Witness Name: Dr Amanda Doyle OBE

Statement No: 1

Exhibits: AD1/001 – AD1/152

Dated: 2 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR AMANDA DOYLE OBE

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I, Dr Amanda Doyle OBE, will say as follows: -

Introduction

My background

1. Before joining NHS England, I was a GP for more than 20 years, practising in a large practice in a deprived area of Blackpool between 1995 and 2018, which, in addition to primary medical services, provides a range of urgent care services for patients across the Fylde Coast. I was awarded an OBE for services to primary care and commissioning in 2014.

2. Between 2006 and 2012 I also held the role of Medical Director/Professional Executive Committee Chair at Blackpool Primary Care Trust. I subsequently became the Accountable Officer of Blackpool Clinical Commissioning Group ("**CCG**") between 2013 and 2021 following the statutory changes that were introduced in 2012. I was also the Co-Chair of NHS Clinical Commissioners between 2013 to 2018.

3. In 2018, I became the Chief Clinical Officer for West Lancashire CCG, Blackpool CCG and Fylde and Wyre CCG. I was also the Integrated Care System Lead for Lancashire and South Cumbria, leading a large health and care transformation programme across the patch.

4. I joined NHS England as North West Regional Director on 2 August 2021. I only held this post for 10 months, taking up the post of National Director for Primary Care and Community Services on 13 June 2022. In my current role I am responsible for primary care and community services. This includes oversight of a number of national programmes, including the Primary Care Access Recovery Plan, the Dental Recovery Plan, the implementation of Pharmacy First, contract reform and negotiation and recovery of community services waits. I also am a member of the NHS England Executive.

Corporate Witness Statement

5. This corporate witness statement was drafted on my behalf, and with my oversight and input, by external solicitors acting for NHS England in respect of the Inquiry. The draft

request received on 8 January 2025 pursuant to Rule 9 of the Inquiry Rules, specifically relating to Module 6 of the Inquiry (the "Module 6 Rule 9 Request") to NHS England is broad in scope and time period and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals (both current and former NHS England employees) in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

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

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

Approach to the Module 6 Rule 9 Request

8. Following the period under investigation in Module 6, 30 January 2020 to 28 June 2022 ("**the Relevant Period**"), NHS England merged with:

   a. NHS Improvement on 1 July 2022;

   b. NHS Digital on 1 February 2023; and

c. Health Education England on 1 April 2023

9. This Statement refers to the legacy organisations above as is necessary to respond to the Module 6 Rule 9 Request.

10. NHS England welcomes the chance to assist the Inquiry to understand the key issues it has identified as in scope for Module 6 of the Inquiry (and in subsequent engagements with the Inquiry team).

11. The purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in understanding a range of matters as set out the Module 6 Rule 9 Request.

12. We understand that the scope of Module 6 is focused on a range of issues relating to the impact of the Covid-19 pandemic on the care sector in England, Wales, Scotland and Northern Ireland, specifically during the Relevant Period.

13. To ensure that this Statement is as accessible as possible, material which is primarily required for contextual or reference purposes, including an overview of the evolution of the NHS in England, a timeline of relevant discharge and support to care home guidance published, palliative care guidance and Do Not Attempt CPR ("**DNACPR**") guidance are contained within the annexes at the end of this Statement.

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

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

Section 1: The NHS in England

NHS England's role in the system before Covid-19 and how that changed

16. To understand NHS England's role in these matters during the pandemic, it is helpful to understand, for context, NHS England's role pre-pandemic, how this changed during the pandemic and the broad reasons for that change. NHS England's role has been set out to a large extent in NHS England's First Module 3 Statement, and is summarised here for the purposes of this statement.

17. NHS England is not:

    a. a core political or governmental decision-making body;
    b. responsible for setting national health or public health policy; or
    c. a provider of patient services.

18. NHS England's primary statutory duty during the Relevant Period was, pursuant to sections 1(H)(2) and 1(1) of the National Health Service Act 2006, to "*continue the promotion in England of a comprehensive health service … except in relation to that part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities*". In discharging this duty, NHS England has the function of "*arranging for*" health services, which are delivered by various NHS providers.

19. NHS England's primary responsibility is for the co-ordination of the provision of health care services in England and oversight of local commissioners and providers of those health care services. Statutory ALBs (such as NHS England) do not set national and/or strategic health policy, but have a key role in implementing and advising on it. The Government, via DHSC, will seek input from NHS England on how to improve existing policies or address new challenges. NHS England may engage other people and organisations across the healthcare sector, including service users before providing its advice. The Government is then responsible for selecting from the policy options and ensuring any policy selected is appropriately financed.

20. In terms of NHS England's role during the pandemic, it is also necessary to understand that NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005. The responsibilities that come with this role are set out in NHS England's First Module 3 Statement.

21. In addition, NHS England has specific responsibilities under the NHS Act 2006 to prepare for and co-ordinate emergencies. For this purpose, NHS England maintains an Emergency Preparedness, Resilience and Response ("**EPRR**") Framework, together with a number of specific incident plans as well as an overarching 'Incident Response Plan'. This is set out in detail in NHS England's First Module 3 Statement.

22. As described in NHS England's First Module 3 Statement, within the NHS, EPRR incidents are described in terms of the level of response and coordination required, which may change as the incident evolves. They must be used by all organisations across the NHS when referring to EPRR incidents. The incident level, determined by NHS England, informs how the EPRR Framework will respond.

23. Throughout the Relevant Period, the NHS in England was at either a Level 3 or Level 4 Incident. The broad difference is:

    a. A Level 4 Incident response requires NHS England co-ordination, often referred to as 'Command and Control', to support the NHS response in England. This would only be required in certain situations such as a pandemic, national fuel shortage or extensive extreme weather events. In such incidents NHS England (national) gives direction on how NHS resources should be used, and this is co-ordinated and actioned through the NHS England regional teams. NHS England has relevant statutory powers under section 252A (Role of the Board and clinical commissioning groups in respect of emergencies) of the 2006 Act and the SSHSC can direct NHS England to take relevant steps by exercising his powers under section 253 (Emergency powers) of the 2006 Act.

    b. A Level 3 Incident requires the response of a number of health organisations across geographical areas within an NHS England region. The relevant NHS England regional team takes command, control and coordination of the NHS across their region with national oversight. Tactical command will remain with local responding organisations, as appropriate. Practically, meetings between regional and national teams are based on an agreed rhythm with mechanisms for briefing on issues and requesting support.

24. During the pandemic, in line with its role and responsibilities as a Category 1 responder and consistent with its command and control role as set out in the EPRR framework, NHS England provided additional support to partner organisations and leadership to the system on a national level where needed. It provided additional input into policies using its operational knowledge, as necessary; it supported the operational delivery and implementation of policies and it published guidance where necessary to assist healthcare professionals and Trusts in the clinical management of Covid-19 during the pandemic.

Categories of health services

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

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

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

    c. Tertiary care includes: highly specialist care provided to patients who are referred from primary or secondary care services. Tertiary care includes neurosurgery, transplants, specialist stroke units and secure forensic mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations also provide this under contract to the NHS. Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

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

Patient interactions with the NHS

26. The vast majority of interactions with the NHS occur outside of acute hospitals, in primary care, community services and mental health services. These services support people with complex health and care needs to live independently in their own home for as long as possible without the need for hospital admission.

27. Different patients will have a different journey depending on their clinical requirements and where their journey begins. Depending on a patient's health condition, there are advisory guidelines, provided by the National Institute for Health and Care Excellence ("**NICE**"), for the diagnostic and treatment 'pathway' that providers and clinicians follow which can determine that journey[1]. Professional guidance may also supplement this.

28. For example, when feeling unwell a patient will probably first see a GP (primary care) or contact NHS 111[2] unless they present through UEC routes (e.g. by calling 999). Following first presentation, they then may be given advice, or referred to an urgent community service, a hospital A&E department or more specialist care, perhaps for investigations and diagnosis. In very specialist (tertiary care) or end of life situations (e.g. hospices), the patient will be referred to an appropriate provider.

29. Decisions about hospital admissions are exclusively made by the relevant hospital's clinical team. For the avoidance of doubt, GPs do not make decisions regarding admission to hospitals, rather they make referrals.

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[1] NICE is a national advisory body established by the 2012 Act as an executive NDPB sponsored by DHSC. NICE's role is to provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services. NICE supports the health and care system by describing what good quality care looks like in the NHS, public health and social care sectors and helps promote the integration of health and social care.

[2] NHS111 services provide prepared advice, referral to community pharmacy, GPs, urgent care facilities including A&E and 999 response as appropriate. This was supplemented by a front end 119 Covid-19 helpline.

30. Patients may be discharged into the social care system and may still receive NHS care following discharge such as through NHS Funded Nursing Care ("**FNC**") or NHS Continuing Health Care ("**CHC**"), where eligible following assessment.

a. FNC is when the NHS pays for the nursing care component of nursing home fees. The NHS pays a flat rate directly to the care home towards the cost of this nursing care.

b. Some people with long-term complex health needs (following an assessment) qualify for free community health and social care arranged and funded solely by the NHS. This is known as CHC. CHC is for adults. children and young people may also receive a "continuing care package" if they have needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. CHC and Children and Young People's Continuing Care can be provided in a variety of settings outside hospital, a patient's home or in a care home.

NHS England's operating structure and governance

31. NHS England is governed by its Board which provides strategic leadership and accountability to Government, Parliament and the public. Further detail regarding NHS England's governance during the Relevant Period is set out in Annex 3 of Amanda Pritchard's First Witness Statement **[AD1/001 INQ000409251]**.

32. NHS England operates by way of a national team and a number of regional teams. From 2019 there have been seven regional teams: East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. Regional teams are managed by regional directors who report to the NHS England Chief Operating Officer. Regional teams are responsible for overseeing the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

NHS re-organisation: the Health and Care Act 2022

33. The NHS is at its best when it is working in an integrated way to provide joined-up care for patients. The following paragraphs set out, at a high level, the plan for Integrated Care Systems ("**ICS**"). These built on earlier initiatives by NHS England to increase

collaboration (as opposed to competition) between local NHS organisations so that population care could be better planned, joined up and more efficient: Sustainability and Transformation Partnerships ("**STPs**"), the vision for which was published in the Five Year Forward View.

34. In December 2015, NHS England, Monitor and the NHS Trust Development Authority ("**TDA**") asked all parts of England to begin planning together in new local partnerships formed of all NHS organisations, local Government and others (for example, GPs and voluntary sector bodies), known as STPs **[AD1/002 INQ000113178]**. Forty-four areas were identified as the geographical 'footprints' on which each STP would be based. Each STP was asked to develop a Sustainability and Transformation Plan for the future of health and care services in their area, and named individuals were identified to lead the development of each STP **[AD1/003 INQ000113174]**.

35. In 2018, NHS England and NHS Improvement named the parts of the country where integration involving the STP was most advanced as the first ICSs, with NHS England working closely with them to pioneer best practice. ICSs were described as partnerships of organisations (NHS, local government and others) that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area **[AD1/004 INQ000113191]**.

36. In January 2019, NHS England published the NHS Long Term Plan **[AD1/005 INQ000113233]**, which set out the ambition for all parts of the country to become part of an ICS by April 2021, within the legal framework that applied at the time. NHS England and NHS Improvement however also recommended changes to legislation to remove barriers to integrated care.

37. While the policy which led to the 2022 Act was being developed, ICSs continued to operate and develop collaborative ways of working. Patients needed support that was joined up across local authorities, NHS and voluntary organisations, based on a common understanding of the risks and issues faced by different people. Providers of NHS care had to rapidly develop new pathways of care across multiple providers, while protecting capacity for urgent non-Covid-19 care. This was all supported by collaborative working across systems, agreements for mutual aid and the sharing of learning. It required

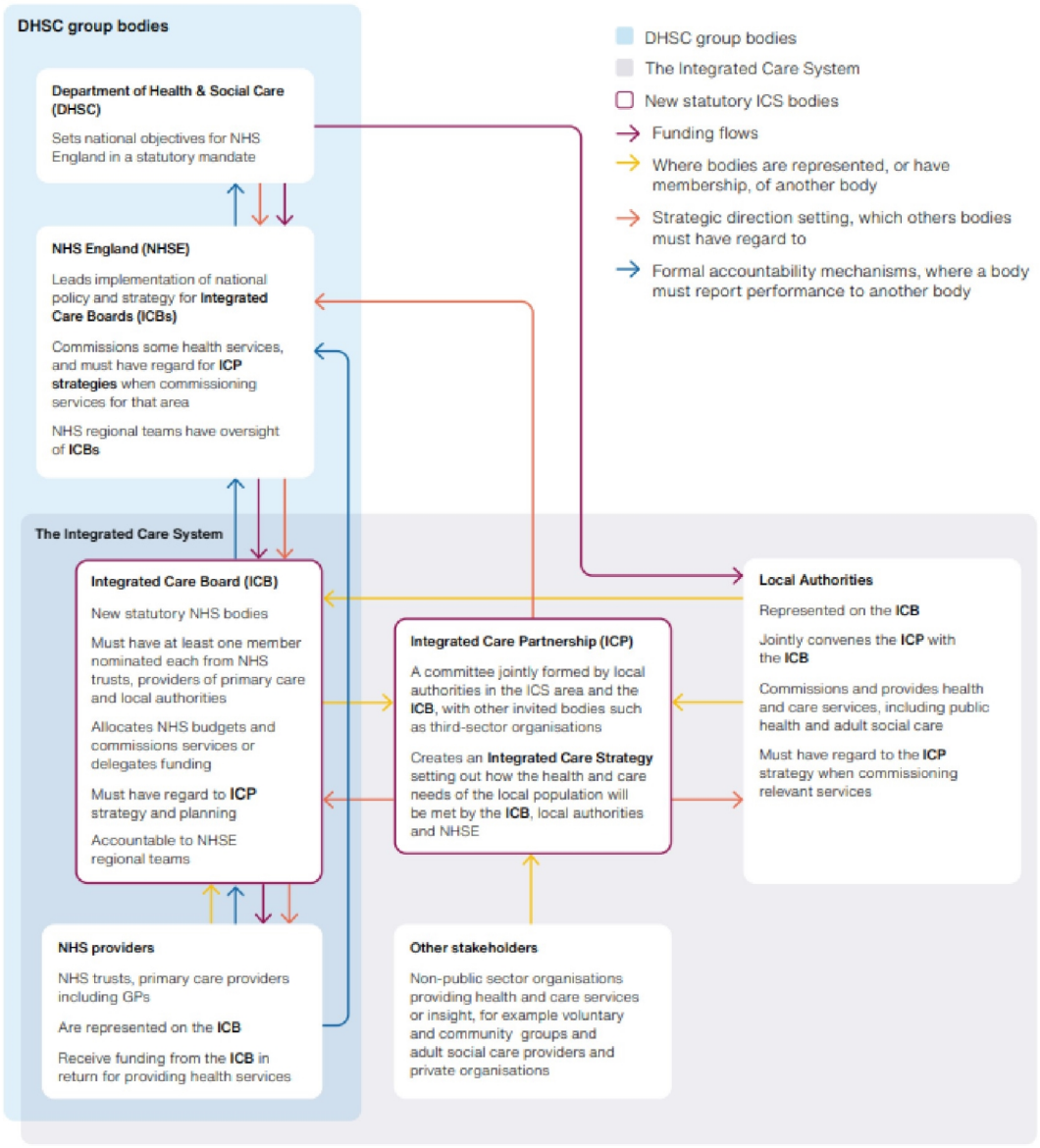
openness in data sharing, collaboration commitment in the interests of patients and communities, and agile collective decision-making, all of which were features of the 'system working' approach of ICSs.

38. The 2022 Act put ICSs on a statutory footing by establishing two new statutory bodies:

    a. ICBs: new statutory bodies that bring together commissioners and providers of healthcare services into a single organisation, and which will take over the functions of CCGs as regards the planning and delivery of healthcare services in order to meet local health needs; and

    b. Integrated Care Partnerships ("**ICPs**"): statutory committees bringing together representatives from the ICB, local authorities within their areas, and other partners (including NHS providers, public health, social care, housing services, etc), responsible for developing an integrated care strategy setting out how the wider needs of the local population will be met.

39. A diagram highlighting how the ICS landscape would look from July 2022 is set out below **[AD1/006 INQ000113289]**:



Working with others

40. In discharging its statutory functions, NHS England works closely with a number of other partners at national and regional level, including HEE and NHS Digital (during the Relevant Period and pre-merger), UKHSA, CQC, NHS Blood and Transplant and NICE, to ensure services are safe, effective and clinically and financially sustainable.

41. NHS England oversees the five NHS Commissioning Support Units ("**CSU**"). CSUs operate across the whole country, providing support to several types of organisations

including NHS commissioners, local authorities and non-NHS bodies. CSUs deliver a range of support services that aim to ensure that the NHS receives the benefits of scale, including clinical procurement services, business intelligence services and human resources. CSU staff are employed by the NHS Business Services Authority. Although operationally distinct (referred to in NHS England's governance framework as 'hosted bodies'), CSUs do not have separate legal personality, and are legally part of NHS England. CSU activities are included in NHS England's Annual Report and Accounts except where otherwise indicated.

42. NHS England's work is also supported by a number of external organisations such as Primary Care Support England (provided by Capita plc), as well as those directly accountable to DHSC via SSHSC, such as NHS Business Services Authority, NHS Shared Business Services, NHS Property Services Ltd, Supply Chain Coordination Limited ("**SCCL**").[3]

NHS England's role in relation to pandemics

43. The roles of NHS England, DHSC, UKHSA, Ministry of Housing, Communities & Local Government ("**MHCLG**")[4] and Cabinet Office and COBR are related but distinct in respect of EPRR. It is the EPRR role of DHSC to work with the devolved administrations and internationally for both planning and responding to emergencies. Health is a devolved issue, so understandably NHS England was not always invited to meetings with the devolved administrations and did not have extensive input.

44. The Government assesses the most serious risks facing the UK or its interests overseas through the National Risk Assessment ("**NRA**").[5] This is a classified assessment of the most significant threats and hazards that the UK could face over the following 5 years and is led by the Civil Contingencies Secretariat ("**CCS**") within the Cabinet Office.

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[3] SCCL is the management function of the new NHS Supply Chain operating model (previously known as the "Future Operating Model" following the Lord Carter Review. SCCL was incorporated with the SSHSC as the sole shareholder on 25 July 2017 and became operational on 1 April 2018. On 1 October 2021 ownership transferred from SSHSC to NHS England.
[4] Since September 2021 this department has been known as Department for Levelling Up, Housing and Communities ("**DLUHC**")
[5] The National Risk Assessment and National Security Risk Assessment merged to be one document in 2019.

45. Individual Government departments lead on key risks relevant to their portfolio - DHSC is identified as the Government lead department for pandemic preparedness.

46. NHS England contributed annually to the NRA, as subject matter experts, in areas such as major incidents and terrorist attacks where the health service has delivered a response. NHS England did not contribute in areas of wider biosecurity, such as pandemic risk, where the expertise lay with PHE. NHS England receives a copy of the NRA.

47. The National Risk Register ("**NRR**") is the public-facing output of the NRA. It outlines the threats and hazards which organisations like NHS England must prepare for based on a 'Reasonable Worst-Case Scenario' ("**RWCS**") basis. RWCS planning allows plans to cover a wide range of potential scenarios within the scope of the incident that is being planned for.

48. The significance of the NRA and the NRR is that they required NHS England to prepare for the worst that could reasonably be expected in relation to a pandemic caused by a non-specified variant of the influenza virus. Emerging infectious diseases were also listed in the NRR and mapped to HCID planning.

49. The management of these risks can be summarised by the following diagram **[AD1/007 INQ000023128**

50. This distribution reflects the response to pandemic influenza based on a "DATER" approach (Detection, Assessment, Treatment, Escalation and Recovery), with different organisations being responsible for each phase consistent with their legal and statutory framework:

    a. Detect and Assess phases: Led by PHE. This is when there are initial cases and small clusters in the country and the focus is on understanding the epidemiology of the virus.[6]

[6] Testing for communicable diseases in the community is and has traditionally been a public health function.

b. Treat and Escalate phases: The NHS takes the lead for pandemic influenza response during the Treat and Escalate phases, when there is an increasing demand on services, as the number of patients with influenza increases.

c. Recovery phase: Alongside planning for and delivering a pandemic response, it is essential that the recovery phase is also planned and managed. It is essential that plans are maintained after it appears the pandemic has abated in the event that there is a further wave of disease.

Civil Contingencies Act 2004

51. NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 ("**CCA 2004**") and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the "**2005 Regulations**").

52. Other Category 1 Responders include:

a. UKHSA (previously PHE) under delegation from SSHSC;

b. DHSC on behalf of SSHSC;
c. NHS foundation Trusts if, and in so far as, they have the function of providing ambulance services, or hospital accommodation and services in relation to accidents and emergencies; and
d. local authorities.

53. There is a reciprocal duty on relevant Category 2 Responders to co-operate with relevant Category 1 Responders, as well as a duty for Category 2 Responders to cooperate with each other. Under the CCA 2004 and 2005 Regulations, responders have a duty to share information with partner organisations.

54. NHS Improvement, NHS Digital and HEE were not Category 1 or 2 Responders under the CCA 2004.

NHS England's Emergency Preparedness, Resilience and Response Function

55. NHS England recognises that the scope of Module 1 deals with preparedness; however, in order to contextualise NHS England's response within the Relevant Period, and

support Module 6, it is helpful to set out, at a high level, details regarding NHS England's EPRR Function.[7]

56. In England,[8] NHS England is responsible for setting a risk-based EPRR strategy for the NHS, ensuring there is a comprehensive NHS EPRR system, and leading the mobilisation of the NHS in the event of an emergency, working with partners where a joint response is needed.

57. In relation to EPRR, NHS England works with a range of national partners, including the devolved administrations and other Government departments and public bodies, as well as regional and local partners.

58. NHS England has had an EPRR team in place since 1 October 2012. The EPRR function is organised on a national and regional basis, to reflect the fact that planning, preparation and response can need different levels of co-ordination. The national EPRR team sits within the NHS England Chief Operating Officer's directorate.

59. NHS England maintains an EPRR Framework, together with a number of specific incident plans as well as a generic overarching 'Incident Response Plan', not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

60. The Incident Response Plan confirms, amongst other things, who in NHS England has the authority to activate a national response as well as the activation of relevant response structures.

61. In the years prior to the pandemic, working with partners, NHS England maintained standing plans for HCID incidents and for pandemic influenza **[AD1/009 INQ000113189]** as directed by DHSC and the NRA. Both plans were maintained and updated in

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[7] 25 Since July 2022, ICBs established under section 14Z25 of the 2006 Act have also been Category 1 Responders.

[8] The Witness Statement of Dr. Michael Charles Prentice in relation to Module 1 (and published on the Inquiry's website) sets out detail NHS England's EPRR role since establishment **[AD1/008 INQ000177805]**.

discussion with national and regional stakeholders and in response to learning from incidents and exercises. The plans supplemented NHS England's overarching national EPRR Framework, and the NHS Core Standards for EPRR ("**EPRR Core Standards**") (the minimum requirements for NHS funded organisations) which every Trust and CCG (as they then were) were required to fulfil **[AD1/010 INQ000113145].**[9]

62. For the purposes of the Relevant Period, NHS England's EPRR Framework 2015 applied **[AD1/011 INQ000113172]**.[10]

63. In relation to the NHS in England, all NHS-funded organisations are required by the EPRR Core Standards to have an Accountable Emergency Officer ("**AEO**") for EPRR. NHS England also has an AEO.[11]

64. NHS England's regional teams represent NHS England on Local Resilience Forums ("**LRF**") and Local Health Resilience Partnerships ("**LHRP**") (including sub-groups) and various regional groups (e.g., steering groups and health protection groups) as well as directly working with, for example, NHS funded organisations, NHS commissioners, safety advisory groups, Ministry of Defence (Joint Regional Liaison Officers), Directors of Public Health and PHE (now UKHSA).

65. LRFs are multi-agency forums made up of representatives from Category 1 Responders and are supported by Category 2 Responders. The geographical area of forums is based on police areas (apart from London, where one area covers London boroughs and the City of London).

66. LHRPs provide a strategic forum for joint EPRR planning across a geographical area; they are not statutory organisations. LHRPs coordinate strategic planning for incidents impacting on health or continuity of patient services and effective engagement across LHRP and local health economies. LHRPs feed into the activity of LRFs in relation to health planning but are not formally part of any LRF **[AD1/012 INQ000226884]**.

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[9] As health is a devolved matter, there are four distinct health systems within the UK.
[10] To take into account changes made by the 2022 Act, an updated version was published in July 2022.
[11] NHS England AEOs since establishment: Dame Barbara Hakin, Ian Dalton, Matthew Swindells, Amanda Pritchard and David Sloman.

67. In 2019, the National Director for Emergency Planning and Incident Response identified a need for an additional resource to provide specific focus on risks which had not yet materialised. This need was based on learning from the increasing frequency of incidents, 'market' conditions and potential incidents (such as potential failures of providers on which the NHS was dependent).

68. To meet this need, a national Potential Incident Investigation, Preparation and Recovery ("**PIIPR**") team was piloted from late 2019. The role of the PIIPR team was to work in support of the EPRR team, undertaking rapid background investigation and analysis in relation to providers. This was so that when a risk materialised the EPRR team would have all of the necessary information on which the Incident Management Team ("**IMT**") could make decisions in relation to its coordination role; the IMT would know that those decisions would be based upon accurate data and information. Once the acute phase of the incident was resolved it was anticipated that the PIIPR team would support the return to business as usual or new business arrangements (as appropriate).

69. The newly formed PIIPR team almost immediately became responsible for leading the NHS England programme to plan for and prepare the NHS for the UK's departure from the European Union ("**EU Exit**"), and for then maintaining an EU Exit response 30 LHRPs were devised during the establishment of NHS England and their purpose was to ensure, at a local level, that all NHS organisations were engaged in planning for emergencies and secondly, and where appropriate, to undertake health related activity on behalf of the LRF (with consent and permission of members).

Section 2: Role of NHS England in Adult Social Care

70. NHS England has very limited statutory functions in relation to care homes beside a general duty to promote "integration" between health and social care services (section 13N(2) of the 2006 Act).

71. Responsibility for care homes lies with a range of other bodies:

    a. The DHSC is responsible for social care policy and funding, including policy in relation to care homes.

b. Pursuant to Part 1 of the Care Act 2014 ("**Care Act**"), local authorities are responsible for meeting individuals' social care needs, including through the commissioning of accommodation in care homes. Sections 14 to 17 and Schedule 12 of the Coronavirus Act 2020 (which came into force on 31 March 2020) relieved Local Authorities of various assessment and other related social care functions;

c. Care home providers owe a range of duties to their residents, including a duty to act compatibly with their European Convention on Human Rights, including Article 2 rights (right to life);

d. Care home providers are also regulated providers for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**CQC Regulations**"), which set out, among other things:

   i. a general duty to provide care in a safe way for service users, which includes, among other things, a specific duty to "*assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated*";

   ii. a duty to employ sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the standards set out in Part 3 of the CQC Regulations;

e. The CQC is responsible, among other things, for monitoring and regulating care home providers' compliance with the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

72. The NHS (usually CCGs within the Relevant Period) does commission healthcare for patients in care homes who need it. This includes those who have been found eligible for NHS Continuing Health Care (**"CHC"**), following an assessment process. For the majority of such individuals, the care package is commissioned either from care homes or from domiciliary care providers, depending on the setting in which their needs can be most appropriately met.

73. Under section 63 of the Health and Social Care Act 2012, the SSHSC has a power to make regulations enabling or requiring Monitor (part of NHS Improvement during the

Relevant Period) to exercise certain specified functions in relation to adult social care in England. As of the date of this Statement no regulations have ever been issued under that section.

NHS England and DHSC cooperation on adult social care

74. A summary of the meetings regularly attended by NHS England and DHSC representatives regarding adult social care is provided below. A broad overview of the purpose of the meeting is provided where possible, noting that adult social care would have likely been discussed as part of wider strategic and operational meetings in addition to those set out below making specific reference to adult social care. In addition to the regular meetings outlined below, NHS England representatives engaged with Ministers and Government colleagues at various levels on a daily basis, and illustrations of these interactions are also set out below.

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

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

*Pandemic Influenza Preparedness Programme ("**PIPP**")*

77. Established by DHSC pre-pandemic, included representation from key organisations including PHE, NHS England and other ALBs.

78. The PIPP was comprised of workstreams, including Workstream 2: Community Care. This workstream was established in 2018, the aim of the workstream was to increase the understanding of and confidence in the ability of community and social care sectors to respond to a reasonable worse-case scenario pandemic **[AD1/013INQ000108354]**.

79. NHS England's Deputy Head of EPRR (London) was joint SRO for this workstream.

Adult Social Care National Steering Group

80. Established by DHSC to coordinate the response from social care providers to the pandemic response. It was convened on 5 February 2020 until 11 March 2020, until it was replaced by the National Adult Social Care and COVID-19 Group.

*National Adult Social Care and COVID-19 Group ("**NACG**")*

81. The purpose of the NACG was to oversee the development and execution of DHSC's preparations for adult social care and Covid-19. The group was to advise on action to be taken nationally to support local authorities and providers respond to Covid-19, and to act as a conduit for communication into Government and for providers and commissioners to provide insight.

82. It was convened in mid-March 2020 and was replaced by the Social Care Sector Covid-19 Support Taskforce in June 2020. It was co-chaired by DHSC and the President of the Association of Directors of Adult Social Services ("**ADASS**").

Social Care Sector Covid-19 Support Taskforce

83. The remit of the Taskforce was to oversee the delivery of the Care Homes Support Package in every care home in England and to oversee the delivery of the remaining actions from the Social Care Action Plan, published on 15 April 2020. It was chaired by the former President of ADASS.

84. The Taskforce was to also consider the impact of Covid-19 on the care sector over the following year and to advise on a plan to support it through this period.

85. The National Director of Strategy and Innovation and Medical Director for Primary Care represented NHS England.

*The Scientific Advisory Group for Emergencies ("**SAGE**")*

86. SAGE meetings were convened in January 2020 by the Government Chief Scientific Advisor ("**GCSA**") and is convened to provide scientific advice to support decision-making in the Cabinet Office Briefing Room ("**COBR**") in the event of a national emergency. It is intended as an advisory group limited to scientific matters and its members vary from meeting to meeting. NHS England did not begin to attend these meetings until 'SAGE 10' (25 February 2020) with NHS England's National Medical Director ("**NMD**") attending regularly, and intermittent attendance from other NHS England colleagues. The primary purpose for NHS England attendance was to support in providing NHS specific information as necessary.

*SAGE Care Home Working Group ("**CHWG**")*

87. Formed in May 2020. The purpose of the CHWG focused on key policy questions around care homes. This was specifically set up to provide advice on the optimum testing strategy for assessing the incidence of Covid-19 in care homes and providing advice on data sources in order to maximise the effectiveness of infection prevention and management in care home settings.

*SAGE Social Care Working Group ("**SCWG**")*

88. The SCWG took over the remit of the CHWG in September 2020. Recognising the intersectionality between systems of care in and across communities the area of scientific enquiry of the revised group encompassed all care sectors, including residential care settings, domiciliary care provision and specialist care settings.

