Witness Name: Daniel Mortimer
Statement No: 1
Exhibits: Attached
Dated: 21 November 2024

UK COVID-19 INQUIRY – Module 5

WITNESS STATEMENT OF DANIEL MORTIMER

I DANIEL MORTIMER of Floor 2, 18 Smith Square, London, SW1P 3HZ, will say as follows:

1. I am the Deputy Chief Executive (CEO) of NHS Confederation and the CEO of NHS Employers, which is part of the NHS Confederation, and I make this statement in response to the Rule 9 request dated 27 June 2024. I am best placed to provide the statement as Deputy CEO of the NHS Confederation throughout the relevant period and interim CEO for the majority of the relevant period (October 2020 to June 2021). As CEO of NHS Employers, I also have an understanding of how Covid-19 impacted the NHS workforce.

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

3. The other senior officials supporting our response to the pandemic within the NHS Confederation during the relevant period were:
    a. Layla McCay, Director of Policy, and Lead for the NHS Confederation's Covid-19 taskforce.
    b. Ruth Rankine, Director of the NHS Confederation Primary Care Network.

c. Joan Saddler, Director of Partnerships and Equality.
d. Darren Hughes, Director of the Welsh NHS Confederation.
e. Heather Moorhead, Director of the Northern Ireland Confederation for Health and Social Care.

Overview of the role, functions and activities of NHS Confederation

General

4. The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole NHS healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than one million patients a day and control £150 billion of public expenditure each year. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. We are a charitable company subject to the regulations of the Charity Commission (charity number: 1090329) and Companies House (company number: 04358614.) The Confederation is governed by a Board of Trustees.

5. While we provide support for our members and advocate for them at the national policy level, we are not accountable for the commissioning or the delivery of services or funding. The NHS Confederation had no formal pandemic response functions, nor any formal responsibilities regarding the response to Covid-19 or any pandemic (though NHS Employers undertook certain specific roles as described below).

6. In England, our networks are:

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

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

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

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

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

7. The NHS Confederation has also hosted the NHS Race & Health Observatory since October 2020. The NHS Race & Health Observatory works to identify and tackle ethnic inequalities in health and care by facilitating research, making health policy recommendations, and enabling long-term transformational change.

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

9. Until 2011, the precursor to NHS Providers was a part of the NHS Confederation, in the form of the Foundation Trust Network. The NHS Confederation and NHS Providers continue to work closely together – staff across both organisations up to Chair of the respective Boards have regular meetings and there was regular contact throughout the period indicated above. A number of times a year NHS Providers and NHS Confederation run joint events, produce joint outputs, and come together to lobby on issues relevant to respective members. An example of some joint work through the relevant period was a joint briefing in September 2021 on the continuing cost of Covid-19 found at Exhibit DM/01 – [INQ000371145]. We also continue to jointly deliver the community network, which represents health leaders working across the community health sector. The relationship between the NHS Confederation and NHS Providers remained the same before, during and following the pandemic.

10. In Wales, all NHS bodies are members of the Welsh NHS Confederation and in Northern Ireland all organisations within the integrated health and social care system are members of Northern Ireland Confederation for Health and Social Care (NICON). The NHS Confederation does not represent, engage or act on behalf of NHS bodies within Scotland.

11. Throughout this statement my responses primarily deal with the position in England rather than in Wales and Northern Ireland as our organisation is not well placed to provide evidence on operational matters in Wales or Northern Ireland. I make clear when my comments are directed to matters concerning Wales and/or Northern Ireland.

NHS Employers

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

NHS trade unions on behalf of the Secretary of State for Health and Social Care and the NHS.

13. NHS Employers leads the national and regional relationship with trade unions. During the pandemic NHS Employers:
    - Convened regional meetings of employers and employers/trade unions to support engagement and co-ordination of workforce activities
    - Chaired regular meetings with NHS trade unions to support pandemic response
    - Took part in discussions regarding amendments to interim staff terms and conditions
    - Participated in discussions to support staff and student deployment
    - Published materials on behalf of NHS England and the DHSC
    - Developed, published and updated staff risk assessment guidance

Leadership support networks

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

Key decision-making

15. During the relevant period, key decisions regarding how best to support our members, voice their experiences and influence national decision-makers on their behalf were made via a dedicated task force, consisting of senior colleagues from across the organisation including representatives from the executive team. In addition, the organisation's full executive team met on a weekly basis and the board of trustees met several times per year. Across both the task force and executive team our approach was to ensure that where intelligence or comment from our members was received, via our networks and

other communication channels, that this was noted and, where useful, referred to the appropriate health leaders for consideration and potential action.

England

16. The majority of NHS Confederation's members had a line of accountability to NHS England. The details of this are best sought from NHS England.

17. The NHS Confederation did not and does not have a formal role in the response of the healthcare system in England in the event of a pandemic (with the stated exceptions of the trade union-related, guidance and communication activities of NHS Employers), nor did we play a direct role in procurement to support their healthcare response. As a membership organisation, our role as agreed by our executive and the board was to aid communication and help cascade information from statutory bodies, and to collate insight from members about the reality on the ground, and then speak on their behalf – both publicly and privately – to national bodies and to the media when required. Whilst the NHS Confederation worked closely with NHS England and DHSC to inform some of their guidance and policy, there was no formal accountability relationship (other than via the commissioning of NHS Employers).

18. For England, NHS England is therefore best placed to explain its role in relation to the provision of healthcare in England and the UK as a whole, and the procurement of premises, services and equipment in response to the pandemic, particularly given the return to command and control during the crisis period, as well as:
    - how and by whom NHS healthcare services were commissioned and provided;
    - the lines of accountability within the healthcare system;
    - how funding for NHS healthcare services and equipment was obtained and allocated; and
    - whether / how any of these arrangements changed during the relevant period.

19. Further to the NHS Confederation having no formal role in the response of the healthcare system in England, the NHS Confederation also had no role in the decisions reached on the making, procurement, supply, standards, recall, or replacement of PPE, medical diagnostics or other essential medical items or equipment including oxygen, ventilation, PCR tests and vaccinations. The NHS Confederation therefore considers NHSE, the Department of Health and Social Care, the Medicines and Healthcare Products Regulatory Agency, the NHS Supply Chain and the Health and Safety Executive best placed to comment individually or collectively across the following themes raised in the Module:

- How and by whom decisions on national, regional and local procurement, including via use of the NHS Supply Chain or through initiatives for UK-make PPE, were reached, reviewed and implemented.

- How and by whom decisions on the quality of PPE, medical diagnostics, oxygen, ventilator and other critical medical devices and medical products were reached in accordance with relevant regulatory standards, domestic and international law and guidance, including in relation to product testing, recall and replacement.

- Remedial actions in place, or established, to sustain supply of essential items including PPE, medical diagnostics, oxygen, ventilators and other critical medical devices and medical products.

20. For these reasons we did not and have not made recommendations or observations on procurement methodology or associated matters, nor contributed to or commented on any other reviews which may or may not have been undertaken across departments or ALBs during or since the pandemic.

21. Due to the rapid nature of guidance development during the pandemic, the NHS Confederation was not consulted in its initial development by the Secretary of State for Health / DHSC; the Prime Minister's Implementation Unit and Number 10 Delivery Unit; the Chief Medical Officer and Deputy Chief Medical Officers or NHS England or other bodies and did not have a role in finalising decisions

regarding such guidance or its content. NHS Confederation members were sometimes invited to briefings which occasionally provided the opportunity to feed in views. As noted later in this statement, the NHS Confederation did at times seek to assist its members with explanation guides linked to the centrally issued guidance.

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

23. As mentioned above, during the relevant period NHS Employers continued to manage the relationship with trade unions on behalf of the NHS and the Secretary of State for Health & Social Care. NHS Employers co-chairs the Social Partnership Forum Strategic Group, which met twice a week (with an extended membership) during this period. A wider Social Partnership Group was regularly chaired by Minister Helen Whately (and latterly Ed Argar) during the pandemic. We understand that the DHSC has provided notes of all these meetings to the inquiry.

