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Report
by the Comptroller
and Auditor General

Department of Health & Social Care

Readying the NHS and adult social care in England for COVID-19

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National Audit Office

Department of Health & Social Care

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This report sets out the facts about government's progress in preparing the NHS and adult social care in England for the COVID-19 outbreak.

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Foreword by the Comptroller and Auditor General

The scale and nature of the COVID-19 pandemic and government's response are without precedent in recent history. The pandemic is a great and ongoing challenge for the entire population and particularly for health and social care workers. Many lives have been adversely affected and a large number of people have died. The impact on government and public services has also been large. The costs of the government response and its long-term impact will be substantial but are still uncertain.

What is clear is that the NHS has had to reorganise its services at great speed. This has been a major and far-reaching undertaking. The adult social care sector has had to respond very quickly too, both to cope with residents coming in from NHS hospitals and to manage the pandemic within care homes. These undertakings, difficult in any circumstances, have undoubtedly been made harder because of historic and unaddressed differences and divisions between the two sectors.

This report is the second in the National Audit Office's programme of work on COVID-19. It is intended to support Parliamentary scrutiny of the government response to COVID-19 and to aid transparency and public understanding of the pandemic's impact. The report focuses on what the Department of Health & Social Care and other bodies did during March and April 2020 to ready the NHS and adult social care for a rapid increase in the number of infected people.

The report is factual and intended to serve as a foundation for evaluative work to come. Already, however, some important themes are emerging both from this report and in the light of our previous work.

• First, the onset of an emergency does not mean that long-standing problems suddenly vanish or can instantly be solved. The relationship between adult social care and the NHS has been problematic for decades. We have reported on successive efforts to integrate the two sectors: there have been 12 government white papers, green papers and consultations, and five independent reviews on integration over the past 20 years. Going into the pandemic, meaningful integration was still to occur, however, and the lack of it has made responding to the crisis more difficult in a number of ways.

• Second, the speed at which an effective crisis response can be mounted is significantly affected by matters beyond government control. Government's ability to increase bed, ventilator, Personal Protective Equipment (PPE) and testing capacity has varied, depending in part on the number of other players, both national and international, with which it has had to engage. Those charged with preparing for the later phases of this pandemic and for future emergencies will

want to pay special attention to this fact.

- Third, since 2010-11 both the NHS and local government have been under financial pressure. Additional funding for health and social care has at times been used to address immediate needs rather than to increase the long-term sustainability of services. The past five years for local government, in particular, are characterised by one-off, short-term funding fixes, with the sector's financial condition worsening. Public bodies in the health and social care sectors now face two challenges: to maintain readiness to respond to COVID-19 and to put other essential services onto a sustainable footing, including working through backlogs that have developed since March. A realistic, costed and prioritised plan will give them the best chance of succeeding.

- Lastly, the pace and intensity with which government has had to respond to the pandemic mean that much important information about cost and performance is yet to emerge. It is vital that, to the maximum extent possible, public bodies continue adhering to the principles set out in HM Treasury's Managing Public Money. Before long, it will be appropriate to assess rigorously the effectiveness and cost-effectiveness of this emergency response so that lessons can be learned for the future. Details of our forthcoming programme of work will be regularly updated and can be accessed via the COVID-19 pages of our website: https://www.nao.org.uk/covid-19/.

Gareth Davies

Summary

Introduction

1   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. A day earlier, the NHS had declared a Level 4 National Incident (its most severe incident level). 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.

2   There is no single precise measure of how many people have COVID-19 in England at any one time. Based on published government data, the average proportion of people who tested positive increased up to early April and stayed above 40% for several days, before falling to around 10% at the end of April. However, due to changes in eligibility for tests, this may not reflect the prevalence of COVID-19 in the wider community. Current research indicates that, overall, most people recover well from the virus although some groups such as older people are much more vulnerable and a larger proportion of people in these groups go on to die. Office for National Statistics (ONS) data show that the total number of deaths increased above the five-year average from the end of March, with over 52,000 more deaths registered between the weeks ending 27 March and 15 May.

3   On 17 March, NHS England and NHS Improvement (NHSE&I) set out in a letter the measures that national and local NHS bodies should take to prepare for the outbreak. After issuing various pieces of guidance to the adult social care sector from 13 March onwards, the Department for Health & Social Care (the Department) published an action plan for adult social care on 15 April. There have been many other developments throughout the pandemic, but these two documents are key to understanding the government's health and adult social care response.

4   The Department has overall responsibility for health and social care policy in England while NHSE&I leads the NHS in England, 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 & Local Government (the Ministry) has responsibility for the local government finance and accountability systems. Public Health England (PHE) provides health protection services and public health advice, analysis and support.

Scope of this report

5   This report is the second in a programme of work by the National Audit Office to support Parliament's scrutiny of the UK government's response to COVID-19. While

the report is intended to provide a factual and high-level overview of the government's actions, we are mindful of the real impact this pandemic is having on individuals' lives, health, well-being and livelihoods.

6 This report sets out the facts about government's progress in preparing the NHS and adult social care for the COVID-19 outbreak, with a focus on:

- actions set out in the 17 March letter to the NHS, and the 15 April action plan for adult social care. It also describes what is currently known about additional funding for health and adult social care;

- actions taken at a national level by those responsible for coordinating health, adult social care and local government in England. The report does not cover providers of children's social care as these were not the focus of the Department's action plan; and

- the period from the start of the outbreak to at least the end of April, when the government announced that the UK was "past the peak". Depending on the data available at the time of writing, we have provided information up to mid-May in selected places.

7 The report does not assess the value for money of the measures adopted by government or the effectiveness of its response. The report does not comment in detail on the government framework for pandemic planning that existed before the outbreak, nor does it set out in detail local responses to COVID-19. It uses a range of published and unpublished data, the latter requested from public bodies under our statutory audit powers. We have not audited the data used in this report for completeness or quality, but relevant bodies have reviewed and confirmed the accuracy of the information relating to them.

Key findings

Coordinating the NHS and adult social care response to COVID-19

8 **On 17 March the NHS set out a range of measures to prepare for the COVID-19 outbreak. After issuing various pieces of guidance to the adult social care sector from 13 March onwards, the Department published its action plan for adult social care on 15 April.** The letter from the NHS England chief executive and chief operating officer set out measures to redirect staff and resources to meet a surge in patients with COVID-19, based on a 'reasonable worst-case' scenario by the Scientific Advisory Group for Emergencies (SAGE). Specific measures included maximising hospital capacity; increasing respiratory support; and increasing staff numbers. The Department's action plan for adult social care set out priority actions to control the spread of the infection; to support the care workforce, local authorities and care providers; and to support independence (paragraphs 1.13 to 1.15).

9   By the end of April, government had allocated £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.

- Of the £6.6 billion, £1.3 billion was allocated to support the discharge of patients from hospitals in order to increase NHS capacity. The NHS has also replaced normal payment mechanisms with block (fixed) payments from April to at least July, while NHS trusts were told they could claim excess top-up payments for costs caused by COVID-19.

- The £3.2 billion funding for local authorities was to help them respond to COVID-19 pressures across all services they deliver, including adult social care. Local authorities that provide adult social care received 91% of the funding but the funding was not ringfenced. There have been concerns in parts of the sector that local authorities have not increased fee rates paid to care providers. Around half of local authorities surveyed by the Association of Directors of Adult Social Services said they were temporarily increasing rates and half of these said they were providing a temporary 10% fee uplift. A further 30% stated they had set aside emergency funding for providers and 16% said they had provided an upfront lump sum. However, provider organisations have told us they have evidence which disagrees with these findings: the picture appears to vary across the country.

Much about the allocation of funding and spend to date is still unclear or has not been finalised at the time of this report (paragraphs 1.17, 1.18 and 1.20 to 1.25).

Caring for people in hospital

10   Between mid-March and mid-April, the NHS increased bed capacity for COVID-19 patients in NHS trusts in England, meaning that the number of patients never exceeded the number of available beds. In response to advice from SAGE, the NHS took a range of actions with the intention of freeing up at least 30,000 beds for the expected surge in COVID-19 patients. The NHS monitors the number of general and acute beds available for COVID-19 patients in NHS trusts in England on a daily basis (which includes those already occupied by a COVID-19 patient). Between 17 March and 12 April, the number of available beds increased from 12,600 to 53,700, while the proportion of these beds occupied by a COVID-19 patient peaked at 29%. 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. 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 (paragraphs 2.2, 2.3, 2.6, 2.7 and 2.15).

11   The government took steps to secure the supply of oxygen to hospitals and to increase the number of ventilators and other breathing aids available; even at the peak, the NHS was able to meet demand for respiratory support, which was lower than forecast. Oxygen is currently the main treatment for patients with severe COVID-19 symptoms, provided through mechanical ventilators and other

breathing aids. During April, the Department told us it funded 18 projects to improve hospital oxygen supply, adding around 2,400 beds with oxygen support. By mid-May, the Department had purchased an additional 8,300 mechanical ventilators, at a cost of £230 million, with 1,300 received to date. It had also received 2,100 from the Ventilator Challenge, which called on UK businesses to design new ventilators. In addition, the Department had purchased around 20,100 non-invasive breathing support devices (11,100 of which had been received by mid-May). Demand for respiratory support has been lower than forecast. The number of unoccupied beds with ventilator or oxygen support more than doubled during April, from 16,900 to 34,900 (paragraphs 2.8, 2.11 and 2.16 to 2.19).

12   Patient demand for emergency and other NHS services decreased during the outbreak, in addition to planned reductions in elective (or planned) services. The 17 March letter instructed hospitals to postpone elective services wherever possible, and elective activity fell by 24% in March 2020 compared with March 2019. Demand for emergency services and other clinically urgent services also decreased. In April, attendances at major (Type 1) Accident & Emergency (A&E) 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. In parts of the NHS where demand was lower, it is not yet known to what extent this will cause more patients to present, potentially with more acute problems, in future (paragraphs 2.4 and 2.21 to 2.23).

Providing adult social care and shielding the most vulnerable

13   Data on the impact of COVID-19 on care providers are limited. Unlike the NHS, adult social care is not one national system. Prior to the outbreak there was no process in place to collect a wide range of daily data from care providers. The Department did not know how many people were receiving care in each area, while local authorities only know about those people whose care they pay for. To monitor the impact of COVID-19, the Department told us that from early April, data was collated on workforce absences, PPE levels and overall risks from nursing and residential homes registered with the Care Quality Commission (CQC). The CQC itself collected data from registered providers of domiciliary care from 13 April. However, not all providers submitted data regularly (paragraphs 3.7 and 3.8).