89. The National Clinical Director for Older People and Integrated Person Centred Care represented NHS England.

Adult Social Care Vaccine Boosters Taskforce

90. Established in January 2022 to oversee the delivery and take up of the Covid-19 booster vaccine within the adult social care sector, by bringing together the NHS England's

vaccination deployment programme, the DHSC adult social care team, other Government Departments, Local Government and senior representation from adult social care providers.

91. The Medical Director for Primary Care represented NHS England.

Covid 19 Operations Committee

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

SSHSC Covid-19 meetings

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

Prime Minister and SSHSC Covid-19 meetings

94. Hosted by the Prime Minister, these meetings were held daily from 21 March 2020 to 15 May 2020. The SSHSC was invited, alongside a range of Government departments. The NHS England CEO was invited. This meeting series was superseded by regular meetings to discuss the 'Covid-19 dashboard', which started on 1 June 2020.

Prime Minister 'Covid-19 dashboard' meetings

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

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

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

UK Senior Clinicians Group

97. Established in February 2020 as a forum at which senior UK clinicians involved in pandemic management could discuss predominantly clinical issues relating to Covid19. It was not a decision-making group. Meetings were chaired by the CMO or an appropriate deputy and involved all the Deputy Chief Medical Officers ("**DCMOs**"), Chief Medical Officers, DCMOs and clinical advisors from all four nations, UK CNOs, and representatives from GCSA, HEE, Scottish Government, Public Health Scotland, NICE, Ministry of Defence, and DHSC as well as NHS England.

SPI-M-O Group

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

*Hospital-Onset Covid-19 ("**HOCI**") Working Group*

99. This sub-group was commissioned by SAGE on the 3rd April 2020 and initially jointly chaired by NHS England (CNO) and PHE (Sharon Peacock), but by 15 April, Sharon Peacock had passed joint chairing duties to NHS England's National Clinical Director for Infection Prevention Control ("**IPC**"). This group focused on hospital onset Covid-19 infection / nosocomial infections, and its purpose was to provide thought leadership, direction to analysis and precipitate policy change and interventions that lead to a rapid and sustained reduction in the rate of HOCI. Information from this group fed into groups such as SAGE and supported NHS England's operational response. Members included several NHS England attendees, PHE/UKHSA, NHS National Services Scotland, Public Health Wales, Northern Ireland Executive and several university academics. The HOCI Working Group was stood down in early 2022.

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

100. The Joint Biosecurity Centre was established in May 2020 by SSHSC as part of the Test and Trace service to help inform actions on testing, contact tracing and local outbreak management in England, and to advise on Covid-19 alert levels and inbound international health risks. Membership included PHE, ONS, academic institutions and

private industry. Regular NHS England attendees included NHS England's NMD, CNO and Strategic Incident Director. NHS England's Chief Executive did not attend.

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

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

GCSA, CMO, NHS England CEO and PHE meetings

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

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

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

DHSC tripartite 'Daily Coordination' calls

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

PHE Strategic Response Group

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

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

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

Daily Finance meetings

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

Cross-System Efficiency and Finance Board

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

Capital Delivery Portfolio Board

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

Monthly Finance meeting

110. This is a monthly meeting organised by DHSC and including MS(H). The NHS England CFO was invited. The meeting series was requested by MS(H) upon entering his post with the intention of providing an informal brief on the latest financial position and an opportunity for an open discussion on any current pressing issues. These meetings were not formal accountability discussions. The request for the series pre-dated Covid19.

Role of nursing in Adult Social Care

111. In February 2020 a part time post of Strategic Advisor for Care Home Nursing was created within the Chief Nursing Officer team to strengthen links across organisational boundaries and give care home nurses a greater role in the centre **[AD1/014 INQ000421233]**.

112. In December 2020, as outlined in DHSC's "*Adult social care: our COVID-19 winter plan 2020 to 2021*" (published on 18 September 2020), DHSC established the post of the Chief Nurse for Adult Social Care to provide social care nursing leadership at DHSC. This post was originally created on an interim basis for nine months before becoming a substantive role for a period of three years from September 2021. The Chief Nurse for Adult Social Care reports to DHSC's Director General of Adult Social Care with a professional line to the Chief Nursing Officer. The Chief Nurse for Adult Social Care is part of team CNO.

Section 3: NHS Support to Adult Social Care During the Pandemic

Executive Summary

113. The care sector and the NHS are inextricably linked; the NHS is reliant upon a functioning care sector to operate effectively, and the care sector relies upon the NHS for residents health care, support and other mutual aid. Residents in care homes can receive NHS Funded Nursing Care and NHS funded Continuing Health Care, along with primary care from a visiting GP, community health services such as speech and language therapy, district nursing and any relevant community health care specialist services that are needed.

114. The NHS Long Term Plan set out a vision for improving healthcare support within care homes, recognising the need for better integration between primary, community and social care services to improve healthcare outcomes for residents.

115. The pandemic accelerated many elements of the NHS Long Term Plan. In particular NHS England scaled up at pace the Enhanced Health in Care Homes framework ("**EHCH**") to provide more structured NHS support to care homes during this period of unprecedented pressure. This was implemented alongside other measures offering support to care homes via mutual aid. Further detail is provided at paragraphs 153-159 below.

116. The need for additional support to be provided to care homes was identified early on in the pandemic by NHS England. By 2 March 2020, NHS England had written to all NHS leaders to emphasise the importance of engaging with social care partners and ensuring that they were ready to manage residents and infection prevention and control **[AD1/015 INQ000087445]**.

117. Acknowledging that overall responsibility for adult social care remained with DHSC and local authorities, NHS England's role was primarily supportive, focusing on clinical leadership, guidance and the coordination of NHS funded healthcare delivered within care homes.

118. On 9 March 2020 NHS England established the Discharge and Community Services cell with the aim of ensuring timely and safe discharge from hospital and strengthening NHS care in the community and NHS support to the care sector. The Cell was primarily staffed by the Ageing Well Programme team, and later expanded in size and remit.

119. NHS England issued a series of operational updates and guidance to strengthen the provision of healthcare into care homes. These included guidance to general practice and community services, support for digital enablement and remote monitoring, and coordination with CCGs and PCNs to deliver consistent and person-centered NHS care to residents in care homes.

NHS Coordination and Mutual Aid Support to Care Homes

Phase 1 Letter

120. NHS England issued the "Phase 1 Letter" **[AD1/016 INQ000087317]** to NHS and adult social care leaders on 17 March 2020, following a Cabinet Meeting earlier that day which HMG approved the key measures set out in the letter. The Phase 1 Letter was unprecedented in its request for a common and coordinated response.

121. The Phase 1 Letter described the following priorities:

a. Hospitals were asked to free 30,000 beds to create critical care capacity, by postponing all non-urgent elective operations from 15 April at the latest, urgently discharging all hospital inpatients medically fit to leave and block-buying capacity in independent hospitals.

b. The Ministry of Housing, Communities and Local Government ("**MHCLG**") and local authorities in conjunction with their Local Resilience Forums ("**LRFs**") would be overseeing support for older and vulnerable people who were going to be 'shielded' at home over the coming months.

c. For patients in the highest risk groups, the NHS would be identifying and contacting them over the coming week. They were likely to need enhanced support from their general practices, with whom they were by definition already in regular contact. GP services should agree locally which sites should manage essential face-to-face assessments.

d. CCGs were asked to work with their local authority partners to commission additional out-of-hospital care and support capacity (expected to be a blend of care home beds, hospices, and home-care support), in particular to facilitate step down of patients from secondary care and so free up acute beds.

e. To make sure that funding decisions do not restrict the pace of discharges, the letter noted that additional resources would be provided to pay for the community bed or a package of care post-discharge for any patient that needed it.

122. In terms of funding, the Phase 1 letter quoted the Chancellor of the Exchequer who had committed in Parliament the previous week that "*Whatever extra resources our NHS*

needs to cope with coronavirus – it will get" so financial constraints would not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

123. The letter also referred to a range of measures to: support NHS staff and maximise staff availability, including enhanced wellbeing and support for frontline staff; a request to PHE to establish targeted testing for symptomatic NHS staff, remote working, and deployment measures; and reduce routine burdens, including the temporary cancellation of CQC inspections, emergency legislative measures being introduced in Parliament to increase regulatory flexibility and the move to block-contract payments.

NHS Support to Care Homes

124. On 16 April 2020, NHS England wrote to all NHS hospitals and community health providers to inform them of the Government's commitment to test all hospital inpatients prior to their discharge from hospital into a care home. The letter emphasised that the new testing requirement should not hold up timely discharges, because hospitals were asked to plan the testing of patients due to be discharged up to 48 hours before the scheduled discharge time. At this time NHS England was focusing on re-starting elective (planned) care alongside the uncertainty as to whether accident and emergency admissions would rebound **[AD1/017 INQ000358460]**.

125. As a result, NHS England gave further guidance on steps to enable hospital recovery from Covid-19, and to minimise the interruptions to non-Covid-19 care.

126. On 29 April 2020, the Covid-19 National Incident Response Board ("**NIRB**") agreed to provide further support to the care sector through mutual aid support. The support was to be delivered through Local Resilience Forums in line with the principle of local mutual aid under the CCA 2004. A 10-point action plan was drawn up of the support that was to be provided by NHS England **[AD1/018 INQ000330952]**.

127. This national offer built on a range of actions that NHS England had already begun to implement to support care homes. These included:

a. Ensuring safe and timely discharge to the community, supported by guidance issued by NHS England;

b. Testing all patients prior to discharge from acute and community hospitals to care homes;

c. Introducing key elements from the Enhanced Health in Care Homes framework and medical monitoring of patients for all care homes;

d. Supporting locally determined mutual aid between the NHS and care homes;

e. Expanding the use of NHS Volunteer Responders to support care homes.

128. The 10-point action plan approved by NIRB aimed to extend this initial support and was structured around three themes (i) training for infection prevention and control (ii) training for testing of care home staff and residents and (iii) workforce support. Specific actions included:

a. Training for infection prevention and control:

i. A rapid survey of chief nurses in CCGs and ICSs to identify gaps and support needed to deliver on IPC and testing training

ii. Delivery of local IPC training using cascade models

iii. Face to face training on IPC and PPE delivered in care homes

iv. Targeted support to small care homes without existing infrastructure

v. Webinars and support to CCG Directors of Nursing

b. Testing of care home staff and residents;

i. Support for the rollout of care home testing

c. Workforce support;

i. A national campaign to support the return of senior care workers, social workers and therapists to return to support the care sector, fronted by the Chief Social Worker and supported by the Chief Nursing Officer

ii. A framework to enable returners to be hosted by local NHS employing organisation

iii. Development of a national framework that supports the return to work process

iv. DHSC to support NHS England's communications to increase use of NHS Volunteer Responders in social care

129. This offer was highlighted in the Phase 2 Letter to NHS leaders setting out the second phase of the Covid-19 response on 29 April 2020 **[AD1/019 INQ000087412]**.

Phase 2 Letter

130. The Phase 2 Letter noted that:

a. The measures set out in the Phase 1 Letter had been the fastest and most far-reaching repurposing of NHS services, staffing and capacity in the NHS's 72- year history.

b. Such measures had enabled the NHS in the space of six weeks to go from zero to caring for 19,000 Covid-19 patients per day. Alongside this, the majority of patients that the NHS was caring for were receiving treatment for other important health conditions.

c. While Covid-19 hospitalisations had reached a peak, the NHS would face an increased demand for Covid-19 aftercare and support in community health services, primary care and mental health, and a likely rebound in demand for A&E activity, which had significantly reduced in previous weeks likely as a result of a combination of a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic

accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes.

d. Given the uncertainties about the timing and extent of the likely rebound in emergency demand, the NHS would need to maintain the ability to quickly repurpose and surge capacity locally and regionally should it be needed again.

131. The Phase 2 Letter instructed all NHS local systems and organisations to:

a. Step up non-Covid-19 urgent services fully as soon as possible over the following six weeks, with sustained attention to infection prevention and control as the guiding principle;

b. Work across local systems and with regional teams over the following 10 days to make judgements on whether local providers had further capacity for at least some routine non-urgent elective care.

132. The letter further addressed the need to continue to partner with local authorities and LRF's in providing mutual aid to colleagues in social care, including care homes. This included:

a. Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid-19; care homes could also check that these tests have been carried out.

b. Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

c. To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes Framework.

d. Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help.

Clinical Reference Group for Care Homes

133. The NHS Support to Care Sector workstream of NHS England's Discharge and Community Cell identified a need for a route of information dissemination to regional and national colleagues and a forum for sharing learning and progress across the system. In May 2020, the Primary Care and Community Health Support to Care Home Residents Clinical Reference Group was established by the National Clinical Director for Older People and Integrated Person Centred Care.

134. The aims of the Primary Care and Community Health Support to Care Home Residents Clinical Reference Group were to:

a. Provide a forum to discuss the detail of current policy and guidance in regard to NHS support to care homes during Covid-19;

b. Be supported by Primary Care and Community Health;

c. Review and analyse policy and guidance being developed;

d. Provide regional updates to inform and update on implementation of policy and guidance;

e. Engage with existing relevant policy and guidance;

f. Ensure that emerging policy around care homes is aligned with and compliments other national policy and direction of travel.

135. The Clinical Reference Group was not a decision-making body and recommendations for delivery and implementation were to be reported to the Director of Community Health.

136. End of Life was also represented in the Clinical Reference Group for Care Homes.

137. An example of work discussed and supported by the Clinical Reference Group was the Insulin Administration Programme. On 5 August 2020, the Group received an update on

the initiative, which aimed to support the safe administration of insulin by suitably trained health and care workers in community settings, including care homes.

138. Originally developed under the direction of the Chief Nursing Officer prior to the pandemic, the Programme was prioritised and had its scope widened to include workers in social care, recognising the need to relieve pressures on community nursing services during the pandemic. The approach sought to improve quality of life for care home residents with diabetes, reduce missed or delayed injections and upskill the care home workforce.

139. The Clinical Reference Group acted as a forum to disseminate this initiative to regional and national colleagues and external stakeholders to support consistent understanding and implementation across the care home sector. While it was not a decision-making body, the Group contributed to the spread and adoption of this initiative through engagement and shared learning across the NHS and social care.

Volunteers and NHS Returners

140. NHS England's mutual aid support for the adult social care sector during the pandemic included facilitating the deployment of volunteers and returners through national programmes, including NHS Volunteer Responders and the Brining Back Staff ("**BBS**") initiative.

NHS Volunteer Responders

141. The NHS Volunteer Responders service, launched on 24 March 2020 in partnership with the Royal Voluntary Service and GoodSAM app, enabled individuals to register to support the clinically highest risk and socially most vulnerable members of their community in four different roles: Community Response Volunteer, Patient Transport Volunteer and NHS Transport Volunteer and a Check-in and Chat Volunteer.

142. Whilst the programme had been set up by the NHS to support healthcare professionals, the programme was swiftly adapted to be sector agnostic, enabling anyone who might be in contact with a vulnerable person the ability to request support, including social care, MPs, police and fire services and voluntary sector groups.

143. On 26 March 2020, a proposal for how volunteers might support the NHS was presented to NIRB, including the agreement to rollout the service to support social care **[AD1/020 INQ000087355]**. It was conceived that volunteers might help to: reduce pressure on health and care staff and services; support timely discharge from hospital; enable the approximately 1.4m people in the clinically highest risk group to shield for 12 weeks; and support people who were (socially) vulnerable to keep safe and well during lockdown (and to self-isolate as appropriate).

144. GPs, other healthcare professionals and local authority staff could refer clinically high risk and socially vulnerable individuals to be matched with a volunteer to receive support.

145. The platform was intended to complement and not replace informal community schemes or the national 'help your neighbour' campaign. It was aimed specifically at helping the most clinically at-risk and socially vulnerable people, in a safe and sustainable way, and also enabling coordination with GPs and other clinicians.

146. From 23 April 2020 the programme was expanded to enable self-referral from anyone who needed support whilst either shielding or self-isolating. Both of these changes meant that the programme was accessible by people who needed support who might not otherwise be known to statutory services already.

147. The GoodSam app's functionality enabled volunteers to be matched with those needing support geographically. Tasks were sent out in real time and could be responded to swiftly by volunteers based within the vicinity of the person needing support.

148. The GoodSam app was already in use by NHS 111 and Ambulance Trusts for other forms of volunteer support and so the NHS were already familiar with its functionality. It was also extensively stress tested by NHSX to ensure it was sufficiently robust to withstand the volume of volunteers and tasks that might be required.

149. Over 2.2 million tasks were completed by volunteers between April 2020 and June 2021. As a programme that was designed as a 'back-up' to existing local authority programmes, the number of referrals from different parts of the country varied, with significantly higher rates of referral in areas of deprivation.

NHS Returners

150. To enable social care employers to access professionally regulated staff groups, NHS England broadened out the scope of the NHS BBS returners initiative, supporting mutual aid between the NHS, care homes, and other social care employers.

151. The BBS programme aimed to coordinate the urgent response to the NHS' ability to cope with the anticipated sharp rise in Covid-19 cases. The rise in cases was expected to lead to a shortage of staff resulting from increased workforce pressures, levels of staff sickness and self-isolation. It was a large-scale and multifaceted programme, led by NHS England and overseen by the Chief People Officer with support from multiple organisations.12

152. The BBS Programme delivery was in 2 phases. The BBS Programme was not initially intended to be a multi-phase programme, but it evolved to address the continued workforce capacity challenges. The phases were:

a. Phase 1 (March 2020 – August 2020): Established a process for the recruitment and deployment of registered and employment checked workforce. To expedite this process, given the scale of the workload and the timescales, Capita were commissioned to support the process;

b. Phase 2 (September 2020 – June 2021): Moved towards a regional delivery model, which was underpinned by the national framework established in Phase 1. Specific focus was shifted towards providing a workforce to support national programmes and social care.

Enhanced Health in Care Homes Framework

153. On 1 May 2020, NHS England followed up on the Phase 2 letter with a letter to GP practices and Primary Care Networks ("**PCNs**"), CEOs of community health providers, Regional Directors of primary care and CCG accountable officers setting out service expectations to support care homes **[AD1/021 INQ000330852]**.

[12] The Leadership Academy, HEE, DHSC, Department for Work and Pensions, GMC, NMC, Health and Care Professions Council, General Pharmaceutical Council, Skills for Care, Capita, NHS Employers, NHS Business Services Authority, NHS Professionals and Indeed

154. The letter set out a clinical service model which was already established and being implemented in much of England, the EHCH framework, but which NHS England was now asking to be immediately rolled-out as part of the Covid-19 response by CCGs alongside: (i) continued NHS testing of all patients prior to discharge to care homes; (ii) CCG directors of nursing assisting local authorities with training in infection prevention and control; and (iii) supporting different staff groups to take up opportunities in care homes. NHS England was requesting primary care and community health services help, building on what practices were already doing, to support care homes.

155. This service focused on the following areas. A clinical service model, which requested for CCGs, working with general practices, community health services providers and engaging LMCs, to take immediate steps to implement the following support for care home residents:

a. Delivery of a consistent, weekly 'check in';

i. be delivered – primarily remotely wherever appropriate – by a multidisciplinary team ("**MDT**") where practically possible, drawing on general practice and community services staff and expertise, including advanced nurse practitioners, clinical pharmacy, social prescribing link workers, dental care, and wider specialist services (eg geriatrician and dementia services) where appropriate

ii. review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed Covid-19 symptoms, in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures

iii. support the provision of care for those patients identified as a clinical priority

iv. include appropriate and consistent medical oversight and input from a GP and/or geriatrician (with the frequency and form of that input determined by clinical judgement)

v. support the introduction and use of remote monitoring of Covid-19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated; and

vi. be supplemented by more frequent contact with the care home where further needs are identified.

b. Development and delivery of personalised care and support plans for care home residents. A process needs to be established to:

i. Support development of personalised and individually agreed treatment escalation plans for care home residents with care home teams, including end of life care plans and preferences where appropriate and drawing on available guidance and templates (including from the Royal College of General Practitioners and the joint statement from the British Medical Association, Care Provider Alliance, Care Quality Commission, and Royal College of General Practitioners). Where time and resources are limited the advance care planning process should not be rushed and appropriate time found as soon as reasonable to complete the task with care and compassion.

c. Provision of pharmacy and medication support to care homes. CCGs, PCNs and practices should co-ordinate pharmacy teams (including CCG employed pharmacists and pharmacists working as part of the Medicines Optimisation in Care Homes (MOCH) programme) to provide support to care home residents and staff. This support should include:

i. facilitating medication supply to care homes, including end of life medication

ii. delivering structured medication reviews – via video or telephone consultation where appropriate - to care home residents

iii. supporting reviews of new residents or those recently discharged from hospital

iv. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (eg through medicines ordering).

156. The Phase 2 letter identified service enablers to deliver the support, including that CCGs should take immediate steps to support individual practices and community health services teams to organise themselves according to their local areas or networks. Existing PCN arrangements should be the default. A network approach to delivery, backed by appropriate information sharing arrangements, aimed to ensure that individual care homes had a single point of access for the majority of their residents and should reduce the infection control risks associated with multiple teams visiting individual care homes. As part of this process, networks were to identify a named clinical lead for each care home.

157. CCGs were asked to ensure that clear and consistent out of hours provision was in place for each care home.

158. Secondary care providers were instructed to accept referrals and admissions from care home residents where clinically appropriate, considering individuals' care and support plans and the benefits and risks of escalation to hospital-based care.

159. Wider guidance to support care homes and the Government's action plan for adult social care provide wider information for care homes (including on management of Covid-19 cases within care homes, testing for care home staff and residents, the provision of remote consultation support to care homes, and personal protective equipment) and should be read alongside this document.

Covid-19 virtual ward and pulse oximetry

160. As outlined in the 1 May 2020 letter, the use of remote monitoring of Covid-19 patients using pulse oximeters was introduced in care homes. Care home residents with suspected or confirmed Covid-19 were supported through remote monitoring (and face to face assessment where clinically appropriate) through the Covid Oximetry @ home ("**CO@h**") programme and separate but complementary Covid Virtual Ward ("**CVW**")

pathway as part of broader wraparound care, providing an additional safety net for residents at risk of deterioration.

161. NHS England's CO@h programme is set out in detail in NHS England's Fourth Module 3 witness statement, and is summarised briefly for the benefit of this statement.

162. The CO@h programme was an example of NHS clinicians on the frontline identifying and implementing an opportunity locally, which was then supported by NHS England to implement the scheme nationally. Frontline clinicians led efforts to deploy pulse oximetry in the community from March 2020. NHS England supported the procurement of initial batches of pulse oximeters and the development of the pathway. By May 2020, a small initial delivery of 5,000 pulse oximeters had been received, some of which went into care homes. This was followed by the receipt of a much larger delivery in June 2020, which allowed the creation of a national stockpile, so that by 4 January 2021 the programme was fully operational throughout England. CO@h supported people with Covid-19 who were well enough to be at home but who were most at risk of becoming seriously unwell, helping them to self-monitor trends in oxygen saturations alongside other symptoms allowing them to get more timely hospital treatment if required.

163. The CVW pathway was implemented from early 2021 to support the earlier and safe discharge of Covid-19 patients who would otherwise be in hospital; this required the active monitoring of patients at home.

164. Pulse oximetry is a well-established technique used in healthcare. Pulse oximeters are non-invasive medical devices that typically clip onto a patient's finger and shine a light into the skin, measuring how this is absorbed by the blood to estimate how much oxygen is present: i.e. the oxygen saturation level (SpO2) of a patient's blood, along with their heart rate. These measurements can provide valuable information about a patient's respiratory status and overall health, particularly in cases of respiratory illnesses like Covid-19, and can help with the early detection of signs of deterioration in a patient.

165. As infection rates rose in March and April 2020, emergency care clinicians identified that Covid-19 can lead to a condition called silent hypoxia, where a patient's oxygen saturation levels drop to dangerously low levels (typically below SpO2 <95%), often

before the patient feels a change in any symptoms. Some patients who had experienced silent hypoxia were seeking help too late and suffered poor outcomes as a result.

166. The programme was facilitated by care home staff. Training and support for using pulse oximetry in this manner was made available on the NHS@Home Future NHS platform, and further support was available from the care home's named clinical lead. Joint guidance for care homes was produced with the Care Provider Alliance **[AD1/022 INQ000470673]**.

167. CVW was distinct to the CO@h programme as it was a secondary care led programme, which allowed patients to be transferred home whilst remaining under the care of the discharging hospital. Unlike CO@h (a programme which relied on self-monitoring for those with mild Covid-19), CVW allowed patients to continue to be supported and monitored by the hospital in their home setting including through virtual consultations and remote monitoring — and a virtual "ward round" each day.

168. The CO@h and CVW programmes were the first to be launched as part of NHS England's broader ambitions for an NHS @home model. This is focused on the delivery of personalised care, using basic technology and self-management approaches to create simple pathways for patients at home, including care homes. The overall aim is to support safe and convenient care for patients, including selfcare, and reduce unnecessary demand on primary and acute services. Other NHS @home approaches include blood pressure monitoring, lung health and heart failure @home.

169. CVW has evolved into the Acute Respiratory Infection Virtual Ward programme, which is now also used for wider respiratory infections including flu and pneumonia. This is now a BAU service commissioned by each ICB individually.

Medication reviews

170. On 1 May 2020, NHS England asked primary and community health providers to deliver Structured Medication Reviews ("**SMR**") – via video or telephone consultations where appropriate – to care home residents, as part of the broader NHS offer to support care homes during the Covid-19 pandemic. From 1 October 2020, PCNs were required,

under the Network DES service specification, to use appropriate tools to identify and prioritise patients who would benefit from an SMR, including patients:

a. in care homes;

b. With complex and problematic polypharmacy, specifically those on 10 or more medications;

c. On medicines commonly associated with medication errors;

d. With severe frailty, who are particularly isolate or housebound patients, or who have had recent hospital admissions and/or falls; and

e. Using potentially addictive pain management medication.

171. PCNs were to offer and deliver a volume of SMRs determined and limited by the PCN's clinical pharmacist capacity. PCNs were required to demonstrate reasonable ongoing efforts to maximise that capacity. NHS England published updated guidance on SMRs in the Network Contract DES in March 2021.

172. Conversations took place between NHS England and HMT throughout June to secure funds to cover the additional costs incurred by general practices for Covid-related activity (including the costs of bank holiday working, care home services, sickness absence and consumables costs). HMT appropriately scrutinised the request to provide extra funds, noting data that suggested the number of GP appointments had fallen (although this did not reflect actual demand for appointments) and other funding was being made available to practices. Additional funding was subsequently provided, and on 4 August 2020 NHS England published guidance to general practices on how they could claim reimbursement for certain additional costs incurred to Covid-19 **[AD1/023 INQ000058034]**.

Digital Support for Care Homes

NHSMail roll-out

173. To facilitate better communication and information sharing between the NHS and social care, NHSmail was made available to all care providers from 23 March 2020. NHSmail is

accredited for sharing patient identifiable and sensitive information, meaning it meets a set of information security controls that offer an appropriate level of protection against loss or inappropriate access. Overview of the NHSmail roll-out:

a. NHSX fast tracked the roll-out of NHSmail, temporarily waiving the completion of the Data Security Protection Toolkit ("**DSPT**"). This was in line with information governance guidance during the Covid-19 pandemic;

b. It was a temporary measure to improve communication. Providers were asked to provide assurance following the Covid-19 incident, with regional NHSmail teams supporting providers through the full DSPT process supporting them to accredit their secure email system or NHSmail for information sharing in the future.

174. By end of April 2021, 10,260 of the reported 14,042 care homes in England had NHSmail, as did 3,838 of the 9,829 domiciliary care providers.

<u>iPad offer and training</u>

175. Before the start of the pandemic, NHSX had already been working with NHS Digital to improve access to the internet in care homes and had negotiated a range of connectivity offers to help staff in care homes and their residents to stay connected.

176. As part of the adult social care winter 2020 to 2021 plan, NHSX gifted 11,000 iPads to care homes to help residents receive ongoing care and stay connected to loved ones.

177. Care homes were invited to apply for the offer in autumn 2020 and were delivered to care homes identified as most in need according to the following eligibility criteria:

a. Receive all or some of their funding for residential care from the NHS or from a local authority;

b. Have less than one tablet device per 40 residents.

178. The iPads helped staff in care homes to:

a. Hold video consultations with health and care professionals;

b. Connect care home residents with loved ones remotely;

c. Get direct access to any other tools or systems needed to support the care of residents;

d. Use NHSmail.

179. A data-enabled SIM card was included with each iPad, free of charge for 12 months so that care homes were able to use the iPads even if they did not have access to a stable WiFi connection throughout their building. Mobile device management software for troubleshooting and security was also included for 12 months. This allowed NHSX to make key updates to the iPads to improve usability and experience for homes.

180. Staff in care homes were supported to set up and use the iPads through the following support package:

a. step-by-step guidance on how to set up the iPads;

b. technical support through a helpline and service desk, provided by Jigsaw24;

c. support through the Digital Social Care website, including access to set up video tutorials;

d. weekly set-up and troubleshooting webinars, run by Digital Social Care;

e. support with using NHSmail, MS Teams and other applications on the iPads.

GP services

181. Primary care within the NHS describes the services that an individual with a health concern typically encounters first. It is their primary contact with the NHS and tends to be local. Primary care includes GP services, certain dental services, pharmacy services and eye health services. This section focuses on GP services.

Background to GP services

182. There is no specific definition of GP services. In legislation they are referred to as primary medical services. They are a large part of the non-hospital medical services that need to be provided to meet the needs of the local population. Patients register with a GP practice and typically make their own appointments with that GP practice. GP

services include diagnosing non-urgent and non-emergency health concerns, managing long term conditions and administering vaccinations and immunisations. GP services are most often the first port of call for patients with a new health concern. GP services are typically provided from a GP practice – patients are seen face to face at an appointment – although GPs may see a patient in their own home (home visits) in limited circumstances or via remote means, i.e. by telephone or online. GP practices are able to refer patients with more serious or complex conditions to secondary care services (health services provided in hospitals) and to services provided in the community, such as weight management or smoking cessation. In this section, the general term "GP services" will be used. Where this section refers to all GP practices providing GP services in England, it uses the term "general practice".

183. GPs and their practice staff are not employed by NHS England. GP practices are independent contractors responsible for their "business".

184. Appointments with patients represent only a part of a GP practice's contracted activity. A GP practice also has requirements relating to forms, filing, reporting, patient record keeping, training, meetings and liaising with other health care professionals ("**HCPs**"). GP practices do not only employ or engage GPs. Other roles include but are not limited to practice nurses, clinical pharmacists and social prescribing link workers (the latter connect individuals to non-medical support with the aim of meeting the practical, social and emotional needs of the individual that are affecting their health and wellbeing).

Commissioning and provision

185. NHS England has the statutory duty of arranging for the provision of primary medical services for the population of England. It discharges this duty by entering into contracts for the provision of these services with primary medical services contractors. In this section, we refer to the contractors as GP practices.

186. At the start of the pandemic, NHS England had already delegated to most CCGs its statutory duty for arranging for the provision of GP services in their area. By 1 April 2021 every CCG in England had these delegated responsibilities. Each CCG had operational responsibility for the arrangements with GP practices. NHS England retains accountability for the performance of primary medical services commissioning and seeks

to ensure that consistent high quality services are available for patients. From 1 July 2022, the CCGs' delegated responsibilities transferred to ICBs when CCGs ceased to exist.

187. GP practices are typically run by a small number of individual GPs acting in partnership. Some GP practices are run by single handed GP or by a company. There are approximately 6,000 GP practices in England.

