating Officer, NHS England and Chief Executive, NHS Improvement), Sir Stephen Powis (NMD, NHS England) gave oral evidence at the Public Accounts Committee hearing on **Readying the NHS and**	This inquiry questioned the methods used to select providers and award contracts for Personal Protective Equipment provision, the use of consultants and other private contractors in mounting the UK emergency response including building and supplying the Nightingale hospitals, the development of the UK's testing capacity and contact tracing system, and what capacity the NHS had to withstand a potential second peak later in the year. This builds on the findings of the NAO's investigation into Readying the NHS and	The Government's response to the Committee's recommendations was published on 18 November 2020 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. This included some joint recommendations for DHSC and NHS England to:

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	social care for the Covid-19 peak	social care for the Covid-19 peak (published 12 June 2020, as referenced in the Government response). Officials from NHS England, the DHSC; Ministry of Housing, Communities and Local Government and PHE were amongst organisations invited to give oral evidence.	• review which care homes received discharged patients and how many subsequently had outbreaks, and report back in writing by September 2020. • develop procedures so that all patients deemed fit to leave hospital are safely discharged into settings in a way which limits the spread of Covid-19. • identify and agree with relevant professional bodies specific actions to support health and social care staff to recover from the impact of the first peak and how they will monitor and provide further support to staff through to the end of the pandemic.
30 June 2020	Lord Simon Stevens (Chief Executive Officer of NHS England), Amanda Pritchard (Chief Operating Officer, NHS England) and Sir Stephen Powis (NMD, NHS England) gave oral evidence at the	This Inquiry considered the following issues: • communication with patients; • managing waiting times and the backlog of appointments; • issues facing NHS and care staff relating to access to Personal Protective Equipment (PPE) and routine testing of staff;	The Government response to the Committee's recommendations was published in January 2021 (Appendix to the Committee Report), which set out which recommendations have been accepted. A number of recommendations were

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	Health and Social Care Committee hearing on **Delivering core services during the pandemic and beyond**.	• issues facing NHS and care staff relating to workforce "burnout"; and • what lessons can be learnt from the pandemic in order to support the NHS in the future.	made to NHS England which include managing waiting times and backlog of appointments, mental health, dental services, workforce, PPE, testing staff, support for Accident & Emergency and technology. In Appendix 2 of the report there are some recommendations that are answered by Prerana Issar (Chief People Officer, NHS England), regarding workforce, wellbeing and discrimination.
14 July 2020	Caroline Twitchett (Children Qualities Lead, Health and Justice, NHS England) gave oral evidence at the Justice Committee hearing on **Children and Young People in Custody**	This forms the second part of an Inquiry into Children and Young People in Custody and considers the condition of the estate in which they live and learn, as well as examining what options are open to children and young people as they leave the youth estate, both to return to the community or to move into adult prison accommodation.	The Government response to the Committee's recommendations was published in April 2021, which set out which recommendations have been accepted. There were a number of recommendations that involved the remit of NHS England, including mental health and self-harm (including during the pandemic), and use of force and pain-inducing techniques.

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
20 July 2020	Ruth May (Chief Nursing Officer, NHS England) and Prerana Issar (Chief People Officer, NHS England) gave oral evidence at the Public Accounts Committee hearing on **NHS Nursing Workforce**	This Inquiry considers what the action being taken to address long term problems in the NHS nursing workforce, and what impact the pandemic has on current and future plans. It builds on the findings of the NAO's investigation into the NHS Nursing Workforce (published 5 March 2020, as referenced in the Government response). Officials from the Department for Health and Social Care, NHS England and HEE were amongst organisations invited to give oral evidence.	The Government's response to the Committee's recommendations was published on 3 February 2021 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. These recommendations included: We welcome NHS England's publication of early lessons from Covid-19. NHS England should ensure it also makes available a full and frank assessment of the new challenges to nursing recruitment and retention specifically and how health providers should address them, particularly where this could disadvantage certain groups for example students or minority ethnic staff. As part of this assessment, NHS England should take stock of the measures in place to support nursing staff's mental health and wellbeing, to share good practice and identify what else staff may need.