14   Care home providers reported having sufficient capacity between 20 April and 15 May, although some had closed to new admissions. Reported bed occupancy ranged from 86% to 90% between 20 April and 15 May. Providers reported that between 10% and 14% of homes were closed or partially closed to new residents. Analysis by the CQC indicates that COVID-19 may negatively impact on the profitability of care home providers in the short term. Provider organisations have also warned of significant and rising costs from resourcing PPE and workforce costs from overtime and agency staff. Falling income and rising costs could impact providers' financial resilience for some time to come (paragraphs 3.10 and 3.12).

15   Reported outbreaks of COVID-19 in care homes peaked at the start of April, with some parts of England more affected than others. It is not known how many residents have had COVID-19. Between 9 March and 17 May, around 5,900 (38%) care homes across England reported an outbreak. This peaked at just over 1,000 homes in the first week of April. Some parts of the country were more affected than others. For example, just under half of all care homes in the North East had reported an outbreak by 17 May. Until mid-April, there was a policy to test no more than five symptomatic residents in any one care home. On 11 May, the Department announced that out of around 400,000 care home residents, more than 45,000 had been tested by health protection teams while 140,000 test kits had been sent to care homes (paragraphs 3.15 and 3.16).

16   Between 17 March and 15 April, around 25,000 people were discharged from hospitals into care homes, compared to around 35,000 over this period in 2019. It is not known how many had COVID-19 at the point of discharge. On 17 March, NHSE&I advised hospitals to discharge urgently all patients medically fit to leave in order to increase capacity to support those with acute healthcare needs. Due to government policy at the time, not all patients were tested for COVID-19 before discharge, with priority given to patients with respiratory illness or flu-like symptoms. On 15 April, the Department confirmed a new policy of testing all those being discharged from hospitals into care homes, which was followed by instructions to that effect from NHSE&I on 16 April (paragraphs 3.19 and 3.20).

17   As at 15 May, the government identified a group of 2.2 million people at the greatest risk of severe illness from COVID-19. As at 15 May, 2.2 million people were classed as clinically extremely vulnerable to COVID-19 because of serious underlying health conditions. The government strongly advised these people to stay at home and avoid all face-to-face contact with others, and to register online for help and support. On 15 May, around 1.1 million people had registered for support; of these around 320,000 requested food parcels (paragraphs 3.21 and 3.22).

Expanding, equipping and supporting the health and adult social care workforces

18   To increase workforce capacity additional NHS staff were redeployed but the absence rates in health and adult social care rose due to COVID-19. By the end of April, an extra 18,200 NHS staff were deployed in clinical and support roles, including 7,000 nursing and midwifery students and 8,000 returning retired and former staff. During the outbreak, the absence rate for NHS acute hospital staff almost doubled, peaking on 4 April 2020 with 9% absent for reasons related to COVID-19. The adult social care action plan set an ambition to attract 20,000 people into social care over three months, but the Department does not know how it is progressing against this aim. On average, reported absence rates in care homes were around 10% between mid-April and mid-May. While measures have been taken across the NHS and adult social care to protect the well-being of staff, by its nature the COVID-19 emergency has placed great additional stress on health and social care workers (paragraphs 4.4, 4.5, 4.9, 4.10, 4.12, 4.29 and 4.30).

19   Under the government's testing policy, front-line health workers became eligible for COVID-19 testing from the end of March, followed by care workers from mid-April. Testing was one of several actions which aimed to support front-line NHS and social care workers to stay well and at work. Eligibility for testing changed throughout April 2020. Despite statements in mid-March, limits on testing capacity meant that the initial roll-out to NHS workers (with symptoms) only began from 27 March, with eligibility extended to social care workers (with symptoms) from 15 April. The government does not know how many NHS or care workers have been tested in total during the pandemic. NHSE&I estimates that, for tests carried out by the NHS itself, the number of NHS staff and household members who were tested increased from 1,500 to 11,500 a day during April. 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 staff and residents) (paragraphs 4.9 and 4.14 to 4.16).

20   The central stockpile of Personal Protective Equipment (PPE) was designed for a flu pandemic and a range of bodies across health and social care have expressed concern about PPE supply. The supply of PPE from central sources up to mid-May only met some of the modelled requirement from health and social care providers. At the start of the outbreak, the only central stockpile - held by PHE - was designed for a flu pandemic. It lacked items such as gowns and visors, which an independent committee advising the Department on stockpile contents had recommended in 2019. Based on modelled PPE requirements for the period 20 March to 9 May (which assumed the reasonable worst-case scenario), the amount of PPE distributed from central stocks only matched health providers' requirements for face masks and clinical waste bags. The lowest level of distribution to health settings was for gowns (where central stocks distributed were 20% of the modelled requirement), eye protectors (33%) and aprons (50%). Central stocks distributed to social care accounted for 15% or less of the modelled requirement for any item of PPE, apart from face masks. Local NHS bodies and social care providers could also source PPE from other routes throughout March and April. However, a range of bodies across health and social care have expressed concerns about PPE supply (paragraphs 4.19, 4.20 and 4.24 to 4.26).

Part One

Coordinating the NHS and adult social care response

The context for this report

1.1 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. Public health bodies initially classified COVID-19 as a High Consequence Infectious Disease (HCID).[1] This technical designation was removed on 19 March, based on factors including new information about the overall mortality rate, increases in clinical awareness and the existence of appropriate diagnostic tests. Nonetheless, COVID-19 has had a great impact on the lives of millions of people.

1.2 Since January, the UK government has been involved in a wide-ranging response to COVID-19, covering health and social care, other public services, support for individuals affected by the pandemic and support for businesses. The response has been underpinned by a four-stage strategy to contain, delay, research and mitigate the virus. **Figure 1** outlines some of the main developments, and our May 2020 report *Overview of the UK government's response to the COVID-19 pandemic* provides a fuller summary.[2]

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[1] HCIDs are acute infectious diseases defined by specific criteria which include: their mortality rate; the availability of effective treatment; difficulty of detection; risk of community transmission; and the need for individuals and organisations to take special measures. HCIDs require specific infection control and prevention measures for suspected and confirmed cases, with treatment in a designated centre. Examples of HCIDs include Ebola and avian flu.

[2] Comptroller and Auditor General, *Overview of the UK government's response to the COVID-19 pandemic*, Session 2019–-2021, HC 366, National Audit Office, May 2020.

Figure 1

Key events at the start of the pandemic

Timeline of key events and health and adult social care announcements in England during the COVID-19 pandemic up to 30 April 2020
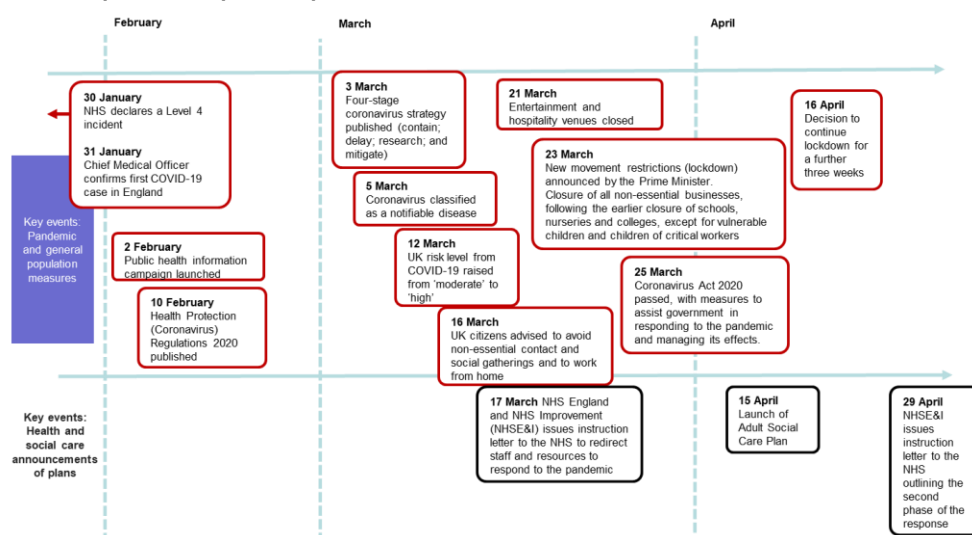
NOTES

1. The figure does not include all government announcements and actions on COVID-19.

2. The Coronavirus Act 2020 included provisions regarding: the emergency registration of health professionals; indemnity for health service activities; NHS and local authority care and support; mental health and mental capacity legislation; and death registrations.

3. In the NHS, a Level 4 National Incident is one that triggers a centrally managed response to a crisis.

Source: National Audit Office review of government documents and websites

1.3   In anticipation of the first infections, the NHS had already declared a Level 4 National Incident on 30 January 2020, triggering a centrally managed response to the outbreak.[3] After the government moved from the 'contain' to the 'delay' stage of its strategy, the chief executive and chief operating officer of NHS England and NHS Improvement (NHSE&I) wrote to NHS providers on 17 March telling them what they should do to prepare for a surge in COVID-19 patients. Later, after issuing various pieces of guidance to the adult social care sector from 13 March onwards, on 15 April, the Department of Health & Social Care (the Department) published an action plan for adult social care, identifying actions to help manage the virus and care for the sick in all care settings. This report provides a detailed update on progress in implementing the principal actions in these documents, based on available published data and unpublished information accessed through our statutory powers.

1.4   The rest of this Part sets out key details of the COVID-19 outbreak, the roles and responsibilities of the different organisations involved in tackling it, the main elements

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[3] Level 4 is the NHS's most severe incident level and indicates an incident requiring NHS England National Command and Control to support the NHS response and collaborate with local commissioners at a tactical level.

of the NHS and adult social care response, and the additional funding government has made available.

Key details of the COVID-19 outbreak

1.5   The COVID-19 virus is new in humans. Knowledge of its impact on the human body is changing all the time, requiring frequent changes in clinical practice and other measures. There is currently no cure for COVID-19. It is highly infectious and deadly in some patients, disproportionately so for certain groups, particularly the elderly, men, some ethnic groups, and those with a number of pre-existing conditions.

1.6   There is no single precise measure of how many people have COVID-19 in England at any one time. There is a range of data available to track the virus's spread, including the results of the government's testing programme, which it has published daily through the outbreak, and information about deaths, which can be calculated in several ways. All measures indicate that the virus spread quickly and widely in England during March and April, before reaching a peak some weeks after the government introduced social distancing policies.