188. The contract with a GP practice is often referred to as the GP contract. It comes in three forms known as the General Medical Services ("**GMS**") contract, the Personal Medical Services ("**PMS**") agreement and the Alternative Provider Medical Services ("**APMS**") contract. All three forms of the GP contract are underpinned by statutory regulations and directions which are drafted by the Government Legal Department, with input by NHS England, and agreed by the SSHSC. Changes to the GP contract are negotiated nationally every year between NHS England and the General Practice Committee of the British Medical Association, which represents the interests of GPs in England. Changes are often brought into force via statutory regulations.

189. GP practices must all offer core GP services, diagnosing illnesses and treating conditions, for which they receive funding calculated in accordance with a nationally set formula. GP practices are additionally remunerated if they undertake the following:

    a. Carrying out specific additional tasks under QOF arrangements. The QOF consists of various measures, agreed as a part of the GP contract each year, which typically promote evidence-based management of long-term conditions (e.g. hypertension, diabetes, or asthma) in line with NICE guidance. Some QOF measures also aim to address public health concerns (e.g. smoking and obesity). More recently, QOF measures have also incentivised GP practices to undertake quality improvement activity. GP practices are awarded points based on their performance against these measures; each point attracts additional funding for the practice, over and above its “core” funding;

    b. Participating in additional programmes such as the Network Contract Direct Enhanced Service (“**DES**") which has been in place since 2019 and which rewards

GP practices providing additional services while working together in PCNs which are described further below. There are three elements of the 93 Network Contract DES that are referred to later in this statement. The Additional Roles Reimbursement Scheme enabled PCNs to be reimbursed a set amount where they employed or engaged certain types of professionals, such as clinical pharmacists and social prescribing link workers. The aim was to increase the number of clinicians working in general practice. The Enhanced Health in Care Homes service required GP practices to provide certain services within local care homes with individual care homes being linked to particular PCNs. The Investment and Impact Fund ("**IIF**") is an incentive scheme which contains indicators that focus on where PCNs can contribute towards improving the quality of care for people with multiple morbidities and helping to make the NHS more sustainable. In a similar approach to QOF, PCNs receive additional funding where they score higher against the indicators;

c. Participating in other enhanced services, such as the minor surgery directed enhanced services and vaccinations and immunisations enhanced services. These services would require GP practices to provide the relevant services with payment being linked to the amount of activity undertaken;

d. Participating in the Dispensary Services Quality Scheme ("**DSQS**") if the GP practice has consent to dispense medication. Dispensing GP practices operate in rural areas, where patients live a long distance from a community pharmacy. Only certain patients are eligible to receive dispensing services from a GP. The DSQS offers annual payments to dispensing GP practices based on the number of dispensing patients on their patient lists. Payment is conditional on the dispensing GP practices meeting several quality criteria, including undertaking an annual review of the medicine usage of 10% of their dispensing patients.

Changes to residential care facilities visits

190. Persons residing in a residential care facility, such as a care home or nursing home, will usually be registered with a local GP practice. Such persons often have mobility issues which impact on their ability to access services from the location of the GP practice

premises. GPs often did "rounds" of residential care on a set day to give those registered with the GP practice an opportunity to have an appointment.

191. In NHS England's letter dated 27 March 2020 to GPs on preparedness **[AD1/024 INQ000470420]**, GPs were told to identify those most at risk who live in care or nursing homes and carry out regular rounds virtually unless their physical presence was required for clinical reasons. This was reiterated in the 5 April 2020 version of the Covid-19 GP SOP **[AD1/025 INQ000470430]**.

192. Providers of NHS community services are also involved with providing services to those within such settings. GPs had to work in a coordinated way with the community services providers to coordinate their interventions. The aim was to deploy the most effective, person-centred care which minimised the number of healthcare professionals visiting the care home while ensuring the needs of the residents were met in a timely and clinically safe manner.

193. With the formation of PCNs in 2019, GP practices became responsible for delivering a number of services at PCN rather than individual practice level. One such service, the EHCH framework, required for PCNs to plan for the introduction of weekly “home rounds” for care home residents by 1 October 2020. NHS England’s letter of 1 May 2020 marked the formal launch of this model, setting out implementation requirements for both CCGs and PCNs to strengthen healthcare support to care home residents.

194. In the 10 August 2020 version of the GP Covid-19 SOP **[AD1/026 INQ000470483]**, NHS England urged CCGs, PCNs and community services providers to prepare for the 1 October 2020 commencement of the weekly home round which was a more comprehensive review based on the clinical judgement of a multi-disciplinary team and the advice of the care home compared to the previous weekly check-ins. From 1 October, therefore, GP practices were regularly visiting residential care facilities under these new arrangements albeit that digital technology could be used to support the weekly home round and facilitate the medical input.

Capacity Tracker

195. The Capacity Tracker tool had been developed prior to the pandemic by the North of England Commissioning Support Unit in collaboration with NHS England and the Better Care Fund to enable the system to better manage hospital discharges by identifying available capacity in multiple care providers, including care homes, hospices and community providers. At the request of the DHSC, during the pandemic, the tracker was adapted and scaled up to cover the whole of England, to create a single source of live data.

196. The "Admission and care of residents in a care home during Covid-19 guidance" required all care homes, community rehabilitation and end of life care bed providers and hospices to use the Capacity Tracker to record their bed vacancies and care homes and hospices to provide business continuity data and a single England wide source of live data.

197. From 24 April 2020, all providers in scope were to use the Capacity Tracker and update it daily. Regional Ageing Well operational leads worked with CCG system champions to increase provider registration and engagement. The data from the Capacity Tracker was for local, regional and national efforts to support discharge planning and to understand the status of care homes and hospices.

198. The data from capacity tracker was vital for local, regional and national efforts to support discharge planning and to understand the status of care homes and hospices.

199. The Capacity Tracker tool also became an essential source to understand vaccination levels in care home residents and staff. While initially this had a fairly low return rate because care homes were not incentivised to complete it (and therefore likely resulted in an underestimate in vaccination levels within that particular sub-group) the return rate did improve over time.

Ambulance services and conveyancing guidance

200. Ambulance services operate across complex regional footprints and manage interactions with multiple ICSs and providers including in particular NHS 111, GP surgeries, hospital services and other health and social care providers. This includes taking referrals directly

from HCPs and attending incidents that have been transferred from NHS 111 that require an ambulance response.

201. NHS England does not have a specific role in coordinating the interface between ambulance services and other healthcare services, as those are primarily matters for local systems. The primary objective of NHS England is to support local commissioners (previously CCGs, now ICBs) through our seven regional teams to improve quality of care, tackle inequalities, and deliver care more efficiently. The exact interface between these services, both during and outside the Relevant Period, was driven by local commissioners and providers at local and regional level.

202. Ambulance service paramedics and technicians are trained to deliver the best outcomes for patients, including history taking, undertaking clinical observations and performing investigations at scene which allow a decision to be made about the most appropriate onward care for the patient.

203. Decisions on whether to convey a patient to A&E or treat the patient at scene (including referral to another service) will usually be based upon primary information gathered from the initial 999 call into the ambulance control room (which is passed on to ambulance crews attending the patient) and information gathered whilst on scene. Some paramedics have specialist skills which enable them to treat a wider range of patients on the scene, and some ambulance services also run joint response services where other professionals (e.g., nurses, mental health clinicians) provide a greater range of alternative care options and treatment at scene for patients. Clinicians in control rooms also provide clinical or alternative service advice to crews on the road supporting decision-making and reduction of conveyances to hospitals.

204. In the early stages of the pandemic, there was huge demand from specialist clinicians across the NHS for clinical guidance on how to respond to the new virus, and how to prepare to adapt in light of emerging reasonable worst-case scenarios. In early March 2020, it became apparent that demand for intensive care beds was increasing and the information on spread of infection was such that it was not yet possible to predict the point at which demand would begin to abate in response to NPIs. While efforts were being made to surge capacity to deal with the pandemic, the expansion of intensive care

was limited by bed capacity – including appropriate staffing and the availability of equipment such as oxygen and ventilators as necessary – and by the supply of appropriate consumables.

205. Around late March and the beginning of April 2020, draft operational guidance on 999 ambulance conveyancing protocols for adult patients was developed by NHS England (as it was uniquely well placed to do so in an extension of its usual role) in conjunction with the NASMeD and with support from the National Association of Ambulance Medical Directors, Resuscitation Council UK, National Strategic Adviser of Ambulance Services, NCDs for cardiology, urgent and emergency care and palliative care, RCEM and the College of Paramedics. For the reasons set out in more detail below, NHS England ultimately decided not to adopt the draft guidance.

206. The aim of the draft guidance would have been to create a single framework for decisions relating to ambulance conveyancing during the pandemic, with a view to reinforcing good practice and preventing the proliferation of inconsistent local guidelines and protocols. The draft guidance document was intended to apply to all adult patients irrespective of their Covid-19 status or the level of care they might require on arrival at hospital. It was aimed at ensuring best use of front-line ambulance service resources in circumstances where those services might have otherwise become overrun with Covid-19 cases (i.e. circumstances that never materialised in the course of the pandemic).

207. The proposed clinically-led operational guidance differed from NHS England's previous approach to ambulance conveyance guidance, which had typically taken a much broader system-based approach to the question of ambulance conveyance.

208. The draft guidance noted that proposed changes in practice were predicated on reemphasising good practice, or were intended to be proportionate to predicted ambulance service capacity, acute care pressures and the probability of good patient outcomes. It also expressly recognised that decisions about conveyance to hospital are often complicated and while paramedic experience and expertise was vital to both patients and the wider NHS, access to a senior colleague should enable shared decision making wherever further support was required.

209. Among other things, the draft guidance advised to consider alternative options before conveying a patient to hospital, and specifically recommended that certain categories of patients should not ordinarily be conveyed to hospital unless the conveyance was authorised by a senior colleague. These included:

a. any patient with dementia whether or not on anticoagulation who following a head injury or fall is functionally unchanged;

b. any patient aged over 70 who following a first syncopal episode (i.e. fainting) has fully recovered and exhibits normal vital signs;

c. care home residents/community hospital patients until discussed with a clinical advisor.

210. The proposed guidance also cross referred to the 25 March 2020 version of the National Institute for Health and Care Excellence ("**NICE**") Covid-19 rapid guideline on critical care in adults which indicated that critical care provision may be inappropriate for patients with a clinical frailty score of 5 and over (whereas it would continue to be appropriate for certain categories of patients with a clinical frailty score of 5 including younger people, people with learning disabilities or autism and people with stable long-term disabilities such as cerebral palsy). On that basis, the draft guidance advised against the regular conveyance of certain patients to hospital unless clearly distressed and attempts to manage the distress in the community had failed.

211. New draft guidance is subject to multiple layers of review before it is issued. This was perhaps even more important for guidance drafted and issued at great speed in the early stages of the pandemic, covering unprecedented requirements upon the NHS, in circumstances where conditions, modelled trajectories, and understanding of the disease were changing rapidly.

212. In the case of the draft ambulance conveyancing guidance:

a. The draft guidance was initially discussed by the NHS England Covid-19 Medical Risk Panel on 1 April 2020. At that meeting, the Panel recommended a number of

amendments, including in particular the need to emphasise the importance of applying clinical judgment to individual circumstances.

b. After a further round of proposed amendments:

i. on 4 April 2020 the Chair of the NHS England Covid-19 Medical Risk Panel contacted NHS England's National Medical Director to confirm that the revised ambulance conveyance protocols were recommended by the Panel for implementation;

ii. the Covid-19 Medical Risk Panel recommendations were accepted by NHS England's Medical Director.

213. The draft guidance was then circulated for further assurance to APAAG. On 9 April 2020 the Chair of APAAG asked that publication of the guidance be put on hold on the basis that more time was needed to determine the best way to implement the proposed changes within ambulance Trusts.

214. Between 10-14 April 2020 a draft was further reviewed by NHS England, identifying concerns in respect of certain elements of the draft guidance, specifically (i) the reference to the Rockwood frailty score at Annex 2 of the guidance, on the basis of the view that scorecards should not be at the basis of decisions on care; (ii) the amended resuscitation protocol for out-of-hospital cardiac arrests; (iii) a lack of clarity in respect of the sections of the document that deviated from the norm; and, more broadly (iv) the view that the NHS remained open during the pandemic: accordingly, it should continue to be the case that people should be conveyed to the place where, in other circumstances, they normally would have been conveyed (i.e. to hospital). The clinical picture was rapidly moving on a day-by-day basis. By this time, it was apparent that the pressure on intensive care bed capacity in hospitals was easing. The introduction of NPIs had reduced the R number to below 1 and therefore the concern that intensive care might be overwhelmed was receding, although there was still significant uncertainty.

215. In parallel, between 9-10 April 2020 steps had been taken to produce a short Specialty Guide CO261 titled "Reference guide for emergency medicine" that drew together, for ease of reference, a number of key charts, checklists, tools and care records with a view

to assisting and informing how emergency medicine teams in Trusts could respond to the current challenges relating to Covid-19.

216. In April 2020, Specialty Guides issued by NHS England were developed and led by clinicians (a process that was subsequently reviewed and changed).

217. Accordingly, despite some internal concerns expressed by NHS England's Covid-19 Strategic Incident Director in connection with the use of "non-conveyancing" terminology, on 10 April 2020 NHS England briefly and erroneously published a version of the "Specialty Guide for Emergency Medicine" that contained the non-conveyancing and frailty score infographic set out in the draft ambulance conveyancing guidance that had not been cleared for publication.

218. The mistaken inclusion of the "non-conveyancing" infographic was identified shortly after publication – with a new version of the specialty guide without the non-conveyancing infographic being re-published on 14 April 2020, and a further version of the specialty guide that omitted the reference to the frailty score published on 22 April 2020.

219. On 15 April 2020, NHS England confirmed the decision not to publish the draft guidance on ambulance conveyancing. The decision not to adopt the draft guidance was immediately communicated to ambulance service colleagues who had been involved in its gestation and further discussed at the NHS England Covid-19 Medical Risk Panel meeting held on 20 April 2020, which noted that "although the sense of urgency has been removed, as services are not overwhelmed, the system needs to consider this guidance as part of a longer term strategy for managing hospital use" following appropriate consultation with external stakeholders. In the event, NHS England never issued any ambulance conveyance guidance of this nature during the Relevant Period.

Section 4: Hospital Discharge Policies

220. We have been asked to set out in detail the key decision-making and the development of policy and guidance with regard to the decisions to discharge patients "from hospitals into care homes".

221. It is important to note that neither NHS England nor individual Trusts have any powers or authority to discharge patients "from hospitals into care homes". As set out above, the admission of any individual to a care home is ultimately a matter for the relevant care home provider and neither NHS England nor NHS hospitals could at any time oblige care homes to accept patients discharged from hospital if the care home provider did not consider it safe to do so, even where the relevant patients were originally resident into that care home before being admitted to hospital.

222. It follows from the above that any references in this section to the discharge of patients "from hospitals into care homes" should be understood as referring to a number of decisions including in particular (a) the decision by hospital clinicians to discharge patients who no longer met the clinical criteria to reside in acute care (b) a multidisciplinary assessment by hospital staff of the patient's health and social care needs outside of hospital (c) for patients whose needs were too great to return to their own home, the decision by a relevant care home provider to admit that patient into the care home.

223. As discussed in more detail in paragraphs 70-73 above, it is also important to note that beside a general duty to promote "integration" between health and social care, NHS England has very limited statutory functions in relation to care homes. This point was expressly addressed by the Administrative Court in the case of *Gardner & Harris v Secretary of State for Health and Social Care and others*, a judicial review challenge to a number of policies in connection with the discharge of patients from hospital to care homes in March and April 2020. In that case the Administrative Court expressly ruled that although in March and April 2020 NHS England was part of the discussion within Government about the need to establish the discharge policies, it was the DHSC and PHE who bore the responsibility of making proper arrangements for those admitted to care homes. [13]

Hospital Discharge Policies before the pandemic

224. Decisions about hospital discharges require a multidisciplinary assessment of the patients' health and social care needs, including appropriate communication with

[13] [2022] EWHC 967 (Admin) para [296].

patients regarding their care needs. For some categories of patients with complex care needs, declaring a patient medically fit for discharge from an acute bed, does not necessarily lead to swift discharge.

225. A delayed transfer of care ("**DTOC**") from NHS-funded acute or non-acute care occurs when an adult patient is ready to go home and is still occupying a bed. DTOCs are caused by a range of factors, but a common problem is ensuring the necessary assessments of the patient are made so that their ongoing needs are met and that the patient can receive continuing care if needed.

226. Prior to the pandemic, the NHS had been working for some time to reduce older and vulnerable patients' length of stay in hospital when a hospital bed is no longer clinically beneficial. Acute Trust clinicians and discharge teams could rely on a large body of literature, studies and best practice guidance on hospital discharges.

227. In May 2016 the NAO reported its findings on the discharge of older people from hospital. Among other things, the report noted that:

a. Nearly two thirds of hospital bed days were being occupied by patients over 65 with an 18% rise in emergency admission for older people over the previous four years.

b. 1.15 million hospital bed days had been lost due to delays in transfer of care in 2015, with an estimated 2.7 million bed days occupied by people no longer in need of acute hospital care.

c. For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Older people can quickly lose muscle strength, mobility and the ability to do everyday tasks such as bathing and dressing. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS.

228. Following the NAO report, in September 2016 NHS England published a quick guide on Discharge to Assess ("**D2A**") **[AD1/027 INQ000269885 and AD1/028 INQ000270098]** aimed at supporting local health and social care systems to reduce the time people

spend in hospital at the point that they are no longer in need of acute care. This was designed to be read alongside the 2015 NICE Guidance on "Transition between inpatient hospital settings and community or care home settings for adults with social care needs" **[AD1/029 INQ000270117]**.

229. The D2A quick guide noted that:

> *Wherever possible, people should be supported to return to their home for assessment. Implementing a discharge to assess model where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do.*

230. In March 2018, NICE published guidance on discharge planning for emergency and acute medical care in over 16s. It set out scientific evidence about the role of discharge planning in improving clinical outcomes for adults in secondary care **[AD1/030 INQ000269887]**.

231. In June 2018, the SSHSC announced a national ambition to lower bed occupancy in hospitals by reducing the number of long stays (21 days or more). This ambition was originally set at a reduction of 25% by December 2018; however this was being extended to a stretch target of 40% by March 2020. The rationale behind that ambition was that by ensuring patients returned to their usual place of residence, or another care setting, as soon as it was safe to do so patient flow would improve right through the system; beds would be freed up for those needing admission for emergency care or a planned operation. Following this announcement, the 'Reducing Length of Stay' programme was established as a priority within the NHS England Emergency and Elective Care Directorate to provide strategic direction and support local delivery.

232. Also in June 2018, NHS Improvement published a "Guide to reducing long hospital stays" **[AD1/031 INQ000269888]** aimed at acute and community Trusts. The guide noted, among other things, that:

    a. Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare-

associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning).

b. A stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk: 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%.

c. Extensive use of audit tools has shown 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care.

d. 39% of people delayed in hospital could have been discharged using different, usually lower dependency, pathways and services more suited to meeting their assessed needs.

e. Typically these audits show that up to half of the reasons why patients are not discharged earlier are under the direct control of the hospital itself and often relate to ineffective internal assessment processes, lack of decision-making and poor organisation of care management.

233. In terms of clinical criteria for discharge, the NHS Improvement guide defined:

a. The "expected date of discharge" ("**EDD**") as the date "*set by the consultant and based on their [clinical] judgement of when the patient is likely to have recovered sufficiently to return home*".

b. The "clinical criteria for discharge" ("**CDD**") as the functional and physiological criteria that the patient must achieve to leave hospital.

234. The guidance noted that the EDD and CCD are linked care co-ordination tools that can be applied in both acute and community bedded settings. They must be clearly defined and consistently used together if they are to work effectively, and should be set by a consultant within 14 hours of the patient's admission as part of the clinical care plan.

Preparing for Wave 1

235. On 2 March 2020, NHS England wrote to senior leaders across the NHS, requiring health providers to work with LRF partners to "*ensure that they are ready to respond to any outbreaks, including social care for supporting discharge and home care arrangements".* It required all NHS organisations to appoint an Accountable Emergency Officer, who was required to "*engage with … social care partners and ensure that they are ready to locally manage their residents that may be impacted and that they have infection prevention control measures in place, and that their staff are aware of how to maintain these measures".*

236. As discussed in more detail at paragraphs 113-119 above, on 9 March 2020 NHS England established the Discharge and Community Services Cell with the aim of ensuring timely and safe discharge from hospital and strengthening NHS care in the community and NHS support to the care sector. The Cell was primarily staffed by the Ageing Well Programme team, and later expanded in size and remit.

237. Measures to free up hospital and critical care capacity were discussed with and agreed by Government in the week beginning Monday 9 March 2020, ahead of issuing NHS operational guidance in the Phase 1 Letter setting out these measures on 17 March 2020.

238. On 11 March 2020, the National Director of Primary Care, Community Services and Strategy at NHS England attended a meeting with DHSC, chaired by the SSHSC. The meeting was held to discuss appropriate steps to assist the adult social care sector in managing the incoming wave of COVID-19 infections **[AD1/032 INQ000328131]**. The meeting covered a number of key issues including:

a. Engagement with the social care sector and joined-up working between NHS and social care;

b. The streamlining of funding mechanisms to prevent delays on hospital discharges;

c. IPC advice for care home workers and care homes receiving people with COVID-19;

d. Ensuring payment of care home staff asked to self-isolate; and

e. Steps to address potential workforce shortages in care homes.

239. It was agreed at the meeting that it was critical that we ensured that discharges happened as quickly as possible. Although this is also important in normal times, it was agreed that the system should now do all it could to enable the timely discharge of those who could leave hospital with the right support into a setting that worked for them, including social care. It was noted that the extra funding agreed would help with that, but that co-ordination was also vital, and that people across Government and the NHS were working at their level best to try to make that happen.

240. On 11 March 2020, Ministers agreed a wide range of policy, legislative and budgetary measures aimed at freeing up hospital capacity to prepare the NHS for an anticipated wave of Covid-19 patients. Those measures included, among other things:

a. The prompt and efficient discharge of patients medically fit to leave hospital, to be supported by an injection of new funding to CCGs to support early discharges and legislative measures to defer the requirement to conduct NHS Continuing Healthcare ("**CHC**") and Care Act assessments; and

b. Legislative measures to facilitate the temporary registration of health and social care workers (e.g., those who had recently retired) and the indemnification of healthcare staff in respect of activities connected with the diagnosis, care and treatment of Covid-19.

241. As of 11 March 2020, national testing capacity was limited to around 3,000 tests per day nationwide. In response to the anticipated wave of Covid-19 infections and hospitalisations PHE identified a prioritisation list for Covid-19 tests for periods when demand for diagnostic testing might exceed local laboratory capacity and a triaging of requests would be required. Given the limited national testing capacity at that point in time, the list recommended by PHE prioritised the use of testing capacity on the basis of clinical need. Accordingly, the list focused on case detection in symptomatic patients requiring critical care or hospital admission (Groups 1 and 2) and did not include, at that time, the testing of asymptomatic patients discharged from hospital:

- Group 1 (test first): patient requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI), or an alternative indication of severe illness has been provided e.g. severe pneumonia or ARDS;

- Group 2: all other patients requiring admission to hospital for management of pneumonia, ARDS or ILI;

- Group 3: clusters of disease in residential or care settings e.g. long term care facility, prisons, boarding schools;

- Group 4: community patient meeting the case definition and not requiring admission to hospital - over 60 years or risk factors for severe disease (recognising that this is challenging); over 60s should be prioritised over other risk factors;

- Group 5: community patient meeting the case definition and not requiring admission to hospital – under 60 years and no risk factors for complications; and

- Group 6 (test last): contacts of cases.

242. Given the constrained testing capacity at that time, PHE's testing prioritisation was accepted by the CMO, DCMO, and senior clinicians in PHE and NHS England (from an NHS operational perspective) and endorsed at a meeting with the SSHSC on 11 March 2020. It is worth noting that whilst NHS England was consulted by the Government in connection with early decisions on Covid-19 testing prioritisation, throughout the pandemic testing policy has always been determined by the DHSC, on advice from PHE. Any NHS England guidance has followed this direction **[AD1/033 INQ000087298, AD1/034INQ000087299, AD1/035 INQ000270015]**.

243. On 12 March 2020, the UK Government also announced that it was moving from the 'Contain' to the 'Delay' phase of its response to Covid-19. People with symptoms were told to stay at home for 7 days and that they did not need to be tested.

244. On the evening of 12 March 2020, NHS England's Chief Executive Officer and National Medical Director attended a meeting with the Prime Minister (known as a Resilience Meeting) focussed on what the NHS was doing to increase hospital inpatient and critical care capacity and to review and agree measures to be taken by the NHS to seek to accommodate the expected influx of emergency Covid-19 patients.

245. NHS England's papers for that meeting included a slide deck entitled "*NHS bed demand for the reasonable worst-case scenario and impact of non-pharmaceutical interventions*". It provided modelling of the impact of three NPIs (home isolation, household quarantine and social distancing for age 65+) on NHS bed demand based on SAGE model assumptions for the RWCS and also on a comparison infection rate of 20% **[AD1/036 INQ000087304, AD1/037 INQ000087305 and AD1/038 INQ000087306]**. The modelling showed that for most of the models, demand would exceed the numbers of beds available.

246. The meeting of 12 March 2020 considered mitigating measures that the NHS could take to increase critical care capacity, the number of G&A beds available and discharge plans.

247. Among other things, the meeting discussed stopping non-urgent operations, reducing hospital long stays and faster hospital discharge, use of the independent sector, and funding for social care providers. It also covered ICUs and general hospital bed capacity, procurement of equipment including ventilators and oxygen supply, and workforce issues **[AD1/039 INQ000087307]**.

248. Information was provided on how NHS expansion would look and attendees discussed potential expansion into recovery areas and theatre spaces. The slides also described in broad terms the limits of the NHS's ability to absorb the projected rise in hospitalisations and highlighted, among other things, that whilst the NHS is highly dependent on social care for patient discharge "*further surge or displacement capacity into the independent sector or discharge to social care would be limited*".

249. Covid-19 bed daily SitReps started to come through from 13 March 2020, with Trusts providing figures on the numbers of beds occupied by Covid-19 patients, with a breakdown of those in G&A beds and those in critical care beds. Information from the Covid-19 SitRep was relayed to the CMO.

250. A joined-up approach between NHS, community care and adult social care providers (under DHSC leadership) was seen as critical to the success of any efforts to rapidly free-up hospital and critical care capacity. NHS England coordinated the work of NHS bodies for the purpose of urgently preparing the NHS for the anticipated mass influx of patients seriously ill with Covid-19. The range, volume and pace of the work undertaken

by NHS England, CCGs and NHS providers in the following days and weeks for the purpose of preparing the national health system to the incoming wave of COVID-19 hospitalisations was unprecedented in the history of the NHS.

251. As explained in an internal NHS England briefing document entitled "*Making optimal use of social care funding to support COVID*" (produced around 1 April 2020) **[AD1/040INQ000514955, AD1/041 INQ000593798]** the "gearing" between social care and hospital capacity was fundamental to the objective of freeing up hospital capacity as "*with around 460,000 care home beds, the ratio to hospital beds is around 5:1. Expansion or loss of care home beds has a major proportionate impact on hospital discharge capacity*". In practice, this meant that a loss of 10-20% of care home capacity (i.e. about 90,000 beds) could have a catastrophic adverse impact on hospital discharge and the same was true for domiciliary care in relation to discharge home with support.

252. To achieve the Government's objective to discharge clinically fit patients from hospitals (a small proportion of whom would have required admission to care homes), it was therefore necessary to facilitate conditions that made that discharge possible and acceptable to care home providers. Accordingly, even though only a very small percentage of discharges from hospitals are to care homes, NHS England recognised the need to support care homes in receiving patients from hospitals.

253. To that end, on 12 March NHS England met with Care England, the National Care Forum and the CEOs of a number of large nationwide care homes businesses to discuss the support that the care home sector needed as a result of the rising Covid-19 infections. During that call, care home provider CEOs expressed mixed views about the general approach to be adopted to protect their residents from COVID-19 infection: some leaders suggested that care homes needed "a ring of steel" around them and close their doors to visitors and further admissions; other leaders accepted that COVID-19 would inevitably enter care homes and that the focus should be on putting in place effective measures and protocols to minimise infection risks and spread within care homes. It was agreed that leads from Care England and the National Care Forum and Matthew Winn would separately follow-up with DHSC to obtain further advice on PPE and IPC **[AD1/042 INQ000593800, AD1/043 INQ000593801]**.

254. On the same day, NHS England also held a meeting with the LGA and ADASS to discuss potential practical and financial arrangements in connection with the discharge of elderly and frail hospital patients to their homes, community care, care homes, nursing homes and potential other independent sector settings **[AD1/044INQ000103769]**. As set out in a note of that meeting, there was consensus in favour of prioritising a "home first" approach by avoiding moving people into other settings (including care home settings) unnecessarily and by focusing efforts on allowing people to return to their home, either unaided or with support. There was also agreement that stringent IPC measures would need to be used to deal with COVID-19 positive patients being discharged from acute wards to the person's own home or a care home.

255. NHS England continued to have regular meetings with ADASS, the LGA and representatives of care home businesses throughout the Relevant Period.

256. As set out in correspondence between DHSC and NHS England on 12 March 2020 **[AD1/043 INQ000593801]**, careful consideration was given to the potential risks of discharging potential COVID-19 patients into care homes, alongside potential mitigation measures including possible DHSC-authorised testing of known or suspected Covid-19 patients before discharge and/or the transfer of suspected Covid-19 cases into holding facilities or care homes with appropriate isolation wings.

257. However, as set out in an email from Dr Susan Hopkins (PHE National Incident Director for Covid-19) sent earlier that day to DHSC and NHS England in response to a DHSC query in connection with the potential extension of COVID-19 testing to care home workers, testing capacity at that point in time was limited to 3,000 tests per day, increasing by 500 tests per day each week, with testing priority being accordingly given to "clinical need" (i.e. the diagnosis of incoming patients) **[AD1/035 INQ000270015]**. In light of this, the testing of all patients that were clinically fit to be discharged into care home settings was considered by DHSC simply not to be a viable option at that time. In line with PHE's projections, it was unlikely to be a viable option for some time without a significant and rapid expansion of testing capacity.

258. As set out in the email correspondence above between NHSE and DHSC, and in subsequent correspondence between NHSE and Care England **[AD1/045 INQ000593806]**, the use of holding facilities for the purpose of quarantining suspected

(i.e. at that time, symptomatic) COVID-19 patients before discharging them into care home settings was considered as a potential short term solution. However, it was clear to NHSE, DHSC and care sector representatives that in light of the imminent requirement to accelerate discharge of medically fit patients from hospital, the projected exponential increase in hospitalisations of frail and elderly patients infected with COVID-19 (coupled with the subsequent need to discharge those who had recovered), and a projected 10-20% health and social care workforce absence rate (largely due to COVID-19) **[AD1/035 INQ000270015]**, adequate holding facilities staffed by qualified staff for quarantining all elderly and frail patients with complex needs before their discharge into care home settings simply did not exist at that stage.

259. For context, it is also important to note that setting-up and funding quarantining facilities for persons clinically fit to be discharged from hospital does not fall within the scope of NHSE's functions, although pursuant to the principle of mutual aid the NHS did where possible provide spare community hospital and unit beds capacity to assist local authorities in the discharge of designated settings policy developed by DHSC after the first wave of COVID-19, as further discussed below.