24. The wider NHS Confederation (with the exception of NHS Employers) did not have a formal affiliation with any NHS England or DHSC committee, working group, specialist body or other decision-making body through which we cooperated during the pandemic.

25. Rather, the NHS Confederation contacted relevant officials and communications teams directly at NHS England, DHSC, the Care Quality Commission (CQC), Public Health England (PHE) and UK Health Security Agency (UKHSA) with the purpose of sharing member insights and explaining

the needs of our members. This includes concerns raised on the range of products, medical devices, and equipment required to support the treatment of patients during the pandemic linked to our primary care, ICS and other networks set out in this statement which were raised with the Confederation through informal or formal engagement and contact. Our role was not restricted to these concerns, for example, the Primary Care Network met NHSE and DHSC regularly to provide detailed commentary on the impact of Covid-19 on primary care and latterly on the implementation of the Covid vaccination programme of which primary care delivered 70% of vaccinations. The nature of those Primary Care Network meetings is set out later in this statement.

Wales

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

27. Due to all Welsh NHS bodies being members of the Welsh NHS Confederation, during the period 1 January 2020 to 28 June 2022, the Welsh NHS Confederation provided corporate and secretariat support to a number of NHS Wales Executive Director Peer Group meetings. These meetings included Nurse Directors, Public Health Directors, Medical Directors, Assistant Medical Directors and Workforce and Organisational Development Directors (from within organisations that are part of the Welsh NHS Confederation's membership). At these meetings the response to the pandemic was discussed, including areas within the scope of Module 5, and Welsh Government officials would attend. In addition, we provided secretariat support to the NHS Chairs and Vice Chairs meetings and the Chief Executive meetings with the Welsh Government officials, taking a high-level note and sharing it with the Welsh Government and the Chief Executives.

28. These meetings were arranged by the Welsh NHS Confederation on behalf of Peer Group chairs and high levels notes were taken to share with meeting participants. The Welsh NHS Confederation, while in attendance at meetings as an observer, was not involved in any operational matters or decisions made by Welsh Government or our members, the NHS bodies.

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

30. Areas relating to healthcare equipment and supplies, including PPE, ventilators and oxygen, lateral flow tests and PCR tests, were discussed in these meetings.

31. However, the Welsh NHS Confederation had no statutory role in relation to increasing capacity around healthcare equipment and supplies. We were aware that prior to the pandemic structures and processes were put in place to increase the NHS capacity as part of the Welsh Government and NHS services contingency plans for when the UK left the EU. A warehouse in Southeast Wales was acquired by the Welsh Government in March 2019 to provide additional storage capacity for medical devices and clinical consumables to ensure continuity of supply for Wales after the UK left the European Union. The increase in capacity put in place prior to January 2020 provided the opportunity to enable the NHS in Wales to be in a position to immediately act and respond during the pandemic, including increasing the space to store consumables, including healthcare equipment and supplies.

32. At the beginning of the pandemic, healthcare equipment, including PPE, was predominantly sourced on a UK-wide basis. However, Welsh businesses responded to the need for more PPE by adapting their production to supply PPE and other products required during the pandemic. The Welsh Government

appointed the Life Sciences Hub Wales to collate all offers of support by industry to health and social care, including cleaning products and PPE for front line workers facing shortages during the Covid-19 pandemic. Life Sciences Hub Wales was the single point of contact for companies who had appropriately certified supplies of such equipment and further information around the range of ways industry responded and supported the NHS during the pandemic can be found in the Welsh NHS Confederation and Life Science Hub Wales briefing, "How industry has supported NHS Wales organisations to improve outcomes throughout the COVID-19 response", published in November 2020 and which can be found at Exhibit DM/02 [INQ000503485].

Northern Ireland

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

34. The Northern Ireland Confederation was not involved in operational matters or decisions made by Government or our members, the aforementioned HSC bodies, in relation to the procurement, supply or quality management of PPE or associated medical devices or equipment critical to the pandemic response; in relation to PPE and infection control guidance or associated guidance changes; or in relation to remedial action or system change across all of these areas. Its primary role during the period in question was to support communication and the dissemination of accurate, reliable and up-to-date information from trusted sources via periodic written briefings and online briefing sessions, the latter of which featured presentations from a range of government officials and HSC staff in leadership roles. However, the Northern Ireland Confederation did not undertake surveys of its members in relation to the range of issues under

consideration in Module 5, nor publish guidance relating to the use of PPE, infection control, procurement and quality standards relating to medical devices, diagnostics or other critical equipment.

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

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

The NHS Confederation's relationships with UK Government Departments, Non-Departmental Public Bodies and Arm's Length Bodies, devolved administrations, regional and local governmental bodies, and other bodies as well as the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser and others

37. The wider NHS Confederation did not have a formal affiliation with any governmental, committee, working group, specialist body or other decision-making body through which we cooperated during the pandemic. Rather, the NHS Confederation contacted relevant officials and communications teams directly at NHS England, DHSC, CQC, Public Health England and later UKHSA

with the purpose of sharing member insights and explaining the needs of our members both in relation to guidance and the situation 'on the ground.'

38. In England, the NHS Confederation had regular (more than weekly) contact with:
    - DHSC
    - NHS England
    - NHS Employers had meetings twice a week with Social Partnership Forum Strategic Group.

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

40. And less regular contact with:
    - Medicines and Healthcare Regulatory Authority
    - NHSX (as existed then).

41. Turning to the NHS Confederation's relationships with other central and national organisations, I can confirm that the Prime Minister's Implementation Unit and Number 10 Delivery Unit reached out to us in June 2020 to seek our support in convening groups of our members with whom they could discuss and test their ideas regarding various government priorities, for example the building of new hospitals, and workforce commitments. They did not share documents with the NHS Confederation. There was no specific focus on procurement. I set out more information, to include the work with the Prime Minister's Implementation Unit, in a later section of this statement.

42. However, the NHS Confederation had no significant engagement in the relevant period with other bodies, such as NHS Procurement, The Ventilator Challenge UK Consortium, the Cabinet Office, or Government Commercial Function or others involved in the Ventilator Challenge. Similarly, we had no significant engagement with Association of Directors of Adult Social Services, the Chief Medical Officer, Chief Nursing Officer, Chief Scientific Adviser or other government medical advisers or expert bodies on these issues in the relevant period.

43. The Independent Healthcare Providers Network (IHPN) were part of NHS Confederation until they left on 31st March 2020. We had limited engagement with them after that though we intermittently exchanged views on matters involving care provision in the context of the independent sector during the pandemic.

England

44. Staff from the NHS Confederation would be invited to briefings at which individual medical, nursing and scientific officers and advisers spoke. We routinely attended the "Fortnightly Covid-19 Deputy Chief Medical Officer call with stakeholders" – this was largely a call to brief patient representative groups on policy changes. On occasion, a senior member of the NHS Confederation would be invited to a call with the Chief Medical Officer or one of the Deputy Chief Medical Officers for them to provide a personal briefing to us on various plans just before they were announced in order to answer our questions and help us understand the plans so we could provide accurate information to our members and/or explainers for the public via the media if we chose to do so. Examples of the above briefings include a change to vaccine policy or infection control plans.

45. Senior NHS Confederation staff members were also intermittently invited to briefings on operational matters with Keith Willett, NHS England's national director for emergency planning and incident response. NHS Clinical Commissioners (now the ICS Network) were in contact with NHSE's Chief

Nursing Officer's office including the Deputy Chief Nurse, Hilary Garrett. Additionally, the Primary Care Network hosted a fortnightly meeting with Jenny Hall, deputy Chief Nursing Officer (CNO) on the Covid vaccine, the vaccine programme and Primary Care Network (PCN) nurse clinical directors. NHS Employers staff did work from time to time with members of the CNO and Medical Director teams on developing relevant guidance regarding the deployment of staff and students.

