



House of Commons
Public Accounts Committee

Readying the NHS and social care for the COVID-19 peak

Fourteenth Report of Session 2019–21

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 20 July 2020*

The Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No. 148).

Current membership

[Meg Hillier MP](#) (*Labour (Co-op), Hackney South and Shoreditch*) (Chair)

[Mr Gareth Bacon MP](#) (*Conservative, Orpington*)

[Kemi Badenoch MP](#) (*Conservative, Saffron Walden*)

[Olivia Blake MP](#) (*Labour, Sheffield, Hallam*)

[Sir Geoffrey Clifton-Brown MP](#) (*Conservative, The Cotswolds*)

[Dame Cheryl Gillan MP](#) (*Conservative, Chesham and Amersham*)

[Peter Grant MP](#) (*Scottish National Party, Glenrothes*)

[Mr Richard Holden MP](#) (*Conservative, North West Durham*)

[Sir Bernard Jenkin MP](#) (*Conservative, Harwich and North Essex*)

[Craig Mackinlay MP](#) (*Conservative, Thanet*)

[Shabana Mahmood MP](#) (*Labour, Birmingham, Ladywood*)

[Gagan Mohindra MP](#) (*Conservative, South West Hertfordshire*)

[Sarah Olney MP](#) (*Liberal Democrat, Richmond Park*)

[Bridget Phillipson MP](#) (*Labour, Houghton and Sunderland South*)

[Nick Smith MP](#) (*Labour, Blaenau Gwent*)

[James Wild MP](#) (*Conservative, North West Norfolk*)

Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No. 148. These are available on the Internet via www.parliament.uk.

Publication

© Parliamentary Copyright House of Commons 2020. This publication may be reproduced under the terms of the Open Parliament Licence, which is published at www.parliament.uk/copyright/.

Committee reports are published on the [Committee’s website](#) and in print by Order of the House.

Committee staff

The current staff of the Committee are Bradley Albrow (Second Clerk), Hajera Begum (Committee Assistant), Jessica Bridges-Palmer (Media Officer), Ameet Chudasama (Senior Committee Assistant), Richard Cooke (Clerk) and Shai Jacobs (Chair Liaison).

Contacts

All correspondence should be addressed to the Clerk of the Committee of Public Accounts, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 5776; the Committee’s email address is pubacom@parliament.uk.

You can follow the Committee on Twitter using [@CommonsPAC](#).

Contents

Summary	3
Introduction	5
Conclusions and recommendations	6
1 Lessons from the NHS and adult social care response to the COVID-19 pandemic	9
Accountability arrangements for the COVID-19 response	9
Discharging people from hospitals to care homes	11
Delays to reforming adult social care	12
2 Resuming services and preparing for the future	14
Public trust	14
Managing staff well-being	15
Securing additional capacity	16
Formal minutes	18
Witnesses	19
Published written evidence	20
List of Reports from the Committee during the current Parliament	21

Summary

The COVID-19 outbreak posed severe and immense challenges to health and social care services in England. After the first cases of COVID-19 in England were reported on 31 January 2020, the NHS and the adult social care sector had to act quickly to prepare for the impact of the pandemic within hospitals and care homes. By the end of April, the government had allocated an additional £6.6 billion to support the health and social care response, and £3.2 billion to local government to help with pressures on local services, including social care. On 15 May it announced a further £600m for infection control in care homes. We were told that in mid-March SAGE predicted that in the worst-case scenario more than 4% of the population might be hospitalised, and 30% of those would require critical care and that ICU capacity in London may well be breached by the end of the month, even if additional measures were in place.¹

Thanks to the commitment of thousands of staff and volunteers and by postponing a large amount of planned work, the NHS was severely stretched but able to meet overall demand for COVID-19 treatment during the pandemic's April peak. From early March to mid-May, the NHS increased the quantity of available ventilators and other breathing support, which are essential for the care of many COVID-patients. The number of mechanical ventilators rose from 9,600 to 13,200. The number of beds available for COVID-patients also increased from 12,600 to 53,700 between mid-March and mid-April.

Unfortunately, it has been a very different story for adult social care, despite the hard work and commitment of its workforce. Years of inattention, funding cuts and delayed reforms have been compounded by the Government's slow, inconsistent and, at times, negligent approach to giving the sector the support it needed during the pandemic. This is illustrated by the decision to discharge 25,000 patients from hospitals into care homes without making sure all were first tested for COVID-19, a decision that remained in force even after it became clear people could transfer the virus without ever having symptoms.

Reflecting on the Government's response to the pandemic so far, we are also particularly concerned by its failure to provide adequate PPE for the social care sector and testing to the millions of staff and volunteers who risked their lives to help us through the first peak of the crisis. The Government needs to work urgently now to ensure that there is enough capacity—including both testing and PPE—and continued support for staff and volunteers so we are ready for future COVID peaks.

There are many lessons that the government must learn, not least giving adult social care equal support to the NHS and considering them as two parts of a single system, adequately funded and with clear accountability arrangements. No-one would expect government to get every decision right first-time round during such an emergency. Rather than seeking to give the impression that it has done so, the government urgently needs to reflect, acknowledge its mistakes, and learn from them as well as from what has worked.