260. The reality was that in the lead up to the Phase 1 Letter and 19 March Discharge Guidance the only available and practicable mitigation measures to manage potential infection risks arising from the discharge of patients from hospital into care homes were the effective implementation of infection control protocols within each care home, associated with appropriate external support to care home providers through the provision of IPC training and the enhanced coordination and communication between hospital, community care and primary care providers. These arrangements in social care settings mirrored the approach taken in the health system at the time in respect of suspected Covid-19 patients.

261. At the same time, further concerns were raised internally in respect of reports about an increasing number of care homes refusing to take patients from hospital with identified COVID-19 **[AD1/043 INQ000593801]**, with further discussions on hospital discharges being held between DHSC, NHSEI and ADASS in connection with out of hospital "isolate to protect" models to support the protection and isolation of high risk groups.

262. On 13 March 2020 PHE published further guidance on residential care provision covering relevant steps care home providers could take to maintain services (which, as further discussed below, included the rollout of the Capacity Tracker and NHSmail to enhance communication, coordination and mutual aid between health and social care providers), isolation protocols for members of staff concerned they might have COVID-19, steps to minimise the risks of transmission within care homes and relevant steps that the NHS and local authorities should take to support care homes.

263. On 16 March 2020, a meeting took place between NHS England, the SSHSC, the permanent secretary of DHSC and other ministers to discuss plans for the rapid expansion of hospital and "step-down" capacity, the publication of the Government's "Covid-19 Hospital Discharge Service Requirements" and the simplification of the financial regime for the funding of hospital discharges.

264. In respect of hospital discharges into care homes, on 16 March 2020 DHSC, the Deputy Chief Medical Officer ("**Deputy CMO**") Jenny Harries, NHSE and the CQC engaged in email correspondence to discuss measures to mitigate potential risks of infection to care home residents **[AD1/046 INQ000325243]**:

265. On 16 March 2020, at 10:31 AM Rosamond Roughton (DHSC) wrote:

> *"Dear Jenny*
>
> *We estimate that approx. two thirds of people in care homes are over 85. When we introduce the shielding policy, what should our approach be to allowing patients to be discharged into care homes who are symptomatic of Covid-19?*
>
> *My working assumption was that we would have to allow discharge to happen, and have very strict infection control? Otherwise presumably the NHS gets clogged up with people who aren't as acutely ill.*
>
> *It is a big ethical issue for care home providers who are understandably very concerned, and are already getting questions from family members."*

266. On 16 March 2020, at 10:39 AM the Deputy CMO (DHSC) responded:

"Whilst the prospect is perhaps what none of us would wish to plan for I believe the reality will be that we will need to discharge Covid-19 positive patients into residential care settings for the reason you have noted.

This will be entirely clinically appropriate because the NHS will triage those to retain in acute settings who can benefit from that sector's care.

The numbers of people with disease will rise sharply within a fairly short timeframe and I suspect make this fairly normal practice and more acceptable but I do recognise that families and care homes will not welcome this in the initial phase.."

267. On 16 March 2020, at 10:49 AM Matthew Winn (NHSE) responded:

"Thanks for looping me in – yes to the point that people who are symptomatic (but not tested) and those recovering from COVID 19 to transfer into care homes.

On my Thursday call last week with the CEO's of the 8 big providers of care homes they were expecting that to be the position and whilst want maximum protection and avoidance in place, they are realistic position cannot last for ever.

The point on could [sic] hygiene and isolation is more important – just as they would do with an outbreak of DandV [diarrhoea and vomiting][14] "

268. The same considerations were further discussed in internal NHSE email correspondence on 17 March 2020, in connection with an early draft of the 19 March Hospital Discharge Guidance **[AD1/047 INQ000593805** and **AD1/048 INQ000593797]**:

"Here's text on the repatriation of patents [sic] from acute settings[15] [...]

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[14] The working hypothesis at that time (with the then limited knowledge of the COVID-19 virus) was that normal IPC protection standards and procedures for other infectious illnesses (e.g. use of gloves, apron and face mask), together with appropriate isolation of infected individuals and good hygiene practices in place, would be sufficient to control the spread of COVID-19 in care homes. Such IPC standards and procedures were and continue to be standard practice for care home providers, as set out in section 5 of the CQC Adult Social Care Key Lines of Enquiry and Prompts.

[15] The text did not make it into the final version of the Hospital Discharge Guidance because it was considered that it did not add anything new to the Guidance.

… there's little we can say that goes beyond recently published guidance (linked in the text) on behaving the same way as you would towards anybody with infectious disease. Hospitals will not be testing everybody, so care homes will have to work out how to manage them safely.

We'll need to say more on this soon […]. Supply chain – especially PPE – is a key issue. Paul was finally able to reach someone in DHSC working on that late this afternoon, and movement is due on this tomorrow (statements that social care should be treated equally with NHS; immediate drop of masks to care homes & domiciliary care – we need to check if the masks are adequate).

Have requested discussion with Ros Roughton on DHSC on this tomorrow before taking up with care home reps to work out some further messaging. For now this is where it's got to […]"

269. As the above email correspondence shows, the discharge of patients from hospital into care homes, with mitigation measures in place in the form of appropriate infection control measures, was the only available option in light of:

a. The imperative to urgently free-up hospital capacity to prepare the NHS for a mass influx of COVID-19 patients (most of whom were projected to be elderly and frail), and continue to free-up capacity throughout the peak of infections;

b. The consequent testing prioritisation decisions given insufficient national testing capacity to test hospital patients before discharge;

c. Lack of appropriate additional facilities to care for potential COVID-19 patients no longer in need of hospital care;

d. The welfare and care needs of frail and elderly patients, and the serious risks to their welfare posed by any prolonged stay in hospital (in the form of likely nosocomial infections,[16] physical deconditioning and the onset or worsening of dementia).

[16] It is worth noting in that respect that there were significantly fewer single rooms (offering some degree of protection from infection) in hospitals than in care homes across England.

Phase 1 Letter

270. On 17 March 2020, NHS England sent the Phase 1 Letter to NHS leaders **[AD1/016 INQ000087317]**. The Phase 1 Letter was unprecedented in its request for common and co-ordinated response.

271. The measures designed to free up inpatient and critical care capacity had the operational aim to expand critical care capacity to the maximum and free up at least 30,000 of England's 100,000 G&A beds by:

a. Postponing all non-urgent elective operations by 15 April 2020, and for a period of at least 3 months (with emergency admission, cancer treatment and other clinically urgent care remaining unaffected). This measure alone was estimated to free up between 12,000-15,000 hospital beds across England.

b. Urgently discharging all hospital inpatients medically fit to leave. This measure was estimated to have the potential of freeing up to 15,000 beds currently occupied by patients awaiting discharge or with length of stay over 21 days. The discharge strategy was designed to reduce delays for patients who were able to leave hospital.

c. The block purchase of independent hospital capacity, which was expected to be completed within a fortnight.

272. That meant that those patients who were ready to be discharged into (or back home to) a care home, were able to get there more quickly. It did not mean that any patients were discharged to care homes who would not otherwise have been, and was not designed to increase the overall number of patients discharged into care homes. On the contrary, the data collected and analysed by NHS England demonstrates that significantly fewer patients were discharged from hospitals into care homes during March – April 2020 compared to the same period the previous year.

Developing the Hospital Discharge Guidance

273. In developing the draft Hospital Discharge Guidance, NIRB took account of the potential benefits of a more extensive testing programme for patients ready to be discharged and requested on 17 March 2020 that further consideration be given to "*Covid-19 testing*

practices at discharge to support safe care home admissions" **[AD1/049 INQ000269992, AD1/050 INQ000593794]**. Ultimately, however, for the reasons set out above, DHSC and PHE considered that testing capacity was insufficient at the time to support the introduction of a policy requiring the testing of patients before their discharge from hospital into a care home.

274. On the morning of 18 March 2020, NHS England's National Clinical Director for Older People and National Clinical Director for End of Life Care sent a letter to NHS England's National Medical Director and National Medical Directors for Primary Care and Acute Care and Emergency Preparedness and Strategic Incident setting out issues for resolution regarding end of life care and recovering Covid-19 patients who were discharged from hospital back into the community or social care settings in line with the draft Hospital Discharge Guidance **[AD1/051 INQ000607138]**.

275. The letter also set out a number of issues to be resolved with regard to the willingness and ability of care home providers to assist NHSEI's hospital discharge efforts:

a. Care homes are independent providers and many are suggesting they won't take patients who still have the infection. There shall need to be some incentive or payment mechanism for them to take on this kind of patient.

b. Care homes have a perception that they are judged by CQC on their death rate. Homes who take on end of life or last days of life care have a higher rate of death which may trigger a CQC inspection process. An explicit supportive statement from the CQC would be helpful.

c. Care Home workforce is an issue with many care homes reliant of agency staff. Residential homes do not necessarily have trained nursing staff and so may not have the leadership required to ensure strict infection control measures when taking back patients who may have communicable diseases. Many Care home staff shall be affected by current quarantine measures for households.

d. Equipment including supplies of oxygen, hoists and hospital beds. Residential Care homes without Nurses may not have basic observation equipment such as Blood Pressure Monitors, Oxygen saturation monitors and even thermometers which are in short supply.

e. Infection control measures - some homes do not have the infection control measures in place to support nursing of patients with increased risk of transmission. Cohort nursing and isolation facilities with correct PPE shall be essential for staff.

f. Personal Protective Equipment – Care homes are not linked to regular NHS supply chain and do not have access to PPE. PPE in general practice may not be suitable for these high acuity patients and resources and training are currently directed to hospitals. FFP3 masks (face fit tested), visors and disposable suits and which are being used to nurse patients in hospitals should be available to care home staff.

276. The letter proposed that further external support to care homes may be required. The contents of the above letter informed NHS England's ongoing meetings with PHE and DHSC around care home related issues, and prompted the NHS England decision (referred below) to appoint a senior social care advisor.

277. Further concerns about the procurement and distribution of adequate PPE to care homes to support infection control and barrier nursing were raised by Care England, the National Care Forum and the UK Home Care Association on 18 March 2020. Those concerns were immediately escalated to DHSC, who were responsible for PPE procurement, which sought to reassure the sector by issuing a letter confirming that an equal supply of PPE would be distributed to the NHS and care home sector.

278. On 18 March, further correspondence took place between NHS England, ADASS and the LGA to discuss how to promote further engagement with the care home sector in connection with the hospital discharge guidance.

279. As part of that correspondence:

a. The LGA agreed the detail of the D2A discharge flow chart at Annex 1 to the draft Hospital Discharge Guidance;

b. ADASS informed NHSE that much of the feedback from the ADASS regional groups was that care home providers were simply refusing discharges or repatriation without testing **[AD1/052 INQ000607139**.

c. In comments on a later draft (version 4.4) of the Hospital Discharge Guidance, Care England also raised concerns about the workforce challenges that were likely to arise in the following weeks in the care home sector in the absence of any provision for the testing of care home staff:

> *"The document is silent on and does not acknowledge that resource levels in care homes will be materially affected in the next few weeks with the absence of testing and increasing infections/self-isolation. There may be challenges in effectively caring for the residents we have, especially in homes with active infection without taking in large numbers of additional residents being discharged from hospitals. To support the intent to discharge people from hospitals into care homes we need: much more testing for our residents and employees, reductions in the regulatory requirements for recruitment to speed this up, PPE etc."*

280. Similar concerns were also raised in a letter from the Care Provider Alliance setting out proposals "*for the make up of a single fee to be utilised in Hospital Discharge during Covid-19*" shared with NHS England on 19 March 2020 **[AD1/053 INQ000593795]**. For the reasons set out above, however, DHSC and PHE assessed that testing capacity at that point in time was insufficient for the purpose of testing care home staff and residents.

281. In the evening of 18 March 2020 a further meeting was held between NHSE, Care England and the National Care Forum to discuss a number of practical aspects of the draft hospital discharge guidance including funding for hospital discharges into care homes, the enhancement of information sharing between NHS and care sector through the roll out of the Capacity Tracker and NHSmail platforms to care homes, availability and distribution of PPE and the recurring question of testing individuals prior to their discharge or transfer into a care home **[AD1/054 INQ000593792]**.

19 March Discharge Guidance

282. On 19 March 2020, the Government published the "COVID-19 Hospital Discharge Service Requirements" ("**the 19 March Discharge Guidance**"), a guidance document co-produced by DHSC, MHCLG and NHS England (with input from the CQC, local government bodies, care home associations and a number of NHS providers) aimed at

setting out the details of the hospital discharge guidance outlined in the Phase 1 Letter. The guidance was developed in parallel with the Phase 1 Letter, and was originally slated for publication on the same day.

283. The 19 March Discharge Guidance was the product of strong collaborative working between a large number of teams and stakeholders across health and social care (including the LGA and ADASS), with the aim of achieving the shared objective of freeing up sufficient NHS hospital capacity to allow the NHS to treat patients requiring hospital treatment as a result of COVID-19 infection.

284. Owing to the large number of stakeholders involved in producing the 19 March Discharge Guidance, it was published two days after the Phase 1 Letter.

285. Some stakeholders raised concerns with the quick turnaround resulting in an inability to consult and engage properly. For example, on 16 March 2020 urgent external input on the Hospital Discharge Guidance document was sought from key stakeholders **[AD1/055 INQ000593804]**. Highlighting the fast pace at which NHSE and relevant government departments were working at the time, and the unprecedented volume of information decision-makers and key stakeholders alike were being asked to process and review during that period of time in response to that request, ADASS raised concerns about the extremely short deadline for responding, the volume of COVID-19 guidance they were being asked to review, and the level of engagement with the social care sector – although these short turnaround times were an inevitable consequence of the immense strain and time pressure the entire system was working under at that time.

286. As discussed earlier in this statement, and as set out in the confidential NIRB submission referred to above, however, DHSC and the NHSE Discharge Cell led by Matthew Winn had been engaging (and continued to engage throughout the relevant period) very closely with the social care sector throughout the development of the Hospital Discharge Guidance through multiple conference calls and email correspondence with all three care home umbrella organisations (Care England, National Care Forum and National Care Association), ADASS, the LGA, various local authority directors of social care and directors of large care home providers.

287. The 19 March Discharge Guidance was published alongside:

a. The announcement from DHSC and MHCLG of £1.3 billion of additional funds to support the NHS discharge process so patients who no longer needed urgent treatment (but may have ongoing health or social care needs) could return home safely and without unnecessary delay.

b. A letter from NHS England to Trusts, CCGs, Directors of Public Health and Community Health Providers setting out guidance on the prioritisation ("**March Prioritisation Letter**") of specific community health services to release capacity to support hospital discharges, subsequently updated on 2 April 2020 **[AD1/056 INQ000269920**].

288. The cover letter to the 19 March Discharge Guidance explained that:

> *"… One of the most important tasks will be to ensure we have the capacity to support people who have acute healthcare needs in our hospitals. To do this we need to organise the safe and rapid discharge of those people who no longer need to be in a hospital bed. The new default will be discharge home today. … Each system will tackle this challenge from a different starting position and should take account of their local workforce and care home/domiciliary care supply dynamics, together with awareness of the capacity of family carers and volunteers in the community to continue to support local action. Supporting and sustaining social care will never be more vital to these efforts.*
>
> *A range of virtual resources and live interactive sessions have been developed to support every sector to work through how to achieve this new way of operating and are detailed in the document."*

289. The 19 March Discharge Guidance promoted a D2A model based on four pathways:

a. Acute hospitals were put in charge of discharge "pathway 0", namely ensuring that the estimated 50% of patients that can leave hospital and only need minimal support to do so on time;

b. Providers of community health services, working together with social care colleagues, the care sector and the voluntary sector, were tasked to lead on providing support following discharge on pathways 1 to 3:

i. **Pathway 1**, namely the estimated 45% of patients able to return home with support from health and/or social care;

ii. **Pathway 2**, namely the estimated 4% of patients in need of rehabilitation in a bedded setting;

iii. **Pathway 3,** namely the estimated 1% of patients for whom home is not an option at the point of discharge from an acute hospital.

290. The Guidance noted that for patients, the D2A model would meant that while they would still receive high quality care from acute and community hospitals, they would not be able to stay in a bed as soon as that was no longer necessary. For 95% of patients leaving hospital that would mean that, where needed, the assessment and organising of ongoing care would take place when they are back in their own home. For patients whose needs were too great to return to their own home (about 5% of patients admitted to hospital), a suitable rehabilitation bed or care home would be arranged.

291. The guidance instructed acute hospitals, among other things, to conduct twice daily clinically-led reviews of all patients in acute beds, with involvement of social care colleagues, to determine which patients were no longer required to be in hospital.

292. Community health services were instructed, among other things, to:

a. coordinate and manage the post-discharge arrangements and care for all patients from community and acute bedded units on pathways 1, 2 and 3;

b. ensure patients on all three pathways were tracked and followed up to assess for long term needs at the end of the period of recovery;

c. maintain the flow of patients from community beds including reablement and

d. rehabilitation packages in home settings, to allow the next sets of patients to be discharged from acute care.

293. Local authorities were entrusted with coordinating their work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery, and to take the lead contracting responsibilities for expanding the capacity in domiciliary care, care homes and reablement services in the local area paid for from the NHS Covid-19 budget.

294. Care home providers were asked to maintain capacity and identify vacancies that could be used for hospital discharge purposes and adopt and implement a care home "capacity tracker" tool to provide real time bed vacancy information to NHS and social care colleagues, and roll out the NHSmail secure encrypted email service to facilitate communication and information sharing between NHS and social care.

295. The care home capacity tracker tool had been developed prior to the pandemic by the North of England Commissioning Support Unit in collaboration with NHS England and the Better Care Fund to enable the system to better manage hospital discharges by identifying available capacity in care homes, hospices, inpatient community rehabilitation providers, substance misuse provides. During the pandemic, the tracker tool was adapted and scaled up to cover the whole of England.

296. Local authorities were entrusted with coordinating their work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery, and to take the lead contracting responsibilities for expanding the capacity in domiciliary care, care homes and reablement services in the local area paid for from the NHS Covid-19 budget.

297. The 19 March Discharge Guidance provided health and social care providers with the flexibility to reach discharge solutions deemed adequate and appropriate to the relevant patient and local social care sector capacity. This was a collaborative process, with social care colleagues participating in the daily ward reviews and discharge planning. The Guidance did not (and could not) require any care home to accept any particular patient discharged from hospital. As set out in paragraph 8.1 of the guidance, it asked care home providers to:

    a. Maintain capacity and identify vacancies that could be used for hospital discharge purposes;

b. Adopt and implement from 23 March 2020 the Capacity Tracker, a tool operated by the North of England Commissioning Support Unit with the purpose of enabling care homes to provide hospitals with live vacancy information to support the timely discharge of patients requiring care in such facilities;

c. Implement the NHSmail system in care homes from Monday 23 March 2020 to support safe and secure transfer of patient/resident information between health and social care providers.

298. Lastly, the guidance also announced the temporary suspension of usual patient funding eligibility criteria (such as CHC assessments), alongside the Government's agreement to fully fund the cost of new or extended out-of-hospital health and social care support packages for people being discharged from hospital to enable quick and safe discharges and more generally reduce pressure on acute services. The new funding, distributed by NHS England, would enable CCGs and their local authority partners to commission the enhanced discharge support outlined in the guidance.

299. The financial package meant that it was no longer necessary to determine, before discharge, who would be responsible for the costs of support (NHS or social care). Thus the policy enabled the process to be neutral as to organisational responsibility for financing immediate support post discharge. It exempted local authorities from having to pay for this period and sought to maximise the individuals' independence (and therefore minimise the ongoing impact on the social care sector).

300. In line with the 19 March Discharge Guidance, the quick guide defined D2A as follows:

> *"Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'. This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement."*

301. The guide defined "*clinically optimised*" as "*the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge'…*".

302. Fundamentally, the D2A model introduced by the 19 March Discharge Guidance echoed and built upon existing best practice guidance on hospital discharge. It required acute Trusts to conduct twice daily rounds to determine which patients were "medically optimised" to be discharged home or to less acute settings.

303. The main differences between the 19 March Discharge Guidance and the previous discharge guidance referred to above included:

a. The context of the pandemic and the imperative of freeing up as many acute beds as possible to help cope with the incoming first wave of Covid-19 hospitalisations; this introduced a significant degree of urgency to the implementation of the D2A requirements;

b. Annex B to the 19 March Discharge Guidance, which set out, for the first time a specific list of clinical reasons to reside in hospital to assist clinical teams across all Trusts in identifying patients no longer in need of an NHS bed; and

c. The Government's decision to temporarily suspend CHC assessments and directly fund the costs of out of hospital health and social care packages for patients who no longer required an NHS bed; this removed significant barriers to timely discharge.

304. On 19 March 2020 NHS England's Strategic Incident Director hosted a webinar to brief NHS system leaders (including CCG leads, hospital CEOs, GP leads, EPRR leads, Directors of Nursing and Sustainability and Transformation Partnerships ("**STP**") / Integrated Care Systems leads) on various aspects of the NHS response to the COVID-19 crisis. The Hospital Discharge Guidance was presented by NHS England's Director of Community Health who, as part of the presentation, acknowledged the difficult situation faced by the care home sector and the expectation that extra funding to local authorities would be used to support care home provider resilience during this time **[AD1/057 INQ000593796]**:

• It is vital that we free up as many NHS beds as possible. This will save lives. This new discharge policy will enable that to happen. Patients will remain the responsibility of the NHS, and CHC assessment won't take place prior to discharge.

• We know that care providers will be facing additional cost pressures, coping with workforce absences, and in some parts of the country are starting from a fragile point. So, we have also put extra funding into local government, and will be setting out expectation that local authorities use this extra funding to support provider resilience during this time.

• We believe that the most effective way to do this will be through using our well established mechanisms for joint health and care funds. No one should be caught up in arguments about who pays, and we are confident that local government and NHS leaders are already working together to deliver this.

305. An initial assessment of the impact of the measures introduced by the Phase 1 Letter and the 19 March Hospital Discharge Guidance on patient flow over the course of Wave 1 of the pandemic was conducted by the discharge cell towards the end of April 2020 and presented to NIRB on 1 May 2020 **[AD1/058 INQ000270099]**.

306. While the analysis noted a significant variation across regions in England, the data indicated an overall significant reduction in long length of stays in hospital. Since the introduction of the hospital discharge requirements in March 2020:

a. Daily numbers of occupied beds by adult patients in an acute hospital for over 7 days dropped from 42,666 to 19,833;

b. Daily numbers of occupied beds by adult patients in an acute hospital for over 14 days dropped from 25,075 to 10,506; and

c. All regions achieved significant reductions ranging between 62-72% (against their 2018 March baseline) in hospital long length of stays of over 21 days.

307. The analysis identified the following "key enablers":

a. Additional funding for new or extended out-of-hospital health and care support packages for people being discharged or who otherwise would have been admitted to hospital which allowed the temporary suspension of CHC eligibility assessments under section 14 of the Coronavirus Act 2020 (a common cause for delays in hospital discharge);

b. Flexible use of NHS workforce to support implementation of new discharge service e.g., re-deployment of around 1,000 CHC staff; acute staff supporting individuals in alternative settings as needed;

c. The reasons to reside tool set out in the 19 March Discharge Guidance to aid discharge decision making;

d. Ongoing national clinical and operational support for regions and systems;

e. Daily data returns from discharge SitRep data and bed capacity tracker information;

f. Emergency legislation including, in particular, the suspension of the duty on CCGs and Trusts, both in a community setting and for those on the acute hospital discharge pathway, to assess for eligibility for CHC and for FNC and the suspension of the discharge notification process under the Care Act.

308. NIRB was asked to support actions to create a new D2A model post pandemic that would entrench some of the key benefits of the new service model, namely:

a. The timely discharge of all hospital inpatients who did not meet the clinical criteria to reside in acute care (thus freeing up hospital beds for patients in need of inpatient healthcare);

b. The assessment of short term rehabilitation, reablement and (if required) longer term support to be made outside hospital;

c. Ensuring patients were discharged on a "home first" principle and do not enter long-term care home settings unnecessarily; and

d. Ensuring that cross system working to ensure appropriate health and care support was provided in the right setting following discharge from hospital.

309. The Inquiry has asked for an explanation of the hospital discharge figures set out in slide 6 of the above analysis. As set out at the top of that page, the data points for that slide were a single day "snapshot" derived from the 28 April 2020 SITREP data collection from acute hospitals and reflected, therefore, the hospital discharge figures for that day only. The relevant hospital discharge figures contained in that slide were only shared for the purpose of demonstrating the type of information that was being collected. The text of the slide made clear that because these figures reflected new data collection requirements introduced earlier in April 2020 (including, as further discussed below, new daily reporting requirements in connection with the number patients and type of setting into which patients were discharged), at that point in time NHS England did not have confidence that the data points provided accurately reflected what was happening in practice.

310. The NAO report "*Readying the NHS and adult social care in England for Covid-19*" published on 12 June 2020 set out further detail on hospital capacity and patient flow during the first months of the pandemic and on the impact of the March 2020 hospital discharge requirements. The headline findings of the NAO report on hospital discharge and patient flow data can be summarised as follows:

a. Further to the instruction to postpone elective services whenever possible, "*elective activity fell by 24% in March 2020 compared with March 2019*".

b. "*The NHS additionally increased capacity through a deal to access up to 8,000 beds in independent hospitals, and by establishing temporary Nightingale hospitals, although use of these was limited up to mid-May.*"

c. "*Between 17 March and 12 April, the number of available acute hospital beds increased from 12,600 to 53,700, while the proportion of these beds occupied by a Covid-19 patient peaked at 29% on 7 April 2020. The proportion of critical care beds occupied by Covid-19 patients in England was highest between 5 April and 14 April, at 50% or just over.*"

d. Demand for emergency services and other clinically urgent services also decreased. In April, attendances at Type 1 A&E 50 departments "*were down 48%*

on the previous year, and indicative statistics for GP appointments also dipped by 31%, with a large increase in the proportion done by telephone. However, ambulance activity rose in March, with an accompanying increase in response times: for example, the response time for emergency calls (category 2 incidents) was 51% higher than in March 2019…"

311. An updated analysis of the impact of the D2A policy on patient flow and hospital capacity was produced on 25 February 2021 in connection with a winter resilience meeting between NHS England and the SSHSC **[AD1/059 INQ000270006]**.

312. The analysis noted how the £588 million additional D2A funding provided for the period between September 2020-March 2021 had demonstrably generated major and sustained improvements in hospital length of stay in both acute and community beds, by freeing up an estimated:

    a. 6,702 NHS beds over the relevant period – the equivalent of almost thirteen and a half additional hospitals – via reduced hospital length of stays for patients aged over 70;

    b. 624 NHS community rehabilitation beds; and

    c. 11,000 members of staff, including 6,800 registered nurses, who were able to turn to other priorities such as tackling the elective backlog built up during the pandemic.

313. The analysis also noted that now that hospital occupancy had returned to near pre-pandemic levels after an initial drop due to reduced engagement with health services, the D2A policies and associated funding had ensured sustained gains in efficiency with reduced length of stays in hospital figures across the board.

NHS England's involvement with subsequent care home guidance

314. Urgent steps to produce further IPC guidance for care home providers to supplement the 19 March Discharge Guidance and assist care homes with the management and prevention of COVID-19 infection were taken almost immediately after its publication.

315. In particular, on 20-24 March 2020 NHS England ran training (via webinar) on hospital discharge service requirements for community health and care home providers, with a view to assisting (and obtaining feedback from) these two sectors in connection with the implementation of the 19 March Discharge Guidance. The webinars covered, among other things, the use and distribution of PPE, the use of the Capacity Tracker and NHSmail, the new hospital discharge funding framework and the EHCH framework **[AD1/060 INQ000593791]**.

316. Support was also offered to social care providers by local systems. One example is North West London CCGs, who shared guidance on IPC and PPE use to local care home providers in light of a high demand on services in relation to Covid-19 in North West London on 20 March 2020.

317. By 21 March 2020, NHS England was aware that many care homes were not accepting new residents or returning residents from hospitals unless they had been tested for Covid-19. This indicates that care homes felt entitled to, and indeed quite prepared, to refuse to accept admissions if they did not consider themselves to have appropriate IPC measures in place to care for them and others safely.

318. During that time NHS England took urgent steps to appoint a senior social care advisor to:

    a. Provide the most senior leadership within NHS England on all matters related to adult social care and the COVID-19 emergency;

    b. Work alongside DHSC colleagues to provide leadership and connection on adult social care workforce and provision;

    c. Lead on specific work designed to stabilise and support the care home and care at home sectors;

    d. Agree policies with the care home sector, Ministers and national social care leadership.

319. The above led to the temporary appointment to the above role (from 25 March 2020) of Sir David Pearson, one of the UK's leading social care administrators, who would later

be appointed by the Government to chair the Social Care Sector COVID-19 Support Taskforce.

320. NHS England's Director of Community Health also made contact with the CNO's Strategic Advisor for Social Care Nursing with a view to discussing urgent steps to provide care homes with further IPC guidance and support (see further detail in Section 5 of this statement).

321. The original aim of NHS England's Nursing Directorate was to work with DHSC and PHE to quickly produce an updated IPC guidance document by close of business on 24 March 2020, with a view to addressing care home concerns with hospital discharges, particularly in London. The guidance was intended to be a supplement to the 19 March Discharge Guidance including practical information and guidance on a range of IPC issues.

322. In the meantime, DHSC made contact with NHS England Nursing and Ageing Well Directorates to seek to coordinate work on further IPC guidance for care homes with PHE and agree key lines to take in the hospital discharge webinars with community and care home scheduled on 23 and 24 March 2020. The proposed "key lines" suggested by DHSC were as follows:

1. *We appreciate the incredible job you are doing under difficult circumstances. But it is crucial that you continue to take people who are discharged from hospital.*
2. *We know there is concern regarding COVID-19 but the majority of the advice is in line with guidance that we would have in place during flu season.*
3. *We want everyone to feel confident that they can continue to operate in these times. Existing PHE guidance on infection control still stands but we are going to provide further advice on some specific circumstances.*
4. *We know there are concerns about PPE, so we will be clearer on what is required and in what circumstances PPE should be used.*

323. In light of the above discussions DHSC, PHE, the Deputy CMO and NHS England's Nursing and Ageing Well directorate started to work at pace to develop an update to the existing PHE guidance ("COVID-19 residential care supported living and care home

guidance") by 24 March 2020. It was agreed that the aim of this workstream was to provide additional detail and clarity to care home providers on good infection prevention and control practice and management of hospital discharges in connection with the issues and practical scenarios identified in the meeting summary note from the Deputy CNO referred to above.

324. The drafting of the new guidance was led by PHE and a first draft of the guidance document entitled "Interim guidance on managing Covid-19 cases and outbreaks in care homes" was circulated by PHE to NHS England for comment later that afternoon.

325. On 24 March 2020, in response to a query on behalf of the Minister for Social Care arising from reports of care homes refusing to admit patients who had not been tested for Covid-19, DHSC, PHE, BEIS, NHSX and NHS England engaged in email correspondence to determine, among other things, whether sufficient capacity could be made available for the purpose of testing patients being discharged out of hospitals into care homes.

