

Preparing for the COVID-19 public inquiry: answers to your webinar questions

On 11 November, NHS Providers hosted a webinar on preparing for the COVID-19 public inquiry with input from the three legal partners from our panel of commercial partners: Capsticks, Browne Jacobson and Hempsons. A number of questions were raised during the event which we didn't have time to cover – our three speakers now helpfully set out their answers, to the best of their knowledge, below.

You can also [watch a recording](#) of the session on our website featuring:

- Georgia Ford, partner, Capsticks
- Gerard Hanratty, partner and head of health, Browne Jacobson
- Liz Hackett, partner, Hempsons.

[Slides are also available](#) on our website of the session.

Inquiry process

Is there a standard timeframe between the nomination of the chair and the confirmation of the terms of reference?

No, there isn't. However, the chair or proposed chair must be consulted on the terms of reference so the announcement as to the chair usually precedes any announcement as to terms of reference, although it is possible for the government to announce the 'aims' or 'purpose' of an inquiry before the specific terms of reference are confirmed.

Who covers legal costs for witnesses or core participants?

The chair of the inquiry can award reasonable expenses to witnesses in compensation for loss of time, costs incurred attending the inquiry, or in respect of legal representation. Most inquiries have their

own costs protocols and any person applying for expenses will need to comply with the protocol. Awards for expenses are not guaranteed, particularly in respect of legal expenses, and will be subject to assessment and for determination by the chair. Refusal can under the Rules be subject to review at the request of the applicant.

Will we know what information is requested from other bodies?

The way in which the inquiry will gather evidence is not yet known but requests for evidence made to organisations are addressed directly to that organisation and therefore one would not ordinarily know what has been requested from other organisations. However, for the COVID-19 inquiry, it is possible this could be slightly different if, for example, NHS England were to act as a conduit between providers and the inquiry or if the same request for evidence is sent out to all providers.

How do you think the inquiry will seek information from the NHS? Do you think it would be from all trusts, some trusts, or via NHS England?

There are varying schools of thought at the moment. It seems likely that requests may go to specific trusts for specific reasons (for example, those with outlier experiences in terms of nosocomial infections or numbers of admissions, those who were providing specialist care, those who were running Nightingale hospitals, those who took charge of Gold command, etc), with broader information collation requests going via NHS England and potentially integrated care systems (ICs). There may also be a role for NHS England and organisations such as Healthcare Safety Investigation Branch (HSIB), which may be asked to expand on some of its short COVID-19 reports.

Focus of the inquiry

Do you think the inquiry will be looking at local authority public health functions, and how decisions were made there and the impact on the NHS?

One of our legal partners offered the view that the inquiry will look across how central government and local authorities responded to the pandemic, including looking at how local authorities and the NHS worked together. While the inquiry may not have capacity to look at all decisions made across the country, they would expect that it will examine some decisions in greater detail. For example, it may decide to look at an area which had a higher-than-expected number of deaths or hospital admissions, when compared with statistics from across the rest of the country. We might expect the inquiry to look at the response and decision making of the relevant local authorities and

NHS bodies, as well as any intervention by central government and what lessons can be learnt from the approaches by the relevant bodies. As a result, we would expect the inquiry to look at how some local authorities exercised their public health functions and the impact that had on the NHS because understanding how those bodies could work better, will help in dealing with any future public health issues and also the greater integration of health and social care.

Do you think it's likely the inquiry will take a "separate streams" approach?

It would seem a sensible option for the inquiry to explore in determining the methodology and process to examine the issues which are set out in the terms of reference, when they are published. Given the vast range of issues that it is possible the terms of reference could cover, then creating a systematic approach to how the inquiry will investigate those matters will mean consideration needs to be given to how they can be sorted. In other public inquiries we have seen, this is done through chapters looking at specific events on a chronological or organisational basis, or through streams looking at specific topics. Generally, we would expect the inquiry to separate out specific issues for it to look at in a systematic way.

Are we likely to be asked about specific incidents at our trust, or our experiences given certain characteristics, for example nosocomial outbreaks or large Black, Asian and minority ethnic communities? Would this mean we might be asked to be core participants?

It may be that the inquiry will look at some specific incidents and seek to understand how NHS organisations approached them. That could relate to any number of issues, including whether people became infected in hospital, specific risks for Black, Asian and minority ethnic communities, the impact of the Nightingale hospitals and how the health and social care workforce was supported, to name but a few. In doing that, the inquiry will seek information and evidence from a wide variety of sources including NHS organisations, but that does not mean you would automatically need to be a core participant. A core participant is normally an organisation or person which/who:

- played a direct role in the subject of the inquiry
- has a significant interest in an important aspect of the inquiry
- may be subject to explicit or significant criticism during the inquiry or in the report.

Generally, it would seem that not many NHS trusts or foundation trusts will be core participants in this inquiry, but that is subject to the above analysis. It is also possible that core participant status can be given for specific parts of the inquiry due to the matters being considered at that time. However, it seems likely that many NHS trusts and foundation trusts will be requested to provide evidence for the inquiry to consider without being designated core participants.

