NHS Confederation

COVID-19 inquiry draft terms of reference consultation

NHS Confederation response

7 April 2022

About the NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Our response to the COVID-19 inquiry draft terms of reference

1. **Do the inquiry's draft terms of reference cover all the areas that you think should be addressed by the inquiry?**

Overall, the terms of reference (ToRs) should be tight enough to deliver timely and practical findings. We think that the areas covered are broadly sufficient and we support the focus on the circumstances faced by the UK healthcare system as it entered the pandemic. We would however like to flag a few considerations as the ToRs are put into practice, including the role of the whole health and care sector in the pandemic response.

The draft ToRs broadly cover the areas we believe should be addressed by the inquiry. We believe the inquiry has two central purposes: to draw practical recommendations to improve health system preparedness and resilience; and to give those most impacted by the pandemic, including the health and social care workforce, the bereaved, and those who experienced particular inequalities during the pandemic, adequate opportunity to contribute to lessons learned and to have their voices and experiences heard.

We welcome that the ToRs take a big picture view of the pandemic rather than focusing on individual cases, as this provides a suitably strong focus on the most influential decisions: those made at the highest level. There will of course be inquests into individual cases where there were serious patient safety concerns, but we believe the starting point should be the role of the government and its role in the handling of the pandemic.

We also welcome the focus on central preparedness and resilience planning, as well as the health and care sector's levels of preparedness, initial capacity and the ability to increase capacity, and resilience. This should include an assessment of the decisions to disinvest in contingency planning and allow the personal protective equipment stockpile to become out of date, which led to an inadequate procurement process and failed to protect staff and vulnerable individuals, particularly in care homes. The circumstances faced by the UK healthcare system as it entered the pandemic should be central to the inquiry, including the lack of national preparedness, lack of spare capacity, underfunding and huge unaddressed workforce issues, which the government, not the NHS, were in a position to influence. We welcome the use of international comparisons to this end.

Alongside understanding the reality of the context in which the pandemic began, we hope the inquiry team will have regard to the complexity of the context in which the inquiry is taking place. System leaders are still operating within a level 4 incident, treating COVID-19

patients and tackling a backlog of elective care with unprecedented levels of staff absence and the lowest level of public and staff satisfaction for decades. In view of continuing pressures on NHS leaders, we hope the inquiry team will take a proportionate approach to requesting information from healthcare leaders.

We would like to flag the risk of only explicitly referring to the pandemic response in acute and care home settings. The UK has a complex health and social care landscape, involving acute, primary, community, mental health and ambulance services and social care provided privately, by local authorities and by voluntary organisations. During the pandemic, services such as 999 and NHS 111 were scaled up, and partners in the voluntary, community and social enterprise sector and independent sector services, including hospices, played a significant role in the response. The healthcare sector innovated at scale to deliver care virtually. This was most notable in primary care, through setting up 24/7 mental health crisis phonelines across England and the provision of 'virtual wards,' which allowed those receiving care to be monitored from home using pulse oximetry and other services, freeing up beds in the acute sector. Without directly addressing the role of the whole sector, the inquiry risks not accurately representing the events, or failing to identify meaningful lessons for the future.

In seeking to establish lessons for the future, it is important to consider the direction of the sector. Health and care are moving towards more integrated ways of working which will be enshrined in law by the Health and Care Act in the coming months. We hope this nuance will be reflected in the way the inquiry team conducts its work, if not in the ToRs themselves. We encourage the inquiry team to work closely with us and other key players in the sector to identify the various actors working across the system, the role they played in response, who they were accountable to and how they were impacted by the pandemic.

Devolution and the different health systems in each UK nation add to this complexity. The inquiry team should ensure its investigations build a comprehensive understanding of the UK-wide response, considering the role of inter-governmental relations in the support of NHS organisations, and examine its impact on communication to the public and stakeholders. Focus should be given to decisions made in devolved nations to understand key points of policy divergence and convergence.

The inquiry's consideration of the disproportionate impact of COVID-19 relating to the Equality Act 2010 protected characteristics is welcome. However, it could go further and investigate how considerations around equity were incorporated into government decisions and actions during the pandemic. We would also be interested in reasons behind the choice to reform to the public health structure during the pandemic, particularly given the public health capacity nationally and locally at the time.

We believe there should be a stronger emphasis in the ToRs on the manner in which key operational changes were communicated from the centre to those delivering services on the frontline. During the pandemic there were several instances where important policy changes with significant ramifications for service delivery were announced very shortly before they were expected to be implemented, and in some cases, were announced in the national media before frontline leaders were informed. We would encourage the inquiry team to look at the government's public messaging around the level of pressure on the healthcare

system, to manage expectations about the delivery of care. This became an issue in particular during the second wave of the pandemic, when reports of abusive behaviour towards frontline staff and inappropriate use of services such as A&E inhibited the system's ability to deliver care and added to pressures on staff.