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
22 July 2020	Dr Celia Ingham-Clarke (Medical Director for Clinical Effectiveness, NHS England) gave oral evidence at the Women and Equalities Select Committee hearing on **Unequal Impact? Coronavirus, disability and access to services**.	This sub-inquiry was established to consider ways of easing some of the problems disabled people are facing when they need access to essential services during the pandemic. It includes consideration of access to food, health and social care and education, and how the Government could improve its communications and consultation with disabled people about guidance and policies that are having substantial effects on their daily lives.	The Government's response to the Committee's recommendations was published on 14 April 2021, which set out which recommendations have been accepted. The recommendations that NHS England are linked to concern barriers to food shopping during the pandemic (NHS responders), annual health checks for learning disabilities, introducing clear face masks in Trusts and public health messages in Accessible Information Standard.
17 September 2020	Matthew Gould (Chief Executive Officer, NHSx) gave oral evidence to the Public Accounts Committee hearing on **Digital transformation in the NHS.**	This Inquiry considers how the NHS is renewing its efforts to transform patient services by making use of modern technology and systems and builds on the findings of the NAO's **investigation into Digital transformation in the NHS** (published 15 May 2020, as referenced in the Government response). NHSx and DHSC were amongst organisations called to give oral evidence.	The Government's response to the Committee's recommendations was published on 4 February 2021 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. NHS England were not present at the Committee but this is included for completeness. The NHSx project came to an end in February 2022.
29 September	Dr Matthew Jolly (NCD for the	This inquiry examines evidence relating to	The Government response to the

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
2020	Maternity Review and Women's Health, NHS England) and Jacqueline Dunkley-Bent (Chief Midwifery Officer, NHS England) gave oral evidence at the Health and Social Care Committee hearing on **Safety of Maternity services in England**	ongoing safety concerns with maternity services and builds upon investigations that followed incidents at East Kent Hospitals University Trust and Shrewsbury and Telford Hospitals NHS Trust, as well as the inquiry into the University Hospitals of Morecambe Bay NHS Trust. It also considers whether the clinical negligence and litigation processes need to be changed to improve the safety of maternity services and explore the impact of blame culture on learning from incidents.	Committee's recommendations was published in September 2021, which set out which recommendations have been accepted. Recommendations were made to the DHSC and NHS England, including recommendations on: supporting maternity services and staff to deliver maternity care (including staffing, funding and training), learning from patient safety incidents (including engaging with Trusts, streamline data collection processes), and providing safe and personalised care for all mothers and babies (including continuity of carer, ending disparity in outcomes, choices at birth, and caesarean section rates).
12 October 2020	Dr Dame Emily Lawson (Chief Commercial Officer, NHS England) gave oral evidence at the Public Accounts Committee hearing on **Covid-19: Supply of ventilators**	This Inquiry considered the findings of the NAO's investigation into the supply chains and procurement of ventilators (published 30 September 2020, as referenced in Government response). NHS England, the Cabinet Office and the Department for Health & Social Care (DHSC)	The Government's response to the Committee's recommendations was published on 25 March 2021 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. This contains one recommendation to

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
		were amongst organisations called to give evidence.	NHS England to work with DHSC to set out how future plans for responding to emergencies will address: Maintaining an adequate asset register of its critical equipment and a method for quickly gathering the up to date data; protocols for rapid procurement of critical equipment and the need for surge capacity in the NHS's supply chains.
20 October 2020	Prerana Issar (Chief People Officer, NHS England) and Claire Murdoch (National Mental Health Director, NHS England) gave oral evidence at the Health and Social Care Committee hearing on **Workforce Resilience and Burnout for NHS and Social Care Staff** *(First session: see also 24 February 2021)*	*See entry for 24 February 2021.*	*See entry for 24 February 2021.*
01 December 2020	Dr Ramani Mooneshinghe (NCD for Critical Care, NHS England) gave oral evidence to the Joint Health and Social	*See 26 January 2021.*	*See 26 January 2021.*

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	Care Committee and Science and Technology Committee oral evidence session on **Coronavirus: lessons learnt to date** *(First Session. See also: 26 January 2021)*		
11 January 2021	Dr Dame Emily Lawson (Chief Commercial Officer, NHS England) and Lord Simon Stevens (Chief Executive Officer, NHS England) gave oral evidence to the Public Accounts Committee hearing on **Covid-19: Planning for the Vaccine**	This Inquiry considers the UKs vaccination programme and follows findings of the NAO's investigation into preparations for potential Covid-19 vaccines (published 16 December 2020, as referenced in the Government response). NHS England, the Department for Business, the Department for Health and Social Care (DHSC), the Vaccine Taskforce, and PHE were amongst bodies called to give oral evidence.	The Government's response to the Committee's recommendations was published on 3 September 2021 in the form of Treasury Minutes. This sets out whether the Government agreed to the recommendations. A number of recommendations were set out for NHS England, around joint activities with DHSC on planning, risk assessment and communications with a specific focus on the vaccines programme. *Note:* Amanda Pritchard (Chief Executive Officer, NHS England) and Dame Dr Emily Lawson (National Director Vaccine Deployment, NHS England) also gave oral evidence to the Public Accounts Committee on the **Rollout of the Covid-19**