Wales

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

Northern Ireland

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

General Engagement and Advice

48. The NHS Confederation in England undertook regular conversations (both spoken and via email) with members across the country to understand the key challenges they were facing in the delivery of care in the context of the pandemic. This work was conducted as part of existing networks set out earlier and also involved on occasion the issuance of surveys which are outlined later in this witness statement.

49. The intelligence was compiled to produce an internal 'sit rep'. Where members identified particular challenges that we considered NHS England or the Department of Health and Social Care or another decision maker might be able to resolve, we shared the relevant insight with them as appropriate. Member insights were shared with wider partners reflected earlier in this statement. Ad hoc requests and particular concerns were raised during regular meetings with senior officials, as appropriate.

50. The NHS Confederation in England, Wales and Northern Ireland is not and was not formally required to input or share information we received from members with government or arm's length bodies. We may choose to do so when we consider this to be helpful to our members. In all three devolved administrations where we represent NHS bodies there are formal national structures in place where information from our members is systematically collected and flows directly to national bodies, without involving the NHS Confederation. Information about this data can therefore be provided more appropriately by these bodies. Below we set out our member engagement channels in more detail.

51. Where there were asks from members for more detailed information, including in relation to guidance issued by national government organisations, we also produced member briefings on topics including:
    - Implementation guidance issued by NHS England at the start of the different phases of the pandemic found at Exhibit DM/03 [INQ000391214], Exhibit DM/04 [INQ000391215] and Exhibit DM/05 [INQ000391170].

- The PHE review of inequalities on the impact of COVID-19 on racialised communities at Exhibit DM/06 [INQ000503501]. Test and trace at Exhibit DM/07 [INQ000503480].

52. Additionally, the NHS Confederation submitted written evidence to parliamentary select committees and generated reports as set out later in this witness statement.

Experiences of NHS Confederation members

Acute care

53. During the relevant period the NHS Confederation's contact with acute leaders at the forefront of the NHS's response to the pandemic increased. This was largely done on an ad hoc basis given the extent of the pressures on acute services. We set up several feedback mechanisms to gather intelligence and feed it directly back to government departments and NHS England.

54. From mid-June 2020 we met with Richard Parasam from the Prime Minister's Implementation Unit (which became the Number 10 Delivery Unit in 2022). This engagement has continued since the conclusion of the pandemic, but during the relevant period the focus was on service recovery, with a particular interest in elective backlogs. These meetings (which involved colleagues drawn from our member organisations) therefore focused on learnings from the first phase of the pandemic and how this impacted on the emerging picture of continued pressures. Meetings took place every six weeks or so. They were designed to provide a link between frontline staff and the advisors writing the briefings for the Prime Minister. They were very informal, and Chatham House rules applied, often with no agenda, and the meeting was driven by whatever issues the advisers were working on at the time. They found it useful to hear frontline operational experiences to help inform briefings and develop their understanding of issues. The findings were not, we understand, routinely shared with NHSE, though from time-to-time DHSC staff joined informally. Later our contact at the Number 10 Delivery Unit was Michelle Rigozzi and discussions focused on Urgent and Emergency Care pressures, how to reduce

discharge delays, reducing winter impact, elective recovery and industrial action.

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

Primary care

56. The NHS Confederation has provided a direct membership offer to primary care providers since December 2019. Initially, this offer was just to primary care networks (PCNs) before expanding to "at scale" primary care organisations above the PCN level too, including GP Federations. For PCNs, the offer is to support their development. This includes a suite of support products, an app, representation to government and other stakeholders and forums, events that provide connections within primary care and elsewhere in the health service, Integrated Care Systems (ICSs) and the wider health systems.

57. Notably, PCNs were the delivery vehicle for COVID-19 vaccinations, although they could also be administered by GP surgeries. The information we receive from PCNs largely focuses on:
    - Operational issues, including vaccine supply
    - Clinical issues e.g. surges of Covid, situation regarding StrepA
    - Organisational issues i.e. how their PCN is developing
    - Systems development i.e. how their local ICS is developing, particularly the inclusion of primary care.

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

59. The key meetings led by the Primary Care Network during the relevant period were:

- NHSE Primary care clinical stakeholder forum – weekly moving to fortnightly then monthly
- Monthly DHSC/NHS Confed call
- Monthly PCN Nurse Clinical Director Vaccinations meeting with NHSE nursing director
- Regular email reporting, varying from daily in March/April 2020, to monthly in 2021-2022
- Ad hoc Teams calls

60. The monthly forums were run without agenda, for free discussion of issues.

Mental health

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

- Parity of esteem for mental health including access to vaccinations and testing
- Law and treatment of people detained under the Mental Health Act during pandemic
- Addressing and meeting high demand for mental health services, whilst adapting to meet needs of mental health patients

- Modelling demand for mental health of the population, recognising projected figures and estimates for a delayed mental health impact on the population after the pandemic
- Children and young people's experience of the pandemic, and specific support needs whilst not in school
- Children and young people's rise in eating disorders and disordered eating services, due to rise in the pandemic

62. The topics discussed with Claire Murdoch's team at NHSE included:
    - Remote Mental Health Act Assessments
    - Electronic Mental Health Assessment forms
    - Oxygen
    - End of life drugs/support
    - Mental health input into Nightingale hospitals
    - Step up and step-down guidance
    - Learning from Italy and Spain about impact on mental health services and demand
    - Evaluation of service changes – how, barriers and innovation
    - Regulation by the Care Quality Commission
    - Pensions/abatement
    - Staff numbers.

    The Mental Health Network also produced publications to advocate for changes for their members, including in particular, *Reaching the tipping point: children and young people's mental health* at Exhibit DM/08 [INQ000391210]; and *Running hot: the impact of the pandemic on mental health services* at Exhibit DM/09 [INQ000401412]. These were both supported by media and communications plans to raise the profile of the work and follow up meetings with NHSE.

63. During the early stages of the pandemic, the Mental Health Network set up a forum for Mental Health Trust chairs to meet virtually (weekly) to share concerns and offer peer support. We also set up a separate group for our

Independent Sector members to share concerns and provide peer support. Topics discussed at the Mental Health Trust chairs weekly meeting included:

- Governance arrangements / adaptations (including arrangements for virtual meetings and streamlined governance papers and record keeping)
- Staff wellbeing Ethics committees
- Mental Health Act reviews
- Adapting mental health services including community teams in light of social distancing
- Access to testing for Mental Health Trust staff
- Social distancing in inpatient settings for staff and patients
- Access to PPE.

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

65. The Mental Health Network shared member's concerns through a number of mechanisms. In April 2020, Claire Murdoch, National Director for Mental Health, NHSE, joined a Medical Directors Forum meeting, to hear directly from medical directors, working in mental health services, about the reality on the ground during the relevant period.

66. In June 2020 the Mental Health Network and Primary Care Network ran a joint webinar on how to prepare for the expected increase in demand in mental health support, with speakers from member organisations. A similar webinar was run jointly by the Mental Health Network and the NHS Clinical Commissioners Network in September 2020; speakers included member organisations and Public Health England.

67. In May 2021 the Mental Health Network ran a round table with members from across the NHS Confederation exploring the impact of additional mental health

demand on the wider system which included speakers from across our membership.

Clinical commissioners

68. The NHS Clinical Commissioners network heard from their CCG members on the issues of NHS Continuing Healthcare (CHC) funding functions and redeployment of CGC nurses to alternative settings, such as to care homes. This was a rapidly unfolding position, where member insight and experience were used to inform NHS Confederation knowledge and understanding of the issue.

69. During the Covid-19 crisis, NHS Clinical Commissioners' (NHSCC) Nurses Forum ran a short series of virtual meetings with NHSE's Chief Nursing Officer's office. These meetings discussed and gathered good practice on issues affecting lead CCG nurses during the health crisis being faced by the NHS and local communities. Topics included:
    - NHS Continuing Healthcare
    - Integrated hospital discharge
    - Integrated support offers
    - Supporting and testing in care homes
    - Following discharge pathways
    - Supporting patients with personal health budgets and trusted assessors
    - Safeguarding
    - System capacity
    - Infection prevention and control training
    - NHSE guidance on Care Homes support in England during Covid-19 lockdown.