1 4% of the population is 2.7 million people based on the current Office of National Statistics estimated UK population of 66.7 million.

This is our first examination of the health and social care response to COVID-19. The committee will be examining the ventilator challenge and the procurement of PPE in more detail in the autumn.

Introduction

In England, the Department of Health and Social Care (the Department) has overall responsibility for health and social care policy while NHS England and NHS Improvement (NHSE&I) leads the NHS, providing oversight and support for NHS trusts and foundation trusts. Local NHS trusts provide hospital, community and mental health services, alongside GPs, while local authorities assess care needs and commission social care and public health services. In March this year, NHSE&I was given temporary emergency powers to lead and organise all NHS services directly as it responded to COVID-19.

The Ministry of Housing, Communities & Local Government (the Ministry) has responsibility for the local government finance and accountability systems. Public Health England, working with local authorities and NHS partners, provides health protection services and public health advice, analysis and support to government and the public. This includes monitoring of, preparing for and responding to public health emergencies such as COVID-19.

Conclusions and recommendations

1. **Unclear responsibilities and accountabilities at the outset and a failure to issue consistent and coherent guidance throughout the pandemic have resulted in confusion and poor central control over critical elements of the pandemic response.** The health and social care sector had to react quickly, including making necessary changes to the way services are organised and provided, to respond to the COVID-19 crisis. While it was clear that the NHS had responsibility for ensuring there were enough beds, oxygen and ventilators to provide treatment for COVID-patients when required, it was unclear who was leading on the social care response. The Department is responsible for overall policy across health and social care but leads a fragmented system of adult social care, where responsibilities are spread between the Department, local government and care providers. Several bodies, including the Department, Public Health England and NHS England and NHS Improvement (NHSE&I) are involved in COVID-19 testing and reporting, and the provision of Personal Protective Equipment (PPE) for NHS and social care staff. Yet there have been frequent reports of the lack of timely testing for both staff and the public and the inadequate provision of PPE for social care workers and residents, with numerous updates to PPE guidance leading to confusion and stress. We note that Lord Deighton, since mid-April, has taken the lead on PPE supply. This direct accountability is a welcome step and we note there have been fewer issues with supply since then.

Recommendation: *The Department should write to us by September 2020 setting out the named individuals who are the Senior Responsible Owners or relevant national leads for all critical elements of the pandemic response, including, for adult social care, an equivalent to the Chief Executive of NHS England; PPE provision and supply; and testing. The Department should ensure these leads work with all relevant local and national bodies and have both the authority and data they need to do their jobs.*

2. **Discharging patients from hospital into social care without first testing them for COVID-19 was an appalling error.** Shockingly, Government policy up to and including 15 April was to not test all patients discharged from hospital for COVID-19. In the period up to 15 April, up to a maximum of five symptomatic residents would be tested in a care home in order to confirm an outbreak. Belatedly, after discharging 25,000 people from hospitals to care homes between 17 March and 15 April, the Department confirmed a new policy of testing everyone prior to admission to care homes. Public Health England confirmed that it was already becoming clear in late March, and certainly from the beginning of April, that the COVID-19 infection had an asymptomatic phase, when people could be infectious without being aware they were sick. The Department does not know how many of the 25,000 discharged patients had COVID-19. The number of reported first-time outbreaks in individual care homes peaked at 1,009 in early April. Between 9 March and 17 May, around 5,900 care homes, equivalent to 38% of care homes across England, reported at least one outbreak. The Department says that it took rational decisions based on the information it had at the time, but acknowledges that it would not necessarily do the same thing again.

Recommendation: *The Department and NHSE&I should review which care homes received discharged patients and how many subsequently had outbreaks, and report back to us in writing by September 2020. The Department along with NHSE&I should develop procedures so that all patients deemed fit to leave hospital are safely discharged into settings in a way which limits the spread of COVID-19.*

3. **This pandemic has shown the tragic impact of delaying much needed social care reform, and instead treating the sector as the NHS's poor relation.** This Committee has highlighted the need for change in the social care sector for many years, particularly around the interface between health and social care. Despite the intentions of successive Governments, there have been ongoing delays to reforming and integrating the two sectors. The stark contrast between the approach taken towards protecting the NHS compared with the care sector has been highlighted by many since the start of the pandemic. Various pieces of guidance were issued to the social care sector, but it took the Department until 15 April to publish their action plan for adult social care, over 4 weeks after the initial NHS letter on plans to respond to the COVID-19 outbreak. The Department has much better and more timely information in the NHS than for social care. It is simply unacceptable to hear reports of inadequate PPE, lack of testing and insufficient guidance on training. There have been warnings of an increased risk of provider failure in the care sector, and the Local Government Association and NHS Providers have reiterated the need for urgent reforms to put social care on a sustainable footing after years of under-funding.