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
			vaccination programme in England on 28 March 2022.
26 January 2021	Lord Simon Stevens (Chief Executive Officer, NHS England) gave oral evidence a Joint Health and Social Care Committee and Science and Technology Committee hearing on **Coronavirus: lessons learnt to date** *(Second Session. See also: 1 December 2021)*	The two Select Committees jointly conducted evidence sessions examining the impact and effectiveness of action taken by Government and the advice it has received. Each Committee drew on specialist expertise and call witnesses to consider a range of issues including: • the deployment of non-pharmaceutical interventions like lockdown and social distancing rules to manage the pandemic; • the impact on the social care sector; • the impact on Black, Asian and minority ethnic groups' communities and other at-risk groups; • testing and contact tracing; • modelling and the use of statistics; • Government communications and public health messaging; • the UK's prior preparedness for a pandemic; and • the development of treatments and vaccines.	The Government response to the Committee's recommendations was published in June 2022. The Committees' recommendations span the issues to be explored, including pandemic preparedness, social care, at risk communities and vaccines.
24 February 2021	Prerana Issar (NHS Chief People Officer) gave oral	This inquiry focused on workforce burnout and resilience across the NHS and social care. It	The Government response to the Committee's report was published in

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	evidence at the Health and Social Care Committee hearing on **Workforce Resilience and Burnout for NHS and Social Care Staff.** (Second session: see also 20 October 2020)	considered: • burnout, resilience and stress levels before and during the pandemic • the impact of workforce burnout on service delivery, staff, patients and service users • workforce planning and projections • the measures set out in the NHS People Plan • any further measures required to tackle burnout, including how to achieve parity for the social care workforce. NHS England, the DHSC and HEE were amongst organisations giving oral evidence.	February 2022 and sets out which recommendations have been accepted. A number of recommendations were made regarding the NHS which focus on health and wellbeing support for the workforce, freedom to speak up, use of targets, the Workforce Race and Equality Standards, monitoring the impact of Covid-19 on the workforce, spreading learning across the system and improving support for colleagues from Black and Minority Ethnic groups.
23 March 2021	Claire Murdoch (National Mental Health Director, NHS England) and Tim Kendall (NCD for Mental Health) gave oral evidence at the Health and Social Care Committee hearing on **Mental health of children and young people** (First session, see also: 22 June 2021)	The Inquiry was established to examine the progress that has been made by Government against their own ambitions to improve children and young people's mental health provision. NHS England and the DHSC were amongst organisations giving oral evidence.	The Government response to this inquiry was published in March 2022 and sets out which recommendations have been accepted.

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
27 April 2021	Claire Murdoch (National Mental Health Director, NHS England) and Professor Roger Banks (NCD for Learning Disabilities and Autism) gave oral evidence at the Health and Social Care Committee hearing on **Treatment of people with learning disabilities and autism**.	This Inquiry was established to consider what the Government plans to reform mental health legislation will mean for autistic people and individuals with learning disabilities. NHS England, the Department for Health and Social Care (DHSC), the Ministry of Justice and HM Prison and Probation Service were amongst organisations giving oral evidence.	The Government response to the Committee's recommendations was published on 27 July 2022 and sets out which recommendations have been accepted. It includes joint recommendations for NHS England and DHSC to consider different models of care and admission for autistic people, consider establishing new professional disciplines for intellectual disability and an independent review of deaths of autistic people.
22 June 2021	Kate Davies (Director for Health and Justice at NHS England and NHS Improvement) gave oral evidence at a Justice Committee oral evidence session on **Mental health in prisons**	This inquiry was established to understand the current scale of mental health need in prisons, and to identify what support exists and whether there are any gaps in provision. NHS England, the Ministry of Justice (MoJ) and HM Prison and Probation Service (HMPPS) were amongst organisations giving oral evidence.	The Government response to this inquiry was published on 4 February 2022 and sets out which recommendations have been accepted. A number of recommendations were made to NHS England which focus on needs analysis, service provision, procurement, integrated care, health screening, health inequalities and monitoring progress of transfers to in-