Finally, there is little focus in the ToRs on the provision of mental health services, children and young people's services and long-term condition management services, despite their importance in preventing morbidity and mortality among disadvantaged populations in particular. We recognise this may be intended to be covered under 'provision for non-Covid related conditions and needs' in the ToR, but we believe there is merit in making this explicit. Statutory inquiries into the pandemic response in Belgium, France, Ireland, Norway and the US have looked specifically at the impact on adults needing long-term care.[1]

We suggest the following alterations to help provide clarity for those involved in the inquiry:

- Clarify if the definition of 'hospital' includes hospitals in mental health, community, specialist and NHS-funded independent settings.

- Clarify if the definition of 'care homes' includes care and residential homes where working-age adults or children and young people with care needs are supported.

- Ensure consideration of the experiences of the health and care sector extends to the breadth of the healthcare system, encompassing acute, primary, community, mental health, ambulance and social care settings.

- Include a more explicit reference to the effectiveness of government actions by looking at 'how **effectively** decisions were made, communicated and implemented,' particularly in respect to how key operational decisions were communicated to those delivering services and how considerations around equity were incorporated in pandemic-related governmental decisions and actions.

- Include a more explicit reference to mental health services, children and young people's services and long-term condition management services.

2. Which issues or topics do you think the inquiry should look at first?

Given the potential longevity of this inquiry, we hope that there will be an initial fact-finding phase from which some practical recommendations can be rapidly drawn and delivered to help the country recover from COVID-19 and improve resilience and preparedness for future health shocks. This could be done in a similar way to the modular approach taken in the Grenfell Tower Inquiry, which first established the events surrounding the fire and is now looking at the wider circumstances. Or, the fast-track inquiry used for the Hillsborough disaster, which enabled quick adoption of recommendations in stadiums to prevent the tragedy from happening again. We suggest the focus of this initial phase should be on

[1] https://www.health.org.uk/publications/long-reads/how-can-the-uk-covid-19-inquiry-bring-about-meaningful-change

ensuring the health and care sector is equipped with adequate preparedness plans for future variants or pandemics, including with regard to preventing further impacts on health inequalities.

The risks posed by not pursuing such an approach are demonstrated in the Public Administration Committee (PAC) report on the Chilcot Inquiry, which found that the drawn-out seven-year process reduced the impact of its recommendations.[2]

The inquiry team will be able to draw from a wealth of evidence that exists in the public domain, such as parliamentary inquiries, PAC and National Audit Office investigations and academic papers, including reports published by think tanks and policy bodies. Many local systems have conducted analysis of the pandemic and these resources could usefully be considered as well.

Our members across the NHS have been building on lessons learned, sharing best practice and innovating at scale throughout the pandemic. However, their ability to do so would be greatly strengthened by a more rigorous investigation and practical, evidence-based recommendations. Staff across the health service want to learn from the experience of COVID-19 and need a public health system and social care system that is equipped to deal with future pandemics.

[2] https://publications.parliament.uk/pa/cm201617/cmselect/cmpubadm/656/65602.htm

3. **Do you think the inquiry should set a proposed end date for its public hearings, to help ensure timely findings and recommendations?**

There is a risk, given the broad scope of the inquiry, that if an end date is not set, the process could go on for several years. This could drive up the cost to the public and delay the implementation of key findings that will be crucial to the UK addressing the next health emergency more effectively. We are also concerned about the impact on witnesses' wellbeing and mental health if proceedings are dragged out over many months and years. For those on the frontline in particular, reliving the pandemic could be a traumatic experience.

We therefore believe there is merit in setting an end date for the initial fact-finding phase to allow the quick adoption of lessons learned. The next phase of the inquiry could have a more flexible end date to allow for a deeper exploration into important issues. However, in recognition of the emotional burden the inquiry will place on individuals involved, in particular those who worked and continue to work on the frontline, it would be important to provide as much detail as possible about the focus and longevity of the investigations.

4. **How should the inquiry be designed and run to ensure that bereaved people and those who have suffered harm as a result of the pandemic have their voices heard?**

We believe there should be a phase or module of the inquiry dedicated to bereaved people and those who suffered harm as a result of the pandemic, so they can contribute meaningfully to the inquiry and its recommendations. This should extend to key workers and those whose mental health was impacted by the pandemic.

The inquiry team should engage directly and meaningfully with the bereaved families for justice groups across the four nations. They should also engage with stakeholder groups which support those who experienced particular inequalities during the pandemic due to their race or ethnicity; those living in poverty; those living with mental health problems (in particular children and young people, those who are LGBTQ+, and elderly); those affected by street homelessness or housing instability; and key workers. Many people falling into these categories came into contact with the health and social care system during the pandemic – some many times. Therefore, engaging with public voice organisations such as Healthwatch will also be an important part of the process.

The inquiry team should make steps to ensure the process is accessible to all those providing evidence and that they are provided with mental health support. We support the decision to provide certain applicants, including bereaved families, with funding for legal representation without the requirement to means test under section 40(4) of the Inquiries Act 2005, which will remove some of the barriers to meaningful engagement in the inquiry process.