1.7   **Figure 2** shows data from the government's testing programme across Great Britain. The data are hard to interpret with precision. The average number of people tested has increased from fewer than 2,000 per day in early March to more than 60,000 per day during May. The government has altered eligibility for testing over this time. It first tested all those with symptoms and their contacts, then narrowed in on critically ill hospital patients and small numbers of symptomatic residents in care homes, and then extended eligibility in stages to include NHS, social care and other key workers and their households, and care home residents more widely, as testing capacity increased (see paragraphs 3.16, 4.14 and 4.15, and Figure 21). Additionally, the UK Statistics Authority has criticised the government for the way in which it counts tests, urging greater clarity about how testing targets are defined, measured and reported.[4] Nonetheless, as currently stated, the average proportion of people tested who were positive steadily increased up to early April, when it stayed above 40% for several days, before falling to around 10% at the end of April.

[4] UK Statistics Authority, Letters from the Chair, Sir David Norgrove, to the Secretary of State for Health and Social Care, dated 11 May 2020 and 2 June 2020.

Figure 2

Average numbers of COVID-19 tests, people tested and proportion of people who tested positive in Great Britain between February and May 2020

The average proportion of people tested that were positive increased to more than 40% by early April before falling to around 10% at the end of the month
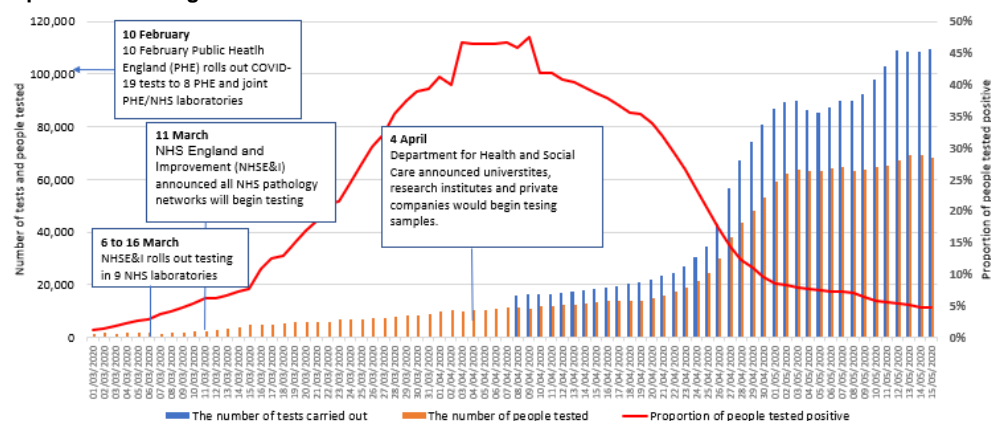
NOTES

1. All data shown are rolling seven-day averages (including three days before and three days after the relevant date). Data are based on the numbers reported daily by Public Health England (PHE) which have not been adjusted by subsequent revisions. Daily figures up to 6 April, and for any days where individual items were not published, are derived from cumulative information published. Data on the number of tests were not reported until early April.

2. The number of tests reported by PHE includes both tests carried out on the day and test kits sent out on the day, but the tests may or may not have been carried out. The number of people tested and the proportion of people tested positive are based on the date when test results are reported and may not relate to the number of tests reported for that day.

3. Tests processed at NHS laboratories are counted as having been carried out once laboratories have completed the tests and the report is available. Tests sent to individuals at home or mobile testing locations are counted as having been carried out before laboratories start to process them.

4. For clinical reasons, some people are tested more than once, meaning the number of tests is higher than the number of people tested.

Source: National Audit Office analysis of the number of COVID-19 cases and risk level in the UK, available at: https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public

1.8 **Figure 3** shows Office for National Statistics (ONS) data for weekly numbers of deaths in England from both COVID-19[5] and other causes. It sets this against the range of deaths for the same weeks over the past five years. From the end of March 2020, the total number of deaths increased sharply compared with the past five years. The peak of additional deaths (also known as excess mortality) occurred in the weeks ending 17 and 24 April. Between the weeks ending 27 March and 15 May, there were

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[5] The ONS defines deaths related to COVID-19 as those where COVID-19 has been mentioned on the death certificate. There are other published measures of COVID-19-related deaths, for example those published on a daily basis by the Department of Health & Social Care (the Department), which capture deaths in hospital with a confirmed test result or where COVID-19 is recorded on the death certificate, based on the date of the death reported. These are available more quickly than ONS data. In this report we use ONS data on deaths by date of registration, which are more comprehensive, allow comparisons over time and enable COVID-19-related deaths to be set in the context of overall counts of deaths in England.

a total of 52,000[6] additional deaths above the average of the past five years.[7] In total for the calendar year up to 15 May, 39,200 deaths mention COVID-19 on the death certificate. Of these, there were 25,500 deaths in hospital, with the highest number, 5,800, recorded in the week ending 17 April. In care homes, there were 11,100 such deaths, peaking at 2,700 in the week ending 24 April. The number of care home deaths recorded as being from other causes was also higher in April than previous months.

1.9   Research by the ONS also indicates that people working in social care had significantly higher rates of death involving COVID-19 compared with the general working population, although the rate of deaths for NHS workers was not statistically different.[8] According to information provided by NHSE&I, 156 NHS workers had died with COVID-19 up to 30 April 2020.[9] According to the ONS, 131 social care workers had died with COVID-19 up to 20 April 2020.

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[6] In paragraph 1.8, references to numbers of deaths have been rounded to the nearest 100.
[7] Additional or excess deaths are here estimated as deaths registered in excess of the five-year average recorded for each weekly period. This is a simple unweighted mean on the total registered deaths.
[8] Office for National Statistics, *Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020*, May 2020, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020#deaths-involving-covid-19-among-health-and-social-care-workers
[9] NHSE&I figures include deaths from acute, community and other non-acute settings, and draw from data on the formal COVID-19 death recording system, with additional confirmation by HR Directors.

Figure 3

Weekly number of deaths with COVID-19 recorded on the death certificate, and deaths from other causes, by place of death, compared with the range in the past five years in England, January to May 2020

Between the weeks ending 27 March and 15 May, there was a total of 52,000 additional deaths above the average of the past five years
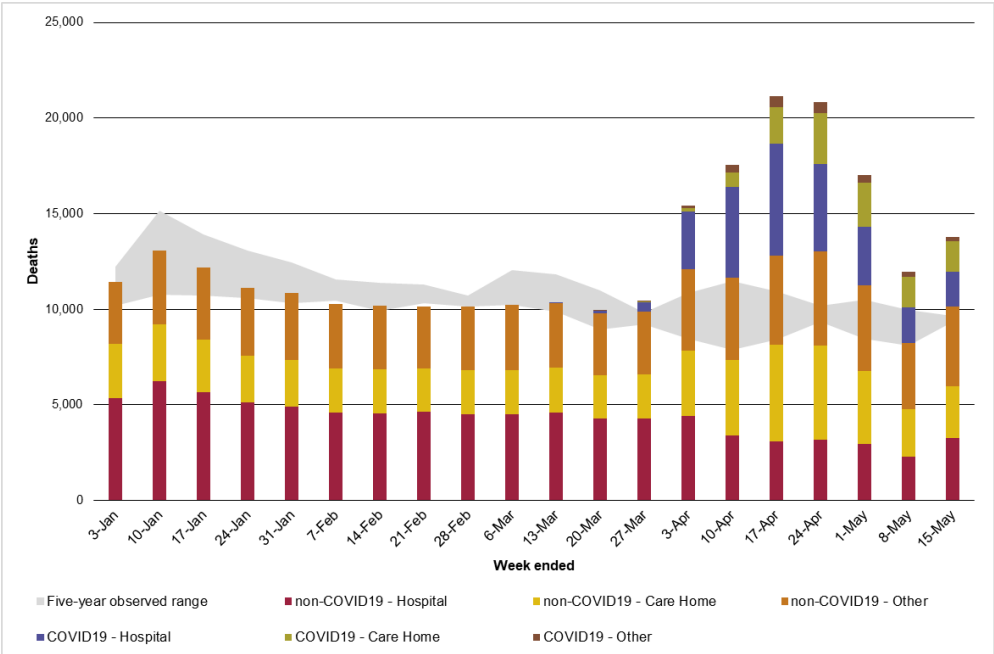
NOTES

1. Figures are drawn from weekly registrations data at local authority and regional level for England, based on the date a death was registered. They include all deaths that were registered up to 15 May 2020, as reported by the Office for National Statistics on 2 June 2020.

2. 'Other' includes deaths at home, in hospices and other communal establishments, and elsewhere.

3. 'Five-year observed range' sets out the highest and lowest number of recorded deaths in the equivalent weeks during the preceding five years. It illustrates the extent to which numbers of deaths are subject to natural variation from year to year. In 2020, there were around 4,500 fewer deaths than expected from the five-year average during the first 12 weeks.

Source: National Audit Office analysis of Office for National Statistics data

Roles and responsibilities

1.10 **Figure 4** sets out the main organisations with national and local responsibilities for health and adult social care.

Figure 4

Health and adult social care responsibilities in England

Some bodies have additional responsibilities in responding to national health emergencies

Department of Health & Social Care
Provides funding to the health system. Accountable to Parliament for health and adult social care policy.

Ministry of Housing, Communities & Local Government
Provides funding to local government. Accountable to Parliament for overall funding to local authorities.

Key arm's-length bodies

NHS England & NHS Improvement (NHSE&I)
Leads the National Health Service (NHS) in England; oversees and supports NHS trusts and NHS foundation trusts, including commissioning and regulation of some healthcare provision.

Public Health England
Provides health protection services, and public health advice, analysis and support to government, local authorities and the NHS. Prepares for and responds to public health emergencies.

NHS Digital
Provides information, data and IT systems for the health system.

Care Quality Commission
Regulates health and social care providers. Monitors and inspects services.

Locally based bodies

135 clinical commissioning groups
Plan and commission healthcare for their areas.

Local authorities
151 councils assess needs and commission social care and local public health services. Some provide services directly. All councils are members of a **local resilience forum** which supports coordination of public services in an emergency

Sustainability and transformation partnerships/integrated care systems
Partnerships of healthcare and social care providers and local authorities, with a role in planning and delivering local health and social care services.

Primary care services
Includes GP and dental services, and community pharmacies.

150 NHS foundation trusts and 77 NHS trusts

Independent healthcare providers

Independent social care providers

Key
→ Source of funding

NOTES

1. Not all arm's-length bodies referenced in this report, and not all funding flows, are included.

2. Since April 2019, NHSE&I have worked jointly under a shared regional structure.

3. The government asked all parts of the country to put in place local support systems ('hubs') to support the most clinically vulnerable people. There are 132 hubs.

4. Independent social care providers usually offer services in care homes (residential, nursing and supported accommodation) or support people in their own homes (domiciliary care, direct payments, supported living and other long-term care).

Source: National Audit Office summary of official documents

The NHS response to COVID-19

1.11 The NHSE&I leadership declared a Level 4 National Incident on 30 January 2020, triggering a centrally managed response to the outbreak. The NHS undertook a range of initial measures, including setting up a dedicated 111 COVID-19 telephone advice service and creating quarantine facilities.