326. In that correspondence, NHS England noted that because those patients were not included in PHE's prioritisation list, such patients could only be prioritised locally if there was spare capacity **[AD1/061 INQ000270151]**. At that time, capacity was unevenly distributed across NHS labs – in the main dependent on what PCR platforms the labs had previously, and availability of supplies for those particular platforms. PHE had issued guidance as to who should be tested, and this was being followed by the NHS. However, given the imbalance between testing capacity and demand in local hospitals as capacity was being increased at pace and the supplies pipeline was – at that stage – unclear, it was possible that, for a limited time, local capacity could become available for the testing of patients falling outside the prioritisation list.

327. On 25 March 2020 DHSC passed on to NHS England an urgent query from West Kent CCG on behalf of a number of care homes, seeking urgent guidance on a number of matters falling within the scope of the draft Interim Guidance that was being developed by PHE, namely (1) whether COVID-19 positive patients were allowed to be discharged into Care Home settings not currently affected by COVID-19, (2) whether Care Homes could insist on only accepting patients that had been tested prior to discharge, and (3) whether asymptomatic patients discharged from hospital were expected to be isolated.

328. Shortly thereafter, PHE circulated to NHS England and the CQC for comment an amended version of the draft Interim Guidance. The hospital discharge section of the new draft guidance focused on clear information sharing between hospitals and care homes about the COVID-19 status of relevant patients and infection control and isolation measures to be applied to any recovering COVID-19 positive patient discharged from hospital:

"Hospitals should inform care homes of the results of any COVID-19 tests the patient has had, the day of onset of symptoms in hospital and provide a care plan for discharge from isolation. The care home should deliver care in a single room with ensuite facilities. The resident should have meals and care in their room for 14 days after the onset of symptoms or after the date of a positive COVID-19 test, whichever is earlier. Staff should wear aprons, gloves and fluid repellent face mask while caring for the resident. The personal protective equipment should be disposed of as clinical waste.

a) *Previously confirmed cases of COVID-19 who are no longer symptomatic, have been isolated for 7 days after onset of symptoms (14 days if they have diarrhoea) and assessed as fit for discharge can be transferred to a care home and care provided as normal. No isolation or additional infection prevention and control precautions are required.*

b) *Confirmed case of COVID-19 medically fit for discharge but not yet beyond 7 day isolation period (14 days if diarrhoea) should return to their care home with strict isolation procedures being in place. Hospitals should inform care homes of the results of any COVID-19 tests the patient has had, the day of onset of symptoms in hospital and provide a care plan for discharge from isolation. The care home should deliver care in a single room with en-suite facilities. The resident should have meals and care in their room for 14 days after the onset of symptoms or after the date of a positive COVID-19 test, whichever is earlier. Staff should wear aprons, gloves and fluid repellent face mask while caring for the resident. The personal protective equipment should be disposed of as clinical waste.*

c) *Residents do not require a negative COVID-19 test prior to their discharge from hospital to a care home or other establishment. If COVID-19 symptoms occur in*

the 14 days after exposure, such as influenza like illness (ILI), pneumonia, acute respiratory distress syndrome (ARDS), a new cough or fever, these residents should be promptly isolated. Where possible a test for COVID-19 and other relevant diagnostic tests should be performed after an appropriate medical assessment."

329. The above section of the Interim Guidance was subsequently submitted by DHSC to the Government's "Behavioural Insight Team" ("**BIT**") for the purpose of clarifying the message to the care home sector in connection with hospital discharges.

330. On 29 March 2020 the Pillar 1 system held a testing capacity of 15,000 PCR tests per day and staff testing for those working in critical care, emergency departments and ambulance services and any other high priority groups (as determined locally) was enabled.

2 April Guidance

331. On 1 April 2020, NHS England was asked to review a further draft copy of the guidance to care homes on the admission and care of residents during the pandemic ('Admission and Care of Residents during COVID-19 Incident in a Care Home', the **"2 April Guidance**"). The draft guidance suggested that because any patient who had exhibited Covid-19 symptoms whilst in hospital would be tested, and the test result would be communicated during the process of transfer to a care home, negative tests prior to transfer to or admission into a care home would not be required.

332. Internal inquiries were made with the NHS England Testing Cell to determine whether the testing of symptomatic hospital inpatients likely to be discharged to a care home reflected existing testing practice. The view expressed by the Testing Cell was that, in practice, a large number of hospitals (but not all) may have already moved to test all symptomatic (and some asymptomatic) patients before discharging them to a care home; therefore the impacts of the DHSC proposal on testing capacity would likely be minimal.

333. While there were benefits from this practice, the proposed national policy proposed by DHSC officials was inconsistent with the CMO advice and the testing prioritisation rules

which NHS hospitals were required to follow, and any formal change to testing prioritisation fell outside NHS England's remit. In light of this, NHS England suggested that the additional draft wording on testing should await pending changes to the CMO advice and testing prioritisation rules.

334. The 2 April Guidance set out, among other things:

a. Guidance regarding the clarification of the COVID-19 status of an individual and any relevant symptoms during the process of transfer from hospital to a care home, with testing prioritised in accordance with the PHE testing priorities;

b. Recommendations for the care of symptomatic residents (including any patients discharged from hospital) in care homes (namely that they should be immediately isolated for 14 days from the onset of symptoms, with care homes taking appropriate IPC measures, e.g. PPE usage);

c. Recommendations for dealing with residents who had tested positive, but were no longer symptomatic, namely isolation for 14 days from the onset of symptoms or a positive test;

d. Recommendations for caring for residents without symptoms, namely following social distancing measures for everyone where possible (with gatherings cancelled and alternative arrangements for communal activities), shielding for the extremely vulnerable, and daily monitoring for COVID-19 symptoms;

e. Recommended restrictions for visitors and non-essential staff (e.g. limiting visits to next of kin in exceptional circumstances such as end of life);

f. Advice on decontamination and cleaning; and

g. Advice on "cohorting" staff who were caring for symptomatic residents away from other residents and staff.

335. In the case of *R (on the application of Gardner & Harris) v Secretary of State for Health and Social Care and others* [2022] EWHC 967 (Admin), the Administrative Court ruled that while the measures contained in the Hospital Discharge Guidance constituted a rational and necessary response to the risks of the NHS's intensive care capacity

becoming overwhelmed (and the absence of sufficient testing capacity or alternative suitable accommodation for patients discharged from hospital in need of residential care) the 2 April Guidance was unlawful insofar as – in light of the failure to take into account the risk of asymptomatic transmission and make an assessment of the balance of risks – it failed to recommend a 14-day isolation policy applicable so far as practicable to asymptomatic new residents (other than those who had tested negative to Covid-19).[17] As mentioned earlier in this statement, however, it is important to note that the Administrative Court expressly concluded that there were no grounds for challenging the role and decision-making of NHS England, as it was the SSHSC and PHE *"who bore responsibility of making proper arrangements for those admitted to care homes"*.[18]

Adult Social Care Action Plan

336. By 10 April 2020 DHSC was developing its "Adult Social Care Action Plan", the overall intention of which was to stem and reduce Covid-19 infections in care homes through a combination of testing before discharge, quarantine requirements for any new or returning care home resident and enhanced isolation provisions within care homes.

337. Whilst the Action Plan fell largely within the scope of DHSC's social care responsibilities, NHS England commented upon it, as the proposed contents of the Action Plan had operational implications for the NHS. In particular, early drafts of the Action Plan – which contained an emerging proposal to use NHS facilities (including Nightingale Hospitals) for the purpose of quarantining hospital inpatients who tested positive for Covid-19 upon discharge (or were awaiting a test result) – raised concerns about the potentially significant major adverse knock-on effect on hospital capacity.

338. Operationally, in early April 2020 the NHS still needed the Nightingale critical care capacity and community beds for potential critical care surge capacity and intensive care discharge step-down. Accordingly, it was imperative that any introduction of Covid-19 testing and/or quarantining requirements upon discharge would be operationally deliverable and unlikely to cause any significant delays to NHS discharge pathways, which were vital for maintaining sufficient hospital care capacity for both acutely ill Covid-19 and non-Covid-19 patients across the system **[AD1/062 INQ000270152]**.

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[17] *R (on the application of Gardner & Harris) v Secretary of State for Health and Social Care and others* [2022] EWHC 967 (Admin) at [290-293].
[18] [2022] EWHC 967 (Admin) at [296].

339. Nightingale hospitals were unsuitable for the purpose of quarantining frail and elderly persons. They were "field hospitals" initially designed and equipped solely for the provision of Covid-19 critical care, where elderly and frail patients would have been exposed to a noisy open plan environment, with no individual isolation facilities to prevent cross-infection between patients, no privacy and inadequate access to toilets or washing facilities (as critical care facilities did not need extensive toilet or washing facilities, given the nature of care provided in a critical care unit) and no staffing to look after such a patient cohort. Similarly, the use of facilities such as supported hotels for quarantining Covid-19 positive patients posed safety and welfare concerns for patients and appropriate facilities would be difficult to scale up at speed. This is because significant work and resources would be needed to make any hotel physically appropriate for a care home resident to use (e.g., with specialist equipment being moved into every room) and recruit enough staff skilled in older people's care.

340. The Government's testing policy in respect of the discharge of hospital inpatients into care homes was ultimately set out in DHSC's Adult Social Care Action Plan – published 15 April 2020. Among other things, the DHSC Action Plan introduced for the first time a requirement on all acute hospitals to test all patients for Covid-19 prior to their discharge in a care home.

341. The final version of the DHSC Action Plan largely addressed the operational difficulties raised by NHS England by placing primary responsibility for the accommodation of patients who tested positive for Covid-19 on local authorities, and those care providers who had the ability to safely isolate Covid-19 patients within a care home. In the absence of local care providers with appropriate isolation or cohorted care facilities to accommodate people who had tested positive for Covid-19, the DHSC Action Plan asked local authorities to secure alternative appropriate accommodation and care for the remainder of their isolation period (which could be funded by the £1.3 billion enhanced discharge funding).

342. Following publication of the DHSC Action Plan, by a letter dated 16 April 2020, NHS England informed all acute hospitals of the new Government policy to test all patients being discharged from hospital to a care home **[AD1/017** **INQ000358460**]. The letter noted, in particular, that:

"This new testing requirement must not hold up a timely discharge as detailed in the COVID-19 hospital discharge service requirements. To ensure testing does not delay a timely discharge, testing for patients due to be discharged to a care home will need to be planned up to 48 hours before the scheduled discharge time. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home.

Some care providers will be able to accommodate individuals with a confirmed COVID-19 positive status, through effective isolation strategies or cohorting policies. If appropriate isolation or cohorted care is not available with a local care provider, the Local Authority will provide alternative appropriate accommodation and care for the remainder of the required isolation period, utilising NHS community and primary care assistance as needed. This alternative accommodation should also be used in the exceptional cases of test results not being available at the point of discharge and the receiving care home not being able to effectively isolate individuals. Therefore, delayed testing will not delay discharge. This additional testing requirement will be a small addition to the testing requirements already underway."

343. On 21 August 2020, DHSC published an updated version of the Hospital Discharge Service Guidance setting out detailed guidance to the system (with input from NHS England) on the implementation of the "home first" D2A model introduced by the 19 March Discharge Guidance, supported by new hospital discharge funding arrangements that supported free care, rehabilitation or reablement for a limited period of up to six weeks following discharge. Health and social care systems were expected to build on the work conducted until then to embed discharge to assess across England as the default process for hospital discharge during the funded period (September 2020 - March 2021).

344. For people discharged between 19 March and 31 August 2020 with a care package, their care would be funded from a ringfenced fund from the remainder of the emergency Covid-19 funding until assessments for long-term care were completed. For people discharged from 1 September 2020, the Government provided an additional £588 million to supplement existing CCG and local authority spend on post discharge support to cover the cost of this care for up to six weeks.

345. As set out in more detail in separate guidance, from 1 September 2020 the requirement to conduct CHC and Care Act assessments for individuals discharged from hospital was to be reintroduced but was to be undertaken during the individual's six-week period of funded recovery services. CCGs and councils were instructed to work together to develop a robust, fair and transparent approach to undertaking all assessments that had been deferred since 19 March, and to ensure all assessments restarted from 1 September were undertaken in good time **[AD1/063 INQ000270064]**. Through a combination of embedding the D2A model and utilising the national discharge fund, there was an expectation that performance would continue to reduce the unnecessary length of stay for people in acute care, thereby increasing hospital inpatient capacity, improving patients' outcomes following a period of rehabilitation and recovery and minimising the need for long-term care at the end of a person's rehabilitation.

Designated Settings Policy

346. On 16 September 2020, NHS England shared data from the Capacity Tracker with regional EPRR leads showing numbers of care homes reporting issues with trusts not following the hospital discharge service guidance by either not testing patient pre-discharge into the care home or not communicating with the care home the patient's test status or if patient had/had not been tested pre discharge. NHS England asked EPRR leads to urgently follow up with trusts to assure NHS England the hospital discharge guidance was being met and understand why care homes are reporting back to the contrary.

347. The DHSC Action Plan was further developed on 18 September 2020 with the announcement of the designated settings scheme ("**Designated Settings Policy**"), which contained mandatory arrangements introduced to support safe and timely discharges and protect care home residents and staff from Covid-19 throughout winter. It included the requirement that every patient discharged to a care home must have a Covid-19 test within 48 hours prior to discharge (unless they had tested positive in the previous 90 days); and the requirement that every patient with a Covid-19 positive test being discharged to a care home be first isolated into a designated setting. This was followed by correspondence and joint guidance on 13 October and 16 December 2020.

348. The details of the new policy were set out in a letter dated 13 October 2020 addressed to directors of adult services ("**Winter Discharges: designated settings**") setting out the following requirements:

a. Anyone with a COVID-19 positive test result being discharged into or back into a registered care home setting must be discharged into appropriate designated setting (i.e., that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.

b. These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.

c. No one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding or without having been tested within the 48 hours preceding their discharge.

d. Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital.

e. The care home's registered manager should continue to assure themselves that all its admissions or readmissions are consistent with this requirement.

349. The November 2020 Covid-19 Winter Plan reaffirmed the need for accelerated discharge to support patients to leave hospital safely and more quickly. The Designated Settings Policy (and subsequent amendments to it) was produced by DHSC, and NHS England supported by providing accompanying guidance and collating data.

350. On 6 November 2020, the Discharge Cell reported to NIRB that there were key barriers to acute hospital discharges being reported by regions, which included a lack of confidence in test results, with some care homes requesting two negative tests before discharge. From the 14 October 2020, DHSC had agreed and implemented changes in data collection for care homes, hosted with the Capacity Tracker which allowed analysis of the number of instances where patients were discharged from hospital to a care home without a Covid-19 test. NHS England tracked this data on a daily basis and ensured

any variance to the policy was followed up with each Acute Trust, when flagged by a care home.

351. On 16 December 2020 DHSC, PHE, the CQC and NHS England issued new joint guidance for local authorities, CCGs and care providers on discharging hospital patients with a Covid-19 positive test result to designated care **[AD1/064 INQ000234652]**. Building on the DHSC letter of 21 October 2020, the guidance provided further advice on the establishment of designated settings and set out the expectation that every local authority would need to have access to at least one designated setting or suitable alternative premises. The guidance also explained the process by which the CQC would "assure" that each designated setting had the policies, procedures, equipment, staffing levels, appropriate skill mix, and training in place to maintain infection control and support the care needs of residents.

352. The 16 December 2020 guidance also provided further information on discharge arrangements, with reference to the discharge service policy and operating model published by DHSC on 21 August 2020 and the need for settings to provide appropriate clinical support. Local authorities were required to work with NHS providers and CCGs to ensure that designated settings could support the diverse care needs and cultural backgrounds of the community.

353. Despite significant efforts and mobilisation by local authorities, the social care sector, and support by local NHS bodies, progression to set up or make available designated care facilities in every part of England was difficult, with full local authority coverage not being achieved until seven months after the introduction of the policy **[AD1/065 INQ000270073]**. The CQC data illustrates the practical difficulties of making available or setting-up adequate alternative care facilities for isolating elderly people with Covid-19, with appropriate staffing, equipment and infection control measures in place **[AD1/066 INQ000270020]**.

Data on hospital discharges

354. Before the pandemic, Secondary Uses Service ("**SUS**") data collected from acute providers indicated that the number of average monthly discharges from hospital to care homes was around 25,000 (an average of 24,577 in 2018 and 26,539 in 2019).

355. The SUS data was known to represent an underestimate of the true number of discharges to care homes, as those who had been admitted to hospital from a care home would be marked as returning to "usual place of residence" upon discharge if they were discharged back to the same care home **[AD1/067 INQ000593789]**.

356. To reflect this known underestimation, the data on hospital discharges to care homes during Wave 1 of the pandemic provided to the NAO in June 2020 for the purposes of the NAO report *"Readying the NHS and adult social care in England for Covid-19"* was calculated by reference to (i) the SUS data on care home discharges; and (ii) an estimate of discharges to care homes which would have been recorded as "usual place of residence" in the SUS data.

357. That analysis showed that a smaller number of patients (c. 25,000) had been discharged to care homes in the period between 17 March – 15 April 2020 compared to c. 35,000 in the same period in 2019. The reduction in the number of hospital discharges to care homes during Wave 1 was likely as a result of a combination of factors, including the decrease in the number of hospital admissions for conditions other than Covid-19 and the suspension of elective surgery.

358. With a view to obtaining daily information on hospital discharges, from 8 April 2020 Daily Patient Discharge SitRep and Additional Covid-19 SitReps were established by NHS England to receive additional information from providers across the country which was not otherwise covered by the Daily NHS Provider SitRep. The supplementary Covid-19 SitReps established during the pandemic (Daily Patient Discharge SitRep **[AD1/068 INQ000270126]**) included data showing the number patients and setting into which patients were discharged.

359. On 23 December 2020, NHS England circulated a letter to all Trusts setting out changes to Acute Daily Discharge and Community Daily Discharge SitReps. More granular detail was needed in order to monitor the impact of the Government's recent designated settings guidance and the mandatory arrangements introduced in it to support safe and timely discharges and protect care home residents and staff from Covid-19 throughout winter **[AD1/069 INQ000269989]**, namely:

a. the requirement that every patient discharged to a care home must have a Covid-19 test within 48 hours prior to discharge (unless they have tested positive in the previous 90 days); and

b. the requirement that every patient with a Covid-19 positive test being discharged to a care home be first isolated into a designated setting.

360. As detailed above, data was already being collected from care homes on a daily basis of the numbers of residents being discharged from hospital with or without a Covid-19 test. The new data collection was acute level data specific to the designated settings policy implementation.

361. In light of the above, the letter requested all Trusts to collect, from 30 December 2020, daily data in respect of (among other things) the following questions:

a. Of the people who are to be discharged to a care home, the total number who continue to reside in hospital because they have not received a Covid-19 test result within 48 hours of their prospective discharge (unless this is not required under the terms of "Discharge into care homes: designated settings")

i. Who have a length of stay of 14 days and over

ii. Who have a length of stay of 21 days and over

362. The datasets **[AD1/070 INQ000270114**, **AD1/071 INQ000270115]** contain the above discharge delay data collected respectively via Acute Discharge Daily SitReps (between 29 December 2020 and 28 June 2022) and Community Discharge Daily SitReps (between 29 December 2020 and 18 April 2022).

363. Broadly, the data suggests that from the end of December 2020, delayed hospital discharges due to patients:

a. still residing in hospital because they had not received a Covid-19 test result within 48 hours of their prospective discharge; or

b. because they were awaiting a place in a designated setting

constituted a very limited proportion of overall hospital discharges.

364. By way of example, in January 2021:

a. Delayed discharges from acute beds due to either of the above reasons in England only amounted to approximately 0.3 to 0.4% of all acute bed discharges (i.e., approximately 200-300 patients / day), and dropped to approximately 0.2 to 0.3% in February 2021.

b. Delayed discharges from community beds due to either of the above reasons in England only amounted to approximately 1.1 to 1.7 % of all community bed discharges (i.e., approximately 60 to 1 10 patients / day), and dropped to approximately 0.7 to 1.1 % in February 2021."

Hospital Discharge Funding

365. As explained above, D2A is a pathway whereby patients are discharged from acute hospital care at the point at which it is no longer needed. Under this model, rapid discharge from an NHS bed is directly facilitated by ringfenced care and support to maximise a patient's ability to recover and any further health or social care assessments are delivered outside of the acute hospital environment. This includes developing a care plan for intermediate recovery services after discharge, before an assessment of longer-term care needs including a Continuing Healthcare ("**CHC**") Assessment or Care Act assessments.[19]

366. D2A was scaled up nationally at the start of the pandemic with an indicative fund for recovery services. These arrangements made significant progress in reducing pressure on acute hospitals. The scheme enabled those considered as medically fit for discharge to be discharged before the CHC assessment / Care Act assessment could be carried out, thus negating unnecessary delays in discharge. At the end of the intermediate recovery period, patients were then assessed for CHC eligibility or other ongoing care where appropriate and usual sources of funding should have paid for this care.

367. Under the first iteration of the scheme (between 19 March and 31 August 2020), CHC assessments, the 3 and 12 month CHC reviews and individual requests to review

[19] In BAU times, the decision about eligibility for a full assessment for NHS CHC should usually be made within 28 days of an initial assessment. If a person is not eligible for CHC they can be referred to the local authority for assessment under the Care Act.

eligibility decisions (local resolution and independent review) were temporarily suspended in their entirety and the care plans for intermediate recovery after discharge were relied on in the interim.

368. From 1 September 2020 DHSC instructed CCGs to reinstate routine NHS CHC assessment processes alongside the management of NHS CHC work that had been deferred between 19 March and 31 August 2020 **[AD1/063 INQ000270064]**. The NHS CHC Restoration and Recovery Programme provided £50m to CCGs (performance monitored by a Programme Board) to restore CHC from 1 September 2020 with completion by 31 March 2021.

369. However, the DHSC hospital discharge policy and operating model published in August 2020 introduced a change of process for the discharge to assess approach. From 1 September 2020, for those individuals being discharged from hospital, an assessment of the individual's longer-term care needs, including Care Act and NHS CHC assessments, would be undertaken during the individual's period of funded recovery services, which was supported by £588m of additional funding made available by HMT to supplement CCG and local authority spend for all patients' post-discharge recovery and support services, rehabilitation and reablement care following discharge from hospital for up to six weeks **[AD1/063 INQ000270064]**.[20]

370. According to an assessment by NHS England in February 2021, the additional funding demonstrably generated major and sustained improvements in length of stay (in both acute and community beds) and that the funding enabled 6,702 NHS beds to be freed up (the equivalent of 13.5 hospitals). Critically, given the workforce shortages, it also resulted in freeing up over 11,000 members of staff including circa 6,800 qualified nurses **[AD1/059 INQ000270006]**.

371. NHS England sought to have this funding extended beyond March 2021 and following discussion with the Government, the Government agreed to fund, via the NHS, new and extended packages of care on discharge from hospital until 30 September 2021 as follows:

[20] The national discharge fund was later also made available to fund the additional costs of designated care settings for those discharged from acute care who were COVID-positive and could not return directly to their own care home until 14 days of isolation had been undertaken.

a. Patients discharged between 1 April 2021 and 30 June 2021 (inclusive) would have up to six weeks of funded care following hospital discharge;

b. Patients discharged between 1 July 2021 and 30 September 2021 (inclusive) would have up to four weeks of funded care following hospital discharge.

372. In September 2021 the Government agreed to continue to fund the first four weeks of post-discharge recovery and support services provided on or before 31 March 2022 for those with new and additional care needs. The scheme ended on 31 March 2022 and no longer funded care delivered after that date **[AD1/072 INQ000470550]**.

373. For completeness, the total CHC spend following consideration of patients' CHC needs reported by CCGs on D2A during the Relevant Period (including NHS CHC, Children and Young People's Continuing Care, Funded Nursing Care and Joint Funding) was:

a. £5bn in 2019/2020

b. £6.3bn in 2020/2021

c. £6.1bn in 2021/2022

Impact of Hospital Discharge Guidance

374. We have been asked to set out NHS England's understanding of the impact of the Hospital Discharge Policy on care homes, their residents and recipients of care. In terms of impacts on care home residents, we note that in subsequently assessing the epidemiological and genomic evidence, the UK Chief Medical Officers' Technical Report found that although some care home outbreaks of COVID-19 were introduced or intensified by discharges from hospital into care homes, "*hospital discharge does not appear to have been the dominant way in which Covid-19 entered most care homes*" and stated that there is genetic evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community. While comparisons are difficult, the correlation with community rates appears also to match the international evidence. **[AD1/073 INQ000203933]**.

375. The above results appear largely consistent with the fact that the number of social care staff going in and out from care homes to the community every day (in the scale of

hundreds of thousands) was far greater than the limited daily number of patients (circa 1,000/day) being discharged from hospital to care homes during the relevant period.

376. While the above does not of course take away from the fact that both the UKHSA and PHS analyses referred to in the "*Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes*" identified "*a small proportion of outbreaks which could have been seeded by a hospital discharge of someone who had tested positive for Covid-19"* **[AD1/074 INQ000215624]** it remains NHS England's view that the Hospital Discharge Policy was a necessary and rational policy having regard to:

a. The RWCS modelling regarding 'overwhelm' in Wave 1;

b. The vivid evidence of the strains actually experienced by hospitals during this period; and

c. The risks presented by continuing stays in hospital, redoubling efforts to ensure that those who were not in need of clinical care were discharged was a necessary and rational policy.

377. It is not helpful to characterise hospital discharge as shifting "the burden" of care to the community. This pits the two sectors against each other when both were under unprecedented strain.

378. Testing policy as at 17 March 2020 was a product of the (very limited) availability of tests (some 3000 per day, nationwide on 11 March 2020), and was determined by PHE, approved by the SSHSC. Only PCR tests were available, so there were delays between testing and delivery of results. Thus testing before discharge was not an available option at the outset of Wave 1. Government policy shifted as more tests became available (by 15 April 2020). By Wave 2 the situation had again changed, and additional measures were introduced by DHSC such as discharge of Covid-19 positive patients to 'designated settings'. In addition, discharge testing did not remove the need for effective isolation, including good IPC, in reducing the risk of infections into and within residential care settings.

379. In terms of broader impacts of the policy on hospital flows and recipients of care, one of the stated aims of the measures in Wave 1 was to release 15,000 beds, as patients became fit for discharge. The immediate impact was to reduce long stays significantly. Although these stays then trended back upwards over time, they remained lower than before the pandemic. The changes in length of stay are measurable, and a proxy for 'beds' in this context. It is more difficult to determine whether the policy met its aim of releasing 15,000 beds as so many factors were in play – not only falling bed occupancy caused by drops in the numbers attending hospital and due to the cancellation of elective procedures, but also because some hospitals started to take measures to accelerate discharges in advance of the national policy. Even in such cases, the clarity of the national policy was welcomed.

380. NHS England understands that the policy's impact was variable across different Trusts, and owed much to the strength of the existing teams working to secure prompt discharge. When relationships were already in place, the policy was more effective. The NIRB report of May 2020 identified c.4000 staff freed up from not doing CHC assessments, to support discharges.. The NHSE analysis conducted in February 2021 suggested that "Critically, given workforce shortages" the D2A model was freeing up 11,000 members of staff **[AD1/059 INQ000270006]**. Given the strains on staff, this was significant.

Section 5: Infection Prevention Control and Personal Protective Equipment to Care Homes

Executive Summary

381. NHS England had no formal responsibility for infection IPC or PPE training in care homes prior to the pandemic. Responsibility for adult social care, including care home provision and associated IPC measures, was primarily shared between DHSC, the CQC, local authorities and individual care home providers. Unlike the NHS, there is no single coordinating body for adult social care, and the sector comprises a large number of independent providers. In the absence of a centralised organisation with formal responsibility, there was no overarching mechanism for coordinating IPC training across the sector.

382. Whilst NHS England was not responsible for adult social care, it provided significant support and input into training related to IPC guidance for care homes and assisted with a training programme which was rapidly rolled out to care homes, referred to as the "Covid 19 Care Homes IPC Training offer" to address the gap in coordination and based on expressed need by the sector. The purpose of this training was to ensure that adequate and consistent IPC training was available to care home staff, which included training in respect of PPE use. As NHS England was not responsible for the provision of training in the care home sector, it could not mandate uptake, and normal governance and accountabilities to statutory bodies remained in place throughout the Relevant Period.

NHS England's Covid-19 IPC training offer to care homes

383. As part of the 29 April 2020 NIRB approval of an offer of support to care homes and care home providers, care homes were to be offered a package of training and education to be delivered locally. This was initiated following feedback from the care home sector, that they would benefit from more IPC support. The training was led by the Deputy CNO for Professional and System Leadership, supported by the Regional Chief Nurses and overseen by the Discharge and Social Care Cell.

384. The scope of the programme was national. Each of the 135 CCGs in England were expected to offer training to every care home registered in their geographical footprint (covering a total of 15,027 care homes in England). The request was made on an urgent basis with offers required to be made by 4 May 2020 with immediate action to mobilise the offers taken thereafter **[AD1/075 INQ000331020]**. Interest in this offer was monitored by a weekly situation report from May 2020 to early June 2020.

385. NHS England rolled out this training over the first three weeks of May 2020 and "super trainers" were then asked to train sufficient local trainers to rapidly enter care homes to deliver face-to-face training (unless individual care home circumstances meant that virtual training was more appropriate e.g. if the care home was self-isolating).

386. A range of outputs were provided to support super trainers, local trainers, and CCGs in the delivery of the training, including PHE approved core training content; training support and tools; train the trainer guidance; SitRep reports to track delivery and

outcomes; regional support leads; weekly national webinars and weekly calls with Regional Chief Nurses.

387. By the middle of July 2020, a formal training offer had been made to almost every care home in England.

388. On 21 July 2020, the data from the final SitRep for the care home IPC training was shared. This showed that 76.8% of care homes had received training, training had taken place in 11,509 care homes to date and that 23.2% declined training and the reasons had been documented locally **[AD1/076 INQ000330953]**. These included care homes having already received relevant training from local authorities or CCGs, relying on in-house training capacity (particularly within larger care homes groups), and operational pressures such as closures, delayed openings or limited staff availability.

389. An evaluation report was compiled in September 2020 entitled "Evaluation Report: Care Home mutual aid IPC training support" **[AD1/077 INQ000330954]** following feedback from care homes and set out feedback, successes, lessons learnt and recommendations. A briefing dated 14 September 2020 entitled "Care Home training: Infection Prevention and Control" **[AD1/078 INQ000330955]** was also prepared updating the Chief Nursing Officer about the outcome the programme.

NHS England's role in procurement of PPE for Adult Social Care

390. The requirement for PPE significantly increased in the health and social care sectors during the Covid-19 pandemic. The global rise in demand for PPE impacted the Government's ability to procure and supply this equipment. The response to this challenge was led by DHSC and the Government, but NHS England played a vital role in supporting its partners, ensuring that DHSC understood the demand within the NHS and working with DHSC and the army to ensure that available PPE was rapidly distributed to those healthcare providers in most need.

391. Before the pandemic, responsibility for managing PPE supply and stockpiles was spread across multiple public bodies and private sector contractors. Local health and social care organisations sourced PPE either directly through suppliers, many of whom were wholesalers who bought their products in what was essentially a commodity market and did not have direct relationships with manufacturers. There was also an influenza

stockpile managed and owned by PHE on behalf of DHSC, and a separate, smaller DHSC stockpile held to mitigate potential EU Exit disruption. NHS England was not responsible for PPE supply and so would not have been sighted on stock levels of PPE within the system.