Recommendation: *After years of promises and false starts, we expect the Department to set out in writing to us by October 2020 what it will be doing, organisationally, legislatively and financially, and by when, to make sure the needs of social care are given as much weight as those of the NHS in future. We will be challenging them on this at future sessions.*

4. **Public confidence is likely to be further undermined without an open and honest debate about current capacity and tangible plans to address gaps, for example, in testing and PPE.** Government has had to and will continue to have to make quick decisions with sometimes imperfect information as the pandemic develops. Yet too often the basis for decisions or changes, such as on PPE, has been unclear; sometimes seemingly based upon what the system could cope with, rather than clinical advice and 'what was right', and at other times without regard to the reality on the ground. On PPE, guidance was changed 40 times without consulting service providers, leading to confusion on the ground. There has been a lack of transparency around the availability and supply of PPE, and a tendency for Government to over-promise and under deliver. After squandering the opportunity to build up supplies in January and February, it remains to be seen whether the Department can meet its intention to have a 90-day PPE stockpile. Testing for COVID-19 is vital for controlling the virus and informing and assuring the public. It will be essential as 'track and trace' is rolled out, yet testing capacity was insufficient for much of the pandemic and, as highlighted by the UK Statistics Authority, public reporting has been inconsistent and lacking transparency.

Recommendation: *Among other measures, the Department should assess the capacity it needs, particularly for PPE and testing, and how it will meet this, to*

cope with a second peak; and report transparently and consistently on progress. It should write to the Committee by September 2020 with further details of its assessment and plans.

5. **Staff in health and social care cannot be expected to be ready to cope with future peaks and also deal with the enormous backlogs that have built up unless they are managed well.** We are deeply concerned about the frontline workers and volunteers who have endured the strain and trauma of responding to COVID-19 for many months. Failure to protect staff by providing adequate PPE has impacted staff morale and confidence, while a lack of timely testing, until after the pandemic had passed its first peak, led to increased stress and absence. These same staff will be called upon in the event of a second peak and the NHS will need extra staff to deal with the backlog of treatment. While the NHS says it is providing much needed support to staff, details are limited, and we remain concerned about the Department's ability and capacity to safeguard the mental health and well-being of the thousands of health and social care staff and volunteers from the lasting effects of the pandemic.

Recommendation: *The Department and NHSE&I should identify and agree with relevant professional bodies specific actions to support health and social care staff to recover from the impact of the first peak and how they will monitor and provide further support to staff through to the end of the pandemic.*

6. **Policies designed to create additional capacity quickly, while necessary, have resulted in a lack of transparency about costs and value for money.** The NHS boosted its potential maximum capacity for the peak in April by building Nightingale hospitals across the country and signing contracts with independent providers for 8,000 additional beds, which was announced on 21 March. The contract ended on the 28 June. The Department expects to continue these arrangements in anticipation of future peaks. However, we are concerned by the scarcity of information on contracts and costs. When asked, NHSE&I was unable, or unwilling, to provide any estimate of the cost of private sector capacity or the Nightingale hospitals. We are fortunate that the Nightingale hospitals have not been required so far during the pandemic, but it will not be a good use of public money if we continue to let them remain empty while elsewhere the NHS requires additional capacity for normal services.

Recommendation: *After failing to provide detail in the session, it is imperative that the Department and NHSE&I write to the Committee as soon as possible – and no later than 1 September 2020—with information on the cost of private hospital contracts, how these have been used, and their intentions for how private and Nightingale hospitals will be made best use of in the coming months, including:*

- *details of what the second phase of contracts will provide;*
- *the total cost and pricing mechanisms; and*
- *how capacity in these hospitals will be allocated?*

They should come to subsequent sessions prepared to disclose cost information on key elements of the pandemic response.

1 Lessons from the NHS and adult social care response to the COVID-19 pandemic

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department), NHS England & NHS Improvement (NHSE&I), the Ministry of Housing, Communities & Local Government (the Ministry) and Public Health England on Readyng the NHS and adult social care in England for COVID-19.²

2. In England, the Department has overall responsibility for health and social care policy while NHSE&I leads the NHS, providing oversight and support for NHS trusts and foundation trusts. Local NHS trusts provide hospital, community and mental health services, alongside GPs, while local authorities assess care needs and commission social care and public health services. The Ministry of Housing, Communities and Local Government (MHCLG) has responsibility for the local government finance and accountability systems. Public Health England, working with local authorities and NHS partners, provides health protection services and public health advice, analysis and support to government and the public.³ This includes monitoring, preparing for and responding to public health emergencies such as COVID-19. Public Health England (PHE) is an executive agency of the Department.⁴ At the start of the outbreak, the only central stock pile—held by PHE was designed for a flu Pandemic. We welcome Lord Deighton’s appointment to lead on PPE supply.

3. COVID-19 is an infectious respiratory disease caused by a newly discovered coronavirus, first identified in China in December 2019. On 31 January 2020, England’s Chief Medical Officer confirmed the first cases of COVID-19 in England. Over the following months, the UK government mobilised a wide-ranging response to COVID-19, covering health, social care and other public services, and support to individuals and businesses affected by the pandemic. By the end of April, the government had allocated an additional £6.6 billion to support the health and social care response to COVID-19 and £3.2 billion to local government to respond to COVID-19 pressures across local services, including adult social care.⁵

Accountability arrangements for the COVID-19 response

4. The scale and nature of the COVID-19 pandemic are without precedent in recent history and the NHS and the adult social care sector have had to reorganise their services at great speed.⁶ Before the pandemic, NHSE&I commissioned most NHS services through NHS local commissioners (clinical commissioning groups).⁷ In March this year, the Department gave NHSE&I temporary emergency powers to lead and organise all NHS services directly as it responded to COVID-19.⁸