How far might the inquiry focus on the impact of those who have suffered disproportionately during the pandemic, such as Black, Asian and minority ethnic groups and those with learning disabilities?

The inquiry could decide that it's going to have a chapter looking at the impact across different populations, for example across ethnic, religious and age groups. It might look there in terms of what happened, how people were cared for, whether there were outliers across the country. It might look at whether certain parts of the country may not have had the resource or the capacity to deal with the issues they were facing because they may have had, for example, a larger population, or a larger ethnic population that was more susceptible to COVID-19. There may also be some focus on discharge to assess and how well it worked given that the law changed in order to enable this policy to be taken forward properly.

The inquiry may go through issues like this because those are the type of things which are about understanding how do you deal with a pandemic if it ever happens again – in the event of another pandemic, how do we protect those groups that are more susceptible?

Is the inquiry likely to draw in all trusts (acute, ambulance, community and mental health) equally, or might there be some variation according to sector?

It seems likely that there is going to be a broad reflection of the sector, rather than just looking at acute trusts, because there has been an impact on our colleagues and patients across ambulance, mental health and community services. Because of this breadth, there may be a role here for the regional hubs in helping to manage input.

Trust information gathering and resourcing

How do you think trusts can calibrate the appropriate level of preparation they should undertake when it's unclear to what extent they might be involved or called upon?

Questions of resource, particularly given the ongoing operational challenges, are always difficult. In circumstances where it is not yet known what role there will be for individual trusts, it is understandable that there may be concern about redirecting resource from other operations. We think we will all agree that preparation should be started now. If you are called upon in due course to

provide disclosure (documentation or statements), you need to be ready to comply with any time timeframe imposed. You also need to ensure that all disclosure that may be relevant (and this could be very broad) is preserved, as failure to do so could adversely impact the accuracy of evidence given to the inquiry, the inquiry's findings, and result in criticism on your trust and registered professionals.

There are some preliminary steps that can (and NHS England recommend should) be taken without extensive resourcing, such as issuing a Stop Notice to all staff (NHS England has offered its document for adapting); identifying key policy changes implemented by the trust in response to COVID-19 and collating the policy or procedural documents; and identifying key issues which impacted your trust and collating Datix (or other), policy and procedural documents. These documents should all be preserved, ensuring that they are stored in a way that will not be adversely impacted by systems changes.

There is a risk that the inquiry is very resource intensive for the NHS at a time when it is already under severe pressure. Do you think the inquiry will give some consideration to this? How can this risk be managed?

There does not seem to be any appetite, either from government or the public, to increase pressures on the NHS unnecessarily. There will be a balancing exercise to ensure that the inquiry is not hindered in exploring those matters which are ultimately determined to form part of the terms of reference, and to prevent the inquiry from being too burdensome and having an adverse impact on operational requirements and the delivery of care.

Any request for information from an individual trust, or the NHS collectively, will need to be reasonable and proportionate. This is in terms of the nature and extent of the information sought, and the timeframe for any response. Where a request (or the timeframe for compliance) is unreasonable or disproportionate, representations can be made to the inquiry team.

Trusts are being asked to start collating documentation now so that when the terms of reference for the inquiry are established and disclosure requests made, trusts are not on the back foot and having to face a mammoth task in an unreasonable timeframe.

How might trusts approach the document management ask involved here? For example, is it a case of mapping or collating information? To what extent do you think we can develop position statements now? What might be a pragmatic approach? What might be the risks to consider?

There are many approaches that may be adopted, and the approach that you take is likely to be dependent on available resource.

Consideration should be given to how are you going to identify documentation, store information, sequence and catalogue it, and make onward disclosure. Identifying and storing information are priority steps, whereas sequencing and cataloguing it for ease of cross referencing and onward disclosure are more time consuming and may be steps that you choose to undertake when the terms of reference are published, and the role of individual trusts are known.

One way to identify information is by reference to generic themes. By making a simple timeline, you could note key dates nationally and locally, against which you should be able to identify when you changed local policy and procedure. Alternatively, you could collate documentation by reference to trust specific issues; those matters which most significantly impacted your organisation. Either way, be flexible until the terms of reference are known.

Whatever approach you take, have a tested system and data management processes in place. At very least, store documents in clearly identifiable sub-folders for each theme or issue; have an index which includes policy / document name, number and dates active. Ensure that your information governance structures are robust and that you are confident that you are not going to be affected by IT changes.

Witness statements or position statements can be considered at this stage but you may wish to take advice from your legal team as to how best to do this and the form that they should take. Once prepared, they will be subject to disclosure rules and care should therefore be taken to ensure that they are both relevant and accurate. Briefly however, you may wish to consider statements for those specific issues that have significantly affected the trust in an adverse way, with any such statement being limited to one specific issue for ease of use and onward disclosure.