1.12 On 12 March, the government moved from the 'contain' to the 'delay' phase of its COVID-19 strategy. This followed advice from the Scientific Advisory Group for Emergencies (SAGE), underpinned by epidemiological models from Imperial

College.[10] The advice indicated that the government's planned measures to date would result in hospital critical care capacity being overwhelmed by a factor of eight, with widespread social distancing needed immediately to reduce an imminent peak in infections. Without social distancing, SAGE considered that the NHS in London was likely to exceed critical care capacity by the end of March.

1.13 On 17 March, the chief executive and chief operating officer of NHSE&I wrote a letter to all NHS trusts and NHS foundation trusts, clinical commissioning groups, GP practices, primary care networks and providers of community health services. The letter set out measures each organisation should take to redirect staff and resources and prepare more generally for the expected surge in COVID-19 patients (**Figure 5**). The letter also described some central measures that were intended to free up resources to tackle COVID-19, such as the suspension of routine Care Quality Commission (CQC) inspections. At this point, the NHS formally deferred key strategic plans, such as publication of the NHS People Plan, the detailed workforce strategy that had been scheduled for spring 2020. In the week following this letter, the Coronavirus Act 2020 was passed, which provided the legislative basis for additional regulatory and staffing flexibility. In March, NHSE&I coordinated an exercise focussed on testing hospital preparedness, which identified lessons about communications, staff access to schools and nurseries, and monitoring of key operational indicators including staff absence and availability.

1.14 NHSE&I told us that at the point of sending the 17 March letter it was responding to SAGE's 'reasonable worst-case scenario'. It told us that, as the pandemic has developed, it has continued to adapt its planning assumptions based on SAGE's advice.

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 SAGE is co-chaired by the government Chief Scientific Advisor and Chief Medical Officer, and includes experts from government, the healthcare sector and academia. It aims to provide scientific and technical advice to support government decision-making during emergencies.

Figure 5

Priority actions for NHS trusts and other bodies set out in 17 March letter from NHS chief executive and chief operating officer

NHS trusts and other bodies were asked to undertake measures in six main areas

Priority action	Specific measures
Free up maximum possible inpatient and critical care capacity	Postpone all non-urgent elective operations from 15 April at the latest, for a period of at least three months
	Urgently discharge all hospital patients who are medically fit to leave
	Block-buy capacity in independent hospitals
	Free up community and hospital intermediate care beds
Prepare for, and respond to, large numbers of inpatients requiring respiratory support	Secure a step-change in oxygen supply and distribution to hospitals
	Nationally procure assisted respiratory support capacity, particularly mechanical ventilators
	Resolve local distribution issues around Personal Protective Equipment (PPE)
	Provide refresher training to all clinical and patient-facing staff supporting patients with respiratory needs
	Segregate all patients with respiratory problems
Support staff and maximise staff availability	Support staff to stay well and at work
	Establish targeted testing for symptomatic NHS staff
	Make adjustments for remote working or to move staff to lower-risk areas
	Support provision of telephone-based or digital/video-based consultation and advice
	Ask clinicians relinquishing their licence to practice within the previous three years if they would be willing to return
	Deploy medical and nursing students and clinical academics
	Ask all appropriately registered nurses, midwives and allied health professionals currently in non-patient-facing roles to support direct clinical practice
Support the government's wider population measures	Support older and vulnerable people
	Roll out remote GP consultations via video, telephone, email or text services
	Identify and contact patients in the highest-risk groups to offer enhanced support
Stress-test operational readiness	Check business continuity plans and review latest standard operating procedures
	Trust Incident Management Teams to be stood up in all organisations to receive and cascade guidance and information
	Participate in a systems-wide stress-testing exercise
Remove routine burdens	Cancel all routine Care Quality Commission inspections
	Ensure that emergency legislation provides wide regulatory cover for staff and institutions
	Review and temporarily suspend certain requirements on GP practices and community pharmacists
	Defer publication of the NHS People Plan and the Clinical Review of Standards
	Move to block contract payments for all NHS trusts and foundation trusts
	Provide additional funding to cover the extra costs of responding to the COVID-19 emergency

Source: National Audit Office summary of NHS letter from Sir Simon Stevens and Amanda Pritchard, dated 17 March 2020

The adult social care response to COVID-19

1.15 The NHS letter of 17 March also implied actions for the adult social care sector. Between 13 March and 15 May, in addition to wider guidance on matters such as PPE, the Department issued various pieces of guidance to the adult social care sector with numerous updates.[11] Provider organisations raised concerns that the number of updates and changes to guidance were hard to follow, and that they left some issues with regard to testing, PPE and the workforce unaddressed. On 15 April, the Department published the adult social care action plan. The plan set out the Department's approach for all settings and contexts where adults receive care (**Figure 6**).

Figure 6

Summary of adult social care action plan published 15 April 2020

The Department of Health & Social Care set out measures in four key areas

Priority action	Specific measures
Controlling the spread of infection in care settings	Published a range of guidance
	Help supply Personal Protective Equipment (PPE) to providers
	Isolate people with COVID-19 and consider moving people to different locations
	Test all symptomatic residents in care homes
	Test all residents prior to admission into care homes
Supporting the workforce	Capacity available for every social care worker who has symptoms consistent with COVID-19, to be tested.
	Ambition to attract 20,000 people into social care jobs over the following three months
	Support for members of regulated professions to return to work
	Publish more detailed guidance about the use of volunteers in social care
Supporting independence, supporting people at the end of their lives and responding to individual needs	Publish guidance for those (both social care providers and family carers) caring for people with a learning disability and autistic adults
	Share best practice on end-of-life visits
	Clarify that local authorities should only take a decision to begin exercising the Care Act easements when necessary
Supporting local authorities and the providers of care	Ask local authorities to provide information about the distribution of additional funding to providers
	Daily tracker in place with information on bed capacity, workforce absences, PPE levels, and overall risks in care homes
	Note that the Care Quality Commission was developing a tool for home care providers

[11] Some guidance that was not specific to social care was published before 13 March. For example, COVID-19: infection prevention and control guidance was first published on 10 January 2020.

Additional funding for health and adult social care

1.16 The government has announced additional funding for health and adult social care during the COVID-19 emergency. Much remains unclear about how this funding has been allocated to different parts of each sector and how much of it has been spent so far.

Funding for NHS services

1.17 In March, the Secretary of State for Health and Social Care directed NHS England to arrange hospital accommodation and commission broader health services, a role normally performed by clinical commissioning groups. To finance day-to-day hospital activity during the outbreak, NHSE&I replaced normal payment mechanisms (partly based on activity) with block (fixed) payments. In addition, it allowed NHS trusts to claim for excess top-up costs arising from COVID-19. These arrangements have been in place since April and are set to run until at least July.

1.18 On 13 April, HM Treasury announced an additional £6.6 billion Coronavirus Emergency Fund for health and social care, including up to £1.3 billion, previously announced on 19 March, to allow the NHS to support faster patient discharges from hospitals.[12] Based on provisional NHSE&I estimates for the period between 19 March and 30 April, which are still to be validated, £113 million had been spent on the COVID-19 hospital discharge programme, accounting for around 9% of the £1.3 billion funding provided. Of this £113 million, around half had been spent by local authorities and around half by clinical commissioning groups. Local authorities had contributed a further £39 million to the programme. According to these provisional estimates, just under half of the programme funding spent to date had been used for care homes. We requested further details about the costs to date of temporary block and top-up payments, or the activities covered by and the level of expenditure from other parts of the Coronavirus Emergency Fund but did not receive these.

1.19 NHSE&I advised GPs that it would ensure their practices were paid at rates that assumed they would have performed at the same levels as prior to the outbreak. It has also provided extra funding where additional opening hours were needed during holidays. Meanwhile, on 1 April, the government announced that it would write off £13.4 billion of NHS debt and replace it with non-repayable public dividend capital.[13]

Funding for local government and adult social care

1.20 Local authorities' spending power (made up of government grants, locally retained business rates and council tax) fell in real terms by 28.7% between 2010-11 and 2019-20. On 19 March, the Ministry of Housing, Communities & Local Government (the Ministry) announced £1.6 billion in funding for local authorities to help them respond to COVID-19 pressures across all the services they deliver. This

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[12] This was separate to other funding given to local authorities, which is detailed in paragraphs 1.20 to 1.24.
[13] The debt will effectively be written off by converting the loans to equity.

included increasing support for the adult social care workforce and for services helping the most vulnerable, including homeless people. The funding was not ringfenced.

1.21 On 8 April, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) issued a framework for considering temporary funding of social care providers in the light of COVID-19.[14] It highlighted three areas where councils could support providers:

- Thorough fee increases for 2020-21 reflecting the increases in the National Living Wage from April (equivalent to around 5% increase in costs), noting that such fee increases would already be budgeted for and would not come out of the £1.6 billion additional funding. Some councils had agreed uplifts to fees as part of their budget setting processes for 2020-21;

- Additional temporary funding to recognise costs caused by COVID-19 from April with the option of extending further. Information from providers suggested that nationally costs could increase by around 10% in April;

- Helping providers with their cash flow, especially in April, for example through paying in advance for anticipated care delivery.

1.22 On 28 April, the Ministry allocated a further £1.6 billion of non-ringfenced funding, bringing the total additional funding to £3.2 billion. The areas that government asked local authorities to prioritise during the COVID-19 crisis in relation to the £3.2 billion additional funding included adult social care; children's services; public health; fire and rescue; waste management; shielding; homelessness and rough sleeping; domestic abuse; and managing excess deaths as set out by the Secretary of State to the Housing, Communities and Local Government Committee.[15] Of the £3.2 billion, councils which provide adult social care have received 91% (£2.9 billion). Figure 7 details the funding, by type of council.

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[14] Local Government Association and Association for Directors of Adult Social Services, *Temporary funding for Adult Social Care providers during the COVID-19 crisis*, April 2020.
[15] On 28 May, the Ministry published the service areas which it had earlier signalled in its communications with local government that councils should prioritise. Earlier on 14 May, the Secretary of State set out these areas in writing to the Housing, Communities and Local Government Select Committee.

Figure 7

Distribution of £3.2 billion funding for COVID-19 to local government in England, by local authority type

Councils with adult social care responsibilities received a higher proportion of the first tranche of additional funding than the second tranche

	London boroughs	Metropolitan districts	County councils	Unitary authorities		Shire districts	Other authorities
		Authorities with adult social care responsibilities				Authorities without adult social care responsibilities	
■ Second tranche of COVID-19 funding	245.0	332.5	385.2	379.6		214.0	37.7
■ First tranche of COVID-19 funding	254.2	395.2	542.2	382.8		9.7	15.8

Local authority type

NOTES

1. London boroughs, Metropolitan districts, County councils and Unitary authorities are responsible for commissioning adult social care.