70. NHS Confederation shared insight obtained from our members with relevant officials at DHSC and NHSE throughout the pandemic, largely by emailing or speaking with officials responsible for that topic area. We also held ad hoc webinars and round tables to facilitate shared learning set out in Exhibit DM/10 [INQ000391162].

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

Individual trusts and primary care networks sharing information with the public

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

Information gathering and escalation of concerns

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

74. For example, the NHS Confederation raised concerns publicly regarding:
    - The need for a one-month extension to the Brexit transition period following the increase in Covid-19 cases in November and December 2020. Exhibit DM/11[INQ000391188].

- The need to pause retendering local authority contracts for community health services to reduce bureaucracy on these teams as they delivered vital services. Exhibit DM/12 [INQ000391180].
- The need for NHS leaders to be able to have quicker access to capital funding to support the delivery of care. Exhibit DM/13 [INQ000391189].
- The chronic undersupply of NHS staff and issues with retention. Exhibit DM/14 [INQ000391183].
- Need to embed leaner, more agile approach to regulation to improve care. Exhibit DM/15 [INQ000391182].
- Need for access to capital funding and medium-term financial certainty to help tackle the elective backlog. Exhibit DM/16 [INQ000391179].
- The need for a clear operational strategy to help the health service deliver test and trace. Exhibit DM/17 [INQ000391198].

75. In Wales, the Welsh Government developed a range of communication assets that all NHS bodies in Wales could use, including those working in primary care, to communicate the change in guidance/ key developments with the public. This included social media cards and standard text to use. The NHS Confederation cannot provide further information about information flows in Wales, beyond what I have described above. NHS bodies in Wales would have highlighted operational issues directly to the Welsh Government in good time.

Guidance

Concerns raised around clinical guidelines, guidance, advice or instructions for healthcare providers and clinicians, supply and use of PPE, medical diagnostics, other medical products, oxygen, ventilators and vaccinations

76. The NHS Confederation was able to gather information and intelligence from its Membership across various informal communication channels - email, telephone conversation, meetings of each NHS Confederation network as set out earlier in this statement. We were able to reflect this in the work of the organisation via our Covid 19 Task Force, as also mentioned earlier, and

engagement with government departments and agencies in subsequent meetings or via written communications.

77. The level of engagement by issue/theme depended on the levels of concerns being raised by members and also resulted in 3 surveys being conducted by the NHS Confederation, directed by the Task Force, as follows:

- A PCN network survey - Exhibit DM/18 [INQ000503476]. This was conducted in April 2020, with 217 respondents.
- A PPE survey – Exhibit DM/19 [INQ000503477]. This was conducted in July 2020, with 5 detailed responses.
- A survey led by the BME Leaders Network – over 100 members were interviewed, and a full report was published by the NHS Confederation in April 2021 as shown at Exhibit DM/20 [INQ000503481].

78. The specific details and outcomes of these surveys are set out later in this witness statement by theme.

79. Our members also raised concerns about the timing and communication of changes and updates to clinical guidance. For instance, there were instances of delays with the publication of urgently needed guidance, but our members also reported how difficult it was when they did not hear about changes to guidance until the last minute; sometimes healthcare leaders found out about decisions impacting the way they delivered services at the same time as the public, who sought to immediately access the new or changed services. Such announcements felt as if they were geared more to the needs of the briefing and media cycle, than the timely and effective implementation of the changed service.

80. As members tried to rapidly implement the announced changes, these announcements created public expectations that meant valuable capacity had to be diverted to explaining to patients when services would be available. For example, healthcare practitioners and leaders did not receive any forewarning ahead of the Prime Minister's announcement of the expansion of the

vaccination programme to 24/7 on 13 January 2021. Our members found it practically very challenging to deliver the substantial and logistically complex change that had been promised and was expected immediately, with no notice, forewarning or time for preparation. Some members noted that this meant some staff felt the need to work late hours and work during their much-needed days off to implement these changes expected to be delivered with immediate effect, creating exhaustion that contributed to staff burnout.

Accountabilities for producing guidance

81. Our members provided feedback on the guidance they were receiving, including concerns around accountabilities for producing clinical guidance becoming confused, which at times led to duplication and uncertainty. In July 2020 some NHS Confederation members highlighted, anonymously, concerns about blurred accountability for public health decision-making.
    a. According to one Director of Public Health, fragmentation of the health, social care and public health systems at national, regional and local levels had led to duplication and poor communication and a lack of understanding about the role of Public Health England, the public health functions of NHS England and Improvement, and local government.
    b. A community CEO made a similar point: "The problem with the issuing of national guidance is that various, individual bodies hold different responsibilities for different risks - PHE, DHSC, NHSE so what is meant to be national, is still piecemeal. So, you just have to put in place what is right as you have staff to inform and services to run."

82. The NHS Confederation raised concerns to the relevant bodies at regular points both formally and informally. For example, the Primary Care Network Director frequently passed on members' questions about new guidance to the NHSE Primary Care Team over email, each time requesting further detail and clarification, which would then be shared with our members so they could effectively implement the guidance. Members shared their concerns that there was often an issue of clarity and understanding for the mechanisms in primary care that would be needed to implement the guidance. The Primary Care

Network also called on NHSE to investigate the impact of a decision in one sector on its system partners to ensure that guidance given to one part of the system did not create additional workload in another.

Infection Prevention Control concerns: guidance

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

84. At various points during the relevant period, our members shared concerns about gaps in some IPC guidance produced by NHSE and other bodies, while recognising that it was necessarily being developed at speed. For example:

    a. Members reported a lack of co-ordination between primary and community teams in March 2020 and told us that each service was receiving different guidance without clear pathways between the services, creating a potential gap in services and care.

b. in April 2020 one of our community members raised concerns around insufficient guidance around management of Covid-19 patients who were discharged from Intensive Care Units (ICU) into the community. One member said at the time: "there is little /no guidance for how community hospital wards and community pathways should be adapted to manage the safety and quality of care and increasing demand or any guidance on when to trigger any peak clinical decision making / escalation tools to then trigger a process of aligning care decisions to the clinical frailty score etc."

c. In July 2020, members expressed some frustration that infection prevention and control (IPC) guidance was issued to the public and to industries, without thinking through implications for healthcare. One said: "Plea to government: try to sort and consult before the policy is issued, not after."

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

e. In April 2022, our members expressed their concerns about receiving late notice of the continuation of free lateral flow tests for staff – this hampered timely communication with staff with impact on staff morale and engagement.

85. Our members also raised concerns about difficulties relating to the feasibility and implementation of guidance. A number of issues were raised in relation to IPC guidance and the huge impact this had on reducing capacity. For example,

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

86. Our members also shared frustrations about guidance at times lacking clarity, which left them confused about the actions they should take and how best to answer the high volume of questions from patients. For example, in April 2022 our primary care members expressed concerns

    a. at the lack of clarity in the Joint Committee on Vaccination and Immunisation (JCVI)'s IPC guidance around what circumstances would require them to ask patients to get tested and
    b. that the lack of detail on patient testing could lead to an increase in request to GPs so that patients can access free testing.

87. A lack of clarity sometimes led to some discrepancies in interpretation. This happened, for instance, in relation to NHSE's national PPE guidance, which was being questioned by some national bodies, including unions. Guidance was occasionally contradictory, and members highlighted examples such as Public Health England's high consequence infection diseases (HCID) guidance which stated, *"As of 19 March 2020, COVID-19 is no longer considered to be a high consequence infectious disease (HCID) in the UK."*

88. In England, IPC guidance was largely provided at the national and regional level which was interpreted locally. Healthcare leaders (including IPC leaders

appointed in each trust) followed national guidance, but ultimately had to make decisions about how to deliver care safely based on their local circumstances, including local outbreaks and the condition of their estate. Our members asked for more local determination in IPC measures which we lobbied for on their behalf but ultimately their calls were not heeded – Exhibit DM/21 [INQ000391206]. The challenges associated with interpreting and implementing IPC guidance, including the condition of estates, are explored in the next section of my statement.