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
			patient care. This includes joint work with the MoJ on community sentence treatment order requirements, and with DHSC, the MoJ and HMPPS to improve accessibility of prisoner patient records.
22 June 2021	Claire Murdoch (National Mental Health Director, NHS England) and Tim Kendall (NCD for Mental Health) gave oral evidence at a Health and Social Care Committee hearing on **Mental health of children and young people** (Second session, see also: 23 March 2021)	The Inquiry was established to examine the progress that has been made by Government against their own ambitions to improve children and young people's mental health provision. NHS England, the DHSC and HEE were amongst organisations giving oral evidence.	The Government response to the Committee's report was published in March 2022 and sets out which recommendations have been accepted. This included recommendations for NHS England on: access to specialist support; managing data and variation; waiting times consultation, transition from child to adult services, community-based provision and in-patient support, community-based crisis care, and data collection. There is also a recommendation for DHSC to work with HEE on planning to expand the children's and young people's mental health workforce. HEE will merge with NHS England

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
			from April 2023.
22 September 2021	Professor Sir Keith Willett (SRO, Covid-19 and Flu Vaccine Deployment, NHS England and NHS Improvement) gave oral evidence to an Education Committee session on **Covid-19 and vaccination of Children**	This is listed as a non-inquiry session.	Only the transcripts of the evidence are available on the Parliament website regarding this session.
19 October 2021	Amanda Pritchard (CEO, NHS England) and Sir Stephen Powis (NHS England, NMD) gave evidence at a Health and Social Care Committee hearing on **Clearing the backlog caused by the pandemic**	This inquiry considered how to quantify the level of pent-up demand for key healthcare services; and to consider whether fundamental changes to the organisation and delivery of NHS services will be required to manage the backlog of cases caused by the pandemic. This included levels of funding, capacity, organisation and leadership for addressing the current backlog for non-Covid health services, and concerns that these issues are likely to continue in the longer-term, with a particular focus on elective surgery, emergency care, General Practice, mental health, and long-Covid. NHS England and the DHSC were amongst	The Government response to the Committee's report was published on 25 May 2022, and sets out which recommendations have been accepted. 2. Recommendations made to NHS England included joint work with DHSC on: scale and impact of the backlog (recovery planning (including elective care, emergency care, mental health, primary care, community care and social care); public communications; NHS 111; digital; Long Covid); funding and

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
		organisations giving evidence.	policies to tackle the backlog (workforce planning; recruitment and retention; health and wellbeing; bed capacity; system working and use of the independent sector; and digital).
15 December 2021	Amanda Pritchard (CEO, NHS England) and Sir Stephen Powis (NMD, NHS England) gave oral evidence at the Public Accounts Committee on **NHS backlogs and waiting times in England**	This Inquiry considered the current position of NHS backlogs and waiting times following the pandemic, including the points at which patients wait for NHS treatment; how trends in waiting times changed before the emergence of Covid-19; and the effect that Covid-19 has had on waiting times. It followed findings of the NAO's investigation into NHS backlogs and waiting times in England (published 1 December 2021, as referenced in the Government response). NHS England and the DHSC were amongst organisations called to give oral evidence.	The Government's response to the Committee's recommendations was published on 27 May 2022 and sets out which recommendations have been accepted. A number of recommendations are set out for NHS England around recovery planning, including joint work with the DHSC on ensuring this has a strong patient focus, and developing a fully costed plan to enable legally binding elective and cancer care performance standards to be met.
20 January 2021	Dame Cally Palmer (National Cancer Director) and Professor Peter Johnson (NCD for Cancer) gave evidence at a Health and	This inquiry was established to consider why cancer outcomes in England continue to lag behind comparable countries internationally and examine evidence relating to the underlying causes of these differences. It also considered	The Government response to the Committee's recommendations was published on 13 June 2022 and sets out which recommendations have been accepted.

Date	Meeting involving NHS England	Summary of aims and methodology	Conclusions and recommendations
	Social Care Committee hearing on **Cancer services**	what impact disruption to cancer services during the pandemic will have on efforts to catch up, and ask whether the ambitions set out in the NHS Long Term Plan will help close the gap with the best performing countries worldwide. NHS England and the DHSC were amongst organisations called to give oral evidence.	A number of recommendations were made to NHS England which focus on raising public awareness of cancer symptoms, investment in Community Diagnostic Centres, and embedding cancer leads in Integrated care Systems. This includes joint recommendations to NHS England and DHSC on analysis of the cancer backlog, estimating additional capacity need, retaining the cancer workforce, reviewing the organisation of cancer services and planning for rare cancers.