2. Shire districts and Other authorities (Local authorities who received funding to support their fire and rescue responsibilities) do not have social care responsibilities.

3. The funding is non-recurrent and is not part of the future funding baseline for local authorities.

4. From the first tranche of funding, £1.4 billion was allocated through the adult social care relative needs formula. The remaining £200 million was allocated in line with each council's Settlement funding assessment.

5. From the second tranche of funding, the funding allocations were based on a per capita basis, with a 65:35 split between county and district authorities. The Ministry of Housing, Communities and Local Government's full methodology can be found here: www.gov.uk/government/publications/covid-19-emergency-funding-for-local-government

Source: National Audit Office analysis of Ministry of Housing, Communities & Local Government data

1.23 From April 2020, local authorities began to highlight to the Ministry financial pressures from the impact of COVID-19. In May, they reported £1.2 billion of additional spending pressures and reduced income of £2.0 billion for March through to May. For the 2020-21 financial year, overall, local authorities forecast additional spending pressures of £3.6 billion and income losses of £5.5 billion. Failure by a local authority to balance its budget over the financial year is unlawful.

1.24 On 15 May 2020, the Department announced a ringfenced £600 million Infection Control Fund. This fund was allocated to local authorities with social care responsibilities based on the number of registered care home beds in each area, with an adjustment to reflect the costs of operating in each area. Of this, the Department expects local authorities to pass on 75% to care homes within their area for infection

control measures. Local authorities can use the remaining 25% on wider infection control measures, including in domiciliary care, but this payment is contingent on the first 75% being used for infection control. The Ministry told us that councils must ensure funds are paid to providers as quickly as possible but must also ensure funds are used appropriately. It said the first £300 million tranche was paid on 22 May.

1.25 The Ministry requested local authorities publish by 29 May the increase in fee rates they were paying to care providers along with other funding support. Provider associations have told us they are concerned that many local authorities are not raising fee rates and there is limited support for providers with a high proportion of clients paying for their own care. In a survey response to ADASS in early May, 97% of local authorities said they were providing financial support to providers, with 30% stating they had set aside emergency funding for providers to claim back excess costs and 16% saying they had provided an upfront lump sum. Around half of local authorities that responded said they were temporarily increasing fee rates, which included around 25% that said they had provided a temporary 10% uplift in fees.[16] However, provider organisations have told us they have evidence which disagrees with these findings: the picture appears to vary across the country.

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[16] Association of Directors of Adult Social Services Rapid Survey, 23 May 2020: 89% of local authorities responded to a survey by ADASS between 28 April and 1 May.

Part Two

Caring for people in hospital

2.1   This Part examines the main actions to prepare hospitals to care for large numbers of people with COVID-19.[17]

Freeing up in-patient capacity

2.2   The 17 March letter to NHS providers (paragraph 1.13 and Figure 5) outlined an intention to free up at least 30,000 beds for patients by:

- postponing all non-urgent elective (planned) operations;

- discharging patients who were medically fit to leave;

- buying additional capacity from independent providers.

Additionally, from 24 March, the NHS announced it was setting up temporary Nightingale hospitals to boost capacity further. All these actions were informed by the 'reasonable worst-case scenario' derived from analysis by the Scientific Advisory Group for Emergencies (SAGE).

Beds available for COVID-19 patients

2.3   On a daily basis, the NHS monitors bed availability, including general and acute bed capacity for COVID-19 patients in NHS hospitals, which it defines as the number of empty beds plus those already occupied by a patient with COVID-19. NHS England and NHS Improvement (NHSE&I) data show that, by this measure, capacity increased quickly after the 17 March letter was sent, from 12,600 on 17 March to 53,700 on 12 April, well above the 30,000 goal (**Figure 8**). The proportion of this capacity occupied by a COVID-19 patient rose from 6% on 20 March to 29% on 7 April, standing at 21% as at 30 April. Paragraphs 2.15 and 2.19 contain further analysis of bed capacity in critical care and beds with oxygen support.

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[17] This report does not cover actions related to community and intermediate care beds, or to hospices and end of life care. Part Four covers supply of Personal Protective Equipment for NHS staff.

Figure 8

Number of general and acute beds in NHS hospitals empty or occupied by COVID-19 patients by NHS region in England, March to April 2020

The number of general and acute beds available increased from 12,600 on 17 March to 53,700 on 12 April
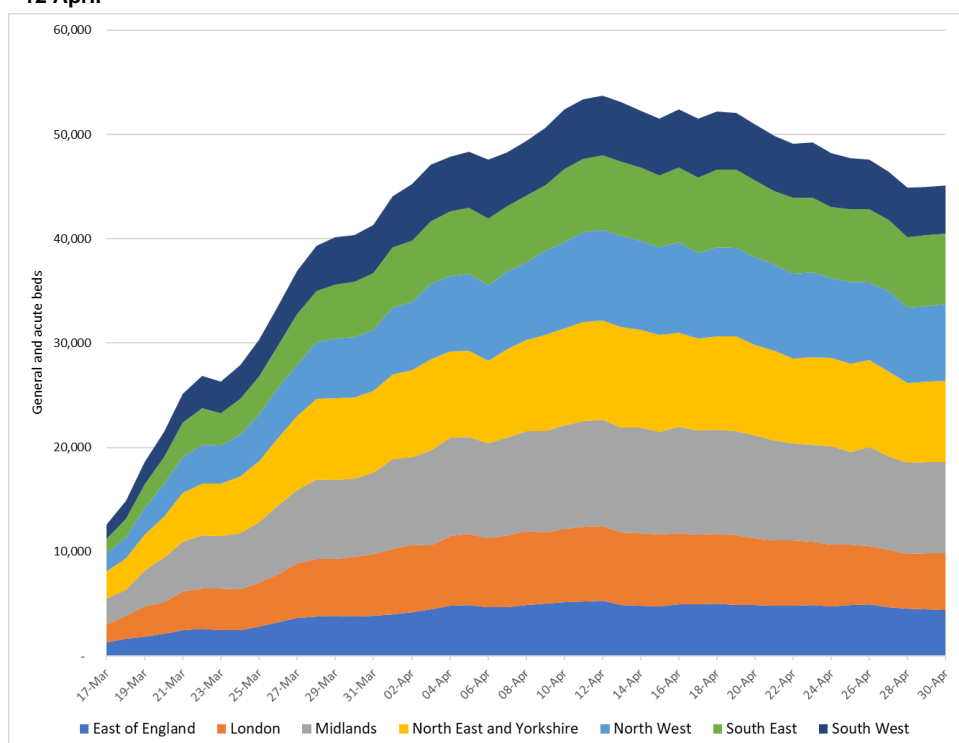
General and acute beds empty or occupied by COVID-19 patients	17-Mar	31-Mar	12-Apr	30-Apr
Total beds (selected dates)	12,600	41,300	53,700	45,100

Notes:

1. Data only include acute NHS trusts with a Type 1 Accident & Emergency (A&E), that is to say, a consultant-led, 24-hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients. They do not include beds in private providers or Nightingale hospitals.

2. NHS England and NHS Improvement (NHSE&I) monitors this measure of available beds which represents beds available to treat COVID-19 patients, including beds currently occupied by such patients.

Source: National Audit Office analysis of NHS England and NHS Improvement data

How extra capacity was created

Postponing elective operations

2.4   NHS trusts were instructed to free up capacity in part by postponing their elective activity from 15 April at the latest and for a period of up to three months. Data from NHSE&I suggest that hospital elective activity fell by 24% in March 2020 compared with March the previous year. Data for April 2020, when reductions in elective activity applied for the whole month, are due to be published in June. The impact and

associated costs of postponing elective activity are complex, and our report on NHS waiting times found limited understanding of the impact of longer waiting times on patient harm and outcomes.[18]

Discharging patients

2.5   Two days after the 17 March letter, the government published further guidance to assist hospitals in urgently discharging patients no longer in medical need of a bed. It expected this would free up at least 15,000 beds by 27 March, a level that could not be achieved if the usual approach to discharges was maintained. To speed up discharges, the government announced it would fully fund the cost of any health or social care support patients needed after leaving hospital. It provided an initial sum of £1.3 billion to pay for this (see paragraph 1.18 which covers provisional estimates on spend to date). Between 17 March and 15 April, the average number of people discharged daily from hospital to any setting fell from 49,200 to 22,700. Compared with the previous year, the total number of hospital discharges over this period was 45% lower. (See also paragraphs 3.19 and 3.20 for discharges from hospital to care homes.)

Purchasing independent capacity

2.6   The NHS also increased capacity by securing access to beds in non-NHS hospitals. On 21 March, NHSE&I announced a deal with the independent hospital sector to provide access to up to 8,000 hospital beds (as well as associated clinical staff and 1,200 ventilators). This contractual arrangement runs for an initial 14-week period through to 28 June but can be extended if necessary. The total number of beds utilised under this arrangement and therefore its total cost is not yet clear.

Nightingale hospitals

2.7   From 24 March, the NHS sought to increase capacity further by setting up seven temporary Nightingale hospitals across England. The first opened in London at the ExCel Centre on 3 April. Based on published information, we estimate that the full planned capacity of the Nightingales was to have been more than 6,000 beds (2,000 general and 4,360 acute).[19] NHSE&I told us it was reassessing the model for using Nightingales after utilisation of the earliest ones was very limited. At the time of writing this report, one hospital was treating patients and five were on stand-by.[20] The cost of creating and running the Nightingales is not yet known.

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[18] Comptroller and Auditor General, Department of Health & Social Care, NHS England, *NHS waiting times for elective and cancer treatment*, Session 2017-2019, HC 1989, National Audit Office, March 2019.
[19] This estimate counts admissions and step-down beds as general or acute, and assumes beds are intensive care if not specified. This estimate does not reflect actual usage by patients and we did not obtain information on how many patients were treated in the facilities. We did not assess the availability of staff and equipment to run the facilities.
[20] The status of NHS Nightingale Exeter (Westport) is unclear.

Preparing to treat large numbers of patients requiring respiratory support

2.8   A second set of actions in the 17 March letter required the NHS to prepare for large numbers of patients requiring respiratory support, securing oxygen supplies and additional mechanical ventilators and other breathing aids. The Department of Health & Social Care (the Department) had responsibilities for the supply of respiratory support, including oxygen.[21]

Oxygen

2.9   The NHS published central guidance on the help it would provide to hospitals to secure additional oxygen. The Department told us that UK industry can produce plentiful supplies of the element, with the main challenges relating to delivery of supplies and the infrastructure within hospitals to pump oxygen to beds.[22]

2.10 In normal times, commercial oxygen suppliers remotely monitor hospitals' main oxygen tanks and deliver fresh supplies when certain trigger points are reached. During the pandemic, the NHS, working with suppliers, raised the trigger points for resupply to allow for more frequent deliveries and to keep stocks high.