89. Turning to the guidance itself, our members regularly raised concerns about constraints on capacity and elective recovery caused by infection prevention and control requirements and challenges accessing capital to address these constraints.

90. In March 2022, acute members welcomed flexibility in IPC restrictions at a national level, as it helped increase capacity in a safe and appropriate way, improving the efficiency of care pathways and patient flow, supporting further progress on the elective backlog. At this time, the situation varied across the country; for example,

    a. While recognising it is not "a decision (to) takes lightly", some acute providers continued to postpone elective procedures and to suspend visiting due to rising Covid cases in the community and increasing numbers of patients with the virus, while local IPC teams maintained a 'close and regular' review of the situation.
    b. Others said: "it is asymptomatic patients who are causing more disruption to flow than symptomatic" and encouraged "small incremental changes in IPC guidance".'

91. As there was still a difference between the IPC expectations in healthcare settings and in general public spaces, members were concerned about patient/visitor compliance and impact on staff.

Infection Prevention Control concerns: Infrastructure and NHS estate

92. The condition and layout of the available NHS healthcare infrastructure in England was a significant issue in the implementation of IPC guidance for many of our members given the inadequacy and age of many parts of the estate and the scale of the NHS maintenance backlog. Older hospitals, for example, tend to have more beds within a unit, which increases the risk of nosocomial infections and reduces staff efficiency. In July 2020, members highlighted the issue of the lack of capital or revenue funding being available for IPC in general practice to stratify the estate or guidance on how to do it. Again, in March 2021, for example, an acute member reflected on concerns about the unsuitability of their existing estates to meet the demands of Covid-19 (e.g. providing non-invasive ventilation on high-dependency respiratory wards), and the requirements for infection control (maintaining green and red zones both short term during Covid peaks, and longer-term). In April 2021, some trusts reported feeling disproportionately affected by having older estates and the loss of significant capacity due to infection control-related requirements.

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

94. In May 2021, the NHS Confederation wrote to the Secretary of State for Health and Social Care calling for a review of social distancing guidance in hospitals in light of falling rates of COVID-19 infection - Exhibit **DM/16** [INQ000391179]. This letter was the result of concerns raised by members that infection prevention and control measures were both disproportionate to the levels of infection and restricting the ability of NHS organisations to prioritise tackling the elective backlog, as instructed by government.

95. In addition, a small number of NHS Confederation members and I met virtually with then-Minister Ed Argar on 3rd March 2021 where they explained that older hospital estates had more limited recovery capacity due to it being harder to

segregate patients in to 'hot' and 'cold' areas. They asked for investment for temporary facilities, but this was not forthcoming at the scale needed.

96. I deal with the issue of oxygen and associated estate and infrastructure issues in later section of this statement under the heading of "Ventilators and Oxygen."

Personal Protective Equipment

Guidance

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

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

99. In early 2022, our members reported that they faced significant challenges due to different guidance on IPC between health and social care settings, and where patients are handed between settings.

Distribution of PPE

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

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

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

103. As explored above, persistent revisions to PPE guidance added to uncertainty. There was a focus on getting PPE to the acute sector, sometimes at the expense of community, mental health, third sector and social care settings. NHS procurement rules sometimes stood in the way of opportunities, for example to enable the use of PPE stock, held by commercial organisations in their geographical area, in the hospital setting rather than waiting for the central system to procure and distribute PPE. This led some NHS organisations to reach out for community donations, and the availability of PPE was also a big issue for social care providers, which also had to turn to community donations.

Members' concerns and escalation

104. In March 2020:
    a. We raised concerns about PPE in primary care with the Deputy Chief Medical Officer.
    b. We contacted NHS Procurement to address the challenge of innovations in PPE not being able to enter the NHS market due to lack of CE certification. We supported the use of safe, CE marked PPE only but reflected on whether the market authorisation process could be more agile and rapid during this period.
    c. We sought encouragement and endorsement from NHS Procurement for local initiatives to access PPE e.g. through the decentralisation of purchasing or possible initiatives to manufacture PPE at community level to CE certification standards.
    d. The Primary Care network began reporting back to NHS England on PPE shortages reported by members, including Clinical Directors having to crowdfund to buy kit and sourcing from local closed businesses.

105. During this time, primary care members felt that there was very little support from their CCGs and elsewhere both in terms of communication and access to sufficient supplies. The national helpline for PPE supplies faced delays and difficulties, which meant that primary care did not benefit from its work in the early days of the pandemic. During a meeting, the Royal College of GPs reported that "even when we get [PPE] it's underwhelming" and the British

Dental Association shared their concerns that they were "stuck outside of the system" and had no PPE. General practice members reported that it became increasingly difficulty to source clinicians willing to work in hot hubs without access to PPE, with the multi-source supply and confusing messaging leading to low confidence in the PPE supply system.

106. In April 2020 the NHS Confederation conducted a PPE survey – Exhibit DM/18 [INQ000503476]. response to concerns raised within the NHS Confederation Primary Care Network (for England only). This survey was issued to all members of our primary care network (674 in total), and 217 responses were received in total. The survey asked a series of questions in relation to PPE guidance and provision with responses as follows:

    a. The PPE Guidance allows for adequate protection for front line staff – a majority disagreed or strongly disagreed.

    b. We have sufficient access to PPE to meet the requirements of the guidance – a majority disagreed or strongly disagreed.

    c. Front line staff feel adequately protected – a majority disagreed or strongly disagreed.

    d. We are able to access core PPE when we need it – a majority disagreed or strongly disagreed.

    e. All frontline staff know (according to the guidance) when they should be using PPE - a majority agreed or strongly agreed.

    f. We are using PPE for all of face-to-face consultations regardless of what the guidance says – a strong majority agreed or strongly agreed.

    g. My PCN currently has sufficient access to staff testing – a narrow majority disagreed or strongly disagreed.

h. I am clear on plans to roll out testing across the NHS – a narrow majority disagreed or strong disagreed.

107. 83% of respondents cited a lack of access to masks with filters, as a key issue. 73% cited a lack of access to googles/visors. 27% cited a lack of access to aprons. 27% cited a lack of access to "other", which is then clarified as relating often to gowns.

108. The survey also afforded the opportunity for free text comment, enabling the following extracted, anonymised statements to be made (with the full set of responses at Exhibit DM/18 [INQ000503476] and which demonstrate a range of concerns on the quality and supply of PPE and the associated guidance and its credibility:

a. *"Had it not been for accessing PPE from schools and other voluntary organisations and our own contacts with suppliers we would have run out a long time ago. The national supply chain has been totally inadequate. The PPE emergency line has been unreliable and failed to deliver what was expected of it and we still have no confidence in it. I do not believe that the initial guidance (without visors or gowns) was sufficient for seeing at-risk patients. These views are shared across our whole PCN."*

b. *"Having tested people previously using level 3 PPE and now testing using level 2 PPE since a guidance change I feel uneasy. I'm struggling in the cold outside as the visors steam up and you can't see, and general practice colleagues are refusing to do any throat examinations without level 3 PPE and we are swabbing in level 2. It makes you feel uneasy when experienced colleagues are saying I wouldn't do it. You feel you need to as it has to be done but can't help feeling concerned, more so about going home to your children and feeling as though you could be putting them at risk. I no longer give them a kiss."*

c. *"The PHE guidance differs from the resuscitation council guidance on cardiac compressions. PHE state that performing cardiac compressions is NOT an aerosol generating procedure (despite their guidance in 2008 that states otherwise) resuscitation council guidance states that*

performing cardiac compressions IS an aerosol generating procedure, please can this be fed back and clarified by PHE."