2 C&AG’s Report, *Readyng the NHS and adult social care for COVID-19*, Session 2019–2021, HC367, 12 June 2020

3 C&AG’s Report, para 4

4 <https://www.gov.uk/government/organisations/public-health-england>

5 C&AG’s Report, paras 4, 9

6 Department of Health and Social Care, *The Exercise of Commissioning Functions by the NHS Commissioning Board (Coronavirus) Directions 2020*, 23 March 2020

7 C&AG’s Report, *NHS financial management and sustainability*, Session 2019–21, HC 44, 5 February 2020

8 C&AG’s Report, para 1.17

5. NHSE&I told us that it declared a level 4 incident, the highest level of emergency response the NHS can provide from 30 January. This was followed by a series of actions to prepare the NHS for the expected surge in COVID-19 patients, including weekly briefings for NHS leaders from early February, and, in a 17 March letter to NHS service providers and commissioners, outlining detailed preparations to free up beds and redirect staff and other resources.⁹ But it was not until the 15th April that the Government published an Action Plan for Adult Social Care.¹⁰ Actions taken by the NHS, alongside the Government’s social distancing policies, ensured that there were sufficient beds and ventilators to provide treatment for COVID-patients when required.¹¹

6. When challenged on the lack of similarly clear leadership in the social care response, the Department acknowledged that statutory responsibilities for social care are spread between national government, local government and individual providers. The Department is responsible for overall policy across health and social care but it recognised the “considerable ambiguity in how social care is managed” and that the fragmented system had made it “*considerably more difficult*” for Government to take action.¹²

7. There have been serious and widespread concerns about the lack of timely testing for both staff and the public and inadequate PPE provision particularly in social care.¹³ When we queried the arrangements for ensuring access to testing, we were told that several bodies were involved, including the Department, Public Health England and NHSE&I. For example, NHS laboratories tested patients and some NHS staff, while other parts of the testing programme were run elsewhere.¹⁴ NHSE&I told us it had followed Public Health England’s strategy on whom to test.¹⁵ Public Health England clarified that its testing policy in March was based on the limited testing capacity at the time as agreed with the NHS and the Chief Medical Officer.

8. Similarly, procuring and distributing PPE involved a range of bodies, including the Department, Public Health England, local NHS providers and care homes, yet until the appointment of Lord Deighton in mid-April no one took the lead in making sure there was sufficient PPE.¹⁶ Public Health England told us that it was responsible for holding and adjusting the PPE stockpile on behalf of the Department, but did not make policy decisions on its contents, management or use.¹⁷ When challenged on its part in ensuring sufficient PPE supply, the Department explained that it had worked with NHSE&I, alongside the Foreign Office and others, to source international supply, but it stressed the difficulties it faced given worldwide demand. We noted the significant increases in PPE supplies since Lord Deighton’s appointment.¹⁸

9 Q 10; C&AG’s Report, para 1.3, 1.13

10 C&AG’s Report, para 1.3

11 Qq 58, 63, 118–119; C&AG’s Report, paras 10–13,18

12 Qq 11, 120

13 Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020, para 22; C&AG’s Report, paras 19, 20; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission; RSC0001 Care England submission

14 Qq 18–20, 23–26, 34, 98

15 Qq 17–19

16 Qq 62, 75, 79, 87–88

17 Qq 75

18 Qq 62, 87–88

Discharging people from hospitals to care homes

9. On 17 March the NHS told trusts to discharge urgently all medically fit hospital patients with COVID-19 to maximise inpatient and critical care capacity. On 2 April, the Department told care homes that they needed to make their full capacity available and could admit patients with COVID-19 by isolating suspected or confirmed cases. Some Local Authorities were pressurising Care Homes to take patients discharged from hospitals.¹⁹ Yet until 15 April there was no policy to test patients for COVID-19 before discharging them to care homes. By this point 25,000 people had been discharged from hospitals to care homes and the Department does not know how many had COVID-19.²⁰

10. Some organisations such as Care England highlighted to us the flawed nature of this policy and reported that, given the absence of testing and inadequate PPE, social care felt abandoned.²¹ When we challenged the Department and the NHS on such a reckless and negligent policy, the Department told us that when the NHS issued its guidance in March COVID-19 was not widespread.²² NHSE&I said it has always been the case that they want to discharge people who are clinically fit and staying in hospital could be harmful for the elderly.²³ When asked why those discharged had not been tested, it told us it was following testing advice provided by Public Health England.²⁴ Public Health England clarified that, at the start of the outbreak, testing was limited to 3,500 tests a day nationally and so it had agreed with the NHS and the Chief Medical Officer priority groups for testing: those in intensive treatment units; those with respiratory infections; and limited testing in care homes to diagnose outbreaks. Public Health England also told us that “what was becoming clear in the back-end of March and certainly from the beginning of April was that there was an asymptomatic phase, which means that people can transfer the virus without ever having symptoms, or a significant pre-symptomatic phase, which is where the virus could be shared”.²⁵ It is clear that the availability of test and testing should have been ramped up much more quickly after the NHS had declared Level 4 National Incident (its most severe incident level) on the 30th January 2020.