2.11 Hospital trusts are responsible for ensuring an adequate supply of oxygen around their estates. With more patients requiring oxygen, some hospitals risked facing problems with maintaining oxygen flow, which can depend both on equipment and infrastructure. On 12 April, the NHS required trusts to request any necessary improvements via a centrally-directed programme, with upgrades prioritised by regional teams. During April, the Department told us it had funded 18 improvement projects, which added oxygen support to around 2,400 beds. In the first part of May, it funded a further 13 projects, adding oxygen to around 900 beds.

Ventilators and other breathing aids

2.12 The NHS estimated that NHS trusts in England had around 7,500 mechanical ventilators before the start of the pandemic. A worst-case scenario, derived from Scientific Advisory Group for Emergencies (SAGE) advice in early March, suggested the NHS would need around 25,000 ventilators to cope with the first peak in COVID-19 patients. This was subsequently revised down to a worst-case scenario of 18,000 based on evidence that some patients could be treated successfully using less invasive methods.

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[21] Providing oxygen is currently the main treatment for people with severe symptoms of COVID-19. Patients who are not able to breathe enough on their own may require oxygen administered by a "mechanical ventilator", which takes over a person's breathing. The oxygen is delivered via a tube going from the nose or mouth into the trachea. Some patients may be treated using 'non-invasive support' (Non-invasive ventilation or NIV), where oxygen is delivered under pressure via a mask or helmet. For this report, 'non-invasive support' includes both BiLevel Positive Airway Pressure (BiPAP) or Continuous Positive Airway Pressure (CPAP) devices. Other patients may be able to receive oxygen via a simple mask or nasal cannula.
[22] Oxygen can be administered to patients by piping it in from storage tanks, or from cylinders placed on wards.

Treating patients with COVID-19

2.13 The number of people being treated for confirmed infection with COVID-19 rose rapidly in English hospitals from mid-March before peaking in the week starting 6 April and subsequently declining. During April, London had the highest number of hospital patients with COVID-19, both in absolute numbers and as a proportion of its population, while in the first half of May the number and proportion were highest in the North West (**Figure 9**).

Figure 9

Number of hospital patients with COVID-19 per 100,000 adult population by NHS region in England, March to May 2020

The number of confirmed infections in English hospitals rose rapidly from mid-March, and peaked in mid-April, before subsequently declining
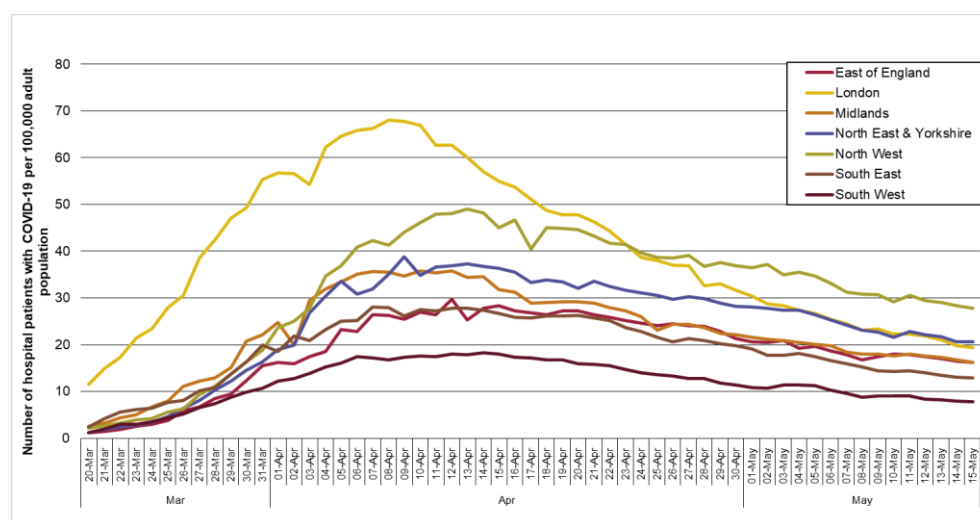
NOTES

1. Cases are patients in NHS Hospital Acute Trusts with a type 1 Accident & Emergency (A&E) in England with confirmed COVID-19 diagnosis.

2. The population measure used is the 2018 Office for National Statistics (ONS) estimate for the adult population (aged 16 and over) by NHS region. To align NHS regions with government regions the Midlands comprises the population of East and West Midlands, and North East & Yorkshire comprises the population of North East and Yorkshire and the Humber.

3. Fluctuations in the North West are the result of data validation changes. Missing data returns created artificial spikes in reporting followed by an artificial drop on 9 April.

Source: National Audit Office analysis of NHS England and Improvement and Office for National Statistics data

2.14 Hospital admissions of COVID-19 patients increased quickly at the start of April, and some hospitals have faced great pressure at times. However, the NHS system's capacity for COVID-19 patients, in terms of beds and respiratory support, has been sufficient during the pandemic to date.
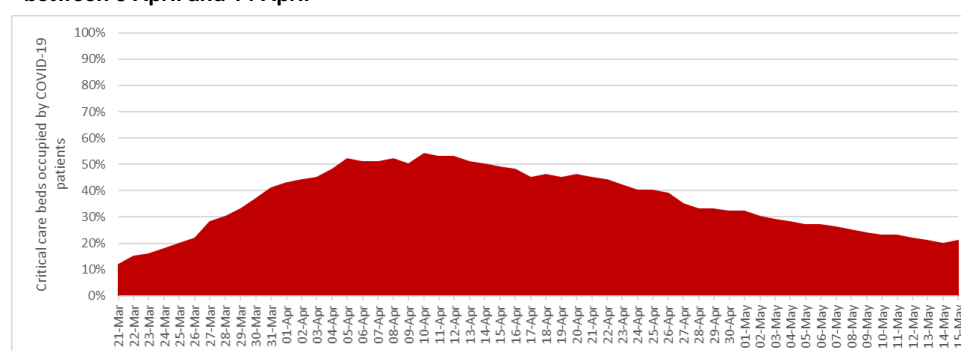
Beds

2.15 Patients infected with COVID-19 need different levels of care depending on the progression of their disease and their pre-existing conditions. The sickest patients require critical care beds, where they can be monitored constantly. Data from NHSE&I indicate that the number of NHS adult critical care beds increased from 3,670 on 20 March to a high of 6,200 on 17 April and remained at around 6,000 until the end of April. **Figure 10** shows that the proportion of critical care beds occupied by COVID-19 patients was highest - at 50% or just over - between 5 April and 14 April. It has since decreased, standing at 21% on 15 May.

Figure 10

Proportion of NHS critical care beds occupied by COVID-19 patients in England, March to May 2020

The proportion of critical care beds occupied by COVID-19 patients was highest - at just over 50% - between 5 April and 14 April

Percentage of critical care beds used to treat COVID-19 patients	21-Mar	31-Mar	10-Apr	30-Apr	15-May
Percentage (selected dates)	12%	41%	54%	32%	21%

NOTES

1. Data as reported by NHS England and Improvement and presented in the daily COVID-19 briefing. The data are based on figures presented as at 15 May as part of the daily briefing (16 May 2020).

Source: Gov.uk, NHS England and NHS Improvement

Oxygen

2.16 Although it is the principal therapy for treating COVID-19 patients, total NHS demand for oxygen did not rise by as much as anticipated during April. This may have been because of reductions in oxygen use elsewhere in hospitals, for instance in operating theatres, as well as changes in clinical practice to reduce oxygen wastage. The Department told us that oxygen use in April 2020 was only marginally higher than in April 2019. At the very height of the outbreak, it estimated that hospitals' use of oxygen piped from storage tanks was around 60% higher than normal - roughly 50% of maximum capacity - with around half this oxygen used for COVID-19 patients.

Ventilators and other breathing aids

2.17 The government sought to increase ventilator numbers through the deal NHSE&I had with independent hospitals, and by the Department buying approved devices from domestic and overseas firms.[23] It also created a 'Ventilator Challenge' programme, which called on UK businesses to design and produce new ventilators and their components.

2.18 Between mid-March and mid-May, the Department estimated that the number of mechanical ventilators available in the UK increased from 9,600 to 13,200. As at 19 May 2020, a more detailed stocktake indicated it had centrally purchased around 8,300 mechanical ventilators (1,300 of which had been received, **Figure 11**), at a cost of around £230 million. The Department had also received around 2,100 mechanical ventilators from the Ventilator Challenge. It told us that, as at 27 May, around 3,100 had been manufactured in total through the Challenge, with less than £200 million spent to date, and it anticipated that overall spend would be less than the original estimate of up to £454 million. In addition, the Department had purchased around 20,100 non-invasive breathing support devices (11,100 of which had been received as at 19 May).

Figure 11

Number of ventilators and non-invasive breathing support available in the United Kingdom, as at 19 May 2020

As at 19 May 2020, the NHS had received around 2,100 mechanical ventilators from the Ventilator Challenge

	Mechanical ventilators	Non-invasive breathing support	
		BiPAP devices	CPAP devices
Already owned by NHS trusts in England	7500 *	3700 *	7000 *
Already owned in NHS in devolved administrations	1000 *	not available	not available
Offered from private sector	1200	100	0
Ventilator challenge	2100	N/A	0
Purchased centrally	1300	7900	3200
Total available	**13000**	**11700**	**10200**
Purchased centrally but not yet received	7000 *	3000 *	6000 *

[23] The Medicines & Healthcare products Regulatory Agency (MHRA) is responsible for ensuring that medical devices meet quality and safety standards. The MHRA introduced expedited approval and temporary authorisation processes to enable purchases of devices that lacked pre-existing approval.

NOTES

1. Purchased centrally includes items not yet dispatched to local bodies. For mechanical ventilators, "purchased" comprises machines recorded as "purchased", and for non-invasive ventilation recorded as "in stock".

2. For CPAP devices, "already owned" includes around 1,500 devices reported by trusts in May 2020, but not at the start of the outbreak.

3. * = the Department indicated that they had low confidence in this estimate.

4. See footnote 22 for details of types of ventilators and breathing support.

5. Figures may not sum due to rounding.

Source: National Audit Office analysis of Department of Health & Social Care data

2.19 Demand for respiratory support was lower than originally estimated by the Department. The number of unoccupied beds equipped to provide mechanical ventilation, enhanced oxygen through non-invasive breathing support, and oxygen via simple masks more than doubled during April, from 16,900 to 34,900 (**Figure 12**). At the end of April, 3,800 beds with mechanical ventilators were unoccupied, compared with 1,500 at the start of the month, a rise of 150%.