d. *"There is a strong feeling amongst clinicians that PHE guidance on PPE was not, and is not, evidence based. It has altered several times seemingly mainly influenced by supply rather than evidence. The scarcest resource in an epidemic is trained clinicians. Poor PPE has burned through our clinician and support workforce at a greater rate than would have occurred if we had good PPE kit and practices. Staff just want consistency and an evidence-based approach. They appreciate the truth and would have been, and would still be, much more accepting of a truthful approach: "this is what you should have, this is what we actually have which is considerably less but do your best until we can upgrade to what you should have". Our ingenuity would have helped us come up with solutions. This has significantly negatively impacted the front-line workforce's confidence and belief in PHE and the NHS (or rather the DoH) centralised procurement and supply process. It will be a long and difficult process for PHE and DOH to win back confidence and trust."*

e. *""We have some visors that have been printed locally not provided by NHS - we would not have any if it were not for this. We are constantly running low on masks and finding the hotlines difficult to get stock from. We have noted from NHS suppliers the cost of face masks increasing from £5 per box to £50. We do not feel that aprons are adequate for entering homes of patient who are known to be positive."*

109. In April 2020, a group of Mental Health Chairs led by Norman Lamb wrote to the Secretary of State for Health and Social Care regarding the clinical need for PPE within mental health settings. Issues were raised about inconsistent PPE supply around the country. While in some areas supply chains were seen as well-coordinated, in others PPE supply was seen as "a total disaster". In April 2020, one trust CEO commented that "National statements on tonnage and number of items are meaningless". In response to these concerns, the NHS Confederation's CEO Niall Dickson called for transparency on PPE supplies at Exhibit DM/23 [INQ000087234]). In May 2020 a community CEO commented that: "There are 2 parallel purchasing systems in place. We have mutual aid

through routes of primary and social care which has also supported swapping PPE as per need."

110. In May 2020 we shared the results from our April survey of our PCN members on testing and PPE with NHSE which revealed that while awareness for the PPE guidelines was high, only 33% of primary care staff agreed that they had sufficient access to PPE to meet the guidelines, 24% were able to access more PPE when they needed it and 77% were using PPE for all face to face consultations irrespective of the guidance. 25% of respondents agreed that they were clear on plans to roll out testing across the NHS and 39% agreed that they had sufficient access to staff testing. Exhibit DM/18 [INQ000503476].

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

112. In May 2020, the NHS Confederation sent a private letter to Emily Lawson then chief commercial officer at NHSE and Jonathan Marron Director General for PPE and Public Health at DHSC highlighting member concerns on procurement and at Exhibit DM/24 [INQ000391177]).

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

114. In June 2020, we held a webinar on PPE with Emily Lawson and Lord Deighton and about 50 members participating. The following issues were raised:
    - The allocation of push stock is not representative of what trusts require, forcing them to source their own materials

- Lack of transparency e.g. FFP3 deliveries stopping completely in one area, forcing trusts to use the Emergency request system
- Mask variation - one member asked for data to be requested centrally and captured locally on failed and successful fit testing and links with ethnic background and gender, to inform procurement for future waves; another expressed concern about being able to use transparent masks for use with patients who have learning disabilities, autism, deafness, who may have difficulty with standard masks.
- Concerns about supply of sterile surgical gowns, including not being able to procure gowns until 48 hours before running out of stock.

115. In June 2020, several members raised concern that the allocation of push stock of PPE was not representative of what trusts required. One member said that: *"Despite sending our PPE modelling and working with McKinsey, the quantities that come through, the push model is still not adequate in terms of quantity. This leads to Trusts being forced to source their own materials."* Another member said: *"We seem to get delivered what is available rather than what we need. e.g. I have several years' supply of visors now, but short of gowns. No ability to return them (so swapping in LRF) but delivery is not related to need."* This was also noted to be an issue for returning to business as usual at a future date, but we otherwise had limited commentary as the NHS Confederation on the specific question of push stock.

116. A second, briefer survey was also conducted of our PCN members by the NHS Confederation in July 2020 following a PCN webinar in April 2020. This was issued to the 53 individuals who attended the webinar and there were 5 respondents. The results are at Exhibit DM/19 [INQ000503477]. This is a less significant level of response than in the April 2020 survey but reflects some of the issues or concerns being raised by NHS Confederation members in the previous survey and informal messaging and feedback received via our networks.

117. NHS Confederation shared the outcome of these two surveys with NHS England and DHSC leads via email and with data attachments. NHS

Confederation members also had direct routes of communication on such concerns to NHS England and its regional offices, as well as potentially to DHSC. We are not aware if any formal surveys were conducted by NHSE or DHSC of NHS Confederation members to which the comments and concerns we shared contributed.

118. In August 2020, our chief executive sent a follow-up letter to Emily Lawson again seeking reassurance on PPE stock and supply at Exhibit DM/25 [INQ000391178]. By October 2020, we heard that members were feeling much more confident about PPE, although the issue was raised again by one member in March 2021.

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

Access to Lateral Flow Tests

120. In January 2021, members indicated to the NHS Confederation that, when available, lateral flow testing was proving useful and effective. However, some described insufficient access to lateral flow tests for all staff; some were reportedly being told that for primary care and for vaccination sites there would be no lateral flow testing until February 2021.

121. In January 2021, there continued to be challenges in accessing sufficient lateral flow tests to use the tests twice weekly – particular concerns were voiced by PCN members and by independent sector mental health members. For those who did have the tests, there were concerns about the government site for submitting results which was described by one member as "long-winded, clunky and doesn't remember user details. Also issues with accepting the data – believe is to do with the batch number on the test strips."

122. In relation to PCR testing, in January 2022, there was some frustration that people were no longer required to use PCR tests which was perceived to have led to underreporting and thus difficulty in accurately projecting the likely

demand on services. In the same period, many staff within member organisations were struggling to get hold of lateral flow tests for Covid, and members were calling for clarity on whether NHS staff had to pay for tests from April 2022 onwards.

Vaccinations

123. In December 2020, some hospital hubs advised the NHS Confederation that they were easily using their allocation of vaccines; others had spare vaccines, and due to concerns about waste, had asked their Primary Care Networks (PCNs) in their locale to enable those within the community over the age of 80 years to be vaccinated in hospital, where mobile, in order to use up the spare vaccines. PCNs were also worried about the risk of vaccine wastage when they started their programmes and had asked for authorisation to move down the cohorts e.g. to under 80s but had been advised not to do this and to focus on using vaccines to vaccinate staff. Many questions remained unanswered, including when primary care services would get vaccines; uptake by PCNs still working through workforce requirements; timescales for PCN sites after wave 1; concerns about contract requirements and risks; whether funding would cover actual costs; storage; uptake and vaccine wastage; whether primary care practices would be penalised; and PCN ability to balance vaccination programmes with routine primary care work.

124. In the same period and in relation to vaccine logistics, members across the sectors described confusion about what was expected of them including in relation to timelines, vaccine transportation and storage practicalities, lack of local coordination, and rapidly changing information. One member noted that *"(we) don't know how to make vaccines work and still don't know if they will be available next week. We have to plan as if it will be available."* There were particular concerns about how to record who has had the first and second doses and the process for linking this to their patient record. There were concerns that an IT solution was not in place for this, and members described this as "risky", with particular worries about tracking whether people had had both doses.

125. There were also early concerns about the fairness of who would receive the vaccine and where, for example having enough capacity and logistical ability to vaccinate housebound people, and questions around consent. One member noted that *"PCNs have made great progress but most practices still want to book in their own patients on their own lists, vaccinate their own patients, do things in a way that they feel comfortable, as if it is just like flu rather than the Enhanced Service. I understand this and I suspect the driver for this is the fear of being blamed for errors and the fear of financial loss."*

126. In the same period members expressed some concern about the significant impact of administering the staff testing and vaccination programme at a time when staff were already "flat out"; discomfort with pushing staff vaccination programmes when there remained a lack information or guidance about safety data, given also the anti-vaccination and conspiracy theories in circulation; a lack of knowledge of whether the vaccines contained pork which would impact certain groups e.g. on religious grounds. There was concern in relation to challenges in communicating different information for different vaccines, including in relation to the possible side effects of different vaccines.