392. NHS Supply Chain faced unprecedented challenges with the increased demand for PPE, global market conditions and pressure on existing infrastructure. The Parallel (PPE) Supply Chain was established by DHSC in March 2020.

Roles

393. As a commissioner of health services, rather than the purchaser of the materials and products used by those delivering health services in England, NHS England is not responsible for the purchasing of PPE on behalf of NHS providers. Purchasing and procurement decision-making generally falls to individual providers who buy the goods and services they need to support service delivery to their local populations.

394. However, NHS England adopted a supporting role in the supply, demand and distribution of PPE alongside various other organisations and groups who were responsible for the supply and distribution of PPE. A summary of the organisations involved in the supply and distribution of PPE during the pandemic along with their roles is set out below.

SSHSC and DHSC

395. SSHSC had primary responsibility for buying PPE. This remained the case in the pandemic with purchase decisions remaining with the Director General, advised and supported in a multi-agency response described further below. DHSC was also directly responsible for PPE distribution.

DHSC PPE Cell

396. DHSC established a “battle plan” in March 2020 to organise various key workstreams (resilience for the NHS, adult social care, supply and distribution, testing, technology accelerating new interventions, social distancing and shielding).

397. Representatives from NHS England worked with DHSC within these workstreams, which included PPE. This was also known as the PPE Cell but to avoid confusion with NHS England's cell, we refer to it as the "DHSC PPE Cell".

398. Twice daily DHSC PPE Cell meetings were put in place in the pandemic. The 08:30 meeting was in place from 28 March 2020 and the 18:00 from early April:

a. The first meeting would take place at 08:30 (example minutes from one such meeting are attached at **[AD1/079 INQ000330856, AD1/080 INQ000330857]**) which brought together representatives from across the DHSC PPE Cell, including logistics, military support, finance, technical assurance, and the buy team's guidance. The meeting was focused on reviewing the work plan and ensuring tasks were appropriately allocated. In these meetings the 'buy' list was reviewed based on that day's intelligence on demand and inventory in the warehouse on one hand, and on intelligence from the 'buy' team about deal availability on the other. Later in April 2020 the buy list also started to be informed by supply in transit, although this data remained patchy until the end to-end supply chain data was secured in mid-summer. In May 2020 it started to be informed by inventory at site level and usage rates. This guidance was used by the buy team to prioritise deals, and by the DHSC Finance team as input to their final review and sign off of each deal.

b. The second meeting took place at 18:00 and focused on reviewing the overall situation and making distribution allocations to be enacted overnight. The second meeting was attended by the Chief Commercial Officer ("**CCO**") and all relevant stakeholders as well as the DHSC SRO, other representatives of DHSC, the army, and NHS England. These updates included National Supply Distribution Response ("**NSDR**") overnight feedback, a PPE dashboard, distribution and buying priorities given the forecasted position based on the latest data and modelling.

PHE

399. PHE owned the pandemic flu ("**PIPP**") stockpile and was responsible for publishing IPC guidance. The PIPP stockpile, which contained around 400 million items of PPE for use during an influenza pandemic, was owned and managed by PHE on behalf of DHSC

(which set the policy for the stockpile). DHSC managed a smaller stockpile which was held in case of disruption following a 'no deal' EU Exit.

NHS England and NHS England's Chief Commercial Officer

400. Prior to the pandemic, NHS England had no direct involvement in the purchase of PPE or its distribution, including no role in estimating the required national supply of PPE for routine use and pandemic use. During the pandemic, NHS England assisted DHSC and its partners with understanding the demand signal from the NHS and therefore the related distribution of PPE to the healthcare system.

401. The demand for, supply and distribution of goods are closely linked. During the pandemic, as a result of this, NHS England's Chief Commercial Officer ("**CCO**") became very closely involved in the Government's response. As part of the 'all hands on deck' approach, NHS England's CCO was designated the SRO for the Oxygen & Ventilation and Medical Devices & Clinical Consumables Group. As part of this role, she reported into the Cabinet Office and No.10 and initially attended DHSC weekly meetings to explain what the NHS needed in terms of urgent supplies.

402. Similarly, she was subsequently closely involved in assisting DHSC with PPE matters and was ultimately seconded to DHSC to join up supply affairs, team leadership and to support the Government's efforts to source PPE. During the period under review, she also continued to report regularly to NIRB. She provided leadership to the DHSC PPE Cell alongside a DHSC SRO but was not the accountable officer for PPE. As such, whilst she could make recommendations in relation to what decisions she believed should be taken - including regarding PPE purchases, strategic decisions and entering into contracts for the purchase of PPE - decision-making on those matters rested with DHSC. Given the urgency of the situation, some day-to-day operational decision-making (i.e., regarding distribution) was shared between the DHSC SRO and the CCO as required, depending on individual capacity and availability.

NHS Supply Chain

403. NHS Supply Chain (a trading name) was created by DHSC in 2006 to provide the NHS with goods. NHS Supply Chain manages the sourcing, delivery and supply of healthcare products, services and food for Trusts and healthcare organisations across England and

Wales. Social care providers and GP practices bought their PPE directly from PPE suppliers – mostly wholesalers.

404. Supply Chain Coordination Limited ("**SCCL**") is the legal body and management function for the NHS Supply Chain operating model. SCCL was incorporated in 2017 and set up in 2018 by DHSC to manage the NHS Supply Chain. It operated as a small management function and outsourced the procurement of goods and services through 11 specialist buying functions called "towers". Towers procure goods via framework agreements. By way of example, three of the 11 towers dealt with PPE. SCCL also operated a logistics operation which it outsourced. During the pandemic, Unipart Logistics was the provider of logistics services to NHS Supply Chain which included delivering all aspects of the logistics, from inventory management to delivery. SCCL aims to deliver savings to the NHS via economies of scale and to increase the volume of Trust procurement through the NHS Supply Chain. During the pandemic, the NAO report **[AD1/081 INQ000145895]** "*The supply of personal protective equipment (PPE) during the Covid-19 pandemic*" confirmed that nine types of PPE products were provided by 24 suppliers under SCCL frameworks.

405. Thus, while SCCL was responsible for the management of the NHS Supply Chain, it contracted out both procurement and distribution of PPE to contractors, which in turn contracted with PPE suppliers.

406. In 2018, DHSC announced that it intended to transfer SCCL to NHS England and Improvement. To plan for the proposed transfer, in July 2019, the then National Director for Transformation and Corporate Operations at NHS England and the then Director of M&A and New Organisational Models at NHS Improvement (now NHS England) joined the SCCL Board. Due to the pandemic, the ownership of SCCL did not transfer from DHSC to NHS England until 1 October 2021. For the majority of the pandemic, therefore, SCCL remained under DHSC.

Parallel Supply Chain

407. The Parallel Supply Chain was established by DHSC in late March 2020. This aimed to urgently and centrally source and distribute PPE to Trusts and other health and care providers by obtaining PPE through SCCL's existing suppliers, new suppliers and new UK manufacturing. This entailed harnessing the wider resources of government including

Department for International Trade ("**DIT**"), Foreign, Commonwealth and Development Office ("**FCDO**"), the Ministry of Defence ("**MOD**") and the Cabinet Office, because of the nature of amongst other things the due diligence needed to assess foreign unknown suppliers.

408. The Parallel Supply Chain included a team of around 450 staff to find and buy PPE, plus a new distribution system. It performed five key functions: to Plan, Source, Make, Order and Deliver.

PPE supply, demand and distribution for Wave 1

409. On 27 January 2020, in expectation of a pandemic requiring PPE measures, NHS England's National Director for Emergency Planning and Incident Response approached DHSC to discuss concerns regarding the PPE stockpile **[AD1/082 INQ000330791, AD1/083 INQ000330792, AD1/084 INQ000330793, AD1/085 INQ000330794, AD1/086 INQ000330795]**.

410. Around this time, at a very early stage of the pandemic and before Wave 1 had taken hold, NHS England was aware of concerns regarding PPE shortages. On 2 February 2020, for example, NHS England's IMT received an informal suggestion of PPE shortages in an ICU in the North West via an email from a clinical director in NHS England. The IMT also noted that the PHE modelling on the Wuhan outbreak may only represent 5% of cases. No specificity was provided in the email about the extent of the shortages; just that stock levels appeared low and there seemed to be a lack of adequate eye protection to prevent corneal transmission **[AD1/087 INQ000409918]**. NHS England escalated this matter to DHSC during a routine call and DHSC's, Head of the Procurement agreed to investigate any reports of shortages. Alongside this, NHS England sought further information from its Regional Team in relation to the products which were reportedly in short supply, which included what action had been taken to address any shortages and whether mutual aid had been sought. At that time, NHS England was engaging with DHSC and NHS Supply Chain about the stockpiles of PPE and consumables held for pan-flu and EU Exit and had also asked trusts to undertake an assurance process resulting in the IMT report of 1 February 2020 confirming "*Generally adequate supplies of PPE reported, organisations reporting deficiencies to be followed up by regions*" **[AD1/88 INQ000409919]**. On 11 February

2020, as part of a longer letter to NHS customers about measures the Government was taking in response to the outbreak and requesting some precautionary actions, DHSC asked them to monitor orders carefully and consider demand management plans in the event of excessive or unusual ordering patterns and to inform the DHSC of the outcomes of supply chain risk assessments **[AD1/089 INQ000049357]**.

411. NHS England had a key role in communicating information to the system, such as what actions organisations should take and how providers should access PPE. On 2 March 2020 NHS England issued a letter to the NHS system: 'Covid-19 NHS preparedness and response' **[AD1/015 INQ000087445]**. This letter asked all NHS organisations, amongst other things, to:

a. Ensure that procurement teams have processes in place to monitor clinical consumables (including PPE);
b. Ensure that stock levels are maintained but not stockpiling in individual organisations;
c. Review business continuity arrangements;
d. Work with local social care partners to ensure they are prepared to manage the impact of Covid-19 on their residents, including infection prevention control measures; and
e. Notify NHS England's EPRR of anything that is or may affect service delivery.

412. On 10 March 2020, NHS England's CEO asked NHS England's CCO to investigate issues arising with PPE and discuss these with DHSC. The CCO was well-placed to have these discussions given that she held a place on the SCCL board. The CCO raised the matter with SCCL's CEO and the Chair that same week. The matter was subsequently raised during a meeting the CCO attended with Government ministers in the Cabinet Office on 17 March 2020.

Distribution

413. Immediately after the above meeting with Government ministers, NHS England's CCO and a member of the Cabinet Office contacted Unipart Logistics, the company that SCCL

used for its logistics provision, to ascertain capacity and to explain that it would need to significantly increase the throughput of its logistics. Within 24 hours, Unipart confirmed that it had already upscaled staffing in its logistics centres and did not have the capacity to expand further. In parallel, it had become clear from the work undertaken to date that SCCL's 'just in case' stockpiles, infrastructure and processes were insufficiently equipped to meet the unprecedented PPE demand pressures, primarily because SCCL had not been established for this purpose.

414. NHS England's CCO suggested that military support would be needed to review the logistical capacity issues and this was accepted. A NIRB briefing on 13 March 2020 **[AD1/090 INQ000330804]** on the supply of PPE confirmed that new structures were being put in place with NHS England and DHSC It also confirmed that PIPP stock was being released to alleviate pressure and that there would be a focus on developing specifications to enable UK manufacturing of PPE.

415. Military support was subsequently secured at strategic level. Over the course of the weekend of 21-22 March 2020 the military identified that a separate logistics solution would be required to deal with increased demand and distribution of PPE to the 232 NHS Trusts in the system. The Parallel Supply Chain was established by DHSC in late March 2020. Between the SCCL supply chain and the Parallel Supply Chain, there was now a need to support over 34,000 customers, including Trusts, primary and community care providers (i.e., GPs, pharmacists, dentists etc).

416. The Parallel Supply Chain also developed mechanisms to support adult social care providers, supplementing the supply going from the pandemic stockpile via their usual wholesalers, as well as other institutions who did not have a dedicated supply chain, such as hospices.

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

418. In the meantime, following the announcement made by the Government of the move from the 'contain' to the 'delay' phase of the virus (on 12 March 2020), NHS England wrote to the NHS system on 17 March 2020 setting out next steps in the Covid-19

response **[AD1/016 INQ000087317]**. The letter instructed the NHS to prepare for and respond to large numbers of in-patients requiring respiratory support and confirmed that there was a dedicated line and email for local issues with PPE distribution. This dedicated line ("**NSDR hotline**") was set up by DHSC's National Supply Disruption Response ("**NSDR**") centre, which had already undertaken work to prepare for potential supply disruptions emanating from a possible no deal EU Exit.

419. The NSDR system was an emergency helpline for health and care providers to report shortages of stocks. The system could also provide immediate stocks to providers in danger of having to suspend services. The unit was staffed largely by NHS England staff and contractors.

Supply

420. Whilst SCCL was placing orders for PPE with its suppliers, it became apparent that due in part to the outsourced supply structure and in part due to the nature of the global wholesale market for PPE, it had no means of understanding when those orders would be received. Manufacturers were receiving orders from around the world due to increased demand and wholesalers did not have the means to ascertain the priority of one order over another. Stockpiles were being used rapidly, and suppliers were alerting SCCL to the fact that securing supplies to meet commitments was increasingly challenging.

421. Additional activities were commissioned by the Government to build more security into the PPE supply chain – specifically to secure more domestic supplies via a "UK make" initiative to increase UK manufacturing capability, as well as an investigation into opportunities to reuse PPE. It became clear very quickly that both these activities would take several months to have any impact on usage and supply, and therefore the Government's focus had to be on rapid purchasing of PPE.

422. The market was extremely 'hot', with deals often failing within minutes of being confirmed, due to competitive bidding by other entities. Any deal was subject to technical assurance and financial diligence.

423. The "buy" team within the Parallel Supply Chain focused both on buying more from existing suppliers (as a first priority), and also finding new sources of supply. Most of these new opportunities were in China. The supply chain team worked both to identify suppliers who acted as intermediaries in the market - which was the case for most of the existing suppliers to the NHS - and to work directly with manufacturers. It is not possible to overstate how challenging the purchasing and supply environment was at the time.

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

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

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

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

projected stock arrivals into the UK. In the interim this data was collated manually from various systems and presented at the distribution meetings.[23]

426. DHSC used information from NHS England's modelling as set out above, which enabled a shift in the way PPE was distributed to Trusts from a "pull" to a "push" system. This meant that DHSC "pushed" PPE to providers based on the expected number of Covid-19 patients. This reduced the load on Trusts regarding the need to predict and order against their needs. It also simplified the distribution system and provided insight into purchasing needs.[24]

427. The DHSC PPE Cell also initiated work in May 2020 to build improved data flows on supply into the UK, linking the buying data on orders placed with fulfilment and international logistics. This work was largely complete by the end of July, at which point the end-to-end system was better placed to guide operational decision-making.

428. In the meantime, on 10 April 2020, DHSC published its PPE Plan **[AD1/091 INQ000050008]**, which confirmed the processes for delivery of PPE to various parts of the system as follows:

> *Supplying PPE to social care providers*
>
> *We are working around the clock to ensure those working in social care are receiving the PPE they need. This is a sector where we have seen a significant spike in demand for PPE to ensure some of the most vulnerable in our communities are protected.*
>
> *As an initial step, social care providers across England received an emergency drop of 7 million items of PPE, so that every CQC registered care home and social care provider received at least 300 face masks to meet immediate needs.*
>
> *Starting in the week beginning 6th April 2020, we have authorised the release of a further 34 million items of PPE across 38 local resilience forums (LRFs), including 8 million aprons, 4 million masks and 20 million pairs of gloves.*

[23] The model was developed using a spreadsheet but later moved to NHS Foundry
[24] The model was later supported on the NHS Foundry platform.

The additional PPE stocks distributed to LRFs will be managed and distributed via Local Authorities and should primarily to be distributed to health and social care settings. If necessary, this equipment can also be used for wider public services where LRFs identify need and in line with the clinical need as advised by PHE clinical guidance on PPE.

We recognise that the social care sector operates differently to the NHS, and we need to take different steps to ensure that providers can continue to access PPE. 23 million items of PPE have been released to designated wholesalers for onward sale to social care providers. We have made arrangements with seven wholesalers to supply PPE to the social care sector. Careshop, Blueleaf, Delivernet, Countrywide Healthcare, Nexon Group, Wightman and Parrish and Gompels will all provide supplies to care providers registered with the Care Quality Commission.

We have taken further steps to make it easier to get PPE. DHSC, NHSE&I, NHS Supply Chain, Clipper logistics and the Armed Forces are working together to develop a Parallel Supply Chain (PSC) to support the normal supply chain. This is a dedicated channel for critical PPE, and core PPE products for Covid-19 are flowing through this.

The PSC is supporting improved speed and reliability of delivery for these items, whilst relieving pressure on the established supply chain so that it can deliver 'business as usual' products. The PSC is intended to service social care providers, as well as others across the health and care system.

This is in addition to a new website for ordering PPE, described in more detail below, which we aim to expand to service social care providers."

PPE supply and distribution after Wave 1

429. By June 2020, DHSC had established a portal which enabled NHS providers to place orders for PPE and for DHSC to monitor the data. The portal was a partnership between DHSC, NHS Supply Chain and Clipper Logistics, Unipart Logistics and distribution suppliers. The PPE portal could be used by social care and primary care providers to get critical Covid-19 PPE. Providers who could use the service would receive an email

invitation to register. A provider could only log in and place an order if they had received an email invitation. In June 2020 the PPE portal could be used by:

a. GPs

b. residential social care providers

c. domiciliary social care providers

d. pharmacies

e. dentists

f. orthodontists

g. optometrists

h. children's care homes and secure homes

i. all special schools and special post-16 institutes

j. community drug and alcohol services

k. residential drug and alcohol services

l. independent sector providers (ISPs) providing NHS services

m. vaccination sites and vaccination centres

n. hospices

o. health and social care settings that were previously supplied via their local authority or local resilience forum (LRF).

430. Demand started to level out by July/August 2020 and a more normalised buying pattern resumed.

431. On 28 September 2020 the Government produced the Personal Protective Equipment (PPE) strategy ("**PPE Strategy**") **[AD1/092 INQ000234522]** to stabilise and build resilience. This anticipated that by November 2020 a 4-month stockpile would be in

place for all products. This strategy confirmed that DHSC would provide PPE to meet the requirements of all health and social care providers in England to support their Covid-19 needs, as well as other public sector organisations such as prisons and the police force until March 2021 at the earliest, with a decision on future procurement to be made in the next year.

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

433. In her evidence **[AD1/093 INQ000087462]**, the CCO explained that the focus of the PPE strategy was on building up sufficient supplies for the winter. By that time, for most items, there was already four months of supply either in the country or with UK-based manufacturers. She confirmed that she was '99%' sure that that would be the case for all items by the beginning of November 2020. Work was being done with Trusts to make sure that they did not just have a set of items, but particular items that were actually required. She also explained that they were continuing to develop the PPE portal (which by that time had been established for PPE requirements) so that smaller volume users such as GPs and smaller social care homes could order exactly what they needed via the portal.

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

Section 6: End of Life Care, DNACPRs and Visitors Guidance

Executive Summary

435. NHS England's role has been set out to a large extent in NHS England's Third Module 3 Statement, but is outlined here for the purposes of this statement.

436. The Covid-19 pandemic presented a number of challenges to palliative and end of life care (i) ensuring capacity continued to be available within the system for Covid-19 and non-Covid-19 patients (ii) the rapidly developing understanding of the clinical implications of Covid-19 at end of life including symptom management (iii) rapid upskilling of non-specialists in palliative care (iv) shortages of key palliative and end of

life drugs (v) significant issues obtaining consistent and reliable PPE for palliative services (v) addressing concerns within the system when examples of inappropriate practice arose, i.e. the application of blanket DNACPRs and (vi) the impact of visitation limitations on those at end of life.

437. NHS England recognised the importance of ensuring people requiring palliative and end of life care, irrespective of setting, continued to receive high-quality care and support throughout the Covid-19 pandemic. This was supported by measures already outlined in this Statement, the EHCH framework, which increased the level and quality of care delivered to care home residents, including access to adequate and timely medication and equipment, direct and specialist support when required and education and training for care home staff. Additional support was also provided to the system, such as regular national webinars and more localised regional support.

Palliative and End of Life Care

438. This section explains NHS England's involvement in palliative and end of life care in the context of those in receipt of adult social care and in care homes during the pandemic, in particular in relation to any concerns raised in palliative care during the pandemic and NHS England's involvement in any related guidance.

What is Palliative and End of Life Care?

439. Palliative care provides support for people who have an incurable illness. The aim of palliative care is to provide personalised care and make a person as comfortable as possible via a holistic approach; both through managing physical symptoms and by providing psychological, social, and spiritual support. This support is available when a person is first made aware of their life-limiting (terminal) illness and should also extend to family and carers. This care is provided to people in the community as well as in care homes and hospitals and applies to all who need it including children and young people ("**CYP**"), people receiving care or treatment through mental health & learning disabilities services, and those in health and justice settings. People requiring palliative and end of life care are supported by variety of healthcare professionals, depending on their level of need which may change over time, and includes GPs and community nurses as well as specialist palliative care healthcare staff.

440. End-of-life care and support provided to people who are likely to be in the last 12 months of their life aims to help a person to live as well as possible until they die, and to die with dignity. People are considered to be approaching the end of life when they are likely to die within the next 12 months, although this is not always possible to predict. NHS England recognised early in the pandemic that a significant part of the NHS response to Covid-19 would include supporting patients with Covid-19 at the end of their lives as well as continuing to care for those dying with and from other conditions.

441. When treating a patient who may deteriorate significantly, advance care planning should be offered, to ensure the person has the opportunity to have their wishes and preferences recorded and considered in future decision-making. End of life care can include input from GPs, community nurses, specialist doctors, nurses and therapists, hospice staff, care home staff, hospital staff, pharmacy teams and social care staff. GPs have overall responsibility for those being cared for at home or in a care home, whereas those receiving hospital care will be cared for under the responsibility of the hospital staff within that provider Trust.

Palliative and End of Life care during the pandemic

442. NHS England recognised the important role that palliative and end of life care would have in the pandemic. On 3 March 2020, NHS England established the End of Life Covid-19 cell ("**EoL cell**"). Its initial purpose was to achieve the following:

a. Ascertain security of supply chain for essential medicines (led by the Medicines Cell and clinically informed by the NCD for End of Life Care) and equipment, including syringe drivers;

b. Explore service capacity in non-hospital provision to enable escalation of response when expected numbers of dying people increased alongside a potential reduced availability of carers. This was to include checking system resilience, mechanisms for monitoring patients who lived alone in the community, and provision of remote advice and support;

c. Develop guidance and training relating to: (a) care of those dying with/from Covid-19 in hospital (b) care at and after death (c) end of life care in the community and (d) guidance for hospices; and

d. Ensure systems were in place for verification and certification of death, care after death, and removal of deceased people, handling of redundant medicines and equipment when deaths take place in the community.

443. The work of the EoL cell was supported by an operational response plan in an Operational Framework Document **[AD1/094 INQ000331018]** dated 7 April 2020 containing relevant workstreams.

444. In Wave 1 the EoL cell ensured that:

a. Working with the medicines cell and shortage teams, a priority list of essential medicines for end-of-life care was identified so that supplies could be monitored and secured.

b. the Nightingales team took EoL considerations into account in the development of each site.

c. guidance was made available to support hospitals to make care as compassionate and personalised as possible for inpatient settings. Further reference to guidance issued on this topic is covered from paragraph 451 below.

445. The EoL cell worked closely with the medicines cell to identify a short priority list of essential medicines for end of life care with the National Clinical Director for Palliative and End of Life care ("**PEoLC**") and other experts in this area so that supply could be monitored and secured. An end of life primary care formulary based on current medicine supplies was produced in conjunction with the NCD for PEoLC, the Royal College of General Practitioners, the Association for Palliative Medicine of Great Britain and Northern Ireland, and the Association of Supportive and Palliative Care Pharmacy. Additionally, NHS England asked CCGs to set up anticipatory hubs for end of life medicines for care home residents out of hours.

446. During the recovery phase of Wave 1, the EoL cell's objectives evolved to ensure business continuity for existing and new patients requiring palliative and end of life care,

including those whose needs had become more complex during the Covid-19 pandemic, and to enable the system to maintain and re-intensify the scale of care and support needed for additional people dying as a result of Covid-19. This included an increased need and complexity of bereavement support required for families and staff.

447. The main focus of the EoL cell in responding to Wave 2 was to support PEoLC staff and services at provider level. This took place via Strategic Clinical Networks, maintaining close communication with stakeholders and continuing vigilance to monitor levels of essential medicines and supplies, whilst working closely with the relevant teams responsible for those areas. The cell worked closely with external organisations, including the voluntary sector, clinical leaders, external partners (including the other members of the Ambitions Partnership), DHSC, HEE, CQC, PHE, CCGs, Trusts and Care Sector organisations.

448. The EoL cell also carried out a significant amount of work ensuring sufficient capacity was available within the system for palliative and end of life care patients. The capacity and clinical expertise available in the hospice sector was of particular importance in the pandemic, including in the delivery of care in the community.

449. Palliative and end of life care clinical teams in hospitals and in the community also played a key role in helping their colleagues in other clinical services understand how best to support patients and families who were dealing with death and dying. They provided peer support as well as practical advice on how to have conversations with patients and families and how to manage PEoL symptoms. Community palliative care teams delivered in-person and virtual palliative care support for patients at home and in care homes.

450. Covid-19 presented a threat to life for many patients and staff. Thanks and appreciation are owed to the many NHS, voluntary sector care workers who cared for people approaching the end of their life with the virus. The burden of that care stretched the emotional resources and resilience of those staff.

Palliative care guidance

451. Going into the pandemic, clinicians involved in palliative care would have been familiar with existing NICE guidance on the care of dying adults in the last days of life. This

guidance covers advice and guidance on how to manage symptoms, as well as discussing the ethics around dignity and respect for the dying person, their relatives and carers.

452. The nature of this virus made 'normal' care very challenging. NHS England therefore provided support to NHS service providers early in the pandemic by issuing the following additional guidance:

a. "Clinical guide for the management of palliative care in hospital during the coronavirus pandemic: Keeping the care in healthcare" (27 March 2020 and updated 22nd April 2020) **[AD1/095 INQ000330845]** and
b. "Clinical guidelines for children and young people with palliative care needs in all care settings during the Covid-19 pandemic" (17 April 2020) **[AD1/096 INQ000330844]**.

453. A fuller chronology of relevant guidance issued by NHS England, with material exhibited is set out in Annex 4 to this statement.

454. In addition to this guidance, NHS England had also established Palliative and End of Life Strategic Clinical Networks in each region. The whole network had regular communications and meetings throughout the pandemic.

455. NHS England's National Clinical Director for PEoLC (who was in post during the Relevant Period) is an eminent expert clinician in the field with a national reputation. Given her reputation and her role as National Clinical Director, clinicians looked to her for clinical leadership particularly during the pandemic. As a result, she chaired weekly seminars with the PEoLC Strategic Clinical Networks to share best practice. A single example of a seminar slide pack, from July 2020, is exhibited by way of illustration **[AD1/097 INQ000331010]**. She also had many informal contacts to ensure consistency in approach. Further, from early April 2020, the Personalised Care Group of the Palliative and End of Life Team issued bulletins by email, weekly at first, to the palliative care network, sharing updated information and knowledge and signposting relevant publications. Again, by way of illustration, an example is exhibited from May 2020 **[AD1/098 INQ000330992]**.

456. The PEoLC Strategic Clinical Networks, established from April 2020, provided an opportunity for professionals and clinicians across providers, third sector partners, social care and commissioners to connect with each other and hear from a national panel in terms of key issues related to Covid-19 and Palliative and End of Life Care. The sessions covered topics such as palliative and end of life care in care homes, advance care planning and personalised care and dementia palliative care.

457. By 21 June 2021 NHS England had delivered 21 national webinars to over 3,000 professionals and clinicians.

Concerns regarding PEoLC capacity during the pandemic

458. Early in the pandemic, when many were concerned about capacity issues in the healthcare service, there was some clinical concern around the potential consequences of capacity issues in PEoLC. NHS England regional teams picked up concerns expressed by CCGs, for example, that if the NHS reached capacity patients might not have a hospital bed available to them if needed for end of life care. As part of the national response, NHS England worked with the hospice sector and secured several tranches of targeted funding to help hospices remain operational and offer additional capacity within the wider PEoLC system. As the pandemic developed, NHS England was not aware of a system issue with capacity for end of life hospital care and provision was available to those who wanted it and needed it.

Resource limitations for in-hospital palliative care teams

459. In this section we set out issues escalated to NHS England regarding the availability of medicines for use in PEoLC during the pandemic and problems with equipment, with particular reference to PPE and syringe drivers.

460. Early in the pandemic there was a significant amount of discussion in the worldwide media regarding potential shortages of medicines. In March and April 2020, some clinical staff raised concerns to NHS England through its regions that a shortage of medicines may affect the delivery of palliative care. These were largely concerns of an expected shortage rather than an actual shortage. They specifically featured concerns about the distribution of appropriate packages of drugs to community services and care

homes. These concerns were addressed swiftly by NHS England through work undertaken across the EoL Cell and the Medicines Cell.

461. Concerns were also expressed to NHS England about syringe drivers, particularly as to whether the NHS had sufficient numbers of drivers and their reliability. A syringe driver is a small portable device enabling the continuous or variable sub-cutaneous delivery of drugs to palliative/end of life patients. They are used in hospitals and in other settings.

462. In 2020, NHS England set up a small steering group of experts and an audit was conducted of the availability to providers of adequate syringe drivers. This was an ongoing piece of work which was monitored, for example, through the regular End of Life Care Status Updates. These covered a very wide range of end of life operational issues, both generated by Covid-19 and BAU. A useful summary of the work done over a period of preceding months is found in the first section of the exhibited update dated 22 March 2021 **AD1/099 INQ000330994]**. In the event, it transpired that fewer numbers of syringe drivers were required than had been expected. However, there remained concerns as to the battery life of the devices and their reliability. NHS England worked with the supply chain responsible for syringe drivers to the NHS. They secured a change to the type of battery and an update to the pump. NHS England also recognised that there was a risk with supply as the NHS was reliant on a single provider of the devices. Steps were taken to secure broader access and NHS England secured an alternative supplier.

463. Throughout the pandemic, the EoL Cell had a Master Risks and Issues Register, identifying the view taken of risks at a particular point in time and steps taken in mitigation.

Reflections

464. In PEoL care planning, patients often choose to die at home. In these circumstances these patients are cared for by the palliative and end of life care community teams or via support provided through the hospice sector, also by their GPs and community nurses, and in many cases, care workers. Whilst care for those at home continued to be available, as with other areas of health care, NHS England was aware that some PEoLC provided to people in the community was delivered remotely. Whilst that was necessary at the time to reduce the spread of Covid-19 amongst patients, those important to them

and staff, care delivered remotely can affect the way that care is provided. That is because without a face-to-face meeting or appointment, it is more difficult to provide compassionate 1:1 care and signs of deterioration in the condition of a patient are less easily detected. This is a problem which may be exacerbated if family members are also prevented from visiting the patient. The decisions taken as part of the response to the pandemic involved difficult considerations such as these

Visitors guidance for end of life and care homes

465. Prior to the Covid-19 pandemic, hospital visiting policies were a matter for local organisations, with most providers outlining their policies in their own guidance. These policies facilitated visiting at appropriate times and offered flexibility in specific circumstances, such as for patients approaching the end of life or patients who required additional or specialist support.