Figure 12

Number of unoccupied beds with respiratory support in England, April 2020

The number of unoccupied beds equipped with ventilation or oxygen support more than doubled during April, from 16,900 to 34,900.
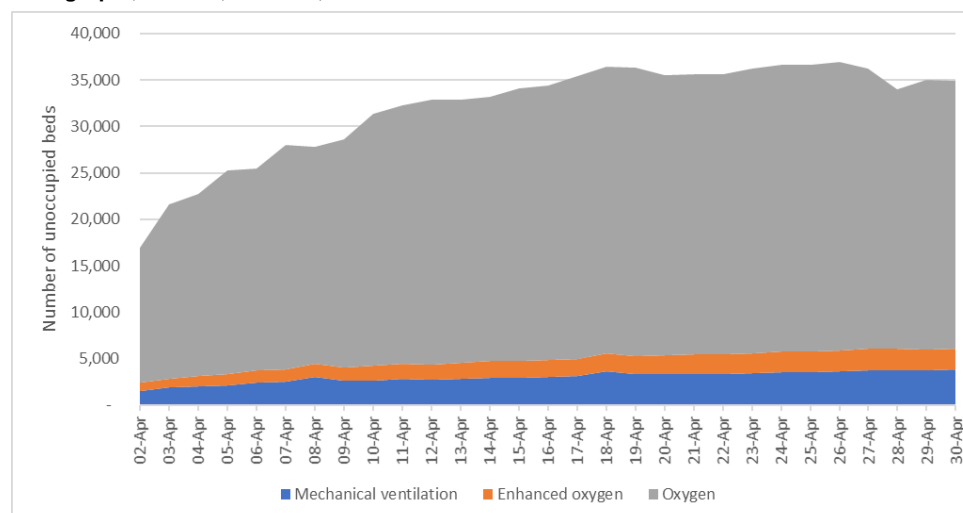
	02-Apr	18-Apr	30-Apr
Total number of unoccupied beds with respiratory support	16,900	36,400	34,900

NOTES

1. Enhanced oxygen refers to beds equipped to provide non-invasive ventilation. See footnote 22 for details of types of ventilators and breathing support.

2. Oxygen refers to beds with oxygen supplied via a simple mask or nasal cannula.

Source: National Audit Office analysis of NHS England and NHS Improvement data

Segregating patients

2.20 The 17 March letter required NHS trusts to separate patients with respiratory problems from other patients, and to separate further those who tested positive for COVID-19. NHSE&I did not centrally monitor how trusts were progressing against this action. From 10 January, Public Health England issued general infection control guidance for COVID-19, which included segregation.

Maintaining other NHS services

2.21 The 17 March letter stated that clinically urgent services, including emergency admissions and cancer treatment, should continue unaffected during the pandemic. The latest available data for cancer services show that urgent cancer referrals during March were 8% lower than in the same month in 2019. The number of patients receiving cancer treatment in March 2019 was broadly in line with patterns in previous months.

2.22 Demand for major (Type 1) Accident and Emergency (A&E) services[24] dropped significantly in March and April: attendances in April were down 48% compared with the same month in 2019 (**Figure 13**). With the lower number of patients, A&E services nationally came closer to meeting the four-hour target for A&E waiting times. The composition of people who did not attend A&E but normally would have, is important, particularly the division between people with minor ailments and those with serious conditions who might have suffered permanent harm or may re-present with more acute problems in future. NHSE&I said its initial analysis indicated that the reductions had primarily been in low urgency or minor conditions rather than major conditions, but we were unable to verify that the data provided supported this. It is not yet known to what extent lower demand for NHS services will cause more patients to present, potentially with more acute problems, in future.

2.23 Activity and performance in other areas of the NHS has also altered during the outbreak. The number of ambulance incidents rose in March (5% up on the previous year), with corresponding increases in response time: for example, the response time for emergency calls rose by 51%.[25] Meanwhile, in April, indicative statistics on the number of GP appointments[26] dipped by 31% compared with the previous year, with a large switch to telephone appointments, up 34 percentage points to 48%[27].

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[24] A&E services reported here cover major (Type 1) A&E departments.
[25] Incidents comprise calls that receive face-to-face response from the ambulance service at the scene of the incident or are successfully resolved with telephone advice.
[26] This includes appointments where mode of appointment is registered as unknown. Excluding these the proportion would be 32%.
[27] Data on GP appointments should be interpreted with caution as there are no national standards for data entry into GP systems, with varying approaches between GP practices, and COVID-19 has led to substantial changes in GP working.

Figure 13

Activity and performance measures for selected NHS services in England, January to April 2020

Demand for emergency services dropped significantly in March and April, and activity and performance in other areas of the NHS have also altered during the outbreak

	January	February	March	April
Accident and emergency (A&E) attendances and emergency admissions				
Number of A&E attendances (000s)	1,330	1,240	1,010	690
% change compared with previous year	-1%	0%	-26%	-48%
Number of emergency admissions (000s)	560	510	430	330
% change compared with previous year	-1%	1%	-23%	-39%
Percentage A&E attendances discharged, admitted or transferred within four hours or less (target = 95%)	71%	73%	76%	87%
Difference compared with previous year	-5%	-3%	-3%	+10%
Ambulance services				
Number of ambulance incidents (000s)	750	700	760	680
% change compared with previous year	0%	4%	5%	-4%
Response times for category 1 calls to ambulances (target = average of seven minutes)	7.08	7.19	8.07	7.08
% change compared with previous year	0%	0%	16%	2%
Response times for category 2 calls to ambulances (target = average of 15 minutes)	21.05	22.07	32.06	18.28
% change compared with previous year	-8%	-6%	51%	-14%
GP services				
Number of appointments (000s)	26,860	23,810	23,770	12,660
% change compared to last year	6%	3%	-2%	-31%
Percentage of GP appointments by telephone	14%	14%	28%	48%
Difference compared to last year	0%	0%	14%	34%

NOTES

1. A&E attendance is Type 1 (major A&E) activity as reported by NHS England. Emergency admissions include all recorded emergency admissions via A&E or otherwise. This analysis uses the adjusted series as published (which excludes 14 pilot sites which were not required to report against the standards from May 2019).

2. Ambulance incidents comprise those calls that receive a face-to-face response from the ambulance service at the scene of the incident or are successfully resolved with telephone advice

3. Category 1 ambulance calls relate to people with life-threatening illnesses or injuries; Category 2 calls are emergency calls.

4. GP services are based on NHS Digital experimental statistics, which only contain information captured on GP practice systems and may not show all GP activity. NHS Digital notes that the COVID-19 outbreak may impact further on data quality and consistency. Around one in eight GP appointments are not attended or the outcome is not recorded. Analysis includes appointments with mode recorded as "unknown".

Source: National Audit Office analysis of NHS England data on A&E and emergency admissions, NHS Digital experimental statistics on GP appointments, and NHS England data on ambulance activity and performance

Part Three

Providing adult social care and shielding the most vulnerable

3.1   This Part examines the main actions to:

- support local authorities and care providers, including oversight and monitoring;

- control the spread of COVID-19 in care settings;

- discharge NHS patients more quickly into care settings (see also paragraph 2.5); and

- shield the most vulnerable people in the community.

3.2   We have concentrated on adult social care in England which was the focus of the Department of Health & Social Care's (the Department's) action plan published on 15 April.

Supporting local authorities and care providers

3.3   Since 13 March, the Department has issued various pieces of guidance to the social care sector (paragraph 1.15). **Figure 14** shows the range of guidance published and updated between mid-March and mid-May. Guidance before mid-March had stated it was unlikely that anyone receiving care in a care home or the community would become infected as there was no evidence of community transmission at the time that particular guidance was published.[28]

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[28] Public Health England, *Guidance for social or community care and residential settings on COVID-19,* February 2020.

Figure 14

COVID-19 guidance for adult social care published between 13 March and 15 May 2020

The Department of Health & Social Care published and updated a range of guidance relevant to the adult social care sector

Guidance	First published	Updated
COVID-19: guidance on home care provision (withdrawn 13 May)	13 March 2020	19 March 2020
COVID-19: guidance for supported living provision (withdrawn 13 May)	13 March 2020	19 March 2020
COVID-19: residential care guidance (withdrawn 6 April)	13 March 2020	
COVID-19: hospital discharge service requirements	19 March 2020	9 April 2020 20 April 2020 13 May 2020
COVID-19: ethical framework for adult social care	19 March 2020	
COVID-19: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable	21 March 2020	24 March 2020 30 March 2020 17 April 2020 5 May 2020
COVID-19: changes to the Care Act 2014	31 March 2020	
COVID-19: admission and care of people in care homes	2 April 2020	20 April 2020
COVID-19: how to work safely in care homes	17 April 2020	23 April 2020 27 April 2020
COVID-19: guidance for people receiving direct payments	21 April 2020	7 May 2020
COVID-19: supporting adults with learning disabilities and autistic adults	24 April 2020	
COVID-19: how to work safely in domiciliary care in England	27 April 2020	30 April 2020
COVID-19: health and well-being of the adult social care workforce	11 May 2020	
COVID-19: support for care homes	15 May 2020	

3.4 On 15 April, the Department published its action plan for adult social care. The Department told us that it produced an action plan to bring together, and describe, all elements of its approach, particularly where there had been some significant policy changes and as its understanding of the virus evolved. The action plan (paragraph 1.15 and Figure 6) confirmed the Department's approach to supporting local authorities and care providers, which included the additional £1.6 billion funding (announced on 19 March) to support the local response to COVID-19 and up to £1.3 billion to support faster patient discharges from hospitals (paragraphs 1.18 and 1.20).

3.5 Another element of support to local authorities were easements made to the Care Act 2014 by the Coronavirus Act 2020 (Figure 1). This allows a local authority to reduce, for example, detailed assessments of care and support needs, but only if workforce absences and increased demand mean it cannot comply with its duties. Eight local authorities used easements between 31 March and 15 May.

3.6 The action plan set out local and national oversight arrangements and systems for managing risks to continuity of care services (Figure 4). It emphasised the importance of both local authorities and the Department having access to robust information about emerging risks to service continuity.