127. Through 2020, into 2021, members faced short implementation times for the new guidance, which was frequently published on Friday afternoons and had to be read, understood and enacted over the weekend. The short turnaround and requirement to work over the weekend contributed to feelings of stress and burnout among GP partners. Those involved in the delivery of the mass vaccination programme shared concerns about guidance availability and were often left with questions around important practicalities such as storage requirements, and interpretation of the guidance contained in the Green Book was often left to local determination. One community NHST Trust CEO stated: "Communications from NHSE need to be simpler. CEOs don't have time to read 64-page briefings. NHSE need to invest in simple plain comms to explain plans for the distribution of the vaccine."

128. In November 2021, as the mandatory vaccination date for staff approached, many members expressed concerns about implementation, tracking and

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

129. In December 2021, a member noted that *"In general this is going well. There has been a strong feeling of being 'up for it' and keenness for staff to play their part in the programme, with acute hospital settings in particular currently being on track, and the programme has engendered a lot of pride."*

130. However, during the same period primary care teams had particular frustrations with vaccine supplies: delivery dates were moved at the last minute, there was a lack of notifications/clarity regarding time of delivery. This meant, as reflected by our members, that some vaccine sites were being stood down at the last minute as the planned supply of vaccines had not been delivered, leading to extra work as many patients had to be re-booked, and anger and frustration at the loss of the work that had been invested by HCPs.

131. Acute members also experienced vaccine deliveries being missed or arriving late, with no communication about these delays, leading not just to problems managing vaccine inventories but also, in some instances, to vaccines arriving thawed. Some community vaccination sites were noted as having to defer their booked patients to January 2022 in this period because NHS England and NHS Improvement (NHSEI) had started to require PCN sites to provide assurance that they could provide/store the equipment and had access to the fridges/IT/supplies on the centrally issued inventory lists.

132. In relation to prioritisation and the vaccination of staff, Trusts noted that they were working to issue the vaccines in line with the mandate for >80s, care home staff and then their health and care practitioners (HCP) staff to be prioritised. Most were trying to prioritise their clinically extremely vulnerable (CEV) staff,

where there was staff willingness to be vaccinated, though the 'no waste' approach meant that other available staff had been vaccinated in the case of no-shows. However, there was growing concern over perceived unfairness/inequalities in access: frontline staff, NHS staff without particular risk factors, and care home staff who may be young, lack key risk factors, or only worked occasional shifts were sometimes seen to be prioritised over staff who were objectively more vulnerable in various ways, for example due to age or pre-existing conditions. An acute CEO also reflected that staff perceived inconsistencies in the proportions of vaccine given to staff in different trusts.

133. Members fed back in this period that acute staff had easier and faster access than those in other parts of the system and others observed that some geographies were disadvantaged. Some members had observed that more-educated, middle class and white colleagues may have been accessing the vaccine faster than their peers, whilst CEV staff were reportedly declining to be vaccinated.

134. In relation to patients there were similar concerns about inequalities in access linked to geography and prioritisation. This was demonstrated in feedback that eligible people on acute wards would have quicker access to the vaccine than mental health inpatients, due to decisions on where to prioritise delivery of the vaccine. Some members considered that people with learning disabilities whose COVID mortality rates were reportedly six times higher than the general population should be higher on the prioritization list. Finally, members noted that the prioritisation of over >80s meant that people who lived in the more affluent areas with longer life expectancies had more access to the vaccine; people who lived in inner-city areas with higher levels of deprivation, higher BAME populations and lower life expectancies, were further disadvantaged by this approach.

135. In relation to consent, mental health leaders also identified the need for decision-making support for people with impaired capacity prior to administering of vaccines in order to ensure informed consent where possible, and the application of a best-interests approach.

136. In April 2022 members noted that there was a disparity in communication meaning that some primary care sites were rushing to prepare for the next wave of vaccinations, having not been forewarned of the announcement by the Government.

Ventilators and Oxygen

137. There was originally public and political concern about whether there would be sufficient numbers of ventilators in the UK. In April 2020 the NHS Confederation heard anecdotally from its members that some ventilators delivered to acute hospitals were not always UK-compatible at the point of delivery. We assume this to be a reference to the UK regulatory requirements. Supply proved less concerning than originally feared, but the Shelford Group and others were expressing concerns and confusion around the different modelling approaches being used. One CEO said the original regional modelling revealed they would be 1,000 ventilators short, but new modelling had found no predicted shortages.

138. Mental health wards in many places had experienced difficulty in accessing enough oxygen tanks to support Covid-19 patients. This was a particular problem because of the higher threshold for moving patients from mental health to acute settings, as a result mental health providers were also having to manage increasingly ill patients.

139. Throughout April 2020, we continued to hear concerns about how additional ventilator requirements would be managed in different locations. Whilst concerns raised about supply of ventilators remained, NHS Confederation understood that concerns about actual numbers in the UK had reduced. Instead, the focus was increasingly on a lack of clarity regarding the planned distribution of ventilators regionally, taking into account predictions of different regions experiencing surges and peaks at different times during the pandemic.

140. In relation to oxygen, in the same period the NHS Confederation understood from NHS England that there was no shortage, but that there were technical

limitations on how much could be processed and delivered to patients in any hospital at any one time. This was linked to the aging infrastructure which meant that oxygen delivery systems were not designed to cope with a large volume of high-flow oxygen. NHSEI had recommended that members ensured patients were not being over-oxygenated, that hospitals ask their gas providers to look at any appropriate tweaks, that organisations avoid running ventilators off cylinders where possible (instead, transferring their patients to somewhere with a vacuum insulated evaporator machine), and that people did not hoard empty or part-empty oxygen cylinders, but return them so they could be refilled. NHSEI had also advised that it was better to make frequent small orders rather than large orders of cylinders, presumably to enable continuity of supply rather than the stockpiling of supply within different settings.

141. However, in April 2020, one trust told the NHS Confederation that they had experienced oxygen supply issues as resources were redirected to a Nightingale hospital. As a result, they did not have the supply of oxygen that they modelled was necessary. In July 2020, an acute CEO advised our networks that their hospital had been close to running out of oxygen in April 2020. The Inquiry requested the details of those Trusts who raised concerns as set out in this statement. However, our records do not enable us to identify which Trusts raised these issues given the anonymous nature in which member feedback was received and documented in this period.

142. On 6 August 2021 NHS Confederation members noted that they were planning for potential increased demand over summer of general and critical care beds, and a particular consideration that had been raised was maintaining oxygen supply. By November 2021, we had heard at least one report of pressure on oxygen supply, which had not been seen since the first wave of the pandemic.

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

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

144. In relation to equipment, in December 2020, at least one level 4 major incident was called as intensive care/ventilator capacity was almost full, resulting in patients being transferred to other hospitals. Our members were at times also concerned that there would be an insufficient number of ventilators (which in the end only affected a minority of our members or that older hospitals did not have the equipment infrastructure to support so many patients requiring high flow oxygen. At various points during the relevant period, including in April/May 2020 and April 2021, members cited access to sufficient diagnostic equipment as a limiting factor for recovering elective activity. The Inquiry requested the details of those Trusts who raised concerns as set out in this statement. However, our records do not enable us to identify which Trusts raised these issues in relation to oxygen and oxygenation given the anonymous nature in which member feedback was received and documented in this period.

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

BME and Associated Equality Considerations

146. Earlier in this statement I have made reference to concerns raised by members of the NHS Confederation in relation to the content of vaccines and the prioritisation of vaccinations across all health settings linked to black and minority ethnic (BME) communities and other protected characteristic communities and groups, including those with learning disabilities (paragraph 120, 121 and 130 - 133).