466. NHS England is not responsible for visiting policies for adult social care settings, nor was it during the Relevant Period.

467. The nature of the pandemic, particularly in the early stages when little was known about transmission of the virus except that it was infectious, meant that visiting restrictions were an essential way to reduce the spread of the virus and necessitated a centrally coordinated approach.

Timeline of visiting rules and guidance

468. The first reference to visiting restrictions in national guidance was in the UK IPC Guidance published by PHE, dated 6 March 2020, which asked for essential visitors only and only those able to wear PPE. NHS England were not involved in drafting this guidance.

469. On 16 March 2020, NHS England issued guidance **[AD1/100 INQ000330806]** asking for visiting to be restricted to essential visits only, with only immediate family members able to visit patients and for only one hour per day. This came about in response to NHS England's COO request for the visitor guidance to be reviewed in light of the latest developments with COVID-19. The draft was shared with a range of NHS England executives, national directors and the Strategic Incident Director for comment. Input was also sought from PHE to ensure they were aligned, before the guidance was published

on NHS England's website. The rules explained that visiting would be limited to the following: one visitor per patient, apart from in the case of a child (where both parents could visit), when a patient was receiving end of life care, when a partner and birthing partner were accompanying a woman in labour, or if the visitor required another person to assist them.

470. Following the announcement of the national lockdown on 23 March 2020, the visiting guidance was amended on 25 March 2020 to signal that all visiting was suspended **[AD1/101 INQ000399381]**. The only circumstances where visiting was permitted was for one immediate family member to visit when a patient was either a child or receiving end of life care or a woman in labour. The rules advised on making greater use of phone and video calls to stay in touch with loved ones.

471. On the 9 April 2020, the guidance was revised to include an additional circumstance where visiting would be permitted. This was to support someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the patient to be distressed.

472. Over these first few weeks of the pandemic, as NHS services came under greater pressure by the impact of Covid-19, many people died in hospitals with their families unable to be with them in their final moments. The impact of this on those involved, primarily the families but also the NHS staff who supported those patients, remains deeply felt to this day.

473. In response to the many cases, NHS England's National Clinical Director for End-of-Life Care worked with NHS England's Clinical Cell, supported by the Deputy CNO, to develop multi-agency visiting principles for those at the end of life to support Trusts to manage these difficult situations. Guidance was subsequently published on 11 May 2020 **[AD1/102 INQ000050424]** and outlined practical steps to facilitate visiting for patients at the end of life in a range of healthcare settings and also care homes including visit coordination and PPE use, along with the emotional support required for visitors.

474. Alongside this work on specific end of life care visiting, on 23 April 2020, a multi-speciality nursing & midwifery group convened to review the visiting guidelines which had been published on 25 March 2020 and updated on 9 April 2020. This group reviewed the guidance on behalf of the Clinical Cell and produced

recommendations for a revised visiting guidelines document. This was subsequently published on 5 June 2020 **[AD1/103 INQ000330865]**.

475. This guidance formally lifted the national visiting restrictions and allowed local organisations discretion in allowing visitors, within specific parameters. These included visitors using PPE (face masks or coverings), maintaining 2 meter physical distancing, restricting visitors to one per patient (apart from for end of life care and maternity, where an additional visitor would be permitted if possible) and arranging visits in advance. This guidance also clarified that other people who are in attendance to support the needs of the patient, for example a familiar carer/supporter/personal assistant, should not be counted as an additional visitor.

476. As the pandemic progressed and greater advances were made in terms of understanding the virus and the measures to help prevent its spread, visiting guidance and principles were amended and nuanced to reflect this progress.

477. On 13 October 2020, the general visiting guidance was redrafted as visiting principles for local NHS organisations, with the separate end of life care guidance brought together with this into one document. A trigger tool was developed to support organisations with local decision making and to manage visiting according to the prevalence of Covid-19 in their local community. A section on additional considerations for patients at the end of life was included in the guidance. For information visiting in care homes, the guidance directed to government guidance.

Reflections

478. Where possible, a balance was struck between the importance of patients being with their loved ones and the need to manage infection risk and maintain safety of the visitor, staff and other patients. Where families could not be present when their loved one died, NHS staff worked hard to ensure that they were with their patient to comfort them and to ensure that the dying person received the spiritual, emotional or religious support that they needed.

479. NHS England recognises and acknowledges the significant impact these visiting policies had on patients, the families and NHS workers involved. These difficult decisions were made with overall patient safety at their heart.

DNACPR

480. Cardio-pulmonary resuscitation ("**CPR**") is an emergency procedure that can be undertaken when a patient stops breathing (respiratory arrest) or their heart stops beating (cardiac arrest). CPR refers to a very specific type of treatment intended to restart breathing and the heart. CPR is an invasive and traumatic medical intervention, and most CPR is unsuccessful. The British Medical Journal ("**BMJ**") published an article in July 2020 titled 'Patients overestimate the success of CPR' **[AD1/104 INQ000331025]**. The article notes that actual rates of survival of CPR range from an average of 12% for out-of-hospital cardiac arrests and 24-40% for in-hospital arrests. Due to the intense nature of the treatment, in some circumstances CPR can cause injuries such as punctured lungs, broken ribs, and/or permanent damage to the heart and/or lungs. This can have a significant physical impact on a patient especially if they have an existing condition(s) as their body may struggle to cope with the resulting injuries.

481. Discussions about CPR should include patients and those important to them, wherever possible and appropriate. Whilst discussions regarding CPR should take place with patients, it is important to understand that there is no general principle that entitles a patient to a particular treatment or procedure if the treating clinician determines there would be no overall benefit to the treatment, i.e. that the treatment would be futile. Often patients decide themselves that they do not want CPR and they ask clinicians to place a DNACPR decision on their notes. But a decision about whether CPR ought to be attempted is primarily a medical treatment decision to be made by the treating clinician based on assessment of likely clinical benefit against the traumatic and invasive nature of the procedure. If a clinician considers that CPR would likely be futile, they can make a clinical decision to place a DNACPR decision on the patient's notes. The clinician should communicate this decision to the patient and those important to them wherever possible. Joint guidance produced by the BMA, Resuscitation Council UK, and Royal College of Nursing assists clinicians with the decision-making process for particularly complex cases. DNACPR decisions are clinical decisions made by appropriately trained professionals. In care home settings, these decisions were typically made by GPs or other NHS community clinicians providing care to residents. Whilst care home staff may have supported personalised care planning, they did not hold responsibility for making DNACPR decisions.

482. All hospitals, general practices, care homes, hospices, and ambulance services, should have a policy about CPR. Policies should cover the systems, processes and structures in place throughout the organisation to provide safe and effective care during resuscitation events to all patients. These policies must be readily available and understood by all relevant staff and should also be available to the public. Although DNACPR policies apply across all settings where clinical care is delivered, including care homes, it remained the responsibility of healthcare professionals, not care home providers, to determine and record DNACPR decisions.

483. Blanket DNACPR policies due to medical condition, disability, or age are inappropriate. DNACPR decisions should only ever be made on an individual basis and should be discussed with the patient and their family where possible. This principle applied equally in social care settings. Care home providers were not permitted to make or apply DNACPR decisions themselves.

484. Whilst it was not ordinarily involved in drafting clinical guidance before the pandemic (this being the role of other organisations such as Royal Colleges and professional bodies), NHS England has from time to time set broad expectations based on values and best clinical practice where necessary. For example, NHS England issued its clear views and expectations in 2019 to the system that "blanket" DNACPR decisions are inappropriate and should not be used in practice. We set out further details on this below.

DNACPR guidance up to 1 March 2020

485. There has been stand-alone professional guidance on CPR decision-making published since the 1990s. Since 2001 CPR decision-making guidance has been published jointly by the British Medical Association ("**BMA**"), the Resuscitation Council UK ("**RCUK**"), and the Royal College of Nursing ("**RCN**"). This guidance is called 'Decisions relating to cardiopulmonary resuscitation'. As of 1 March 2020, the guidance was in its third edition, having been revised in 2017 **[AD1/105 INQ000331016]**. It remains in place today. It is widely used amongst clinicians and renowned for being the authoritative text on CPR clinical decision-making.

486. The guidance makes notable reference to the issuing of blanket DNACPR notices, citing them as "unethical and probably unlawful". The underlining below has been added for emphasis:

a. *"Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by `blanket' policies*" (page 4)

b. "*Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all people with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability, or on a professional's subjective view of a person's quality of life. Blanket policies that deny CPR or apply CPR to groups of people, for example to all patients in a hospice, nursing home or particular hospital ward, or to people above or below a certain age, are unethical and probably unlawful. Decisions or policies that discriminate in favour of, or against, people with defined disabilities would be unlawful under the Equality Act 2010 (in England, Wales and Scotland) or the Disability Discrimination Act 1995 (in Northern Ireland)*" (page 9)

c. "*When a person is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful. CPR cannot reverse the person's underlying condition and it may prolong or increase suffering. In most cases it will be appropriate for a DNACPR decision to be made. However, 'blanket' policies are inappropriate. All decisions should be based upon the individual person's circumstances and wishes at the time*" (page 10)

d. "*The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one care setting, so the frequency must be based on the needs of the individual patient and not on any "'blanket' policy*" (page 30).

487. The GMC also includes a section on CPR in its published ethical guidance on treatment and care towards the end of life. This guidance was first published in May 2010 and was updated on 15 March 2020. The section on CPR begins at page 62 of the guidance.

488. In addition to this guidance, in 2019 NHS England issued communications to the system making clear its position that DNACPRs applied generically to patients with long term conditions are clearly inappropriate. This arose from findings in the annual Learning Disability Mortality Review ("**LeDeR**"). The LeDeR is an annual report funded by NHS England. The 2018 report was published in May 2019 by the University of Bristol **[AD1/106 INQ000330789]**. The report noted that, of the deaths reviewed in 2018, 69% had a DNACPR decision on their file. Reviewers felt that 79% of those DNACPRs were appropriate. 13 reviews noted that 'learning disabilities' had been included as a reason for not resuscitating the person. As a result of the LeDeR review findings, in May 2019 NHS England's National Medical Director issued a letter **[AD1/107 INQ000330788]**, in which he emphasised that "*The terms "learning disability" and "Down's Syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death [..]."*

Guidance and NHS England involvement after 1 March 2020

489. In Wave 1 of the pandemic concerns regarding the inappropriate use of DNACPR notices were reported in the media. These concerns were also expressed by charities such as Mencap. NHS England became aware of concerns through its regional teams. Upon hearing of concerns, NHS England — in its pandemic role and recognising its ability to issue correspondence rapidly to the system - swiftly issued communications to the healthcare system to remind clinicians that DNACPR decision- making should never be the result of blanket application (applying to a group of people at once due to their condition, age or disability), or discriminate unlawfully, but should always be addressed to matters of individual patient presentation and benefit. A fuller chronology of relevant NHS England letters and publications is set out at Annex 2 to this statement.

490. It is important to note that, whilst it is very clear that the "blanket" application of DNACPR decision making, i.e., where DNACPRs have been applied to a category of people on the basis of their condition, is inappropriate, these should not be confused with letters that were sent to groups of people simultaneously to encourage consideration of new or existing preferences for future care through individualised, personalised conversations. Such letters were not intended to ensure DNACPR decisions were made for a group of

people at once, but rather to encourage consideration of preferences and wishes at an individual level and to ensure that these continued to be relevant in the wider context of Covid-19. For example, an individual with an existing advance care plan stating they would not wish to receive antibiotics in the case of a severe chest infection may have wished to amend the plan to ensure clarity that they would wish to receive treatment for Covid-19.

491. On 3 April 2020 senior leaders from NHS England, including the National Clinical Director for Learning Disability and Autism, the National Mental Health Director and the Medical Director for Primary Care, sent a joint letter to the system **[AD1/108 INQ000216427]** to provide clarity on the use of DNACPR where people have a learning disability or are autistic. It reminded readers of the May 2019 letter sent by the National Medical Director for NHS England.

492. On 7 April 2020, a briefing was cascaded internally in NHS England highlighting concerns about the use of blanket DNACPR decisions and including a list of proposals, one of which being a letter written jointly by the National Medical Director and CNO. That letter, **[AD1/109 INQ000192705]** which was sent to the system on 7 April 2020, stated that:

a. "*The NHS Constitution is clear that we should deliver care and support in a way that achieves dignity and compassion for each and every person we serve. We should be cognisant of the principle of equity of access for those who could benefit from treatment escalation, and the principle of support for autonomy for those who want to be involved in decisions....each person is an individual whose needs and preferences must be taken account of individually.*

b. *By contrast blanket policies are inappropriate whether due to medical condition, disability, or age. This is particularly important in regard to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, which should only ever be made on an individual basis and in consultation with the individual or their family*"

493. Further, on 7 April 2020, the NHS England COVID-19 NHS Leaders Update bulletin signposted healthcare professionals to the letters of 3 April and 7 April

2020. **[AD1/110 INQ000330840]**. This was repeated on 23 April 2020 **[AD1/111 INQ000330846]**.

494. On 8 April 2020, the NHS England Primary Care bulletin **[AD1/112 INQ000331007]** sent to primary care, made the same reference to the 7 April 2020 NHS system letter on DNACPR and 3 April 2020 NHS system letter. The message also reminded healthcare professionals of the following:

> "*The key principle is that each person is an individual whose needs and preferences must be taken account of individually. By contrast blanket policies are inappropriate whether due to medical condition, disability, or age. This is particularly important in regard to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, which should only ever be made on an individual basis and in consultation with the individual or their family*".

495. On 11 May 2020, the NHS England Covid-19 Primary Care bulletin **[AD1/113 INQ000331009]** included a message `to remind everyone about inappropriate and unacceptable applications of DNACPR orders to people with a learning disability and autistic people'.

496. On 20 May 2020, Baroness Campbell of Surbiton DBE (Disability Rights UK) and NHS England's Director of Personalised Care released a joint statement **[AD1/114 INQ000339275]** on personalised approaches to care and treatment. The statement was the culmination of a substantial piece of work which included a large stakeholder engagement session, including disability organisations and health experts, and round table meetings to discuss content and drafting. It stated:

a. "*The outbreak of coronavirus does not change long-established best practice that decisions around care and access to treatment, including end of life care, are made on an individual basis and with clinicians, following the principles of personalised care.*

b. *Every individual should be provided with ongoing opportunities to participate in decisions that affect them. In relation to treatment decisions, patients should be*

supported to make informed decisions by the provision of clear advice on options from their clinicians, with family support or advocacy support if required and possible, and in compliance with the provisions of the Mental Capacity Act 2005 and related guidance where relevant.

c. *This means people making active and informed judgements about their own care and treatment, at all stages of their life, and recognises people's autonomy, as well as their preferences, aspirations, needs and abilities. This also means ensuring reasonable adjustments are supported where necessary and reinforces that the blanket application of do not attempt resuscitation orders is totally unacceptable and must not happen*".

497. On 22 July 2020, NHS England's Medical Director for Professional Leadership and Clinical Effectiveness gave oral evidence to the Women and Equalities Committee inquiry 'Unequal impact? Coronavirus, disability, and access to services' and made the following comment:

a. "*We need to be absolutely clear that we do not think it is appropriate to use blanket "do not resuscitate" notices in any circumstances. Discussions about access to treatment and admission to hospital need to be taken on an individual basis, involving the individual themselves, their family and carers, plus an understanding of their normal health and what the acute situation is for them. We do not approve of blanket "do not attempt resuscitation" notices*".

498. On 27 August 2020, NHS England's Medical Director for Professional Leadership and Clinical Effectiveness submitted written evidence to the Chair of the Women and Equalities Committee:

> "*As agreed, I am writing back to the Committee to provide further information on blanket Do Not Attempt Resuscitate (DNAR) notices. NHS England and NHS Improvement remain clear that the blanket application of DNARs is unacceptable and that standards and quality of care should be maintained, even in pressurised circumstances...*

The NHS England/I Palliative and End of Life Care team are currently developing public facing information which explains how a patient or their representative can raise concerns if a DNAR order has been made without their knowledge or if disagree with it. This will be relevant for all people, not just people with a learning disability or who are autistic and will be shared with a range of voluntary sector stakeholders.

As noted in our 9 July 2020 letter to General Practice we have agreed with the General Practitioners Committee of the BMA that the QOF Quality Improvement (QI) Domain requirements for 2020/21 will be recast to focus upon restoration of services for the remainder of this financial year. Improving the care of people with a learning disability is a QI topic for 2020/21. As part of the revised requirements, practices will be required to review the records of patients on their learning disability register to identify those recorded as DNAR and confirm that this decision remains appropriate or to amend as clinically indicated. Practices will additionally be asked to declare that they have a process in place to review DNAR instructions via their annual contract declaration which takes place in the autumn."

499. On 4 September 2020, NHS England published updated guidance **[AD1/115 INQ000330884]** for GPs on the Quality Outcomes Framework ("**QOF**"), as part of the 2020/21 General Medical Services (GMS) contract. The QOF consists of various measures agreed as a part of the GP contract each year. GP practices are given points based on how they are performing against these measures. The QOF approach for 2020/21 had been revised to reflect the impact of Covid-19 on general practices. The revised approach aimed `to release capacity within general practice to focus efforts upon the identification and prioritisation of people at risk of poor health and those who experience health inequalities for proactive review'. GPs were asked to focus on the `restoration of proactive annual health checks' for people with learning disabilities and autism. Specifically, practices were asked:

a. *"Review all Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and confirm that they were determined appropriately and continue to be clinically indicated'; and*

b. *"It would be reasonable for a clinician to consider, on review, whether a DNACPR may be appropriate, if the patient has significant co-morbidities such that they may not benefit from CPR in any event."*

500. The QOF referred back to the NHS England 2019 letter and to guidance from the BMA, Resuscitation Council (UK), and the Royal College of Nursing. It stated that the review of all DNACPR decisions `should be completed by all practices even if they have already commenced wider QI [Quality Improvement] work'.

501. On 1 December 2020 the National Clinical Director for critical care at NHS England gave substantial oral evidence to a joint session of the Health and Social Care Committee and the Science and Technology Committee in their `Coronavirus: lessons learnt' inquiry. Her evidence included the following statement:

a. "*One thing that is important to recognise is that cardiopulmonary resuscitation is the final event of a pathway of care and treatment. Decisions are made throughout a patient's care, in discussion with them and/or their family as appropriate, about treatment escalation. A key part of the way in which healthcare professionals have worked during Covid is to try to understand what is in the patient's best interests, what they want and what healthcare professionals believe to be in their interests, and to work together to establish treatment escalation plans. There is an emphasis both on considered decision making between multiple healthcare professionals when coming to those decisions as well as, obviously, on consulting patients and families.*"

502. On 4 March 2021, NHS England wrote to Trusts, CCGs, and GPs (primary care) **[AD1/116 INQ000339282]**, regarding the use of DNACPR notices for people with a learning disability and or autism. The letter reiterated that:

a. "*The NHS is clear that people should not have a DNACPR on their record just because they have a learning disability, autism or both. This is unacceptable.*

b. *The terms "learning disability" and "Down's syndrome" should never be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause*

of death. Learning disabilities are not fatal conditions. Every person has individual needs and preferences which must be taken account of and they should always get good standards and quality of care."

The CQC Report and the Advance Care Planning Document

503. In October 2020, DHSC commissioned CQC to conduct a review into how DNACPR decisions were made in the context of advance care planning. The review covered care provided in care homes, primary care and hospitals. The CQC sought engagement with a number of stakeholders, including NHS England, before producing its interim report in November 2020 **[AD1/117 INQ000235491]**. The interim report stated that there was evidence of unacceptable and inappropriate DNACPR decision-making at the start of the pandemic but that following a quick response from multiple agencies, there was no evidence to suggest that this had continued as a widespread problem. However, there were different views as to the extent to which people were then experiencing positive person-centred care. NHS England reflected on the interim report, its own position and the steps taken to that point in an internal briefing note dated December 2020 **[AD1/118 INQ000330993]**.

504. The CQC's substantive review took place between November 2020 and January 2021, and it published its final report in March 2021. The report notes that some people felt that they had been involved in the decision-making process around DNACPR and advance care planning, but others felt that conversations around whether they would want to receive CPR came 'out of the blue' and that they were not given the time or information to fully understand what was happening. The report recommended a focus on three key areas, namely: (1) information training and support on how to have conversations around advance care planning, (2) a consistent national approach to advance care planning, such as a consistent use of accessible language and communication and (3) improved oversight and assurance for CCGs (now ICBs) and patient representative bodies. Before publication of the report and following a conversation between the CQC and the National Clinical Director for Learning Disability and Autism about the broad content of the report, NHS England began to establish a task and finish group to develop a national approach to advance care planning.

505. The recommendations of the final report applied to a number of different bodies in the health system, including NHS England and DHSC. There were 11 recommendations, and a lead body was identified in respect of each. NHS England was named as a lead body — jointly with DHSC — in respect of one recommendation, namely:

a. "*People, their families and representatives need to be supported, as partners in personalised care, to understand what good practice looks like for DNACPR decisions. This should include what their rights are and how to challenge and navigate experiences well. In addition, there needs to be positive promotion of advance care planning and DNACPR decisions, as well as a more general focus on living and dying well. To do this, there needs to be more widely publicised and accessible information available via a national campaign and in partnership with the voluntary sector and advocacy services*".

506. In April 2021 NHS England's assembled task and finish group met to consider and discuss the above CQC recommendation. The group decided to produce an Advance Care Planning ("**ACP**") document. In addition, one of the CQC recommendations directed at DHSC was the creation of a Ministerial Oversight Group, which DHSC duly established. That group, chaired by a DHSC Minister and attended by NHS England, gave further consideration to the recommendations made by CQC.

507. By August 2021 NHS England had prepared an outline summary **[AD1/119 INQ000331026]** of its plans around the content of the ACP document and the process and intended timeline for its production. An update was produced for the Ministerial Oversight Group in September 2021, including the plan for stakeholder engagement. A further update was generated in December 2021 **[AD1/120 INQ000331019]**.

508. The final ACP document was published in March 2022 **[AD1/121 INQ000339327]**. The Resuscitation Council had already produced a tool known as a ReSPECT form which was an advance care planning document in its own right for use operationally in individual patient circumstances. NHS England had, however, wanted to produce a document which could be applied to advance care planning more generally

(including DNACPR decisions), rather than just confined to DNACPR decisions, as it was important to set these in the wider context of decision making, preferences and wishes. The ambition was that such a document would provide clarity to the overall concept and process of advance care planning, ensuring that it sat within the context of a personalised approach to care and support. The ACP document thus refers to a ReSPECT form as one of the tools available but is broader in scope. The ACP document was named Universal Principles for Advance Care Planning. It was published jointly with a significant list of partners, including the Royal College of General Practitioners, Royal College of Physicians, the BMA, Hospice UK, Marie Curie and others. It contains a ministerial foreword written by Maria Caulfield MP, Parliamentary Under-Secretary of State for Primary Care and Patient Safety and the Ministerial Oversight Group Chair. The document is aimed at people, practitioners and organisations and is also available in easy read. The six principles identified in the executive summary emphasise the central role of the person in personalised discussions and decisions about their advance care plan:

a. The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.

b. The person has personalised conversations about their future care focused on what matters to them and their needs.

c. The person agrees the outcomes of their advance care planning conversation through a shared decision-making process in partnership with relevant professionals.

d. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.

e. The person has the opportunity, and is encouraged, to review and revise their advance care plan.

f. Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

509. The ACP document was purposefully developed for a broad audience and range of settings:- professionals, patients and the public alike, irrespective of setting. Its principles were not therefore confined to a hospital setting and remain accessible to those people who choose to undertake advance care planning without a healthcare professional involved. Although those principles may be applicable irrespective of the country in which they are being used, the ACP document was not developed with the specific intention that it would be applied across all the Devolved Nations.

510. The Ministerial Oversight Group monitored progress across a number of actions which were responses to the CQC report. Its records and minutes are held by DHSC. NHS England does, however, have read-outs of meetings on 8 June 2021, prior to the bulk of the work done by NHS England to generate the ACP document **[AD1/122 INQ000274188]**, and 17 May 2022 **[AD1/123 INQ000409938]** after the publication of the ACP document and shortly before the end of the Relevant Period. Following the May 2022 meeting, NHS England explored further the possible use of a single tool for Advance Care Planning. However, it concluded that the ACP principles developed in the document could be implemented effectively without the requirement for a single tool or product across England, consistent with operational implementation being a matter for local consideration.

NHS England's involvement in guidance on communication with families

511. We have been asked by the Inquiry to set out NHS England's involvement in formulating guidance on communicating with patients and their families around issues such as treatment decisions, advance care planning, DNACPR and end of life care. As described above, NHS England issued a number of communications to the system on advance care planning and the use of DNACPR in particular. This communication set out the importance of making decisions about a person as an individual and communicating with them about those decisions where possible. NHS England also published the Universal Principles for Advance Care Planning document. The principles set out in this document revolve around personalised discussions with the person regarding their preferences and wishes.

Section 7: Lessons and Recommendations

512. NHS England has made a number of reflections throughout its statements to the Inquiry and has also produced a separate Lessons Learned report, which has been disclosed. That report includes a section on patient discharge into the community. Some further reflections are included in the body of this statement; I do not seek to repeat those here.

513. It is important to note that NHS England does not routinely undertake lessons learned exercises outside of its statutory remit. As such, it has not produced a comprehensive review of all the issues under consideration of Module 6 of the UK Covid-19 Inquiry. However, to assist the Inquiry in developing its recommendations, NHS England offers the following reflections.

514. In considering future preparedness, NHS England encourages the Inquiry to observe the progress made across health and social care since the pandemic, and to build upon this work.

515. **Interdependencies Between Health and Social Care**. The pandemic underscored the deep interdependencies between the NHS and social care. Not only did it reaffirm that the effective functioning of a joined-up system is critically dependent on the resilience and capacity of the other, but it also highlighted the value of sharing expertise, resources, and skills between these sectors.

516. NHS reach into care homes, along with integrated working between hospitals, community services, and social care, remains essential for optimising resource use and ensuring a good quality of life for individuals. As noted earlier, the NHS was, at times, able to offer substantial support to the social care sector, including infection prevention and control (IPC) training, support with digital tools such as NHS Mail, PPE coordination and distribution, shared end-of-life care training, and deployment of the NHS Volunteer App.

517. The NHS is, and remains, heavily reliant on an effectively functioning social care system. Resilience of the health sector in future public health emergencies will not solely depend on the NHS but will also hinge on the care sector being adequately resourced and enabled to respond. NHS England has long maintained that sufficient investment in adult social care is not only necessary to meet individual needs but also vital for maintaining patient flow, reducing hospital pressures, and supporting overall system resilience.

518. As highlighted in Module 1 of the Inquiry, resilience requires headroom. Instead of having spare capacity, the pandemic exposed the limitations of both health and social care sectors. In order to ensure the country, and the social care sector in particular, is ready for the next pandemic, the Inquiry may wish to consider how to ensure we are all better prepared, more robust, and sufficiently resourced — including the workforce support required. In this context, NHS England welcomes the government's planned independent commission on social care to be chaired by Dame Louise Casey and note that the Inquiry may wish to reflect on any findings it published in the interim as part of its own conclusions and recommendations.

519. **National Coordination and Governance**. The pandemic demonstrated the benefits of having a national health service, led by a single NHS organisation designated as a Category 1 responder. This structure enabled the NHS to rapidly implement Level 4 command and control arrangements across an otherwise highly complex system. NHS England established national incident management structures under these protocols, with the system operating at Level 3 or 4 throughout the pandemic. These arrangements—and their strengths and limitations—were considered in detail in Module 3 of the Inquiry.

520. In contrast, the social care sector does not have an equivalent national coordinating body nor the ability to act in the same way as the NHS operating at Level 3 or 4. The adult social care sector serves a broad spectrum of need and is delivered through a diverse, independent provider market. Local authorities hold statutory responsibility for shaping care markets to meet the needs of their local populations. This complexity, combined with local variation in provision, presents challenges during a national emergency and needs to be fully considered in any future emergency response – particularly in terms of equitable access to PPE, vaccinations, medicines and equipment for all care settings.

521. The Inquiry should consider the implications of these structural differences—including variations in funding, leadership, accountability, and coordination—and assess the best way to mitigate their impact on decision-making and national system-wide responses, particularly in the early phases of the pandemic. In doing so, the Inquiry should be mindful of recent legislative changes introduced under the Health and Social Care Act

2022, which have sought to strengthen central oversight, including new powers for the SSHSC to intervene where local authorities fail to meet required standards.

522. **Bed capacity and discharge**. The pandemic reinforced the longstanding planning assumption that NHS hospital bed capacity is finite and those who are fit to leave hospital should be discharged as promptly as possible. Looking ahead, it is likely that any future pandemic response will again require rapid action to free up hospital capacity in order to care for those with urgent and complex health needs. NHS England welcomes the Inquiry's learning in this area and supports efforts to ensure that the NHS, the social care sector, and patients are all properly supported to respond effectively.

523. The pandemic demonstrated the power of collaborative working across systems, with many strong examples of joint effort and shared purpose. Effective and timely discharge relies on close collaboration between NHS services, local authorities, ICBs, adult social care providers, and primary care. During a pandemic, such coordination becomes even more critical to minimise delays, reduce the risk of nosocomial infection, maintain patient flow and support patient recovery in appropriate care settings.

524. Whilst successive attempts to integrate or align funding have been made, before and since the pandemic — through mechanisms such as the Better Care Fund, personal budgets, and Integrated Care Systems —to improve patient flow and shift focus from institutional care to more person-centred approaches, different funding models across health and social care were an early challenge to be overcome. Therefore, one of the most effective enablers of hospital discharge was the Government's introduction of the £1.3 billion discharge fund in March 2020. This removed a key barrier between health and social care, and enabled rapid implementation of the Discharge to Assess (D2A) model across England, allowing medically fit patients to be discharged without the usual delays caused by funding complexities, Continuing Healthcare (CHC) decisions, or placement challenges, helping to create the hospital bed capacity needed for patients requiring acute care during the pandemic.

525. Since the pandemic, improvements have been made to strengthen discharge processes. Following the 2023 Urgent Elective Care Recovery Plan, NHS England has introduced new measures including the new Discharge Ready Date metric, an improved 'Reasons for Discharge Delay' collection and establishing Care Transfer Hubs, staffed by acute,

community and local authority colleagues to more effectively manage discharge of patients who have post-discharge health and social care needs. These changes are helping to ensure that patients are discharged safely and promptly, with necessary support in place. The Inquiry may wish to consider how to maintain and build on these improvements, including by ensuring adequate capacity and resource availability across the discharge pathway.

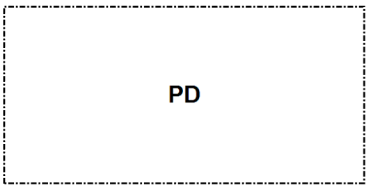
Shifting from hospital to community

526. The development and implementation of a neighbourhood health and care model, shifting care from hospital into the community, is a key policy aim that is well underway. The model supports people of all ages live healthy, independent lives while improving their experience of care and reducing avoidable hospital admissions. In many parts of England, key components of this approach are already in place including multidisciplinary neighbourhood teams, integrated intermediate care services with a "Home First" approach and greater use of population health management to anticipate and meet peoples needs more effectively. This work is designed to reduce system pressure, support resilience and ensure that integration between health and social care becomes the norm, not the exception.