11. We remained concerned that the Department had continued its policy of discharging people untested into care homes even once it was clear there was an emerging problem.²⁶ The number of first-time outbreaks in individual care homes peaked at 1,009 in early April. Between 9 March and 17 May, around 5,900 care homes, equivalent to 38% of care homes across England, reported at least one outbreak of the disease.²⁷ The Department defended the decisions it took as rational based on the information it had at the time and stated its belief that the clearest correlations between social care outbreaks and other issues related to staff with the disease rather than patients discharged from hospital. However, it also acknowledged “that is not the same as saying that we would do the same again”.²⁸

19 Q13

20 C&AG’s Report, paras 3.19–3.20

21 RSC0001 Care England submission

22 Qq 21–22

23 Q 16

24 Qq 14, 16–18

25 Qq 20, 84

26 Qq 19, 21–23

27 C&AG’s Report, para 3.15

28 Qq 23, 43

Delays to reforming adult social care

12. This Committee has warned before that the Department lacked an effective overall strategy or plan to integrate health and care and that poor outcomes could arise as a result.²⁹ As Care England told us, for too long “adult social care has been kicked into the long grass by governments of all stripes.”³⁰ Despite numerous white papers, green papers, consultations, and independent reviews over the past 20 years, meaningful integration of health and social care was yet to occur going into the pandemic.³¹ The Department noted that the experience with COVID-19 had heightened the need for reform.³²

13. We heard how frequently social care had taken second place to the NHS’s needs, particularly in accessing test kits and results, and securing reliable PPE supply for care homes, which had been neither timely nor coordinated.³³ When questioned, the Department denied that social care had been forgotten, citing the work it had done in the sector and that it had “taken a more national and more interventionist role in social care than ever before” when issuing guidance and additional funding, for example. It said that testing capacity had been limited but as it increased was opened up to all care staff.³⁴ On the subject of PPE supply, the Department asserted, “at no point has there been an instruction for the NHS to be prioritised over the care sector”.³⁵ When we pressed the Department on why it did not publish its action plan for adult social care until 15 April, over four weeks after the initial NHS letter on plans to respond to the outbreak, it told us the plan brought together and enhanced previous guidance given.³⁶ Government Policy prior to the action plan was that the social care sector procure their own PPE. This was against a background of the NHS’s huge purchasing power and tightening domestic and worldwide demands for PPE. It did acknowledge, however, that the thousands of independent providers and the funding model for social care made for a very challenging and tough context in which to respond to COVID-19. This was apparent in the imperfect data it had to work with. The Department told us that data was much better and more timely in the NHS than for social care, due to the structural differences between the two.³⁷

14. This Committee has also challenged the Department before over not delivering on its overarching responsibilities towards the care market, and having no credible plans to ensure the sector was sustainably funded.³⁸ We note it was not until June 2020 that the Department appointed a director general for adult social care to lead on its social care policies, four years after the previous director general left the post.³⁹ The Ministry of Housing, Communities & Local Government told us that it had provided £3.2 billion additional funding to local government with instructions to prioritise social care and, of the £1.25 billion spent so far, £500 million had gone on social care.⁴⁰ On 15 May 2020 the

29 Committee of Public Accounts, *Interface between health and adult social care*, Sixty-Third Report of Session 2017–19, HC 1376, 19 October 2018

30 RSC0001 Care England submission

31 C&AG’s Report, foreword

32 Q 121

33 RSC0002 Local Government Association submission; RSC0005 Association of Anaesthetists submission

34 Qq 11–12, 27, 38

35 Q 42

36 Qq 11–12

37 Qq 31–38, 40; C&AG’s Report, para 13

38 Committee of Public Accounts, *The adult social care workforce in England*, Thirty-Eighth Report of Session 2017–19, HC 690, 9 May 2018

39 HSJ article: [Government’s social care directorate restored after four-year gap](#), 15 June

40 Qq 28–29

government also announced a £600 million Infection Control Fund for local government, to tackle the spread of COVID-19 in care homes in England, which was in addition to the £3.2 billion.⁴¹ Given reports of increased risk of provider failure and calls from the Local Government Association and NHS Providers to secure a sustainable future for social care, we pressed the Department on whether it would have to rescue any failing providers in the weeks ahead. It told us it was focusing on ensuring the continued provision of services to individuals but was looking closely at the evidence base to understand the different challenges faced by different providers, including increased costs and in some, but not all, cases, reduced demand.⁴²

41 C&AG's Report, *Overview of the UK government's response to the COVID-19 pandemic*, Session 2019–21, HC 366, 21 May 2020, Figure 4

42 Qq 30, 92–93; C&AG's Report, para 14; RSC0004 NHS Providers submission; RSC0002 Local Government Association submission

2 Resuming services and preparing for the future

Public trust

15. The Department stressed that it had to respond quickly to the COVID-19 pandemic often with “imperfect knowledge”, which was why its approach had altered over time.⁴³ But Care England told us that PPE guidance had changed no fewer than 40 times, causing confusion and anxiety to service providers and staff.⁴⁴ When we asked why the PPE guidance had constantly changed, the Department said that when updating its guidance it was trying to match clinical advice, as understanding of the virus changed, to available supply. We challenged it on why it would in effect toughen guidance when it knew there was already insufficient supply. For example, guidance which said care homes needed new PPE for each patient had caused considerable anxiety. The Department told us it could not “simply be driven by supply in this case”.⁴⁵