147. With funding and support from the Health Foundation, in December 2020 the NHS Confederation also published a report based on interviews conducted with over 100 members of the NHS Confederation's BME Leadership Network at Exhibit DM/26 [INQ000237273]). The study was undertaken in response to the early warning signs of a disproportionate impact of COVID-19 on black and minority ethnic (BME) communities in order to assess inequalities. Participants pointed to long-standing inequalities and structural and institutional racism as root causes. Interviewees were united in the view that successive governments had not taken sufficient action to address these underlying issues.

148. The key points set out in the report, and which are relevant to this module were as follows:
    a. The COVID-19 pandemic has foregrounded the issue of health inequalities in the starkest terms. From early on in the crisis, warning signs emerged of a disproportionate impact on black and minority ethnic (BME) communities, prompting questions over what accounted for the disparity and what measures could be put in place to mitigate risks and protect lives.
    b. Overwhelmingly, participants point to long-standing inequalities and structural and institutional racism as root causes. Interviewees were united in the view that despite the wealth of data collected by national bodies and numerous reviews on the relationship between health,

inequalities and BME communities, the NHS and government had not taken sufficient action to address the underlying issues.

c. To redress this issue, the government and health and care organisations must make every effort to pay greater attention to local and national health inequalities data and to act on the insights. More fundamentally, it will be crucial to treat long-term structural health inequities and institutional racism as critical factors when planning services and emergency responses.

d. The absence of translation services and appropriate communications strategies targeting BME communities was one of the most widely reported institutional failures cited in our interviews. We recommended that the government should take action on this area by commissioning a review of the availability of translation services, and to identify immediate opportunities to co-produce community-facing COVID-19 messaging and secure the rapid availability of translation services.

e. BME health and care professionals were reported to be more likely to take on high-risk roles, including working on COVID-19 wards, due to fear that contracts may not be renewed or shifts reduced – especially if they were agency staff or had a vulnerable immigration status. This, interviewees suggested, was compounded by a bullying culture which meant that BME employees were less likely to raise concerns or share their experiences. Nearly 9 in 10 survey respondents (88 per cent) said that staff do not speak out because they fear losing their jobs. This culture was also suggested as contributing to a lack of personal protective equipment (PPE) for BME staff during the first wave.

f. Plan commitments towards transparent, safer staff rostering practices, and supporting the Chief Nursing Officer's BME Action Plan on COVID-19.

Other Interventions and Recommendations made by the NHS Confederation

149. The NHS Confederation was in regular communication with organisations responsible for the various guidance, systems and processes in order to convey member views and encourage improvements that our members considered

would benefit the NHS. When there were very significant concerns, we made formal interventions some of which have already been set out earlier in this statement by theme.

Select Committees

150. In April 2020, the NHS Confederation submitted written evidence to the Health and Social Care Select Committee in response to a request for information about members concerns in relation to the management at that time of the Covid 19 pandemic. The full response is at Exhibit DM/27 [INQ000503484]. The key points which the NHS Confederation made were as follows:

- Testing: The availability of testing continues to be a major concern across the health and care system. Testing capacity has been constrained and only recently did the government commit to expand the number of tests to 100,000 per day by the end of April. It is unclear what the milestones are towards meeting the target, and whether it will be met. Given the vital role that staff testing will play in controlling coronavirus, it is unclear why it has taken so long to ramp up testing capacity.
- Personal protective equipment (PPE): Another key area of concern has been the supply of PPE. There has been government action to address this, but we are still being told by our members that more is needed, and we know this is a key concern among care homes and other social care providers. A key issue is the long-term supply of PPE and whether stock levels will be maintained – this is an area where greater transparency from government is needed.
- Ventilation: Given the potential shortage of additional ventilators as the virus peaks, NHS organisations are concerned about the lack of clear guidance about how the demand and subsequent distribution of ventilators will be managed, and how competing demands will be addressed. There is also growing concern regarding the availability of additional medical consumables related to the provision of mechanical

ventilation, especially oxygen, as a result of the increased demand. Our members are increasingly concerned about oxygen flow infrastructure and whether their estate pipes are sufficient to deal with increased demand.

- Health inequalities: There is emerging evidence to suggest coronavirus is having a disproportionate impact on staff and patients from Black and Minority Ethnic (BME) groups. The Intensive Care National Audit and Research Centre has found that around 34 per cent of more than 3,000 critically ill coronavirus patients were from a BME background. The government and its agency bodies need to explore the emerging evidence to better understand the reasons behind this.

151. By the early summer of 2020 we had a number of clear reflections regarding the experience of our members which can be summarised as follows:

- PPE: Supply and adequacy of PPE has been a challenge for the NHS and social care sector throughout the COVID-19 pandemic as demand surged far above previous levels and overwhelmed existing procurement systems. While significant investment has seen the situation improve substantially, continuing shortages and uncertainties have caused anxiety for both health leaders and health and care staff. More security will be needed to resume non-COVID-19 services.
- Testing: Testing availability was perceived by our members as slow to develop and access has been challenging for staff, particularly for those working in primary care, community services and social care. The situation is improving though still has challenges and uncertainties, including with turnaround time, frequency of staff testing, and with the antibody test.
- Test and trace: Our members are very concerned that the test and trace system is not yet fully operational, which could lead to a second COVID-19 wave as lockdown is eased. There are also concerns about the impact on delivering NHS services if whole teams become subject to quarantine.

- Ventilators: While ventilator capacity within the NHS did not achieve the government's target, supply was increased sufficiently to meet demand during the COVID-19 peak.

Lessons learned and Recommendations

152. From May 2020 to July 2021, the NHS Confederation ran an NHS Reset campaign at Exhibit DM/28 [INQ000391148] in order to take stock of the pandemic experience, including what worked well and which should be retained or followed in the event of a future pandemic. This was the only major review conducted by the NHS Confederation on lessons learned from the pandemic, with two specific reports (Exhibit DM/29 [INQ000391197]; and Exhibit DM/30 [INQ000391196]). The campaign was split into three phases:
    - **Recognise** - recognising both the sacrifice and achievements of the health and care sector's response to COVID-19, including the major innovations that were delivered at pace.
    - **Rebuild** - Rebuilding local service provision to meet the physical, mental and social needs of communities affected by severe economic and social disruption.
    - **Reset** - Resetting our ambitions for what the health and care system of the future should look like, including its relationship with the public and public services.

153. Four key areas of activity shaped the delivery of the campaign:
    - **Informing members** on the latest developments to ensure they were regularly updated, and receiving the guidance they needed, including by synthesising and making sense of the vast range of guidance that is being sent to them.
    - **Collection of member insight** to ensure we had access to the views of the front-line – across all parts of our membership – in real time. This was collected through a variety of mechanisms and fora including member surveys, round tables, meetings, webinars and other online events.
    - **Analysis of member insight** to ensure we were able to understand pressures across the system, as well as in specific sectors, and group up

concerns and needs into key themes. This was achieved via informal feedback calls and the distribution of discussion papers.

- **Action** on issues that members raised concerns over, including recommending action that reduces the administrative burden on members while they were dealing with the virus. This was conducted both privately and through public-facing communications.

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

155. Our 'NHS Reset' campaign had ten key themes which spanned a range of issues affecting how health and care services are planned, delivered and experienced across the UK. Some of these recommendations were specific to the Covid-19 experience; others were wider but recognised to be important within that context.

156. With specific reference to the supply of essential products, as is the focus of Module 5, the NHS Confederation also published a short briefing on this in 2022 with NHS Supply Chain which can be found at Exhibit DM/31 [INQ000503505]. The key points made in this report relate to the NHS and wider system response to the Boardman Review, as commissioned by the Cabinet Office. The report focuses on the future role of the NHS Supply Chain as a key central provider for NHS Trusts and lead on PPE and wider procurement for any future health pandemic.

Statement of Truth

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

Signed: Personal Data

Dated: 21 November 2024