527. As work continues in 2025/2026 to extend the neighbourhood care model system-wide, NHS England remains committed to supporting joined up, person centred care that reduces pressure on acute hospital services while improving outcomes and experiences. The Inquiry may wish to consider how future recommendations can build on this work, ensuring that health and social care services across the country are equipped not only to respond to future emergencies but also to deliver integrated, high-quality care routinely and not just at times of emergency.

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: 

Dr Amanda Doyle, OBE MRCGP

National Director Primary Care and Community Services

NHS England

Dated: 2 May 2025

Annex 1

Evolution of the NHS in England

1. To assist the Inquiry, it is helpful to set out, briefly, the background to the legislative framework which established NHS England and the roles and functions of those bodies which have at the date of this Statement merged with NHS England.

Lansley Reforms

2. Following the general election of 2010, the Government proposed extensive NHS reforms, known as the "Lansley Reforms" after the then SSHSC, Andrew Lansley. The proposals were set out in the White Paper "Equity and Excellence: Liberating the NHS" published 12 July 2010 **[AD1/124 INQ000113304]** and formed the basis of the Health and Care Bill introduced in the subsequent year, which became, on enactment, the 2012 Act. The proposals included an "independent and accountable" and "autonomous" NHS Commissioning Board supporting local "GP commissioning consortia" (later to be called CCGs) who would be responsible for commissioning NHS services in local areas.

3. Section 9 of the 2012 Act provided for the establishment of the NHS Commissioning Board, and its general functions, by inserting a new section 1H of the 2006 Act. The Board was legally established on 1 October 2012, albeit without its full functions at that stage, following partial commencement of section 9. The Board became fully operational on 1 April 2013.

4. As part of the preparations for the prospective NHS legislation contained in the Health and Social Care Bill, the NHS Commissioning Board Authority was established as a Special Health Authority on 31 October 2011. This Authority was established to exercise functions in connection with preparing for the establishment and operation of the Board, and was abolished on the same date as the Board itself was established (1 October 2012).

5. Shortly after it was established, the Board adopted the operational name "NHS England" with the agreement of the SSHSC **[AD1/125 INQ000113148]**.

6. To understand the development of NHS England, it is helpful to understand the legal framework which preceded its establishment. Before the amendments made by the 2012 Act, the 2006 Act conferred statutory responsibility for providing or securing the provision of services for the purpose of the health service on the SSHSC, rather than directly on national, regional or local NHS bodies (although Trusts had the general function of providing services). The SSHSC had powers to direct regional and local NHS bodies (Strategic Health Authorities and Primary Care Trusts respectively) to exercise those functions and as to how they exercised them. Those powers were used to confer responsibility on those bodies for administering the health service and commissioning services, subject to SSHSC control via further direction.

7. At a national level, DHSC's functions in relation to the NHS were performed by part of DHSC known as "the NHS Executive", headed by a civil servant known as the NHS Chief Executive. Within DHSC there was a team known as NHS Operations who had an Emergency Preparedness Function. 8. At the regional level, the Strategic Health Authorities were responsible for overseeing and managing the health service.

8. At a local level, NHS services were provided under arrangements made by Primary Care Trusts in exercise of the directed SSHSC functions, with a combination of statutory NHS providers (Trusts) and independent or third sector providers. Primary Care Trusts also provided some services, such as community health services, using their own staff and facilities.

9. The 2012 Act provided for an extensive reform of the health service legislative structure, implementing the proposals set out in the 2010 White Paper. A core part of this reform was the separation of the health service into NHS and public health services, with the SSHSC and local authorities being responsible for public health.

10. NHS England was a key part of that reform, with responsibility for the commissioning of NHS services – both to commission certain NHS services itself and to oversee the operation of CCGs. This role of NHS England was set out in section 1H of the 2006 Act, which provided that, concurrently with the SSHSC, NHS England had a general duty to promote a comprehensive health service, except in relation to the part of the health

service provided pursuant to the public health functions of the SSHSC and local authorities.

11. In other words, NHS England is not responsible for public health services; local authorities and DHSC, and its executive agencies (PHE (now UKHSA)), are responsible.

12. Section 1H went on to provide that the general functions of NHS England are to: a. arrange the provision of services for the purpose of the health service in accordance with the 2006 Act; and b. to exercise functions in relation to CCGs, so as to secure that services for the purpose of the health service are provided in accordance with the Act.

13. In relation to the first function, the other provisions of the 2006 Act which confer on NHS England the responsibility for arranging the provision of specific services (often referred to as its 'direct commissioning' functions) are:

14. Section 3B, which provides that NHS England is responsible for commissioning such dental services, services for the armed forces and their families, services for prisoners and other detained persons, and certain other services which SSHSC considers is appropriate for NHS England rather than CCGs to arrange (often referred to as "specialised services"), as set out by the SSHSC in regulations. The relevant regulations are contained in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).

15. Section 4, which requires NHS England to commission hospital accommodation and services for persons detained under the Mental Health Act 1983 and who in the opinion of the SSHSC require treatment under conditions of high security on account of their dangerous, violent or criminal propensities – referred to as "high security psychiatric services". c. Parts 4 to 7, which provide for primary care services. This includes primary medical services (often referred to as GP services), primary dental services, primary ophthalmic services and pharmaceutical services.

16. The commissioning of all other NHS health care services, including hospital, ambulance and community health services as listed in section 3 of the 2006 Act, were the responsibility of CCGs. The former local commissioning bodies, Primary Care Trusts,

and regional bodies, Strategic Health Authorities were abolished, and replaced by those CCGs and NHS England respectively. A key feature of the CCG framework was that their members were the providers of primary medical services for the area of the CCG – i.e., the GP practices which served the CCG's population. CCGs were therefore intended to deliver a 'clinically-led' approach to the commissioning of local NHS services. CCGs were not responsible for local public health services, with statutory responsibility for those services transferring to local authorities.

17. NHS England is not a provider of any patient services but does establish transformation programmes and work alongside the providers and wider NHS to work out how these programmes are operationalised.

18. Their functions were conferred directly by the 2006 Act or regulations under the 2006 Act. The SSHSC's general duty to provide or secure the provision of services for the purposes of the health service was changed to a duty to exercise the SSHSC functions so as to secure the provision of services (see section 1 of the 2006 Act as substituted by section 1 of the 2012 Act). The stated policy aim was that there should be more independent management and operation of the NHS, with less direct political control and influence, and the 2012 Act provided a different framework of statutory oversight and control.

19. Regulations made by the SSHSC could impose requirements (to be known as "standing rules") on NHS England and CCGs (section 6E of the 2006 Act). These could, for example, include requirements as to: arranging for specified treatment to be provided in a specified way; arrangements for making decisions about treatments or other services that are to be provided; NHS England preparing draft standard terms and conditions for CCGs to use when commissioning NHS services. The relevant regulations are set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (S.I. 2012/2996).

20. The SSHSC had a power to give directions to NHS England if in the SSHSC's opinion it was failing to discharge one or more of its functions, properly or at all (section 13Z2 of the 2006 Act), but these have never been exercised. NHS England had a similar power with respect to CCGs (section 14Z21 of the 2006 Act), which it did exercise.

21. For completeness it is highlighted that on 1 July 2022, CCGs were abolished and their commissioning responsibilities now fall on ICBs.

NHS Improvement

22. NHS Improvement was established on 1 April 2016, bringing together Monitor, TDA, Patient Safety (from NHS England), National Reporting and Learning System, Advancing Change Team and Intensive Support Teams. 22. Acting together as NHS Improvement, Monitor and the TDA were therefore responsible for overseeing and supporting providers of NHS services. This included issuing guidance to Trusts about how they performed their responsibilities, and taking steps to ensure those trusts operated effective governance arrangements to comply with relevant health care standards set by other bodies (such as CQC, NHS England or the statutory regulators of health care professions).

23. The NHS Improvement rules of procedure set out the joint governance arrangements for NHS Improvement. They constitute both rules of procedure for Monitor under paragraph 12 of Schedule 8 to the 2012 Act and standing orders of the NHS TDA under Regulation 12(2) of the National Health Service Trust Development Authority Regulations 2012 (SI 2012 no 922, as amended).

24. Monitor was originally (from 2006) the independent regulator of NHS Foundation Trusts - a category of health care provider with greater freedoms and 'independence' from central administration than NHS Trusts. Under the 2012 Act, Monitor's role was expanded and it became an independent regulator for NHS health care services in England, and in exercising its functions was required to protect and promote the interests of patients by promoting the provision of health care services which are economic, efficient and effective and which maintains or improves the quality of the services. A key part of this regulatory role was to licence providers of NHS health care services, and to enforce the conditions of the licence, under Chapter 3 of Part 3 of the 2012 Act. In this role, Monitor worked alongside the CQC to take action, using its licence enforcement powers, when the CQC reported that a hospital trust was failing to provide good quality care.

25. The TDA was a Special Health Authority established by the SSHSC by order under section 28 of the 2006 Act. The TDA was established primarily to exercise such functions as the SSHSC may direct in connection with the management of the performance and development of NHS Trusts (a category of health care provider subject to greater SSHSC oversight), in particular with a view to those NHS Trusts becoming NHS Foundation Trusts.

26. From 1 April 2019, NHS Improvement and NHS England came together to work as a single organisation to help improve care for patients and provide leadership and support to the wider NHS. They were collectively referred to as “NHS England and NHS Improvement” or “NHSE/I”.

27. In February 2021, the Government confirmed its intention to formally merge NHS Improvement into NHS England in its Integration and innovation White Paper. The merger took place on 1 July 2022.

NHS Digital

28. NHS Digital was established as the 'Health and Social Care Information Centre' pursuant to section 252 of the 2012 Act was the. The organisation came to be known (and is referred to throughout this statement) as 'NHS Digital'; this has been the case since 2016. 29. NHS Digital's statutory functions were principally set out in Chapters 2 and 3 of Part 9 of the 2012 Act. Its core statutory functions being summarised as:

    a. Establishing and operating information systems for the collection and analysis of data, where directed by the Secretary of SSHSC or NHS England under section 254, or requested by other eligible bodies under section 255 of the 2012 Act;

    b. Publishing data under section 260 of the 2012 Act and in accordance with the Code of Practice for Statistics;

    c. Disseminating data under section 261 of the 2012 Act and other relevant legislation, including in relation to the pandemic, under Regulation 3 of the Health Service (Control of Patient Information) Regulations 2002 ("**COPI Regulations**");

d. Exercising IT system delivery functions of the SSHSC or NHS England when directed to do so under Regulation 32 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social care Information Centre (Functions) Regulations 2013/259 ("**NICE Regulations**"); and

e. Supplying digital, data and technology services under section 270(1)(d) of the 2012 Act.

Health Education England

29. HEE was established as an Executive NDPB pursuant to section 96 of the Care Act 2014 on 1 October 2014 and the Special Health Authority, known by the same name, established in 2012 pursuant to the Health Education England (Establishment and Constitution) Order 2012 (S.I. 2012/1273) was abolished.

30. HEE's function was to provide national leadership and co-ordination for the training and development of the workforce. HEE was responsible for planning, education and training of the future workforce, and development of the existing workforce working alongside commissioners and service providers.

31. HEE served the wider healthcare system (including private and third sector providers) but had no remit over social care.

32. HEE had six levers to achieve its purpose of improving the quality of patient care:

a. Workforce planning: each year they identified the numbers, skills, values and behaviours that employers told them were needed for future. Ensuring that the shape and skills of workforce evolve with demographic and technological change;

b. Attracting and recruiting the right people to the education and training programmes they plan to commission: using mechanisms such as Health Careers Oriel and Come back;

c. Workforce Transformation: Supporting the work of Local Workforce Action Boards in workforce transformation activities;

d. Commissioning education and training programmes for medical students: using commissioning levers to best effect so that medical students can learn to provide safe, high-quality care for patients;

e. Lifelong investment in people: encouraging employers to continue to provide high quality care for patients through on-going training;

f. Leadership Academy Developing better leaders, delivering better care: To develop outstanding leadership in health, in order to improve people's health and their experiences of the NHS.

33. Additionally HEE supported healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards ("**LETBs**"), which were statutory committees of HEE.

34. LETBs were responsible for education and training at regional level. Their main role was to:

a. Plan and commission high quality education and training in order to secure future workforce supply with the right numbers and right skills to improve health outcomes;

b. Identify the local education and training needs of health and public health staff required to build skills and meet future service needs;

c. Bring providers and relevant stakeholders together to develop the workforce in line with local health needs and the service transformation agenda.

Annex 2

Provides a non-exhaustive list of key documents which are relevant to the content of this Statement and may assist the Inquiry.

Date	Event
2 March 2020	**Minutes of COBR(M) Meeting [AD1/126 INQ000056217]** COBR discussed that the NHS would be severely disrupted by the outbreak and that modelling for the potential hospital bed requirements was underway. Discussion was also had about whether the NHS had enough ventilation capacity.
2 March 2020	**Letter: Covid-19 NHS preparedness and response [AD1/015 INQ000087445]** Letter from NHS England's Strategic Incident Director and Incident Director setting out urgent preparatory actions for NHS organisations in response to the emerging pandemic. It required all NHS bodies to engage with Local Resilience Forums (LRFs), including social care providers, to support discharge and home care arrangements. The letter highlighted the need to support care homes with IPC measures and directed organisations to review continuity plans, monitor PPE stocks, and ensure system-wide coordination.
11 March 2020	**Minutes of COBR(M) Meeting [AD1/127 INQ000056220]** NHS England's CEO explained in light of the high pressure facing services, that elective surgery would need to be postponed which would release 30,000 beds – an equivalent of 60 hospitals across the UK.
12 March 2020	**Email between DHSC and NHS England regarding readout of NHS resilience meeting between the Prime Minister, SSHSC and NHS England [AD1/039 INQ000087307]**

	The readout of the meeting includes discussion of social care funding, including the need for a further discussion on resilience of the social care provider market given the pressures expected.
16 March 2020	**Quad meeting between NHS England, SSHSC, Permanent Secretary of the DHSC and other ministers [AD1/128 INQ000087491]** to discuss plans for the rapid expansion of hospital and "step-down" capacity, the publication of the Government's "Covid-19 Hospital Discharge Service Requirements" and the simplification of the financial regime for the funding of hospital discharges.
17 March 2020	**Cabinet Meeting AD1/129 INQ000056135]** The Cabinet, chaired by the Prime Minister, endorsed the Government's approach to the Covid-19 response, noting the need for timely and decisive action. The SSHSC confirmed the NHS was significantly increasing its capacity to respond to rising case numbers. As part of this effort, Cabinet was advised "to free up hospital beds over 30,000 patients were expected to leave hospital into social care imminently". The Prime Minister supported this action, noting individuals occupying hospital beds who would otherwise be in social care should be supported to leave hospital.
17 March 2020	**Letter: Important and Urgent – Next Steps on NHS Response To COVID-19 [AD1/016 INQ000087317]** Letter from Sir Simon Stevens and Amanda Pritchard to the NHS setting out the next steps for the NHS response to the pandemic. Relevant sections include: • Hospitals were asked to free 30,000 beds to create critical care capacity. • Community health services and voluntary organisations should engage with LRFs on how best to oversee support for older and

	vulnerable people who are going to be 'shielded' at home over the coming months. • Financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category. • CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, to facilitate step down of patients from secondary care and so free up acute beds. • To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any patient that needs it [INQ000
19 March 2020	**Guidance and letter: COVID-19 Hospital Discharge Service Requirements [AD1/130 INQ000049702]** Publication of Covid-19 Hospital Discharge Service Requirements, letter and patient leaflets. This was to ensure discharge is clinically led and that people can be safely and quickly discharged into places where they can receive appropriate care. The guidance requested following of the Discharge to Assess Model.
19 March 2020	**Announcement from Department of Health and Social Care and Ministry of Housing, Communities & Local Government:** Securing the use of £1.3bn of additional funds to enhance the NHS discharge process so patients who no longer need urgent treatment can return home safely and quickly.
19 March 2020	**Guidance and letter: Community health services prioritisation [AD1/056 INQ000269920]**

	Letter from the Director of Community Health and National Clinical Director for Older People and Person Centred Care to Trusts, CCGs, Directors of Public Health and Community Health Providers on prioritisation of community health services i.e. partially or fully stopping services to support hospital discharge. The guidance was superseded on 7 August 2020 by guidance on the restoration of adult and older people's community health services.
23 March 2020	**Meeting between the Prime Minister, Chancellor, senior ministers and NHS England to discuss (amongst other items) the creation of Nightingale hospitals designed and equipped as open-plan dormitory style facilities for sedated/unconscious ventilated Covid-19 patients.**
23 March 2020	**Covid-19 Strategy Ministerial Group Meeting [AD1/131 INQ0000056264] NHS CEO explained the increasing pressure on hospitals and the plans in place to increase number of ventilators on boosting workforce numbers. The Prime Minister said that all specialist hospitals should ramp up available capacity.**
28 March 2020	**Letter: Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic AD1/132 INQ000049879]** Detailing the service prioritisation necessary to release capacity to the system.
2 April 2020	**Guidance: Key Changes to COVID-19 prioritisation within community health services [AD1/056 INQ000269920]** Detailing the service prioritisation necessary to release capacity to the system.
2 April 2020	**Admission and Care of Residents during COVID-19 in a Care Home [AD1/133 INQ000325255** - co-badged
8 April 2020	**Supplementary FAQs COVID-19 Hospital Discharge Service Requirements (available on Better Care Exchange) [AD1/134 INQ000593786]**

	Detail on the NHS England funding support that commenced from Thursday 19 March 2020 and reimbursement, via CCGs, for the costs of out-of-hospital care and support that arise because of the approach outlined (both new packages and enhancements to existing packages), where it is provided to patients on or later than this date. Any patients already receiving out of hospital care and support that started before this date will be expected to be funded through usual pre-existing mechanisms and sources of funding.
15 April 2020	**Adult Social Care Plan published**
16 April 2020	**Letter: New requirement to test patients being discharged from hospital to a care home [AD1/017 INQ000358460]** Following the government's publication of the Adult Social Care Plan on 15 April 2020, NHS England issued instructions to all hospitals to test all patients prior to discharge back to their care home/new admission to a care home.
17 April 2020	**Letter: Data collection during the COVID-19 crisis [AD1/135 INQ000593787]** A joint letter from the Care Provider Alliance, Care Quality Commission, DHSC and NHS England to adult social care providers requested completion of daily data returns on care sector capacity on the NHS Capacity Tracker tool.
29 April 2020	**Letter: Important - For Action - Second Phase of NHS Response to COVID-19 [AD1/019 INQ000087412]** Letter from Sir Simon Stevens and Amanda Pritchard to the NHS on the second phase of the COVID-19 response • Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

	• Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains. • To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.
1 May 2020	**Letter: COVID-19 response: Primary care and community health support care home residents [AD1/021 INQ000330852].** NHS England wrote to primary care and community service providers asking them to step up their support to care homes. Practices and community providers will want to ensure: • timely access to clinical advice for care home staff and residents • proactive support for people living in care homes, including through personalised care and support planning as appropriate • care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and • sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.
1 May 2020	**Letter: Urgent - Further CCG assistance to Local Resilience Forums in supporting care homes: 'Training the Trainers' on infection prevention and control. Ruth May and Matthew Winn wrote to CCG**

	chief nurses to mobilise the "Mutual Aid" offer [AD1/075 INQ000331020] NB this letter was not published.
12 May 2020	**Letter: COVID-19 response: Identifying a clinical lead for all care homes. Support from primary care was extended to include a named clinical lead for each care home and virtual care home round [AD1/136 INQ000593788]** This clinician will provide clinical leadership for the primary care and community health services support to the care home and is responsible for the co-ordination of the service provision set out in the 1 May letter to the care home residents.
5 June 2020	**After-care needs of inpatients recovering from COVID-19 [AD1/137 INQ000050846]** This guidance supports primary care and community health services to meet the immediate and longer-term care needs of patients discharged following an acute episode of COVID-19, by working with partners to develop recovery/rehabilitation services.
31 July 2020	**Letter: Important - For Action - Third Phase of NHS Response to COVID-19 [AD1/138 INQ000051407]** As part of this wider letter to system, specific detail on restoration of services was included for community services: • General practice, community and optometry services should restore activity to usual levels where clinically appropriate and reach out proactively to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face-to-face interventions. We recognise that capacity is constrained but will support practices to deliver as comprehensive a service as possible.

	• GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes and begin a programme of structured medication reviews.
21 August 2020	**Discharge guidance** Detailed guidance to the system on the implementation of the Discharge to Assess model. The discharge to assess model has been implemented since March 2020 with an intention to support more people to be discharged to their own home. Health and social care systems are expected to build on this work during the first half of 2021 to 2022 to embed discharge to assess across England as the default process for hospital discharge during the funded period. Through a combination of embedding the discharge to assess model and utilising the national discharge fund, there is an expectation that performance continues to reduce the length of stay for people in acute care, to improve people's outcomes following a period of rehabilitation and recovery and minimise the need for long-term care at the end of a person's rehabilitation.
16 December 2020	**Guidance: Designated settings for people discharged to a care home AD1/064 INQ000234652]**
20 January 2021	**Letter: Improving Discharge patient flow from acute settings [AD1/140 INQ000059633** The letter sets out three schemes (hotel accommodation, independent sector provision for hospitals@home services and designated care home facilities indemnity cover) that systems can immediately implement for discharging people home from hospital. All of these options were funded from the £588m hospital discharge 'scheme two' fund up until 31 March 2021.

5 July 2021	**Discharge Guidance update (Update to guidance published on 21 August 2020)**

Annex 3

DNACPR guidance chronology

This table sets out the communication and guidance issued by NHS England with regard to DNACPR

Directive/Guidance	Author	Date
Joint statement on advance care planning **[AD1/141 INQ000235489]** *"Such advance care plans may result in the consideration and completion of a Do Not Attempt Resuscitation (DNAR) or ReSPECT form. It remains essential that these decisions are made on an individual basis. The General Practitioner continues to have a central role in the consideration, completion and signing of DNAR forms for people in community settings."* *"It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need"*	British Medical Association (BMA) Care Provider Alliance (CPA) Care Quality Commission (CQC) Royal College of General Practice (RCGP)	30 March 2020
Covid-19 Primary Care Bulletin **[AD1/142 INQ000331005]** Contains links to the Joint Statement issued on 30 March 2020	Primary Care Medical Director & Director of Primary Strategy and NHS Contracts	2 April 2020

Directive/Guidance	Author	Date
Letter on DNACPR **[AD1/111 INQ000216427]** *"It is imperative that decisions regarding appropriateness of admission to hospital and for assessment and treatment for people with learning disabilities and / or autism are made on an individual basis and in consultation with their family and /or paid carers, taking into account the person's usual physical health, the severity of any co-existing conditions and their frailty at the time of examination. Treatment decisions should not be made on the basis of the presence of learning disability and / or autism alone."*	National Director for Mental Health National Clinical Director – Learning Disability and Autism Medical Director for Primary Care	3 April 2020
Guidance and Standard Operating Procedures (General Practice) **[AD1/143 INQ000049958]** and (Advance Care Plan template as updated on 11 May 2020 **[AD1/144 INQ000330854]** This publication set out a broad range of guidance for general practice early in the pandemic but included important sections on advance care planning and palliative care, emphasising in particular the individual nature of plans.		6 April 2020
CMO and CNO joint letter to the system on 7 April 2020 **[AD1/109 INQ000192705]** Maintaining standards and quality of care in pressurised circumstances.	Chief Nursing Officer National Medical Director.	7 April 2020
Covid-19 Primary Care Bulletin **[AD1/112 INQ000331007]**	Primary Care Medical Director	8 April 2020

Directive/Guidance	Author	Date
Maintaining standards and quality of care in pressurised circumstances The bulletin issued to primary care contained signposts to the letter of 7th April 2020 (see this Annex above) and its key principles	Director of Primary Strategy and NHS Contracts	
Covid-19 Primary Care Bulletin **[AD1/145 INQ000331008]** Advanced care planning guidance *Stating that NHS England has developed guidance and a template for advanced care planning in the context of coronavirus (Covid-19)*	Primary Care Medical Director Director of Primary Strategy and NHS Contracts	15 April 2020
Clinical guide for the management of palliative care in hospital during the coronavirus pandemic [**AD1/095 INQ000330845**] *Includes the following extract:* ***Treatment escalation planning*** *In the context of the coronavirus pandemic, decisions about further treatment escalation or shifting the focus to palliative care will need to take place rapidly. It may not be possible to have joint discussions involving the patient, those close to them and the clinicians because:*		22 April 2020 (updated on 18 May 2020)

Directive/Guidance	Author	Date
• *the patient may have become ill and deteriorated very quickly, so they may not be able to fully participate in the decision-making.* • *the patient's family and those closest to them may not be able to be present because of hospital* infection *control procedures, or they may be in self-isolation or looking after family members who are ill.* *Conversations with the patient's family may well have to take place remotely. They are likely to be anxious and shocked by what has happened. These are not easy conversations to have but it is important that honest and timely conversations do take place. Senior clinicians should role model these conversations and support their teams to do so. Palliative care teams are skilled at these conversations and will do their best to support colleagues in doing so, but there will not be enough capacity for palliative care teams to undertake all conversations themselves.* *Appendix 2 for 'three talk' model for shared decision making.*		
Covid-19 response: Primary care and community health support care home residents. [AD1/021 INQ000330852] Letter to primary and community health care and CCGs addresses need to develop individually agreed treatment escalation plans including as follows:- ***"Development and delivery of personalised care and support plans for care home residents.*** *A process needs to be established to: i. Support development of*	Primary Care Medical Director Director of Community Health	1 May 2020

Directive/Guidance	Author	Date
personalised and individually agreed treatment escalation plans for care home residents with care home teams, including end of life care plans and preferences where appropriate and drawing on available guidance and templates (including from the Royal College of General Practitioners and the joint statement from the British Medical Association, Care Provider Alliance, Care Quality Commission, and Royal College of General Practitioners). Where time and resources are limited the advance care planning process should not be rushed and appropriate time found as soon as reasonable to complete the task with care and compassion."	Director of Primary Strategy and NHS Contracts	
Covid-19 Primary Care Bulletin **[AD1/113 INQ000331009]** Included the following reminder: *We continue to remind everyone about inappropriate and unacceptable applications of DNACPR orders to people with a learning disability and autistic people. Previous communications have been clear that decisions should be made on an individual basis and in consultation with the person themselves and / or their family; blanket policies are "inappropriate whether due to medical condition, disability, or age".*	Primary Care Medical Director Director of Primary Strategy and NHS Contracts	11 May 2020
Joint statement on personalised approaches to care and treatment **[AD1/114 INQ000339275]**	Baroness Campbell of Surbiton, DBE	20 May 2020

Directive/Guidance	Author	Date
Includes the following:- *Every individual should be provided with ongoing opportunities to participate in decisions that affect them. In relation to treatment decisions, patients should be supported to make informed decisions by the provision of clear advice on options from their clinicians, with family support or advocacy support if required and possible, and in compliance with the provisions of the Mental Capacity Act 2005 and related guidance where relevant.* *This means people making active and informed judgements about their own care and treatment, at all stages of their life, and recognises people's autonomy, as well as their preferences, aspirations, needs and abilities. This also means ensuring reasonable adjustments are supported where necessary and reinforces that the blanket application of do not attempt resuscitation orders is totally unacceptable and must not happen.*		
Updated guidance published for GPs on the Quality Outcomes Framework (QOF), as part of the 2020/2021 General Medical Services (GMS) contract **[AD1/115 INQ000330884]**		4 September 2020
Letter re: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and people with a learning disability and or autism **[AD1/116 INQ000339282]**	National Medical Director Chief Nursing Officer Director Primary Care	4 March 2021

Directive/Guidance	Author	Date
	Clinical Director for End of Life Care National Director for Learning Disabilities and Autism National Clinical Director for Learning Disabilities and Autism	

Annex 4

Palliative care guidelines chronology

Below is a chronology of the guidelines published on Palliative and End of Life Care throughout the pandemic relevant to adult social care.

27 March 2020	**Speciality guide Palliative care and coronavirus**: Clinical guide for the management of palliative care in hospital during the coronavirus pandemic. This guidance is aimed at all professionals looking after patients with coronavirus, and their families, in the hospital setting.	**[AD1/095 INQ000330845]**
2 April 2020	**NICE Guidance Covid-19 rapid guideline: managing symptoms (including at the end of life) in the community**: NG 163. The purpose of this guideline is to provide recommendations for managing Covid-19 symptoms for patients in the community, including at the end of life. It also includes recommendations about managing medicines for these patients and protecting staff from infection. This was not an NHS England document. It has since been replaced by NG 191.	**[AD1/146 INQ000331017]**
7 April 2020	Maintaining standards and quality of care in pressurised circumstances, and the risk of blanket decisions regarding DNACPR. A letter to the system emphasising the importance of individual care and decision-making).	**[AD1/109 INQ000192705]**

10 Aril 2020	**Covid-19 Primary Care Bulletin** Round-up for Primary Care includes short section on Anticipatory medicines at the end of life, which advises against care homes and individual patients routinely holding anticipatory medicines stocks, stating that stocks should be centralised as much as possible and distributed through local hubs set up by CCGs such as to ensure rapid access to end of life medicines for patients.	**[AD1/147 INQ000331027]**
15 April 2020	**Novel coronavirus (Covid-19) standard operating procedure: Community health services.** This guidance applies to all providers of community health services in England operating within the NHS Standard Contract. It clarifies the expected approach of community health services to the management of patients, both adults and children, in the community during the Covid-19 pandemic.	**[AD1/148 INQ000330841]**
22 April 2020	**Clinical guide for the management of palliative care in hospital during the coronavirus pandemic:** Treatment escalation planning in the context of the coronavirus pandemic, where decisions about further treatment escalation or shifting the focus to palliative care need to take place rapidly.	**[AD1/095 INQ000330845]**
23 April 2020	**SOP for running a medicines re-use scheme in a care home or hospice setting (published by DHSC)**	**[AD1/149 INQ000050153]**

	This standard operating procedure (SOP) supports timely access to essential prescribed medicines during the Covid-19 pandemic for patients who are being cared for in a care home1 or hospice setting.	
29 April 2020	**Priority medicines for palliative and end of life care during a pandemic** This guidance was published by the Association for Palliative Medicine of Great Britain and Ireland, the Royal College of General Practitioners and The Association of Supportive and Palliative Care Pharmacy and not by NHS England. However, NHS England worked with those bodies on its production. It sets out a short list of medicines for palliative and end of life care that needed to be managed nationally with local collaboration across all sectors.	**[AD1/150 INQ000239708]**
11 May 2020	**Clinical guide for supporting compassionate visiting arrangements for those receiving care at the end of life** Provides advice to the healthcare system concerning how visiting at the end of life can be facilitated across a range of settings including inpatient settings, care homes, hospices and the patient's home.	**[AD1/102 INQ000050424]**
20 May 2020	**Joint statement on personalised approaches to care and treatment** Statement issued jointly with Baroness Campbell of Surbiton concerning the importance of individual involvement in decision-making.	**[AD1/114 INQ000339275]**

23 September 2020	**Dementia wellbeing in the Covid-19 pandemic** Guidance and resources to support professionals, people with dementia and carers.	**[AD1/151 INQ000330897]**
15 June 2021	**Dementia wellbeing in the Covid-19 pandemic v3** Updating previous guidance document.	**[AD1/152 INQ000330911]**