16. By comparison, because testing capacity was limited during the earlier stages of the pandemic, the Department said it had sought clinical advice on where that capacity was best deployed. Eligibility for tests changed as capacity increased and the Department noted that testing was the area which had evolved the most over time.⁴⁶

17. Concerns about the transparency of Government’s reporting about the measures it has taken, particularly around PPE and testing, have been widely publicised.⁴⁷ We heard from stakeholders in the health and social care sector who highlighted issues with inadequate and unreliable PPE supply.⁴⁸ For example, despite the fanfare around a large consignment of PPE being secured from Turkey, it did not contain the volume expected nor meet required standards.⁴⁹

18. Testing for COVID-19 is fundamental to controlling the virus, and to informing and reassuring the public.⁵⁰ Yet, while Government’s announcement of its 100,000 daily test target by the end of April had a galvanising effect to start with, NHS Providers reported that it had ended up being a distraction from developing the right kind of capacity and testing approaches in all areas of the country.⁵¹ The UK Statistics Authority publicly criticised the Government for the way it counted tests and has urged greater clarity about how testing targets are defined, measured and reported.⁵² Similarly to PPE, we heard how unkept promises on tests had led to a loss in confidence among some providing NHS services.⁵³

43 Q 32

44 RSC0001 Care England submission

45 Qq 90–91

46 Qq 20, 25

47 For example, [BBC news on its Panorama programme on PPE](#) and BBC statement on Panorama, Monday 27 April: [Has The Government Failed the NHS?](#)

48 RSC0001 Care England submission; RSC0002 Local Government Association submission; RSC0004 NHS Providers submission; RSC0005 Association of Anaesthetists submission; RSC0010 NHS Confederation submission

49 HSJ, [Exclusive: Turkish delivery contained just a few hours’ worth of gowns](#), 23 April; [The Guardian, Coronavirus PPE: all 400,000 gowns flown from Turkey for NHS fail UK standards](#), 7 May

50 Qq 24–26

51 RSC0004 NHS Providers

52 [Sir David Norgrove letter to Matt Hancock regarding COVID-19 testing](#)

53 RSC0010 NHS Confederation submission

19. We were keen to know how the Department would ensure sufficient stockpiles of PPE and testing capacity as it rolls out its ambitious ‘track and trace’ programme and the NHS resumes routine services while continuing to deal with COVID-19 this autumn and winter.⁵⁴ It reiterated that testing capacity had now expanded significantly.⁵⁵ Public Health England also explained that it was “ramping up” the size of its local health protection teams from 360 staff to 1,100 by the end of July, in light of the test and trace part of the programme.⁵⁶ Given its failure to boost the PPE stockpile during January and February despite recommendations from the New and Emerging Respiratory Virus Threats Advisory Group, we asked how the Department was going to ensure lessons were learned so there would be adequate PPE this winter. The Department claimed it had been in the process of responding to this advice when COVID-19 hit. It said it was aiming in future to have PPE supply for 90 days ahead by signing longer-term contracts to guarantee overseas supply; increasing the proportion of PPE made domestically; and better understanding demand.⁵⁷

Managing staff well-being

20. NHSE&I explained that the NHS was carrying 100,000 staff vacancies going into the pandemic.⁵⁸ It said the workforce had been boosted by around 20,000 students; retired NHS staff; and a further 600,000 volunteers (working across a range of public services, including the NHS) who stepped forward to work on the frontline during the crisis.⁵⁹ Given the potential reliance on the student workforce in the event of a second wave, we asked about the operational impact of the NHS’s June decision to cut short its student nurse programme, which was providing paid placements. NHSE&I told us that this had always been the intention as final year students who qualified would move into substantial placements at more senior grades while second year students would need to return to the academic part of their courses.⁶⁰

21. There have been numerous media reports of PPE shortages for health and social care staff and stakeholders have told us how the failure to provide adequate and timely PPE has impacted staff morale, trust and confidence.⁶¹ In the period from 6 April to 19 May, more than 80% of local resilience forums reported that PPE was having a high or significant disruptive impact in their area across health and social care services, putting staff and others at risk.⁶²

22. Testing for NHS workers (with symptoms) only began from 27 March, with eligibility extended to social care workers (with symptoms) from 15 April, after the pandemic had passed its first peak. In the period up to 15th April up to a maximum of five symptomatic residents in each care home would be tested, and from the 28th April all symptomatic care home residents were offered testing but this was capped at 30,000 tests per day between residents and staff. From 28 April, all social care workers were eligible for tests, but the Department capped the daily amount of care home tests at 30,000 (to be shared between

54 Qq 51–52, 56–57, 78–79

55 Qq 25, 27

56 Qq 49–50; Public Health England letter from Professor Paul Johnstone to PAC Chair, 2 July 2020

57 Qq 76, 78, 79

58 Q 109

59 Qq 5, 94

60 Qq 96–97

61 Qq 21,23, 26–27; Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020; RSC0010 NHS Confederation submission; RSC0001 Care England submission; RSC0002 Local Government Association submission; RSC0004 NHS Providers submission

62 C&AG’s Report, para 4.28

staff and residents).⁶³ Stakeholders told us that failures in testing had also led to increased anxiety and frustration as well as increased absence due to unnecessary isolation. For example, the NHS Confederation told us that the NHS had had an unprecedented level of absence during the first weeks of April.⁶⁴ When asked about testing staff, the Department said it had made this available in care homes as capacity increased and there were now around 70,000 tests a day available to all care home staff as well as residents. NHSE&I told us it had now started testing asymptomatic staff and referenced Public Health England’s large-scale study testing staff to see if they had COVID-19 now, or had previously had it, which would provide more information on how and when it was best to test.⁶⁵

23. We were concerned about the NHS needing to call on the same staff who have already worked exceptionally long hours during the first peak in order to deal with the backlogs of treatment, while also standing ready for a potential second peak.⁶⁶ NHSE&I explained that it was “encouraging people to take leave, so that they are refreshed going into the autumn and winter, as well as encouraging people who have returned to stay with us and those who have volunteered to continue to offer their support”.⁶⁷ We asked how the NHS was looking after its workforce given the emotional trauma of treating patients with COVID-19 and the fact that the NHS interim people plan had not referred to treating the mental health of its staff. In response, NHSE&I sought to assure us that staff health and wellbeing was a “primary focus nationally, regionally and locally”. It recognised the need for targeted psychological and mental health support for staff across the health service and pointed to plans to roll out more widely an existing mental health programme for doctors as well as helplines and other support for particular staff groups.⁶⁸

Securing additional capacity

24. Under its reasonable worst-case scenario, the Government expected over 4% of the population might require hospital admission for COVID-19 and 30% of those would require critical care. NHSE&I told us that the number of COVID-19 patients admitted to hospital had risen from a few hundred in mid-March to 18,000 two weeks later.⁶⁹ As NHS Providers stated, the healthcare sector responded at pace to ensure that the NHS had enough capacity for the expected large number of COVID-19 patients.⁷⁰ The additional capacity secured by NHSE&I included new Nightingale hospitals as well as contracts with independent providers for an additional 8,000 beds, 18,700 staff and 1,200 ventilators. The contracts were to run until 28 June but could be extended. Use of the Nightingale hospitals so far has been limited.⁷¹

25. Between mid-March and mid-April, the NHS and armed forces are to be commended for increasing the number of beds available for Covid-19 patients from 12,600 to 53,700 in

63 C&AG’s Report, para 3.16

64 RSC0012 National Institute for Health Research (NIHR) Health Protection Research Unit in Merging and Zoonotic Infections; University of Liverpool, Institute of Infection and Global Health, and University of Oxford, Nuffield Department of Primary Care Health Sciences submission; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission; RSC0005 Association of Anaesthetists submission

65 Qq 98–101

66 Qq 102–105, 108–111; C&AG’s Report, para 4.30; RSC0010 NHS Confederation submission; RSC0004 NHS Providers submission

67 Q 57

68 Qq 102, 105, 111

69 Qq 14, 109, 116

70 RSC0004 NHS Providers submission

71 C&AG’s Report, paras 10, 2.6, 2.7, 4.4; Ev Independent Healthcare Providers Network submission

a very short space of time. The additional capacity inside existing NHS hospitals helped to ensure that at no point during the pandemic did the number of patients exceed the number of available beds.⁷² Independent and Nightingale capacity created a ‘buffer’ on top of that, and NHS Providers also welcomed the private sector support which had been offered to date.⁷³ We recognise the need to have moved at speed to set up these arrangements. However, we were also concerned about the trade-offs with securing value for money and an apparent lack of transparency. We asked NHSE&I about the use and cost of the capacity secured through independent hospitals. NHSE&I told us that “several hundred thousand patient treatments”, such as chemotherapy and diagnostic tests, had been delivered as well as equipment. Despite the open book accounting arrangements in the contract, NHSE&I would not provide even a rough estimate of costs until these had been audited and said it might be “several weeks” before it could share the data with us.⁷⁴ The use and cost of the Nightingale facilities are also not yet known. We also noted with concern some evidence from stakeholders that contracts awarded during the period have lacked transparency.⁷⁵ When asked about stories of bonuses to directors in independent hospitals being charged to the taxpayer, NHSE&I told us the contract explicitly prohibits compensation for bonus payments beyond what would have been acceptable in the NHS.⁷⁶

26. Access to NHS services has reduced significantly during the COVID crisis, potentially creating huge pent-up demand, which will add to the substantial waiting lists that existed before the pandemic.⁷⁷ NHSE&I told us that access to emergency and critical services, such as cancer, has been maintained throughout the crisis although use of these services had been lower than usual. It also told us that it was now encouraging the NHS to resume more routine services.⁷⁸ Stakeholders from the NHS and independent provider sectors have expressed concerns that resuming services, while the pandemic is still ongoing and with the potential for a second peak, will be challenging and will require full use of capacity across both sectors.⁷⁹ We asked NHSE&I what plans it had to address these concerns in the near future. NHSE&I told us that the arrangements with the private sector were likely to continue for the rest of the year in order to provide a continuing ‘buffer’ for routine surgery, cancer care and other conditions but it noted that the basis on which it contracted with independent hospitals was likely to change and it was likely to follow a competitive procurement. As discussions are still ongoing, NHSE&I could not provide details on how independent hospital capacity would be allocated but assured us that it would be available for networks of hospitals and GPs in a given area to draw on. It also said that the Nightingale hospitals would be on standby in case of a second pandemic peak.⁸⁰

72 Q 56; C&AG’s Report, para 10; RSC0007 Independent Healthcare Providers Network submission; RSC0010 NHS Confederation submission

73 Q 63; RSC0004 NHS Providers submission; RSC0007 Independent Healthcare Providers Network submission; RSC0006 Spire Healthcare submission

74 Qq 64–74

75 C&AG’s Report, para 2.7; RSC0011 Future Care Capital submission

76 Q 65

77 Q 59; C&AG’s Report, para 12; Committee of Public Accounts, *NHS waiting times for elective and cancer treatment*, One Hundredth Report of Session 2017–19, HC 1750, 12 June 2019; and *NHS capital expenditure and financial management*, Eighth Report of Session 2019–21, HC 344, 8 July 2020; C&AG’s Report, *NHS financial management and sustainability*, para 4; RSC0007 Independent Healthcare Providers Network submission; RSC0006 Spire Healthcare submission; RSC0005 Association of Anaesthetics submission

78 Qq 56, 59; C&AG’s Report, para 2.21

79 RSC0010 NHS Confederation submission; RSC0007 Independent Healthcare Providers Network submission; RSC0005 Association of Anaesthetics submission

80 Qq 56–59, 63

Formal minutes

Monday 20 July 2020

Virtual meeting

Members present:

Meg Hillier, in the Chair

Olivia Blake

Sir Bernard Jenkin

Sir Geoffrey Clifton-Brown

Mr Gagan Mohindra

Dame Cheryl Gillan

James Wild

Peter Grant

Draft Report (*Readyng the NHS and social care for the COVID-19 peak*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 26 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Fourteenth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 21 July at 9:45am]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 22 June 2020

Sir Chris Wormald, Permanent Secretary, Department for Health and Social Care; **Sir Simon Stevens**, Chief Executive, NHS England; **Amanda Pritchard**, Chief Operating Officer, NHS England and NHS Improvement; **Catherine Frances**, Director General, Communities, Ministry of Housing, Communities and Local Government; **Rosamond Roughton**, Director General, Adult Social Care at, Department for Health and Social Care; **Professor Steve Powis**, National Medical Director, NHS England; **Professor Paul Johnstone**, National Director for Place and Regions, and Deputy SRO for PHE COVID-19 response, Public Health England

[Q1-121](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

RSC numbers are generated by the evidence processing system and so may not be complete.

- 1 ADASS (ADASS, Deputy Chief Officer) ([RSC0013](#))
- 2 Association of Anaesthetists (Jenny Gowen, Advocacy and Campaigns Manager) ([RSC0005](#))
- 3 Care England (Mrs Louisa Collyer-Hamlin, External Affairs) ([RSC0001](#))
- 4 Future Care Capital (Dr Peter Bloomfield, Head of Policy and Research) ([RSC0011](#))
- 5 Gumber, Dr Anil ([RSC0003](#))
- 6 Independent Healthcare Providers Network (Ms Megan Cleaver, Senior External Affairs Manager) ([RSC0007](#))
- 7 Johnson, Elliott Aidan ([RSC0008](#))
- 8 Johnson, Dr Matthew Thomas ([RSC0008](#))
- 9 Local Government Association (Miss Jade Hall, Public Affairs and Campaigns Adviser) ([RSC0002](#))
- 10 Nettle, Prog Daniel ([RSC0008](#))
- 11 NHS Confederation (Mr Niall Dickson CBE, Chief Executive) ([RSC0010](#))
- 12 NHS Property Services (Miss Rosalia Wood, External Communications Manager) ([RSC0009](#))
- 13 NHS Providers (Ms Susan Bahl, Head of Policy and Public Affairs) ([RSC0004](#))
- 14 The Royal College of Nursing ([RSC0014](#))
- 15 Spire Healthcare (Paul Lehmann, Head of External Communications) ([RSC0006](#))
- 16 University of Liverpool, Institute of Infection and Global Health, and University of Oxford (Dr Paul Atkinson) ([RSC0012](#))
- 17 Webber, Dr Laura ([RSC0008](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2019–21

First Report	Support for children with special educational needs and disabilities	HC 85
Second Report	Defence Nuclear Infrastructure	HC 86
Third Report	High Speed 2: Spring 2020 Update	HC 84
Fourth Report	EU Exit: Get ready for Brexit Campaign	HC 131
Fifth Report	University Technical Colleges	HC 87
Sixth Report	Excess votes 2018–19	HC 243
Seventh Report	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
Eighth Report	NHS expenditure and financial management	HC 344
Ninth Report	Water supply and demand	HC 378
Tenth Report	Defence Capability and the Equipment Plan	HC 247
Eleventh Report	Local authority investment in commercial property	HC 312
Twelfth Report	Management of tax reliefs	HC 379
Thirteenth Report	Whole of Government Response to Covid-19	HC 404