Oversight and monitoring

3.7 There are limitations with care data collected in relation to COVID-19. Unlike the NHS, adult social care is not a single national system. It is commissioned by 151 local authorities, delivered by around 20,000 independent care providers and paid for through a mix of public funds and people's own resources. There are some data sets, for example, the Adult Social Care Workforce Data Set, which collects workforce information across the care sector from local authorities and, on a voluntary basis, from care providers. Also, as part of its monitoring role, the Care Quality Commission (CQC) asks registered providers for information annually including on people using the service and funding arrangements of those cared for. However, the Department does not know, for example, how many people overall receive care in each area, including self-funders; and local authorities only have data on those whom they pay for. At the start of the outbreak, therefore, there was no systematic national process to collect a wide range of daily data from care providers. We have commented previously on gaps in adult social care data, particularly on self-funding recipients of care.[29]

3.8 To identify emerging risks requiring a local or national response, the action plan confirmed a new approach to monitor the impact of COVID-19 on some care home

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[29] Comptroller and Auditor General, *Department for Communities & Local Government, Adult Social Care in England*, Session 2013-14, HC 1102, National Audit Office, March 2014.

and domiciliary care providers.[30] For care homes, a tool commissioned by NHS England and NHS Improvement (NHSE&I) in 2019 to capture and share information between local authorities and the NHS on care capacity, such as vacant beds, was adapted.[31] Following the COVID-19 outbreak, this tracker was expanded to include further data such as workforce absences, Personal Protective Equipment (PPE) levels, and overall risks in care homes. The Department told us that these data from nursing and residential homes registered with the CQC (the care home tracker) had been collated since early April. We requested the capacity tracker data from when it began to be used to monitor the impact of COVID-19 and we have analysed data from 20 April onwards. From 13 April, the CQC itself began collecting data from some registered domiciliary care providers (the home care tracker) (Figure 15). The government has asked care providers to provide data daily through this tracker exclusively. On average, around one-third of care homes, and half of domiciliary care providers had entered information during the preceding 24 hours between mid-April and mid-May.

Figure 15

Monitoring emerging risks: coverage of care home and home care trackers and response rates

Not all providers submitted data to the trackers regularly

Tracker	Providers covered	Data collected	Overall response rate
Care Home Tracker[1]	7,434 care providers registered with the Care Quality Commission (CQC) operating 15,519 care homes[3]	Bed capacity Suspected and confirmed COVID-19 cases Admission status: closed/partially closed Overall risk status Workforce absences Personal Protective Equipment (PPE) levels	Between 16 April and 15 May, 41% to 61% of care homes submitted data at least once in the prior seven days. The daily response rate averaged around 29%.[8]
Home Care Tracker[2]	6,572 domiciliary care providers registered with CQC operating from 9,084 locations4	Number of people using services Suspected and confirmed COVID-19 cases Capacity - extra care hours available Workforce numbers and absence rates PPE remaining	Between 13 April and 17 May, 73% to 77% of locations submitted data at least once in the prior seven days. The daily response rate averaged around 52%.[9]

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[30] Domiciliary care services provide personal care for people living in their own homes.
[31] NHSE&I commissioned the capacity tracker from the North of England Commissioning Support Unit in 2019.

NOTES

1. Includes nursing homes and residential homes only.

2. Domiciliary care providers only.

3. Number of care home providers and the number of care homes, excluding those dormant as at 2 June.

4. Number of domiciliary care providers and operating locations, excluding those dormant as at 15 May.

5. The data collected have not been validated by NHS England and NHS Improvement (NHSE&I) or CQC.

6. We do not know how many of the respondents completed individual questions on the trackers.

7. On 13 April the home care tracker was piloted with a small number of domiciliary care providers. On 14 April it was rolled out to all domiciliary care providers.

8. The daily average response rate on the care home tracker was calculated based on response rates on weekdays and was based on the numbers who provided an update that fed into the business continuity report. On 16 April the daily response rate to the care home tracker began to be captured.

9. The daily average response rate on the home care tracker was calculated based on response rates on weekdays and excluding the first two days when the tracker was being piloted and then rolled out.

Source: National Audit Office analysis of NHS England and NHS Improvement and Care Quality Commission data

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3.9   The action plan encouraged local authorities to draw on all available information, including the care home tracker and home care tracker, to identify and address emerging risks. Both trackers were brought together to provide councils with a picture of the local provider market. The Department asked regional directors of Adult Social Services to talk to ministers about key challenges and their approach to addressing them, as well as whether national support was needed.

Care provider capacity

3.10 The care home tracker showed that reported bed occupancy in care homes ranged from 86% to 90% between 20 April and 15 May. Despite available beds, care providers might opt not to take new residents due to concerns, for example, about workforce absence, ability to isolate residents with suspected or confirmed COVID-19, or available PPE. Between 20 April and 15 May, the daily number of homes reporting as closed or partially closed to new residents ranged between 10% and 14% of all those providing data. There were some regional variations, with the proportion closed or partially closed in the North West ranging between 13% and 22%, and in the East of England from 8% to 12%.

3.11 Between 13 April and 17 May, in every region, providers collectively had spare capacity to offer at least 11,300 extra hours of domiciliary care per week. In early May, the CQC estimated that weekly hours of care provided had declined mainly due to people refusing visits for fear of infection, families taking on caring responsibilities and fewer care hours being commissioned.

Risks to provider sustainability

3.12 The CQC's analysis suggests there may be a further increase in vacant beds in the coming months. Such spare capacity could mean less income for many care home providers in the short term. Analysis by the CQC has shown that the impact of COVID-19 may negatively impact profitability of care home providers as they seek to rebuild occupancy and it could be 18 months at best to return to former occupancy levels subject to normal admission levels and seasonal admission trends. Analysis by the CQC has detailed that a sustained decrease in hours combined with additional rising

costs, such as PPE, and workforce costs, such as overtime and agency workers, may adversely affect profitability of domiciliary care providers. Provider organisations are warning of significant and rising costs primarily due to resourcing PPE and extra workforce costs such as overtime and agency workers. Provider organisations told us that PPE costs represent a real threat to the financial stability of many providers. The CQC has warned of a reduced resilience to future shocks and an increased risk of provider failure in the care sector.

Controlling the spread of infection

3.13 The action plan confirmed measures to help control the spread of infection, including providing support and advice on keeping care settings safe. The plan referenced a range of published guidance to help care providers. Visitors to care homes were restricted, with a few exceptions such as end-of-life visits.
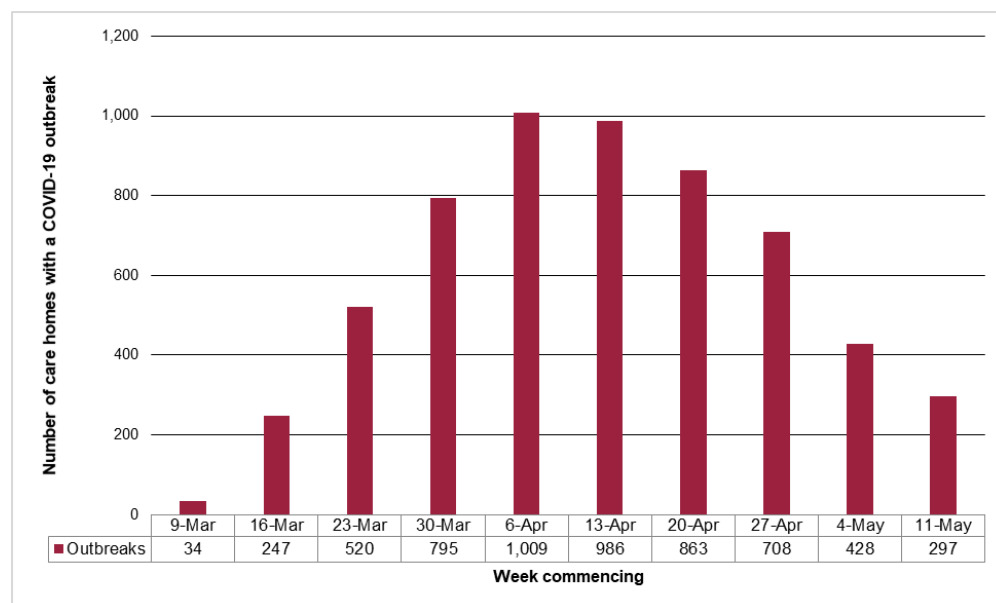
Managing outbreaks

3.14 If a care home manager suspected an outbreak of COVID-19 they had to inform one of Public Health England's (PHE's) local Health Protection Teams. PHE collects data on outbreaks in residential and nursing care homes. An outbreak might require some residents to be isolated and to reinforce infection prevention and control. Health Protection Teams make an initial assessment and order tests if they consider there is a risk of COVID-19. On confirmed diagnosis or suspicion of diagnosis of a case, the team would provide outbreak and infection control advice.

3.15 Between 9 March and 17 May, around 5,900 care homes, equivalent to 38% of care homes across England, reported at least one outbreak to PHE. The number of first-time outbreaks in individual care homes peaked at 1,009 in early April before falling (**Figure 16**). In four out of nine regions, at least 40% of care homes had reported an outbreak, including just under half of care homes in the North East, by 17 May.

Figure 16

Overall numbers of care homes in England reporting an outbreak of COVID-19, by week between 9 March and 17 May 2020

Outbreaks in care homes peaked in the first week of April before steadily declining

	9-Mar	16-Mar	23-Mar	30-Mar	6-Apr	13-Apr	20-Apr	27-Apr	4-May	11-May
■ Outbreaks	34	247	520	795	1,009	986	863	708	428	297

Week commencing

NOTES

1. This dataset is derived from reports to Public Health England (PHE) of infectious disease outbreaks in care homes. Care homes include residential and nursing homes registered with the Care Quality Commission. As the details of an outbreak are investigated data will be subject to revision and the numbers in this dataset may change in future publications.

2. Any individual care home will only be included in the dataset once. If a care home has reported more than one outbreak, only the first is included in this dataset.

3. This dataset contains no indication of whether reported outbreaks are still active.

4. Each weekly total refers to a period from Monday to Sunday.

Source: National Audit Office analysis of Public Health England data on weekly number and percentage of care homes reporting a suspected or confirmed outbreak of COVID-19. Available at: https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

Suspected and confirmed COVID-19 cases

3.16 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. The Department told us that as testing capacity increased, eligibility for tests expanded. On 15 April, the action plan announced that COVID-19 testing would subsequently be available to all symptomatic care home residents. From 28 April, all care home residents, whether or not they were symptomatic, were offered testing but the Department initially capped capacity at 30,000 tests a day (shared between staff and residents). From 11 May, it became possible for care homes to request tests from a care home portal; these tests counted towards the cap. PHE local health protection teams have continued to

arrange tests to confirm outbreaks. On 11 May, the Department announced that more than 45,000 residents had been tested by Health Protection Teams and 140,000 test kits had been sent to 4,387 care homes. There are around 400,000 residents in care homes.

3.17 Care home providers reported on the tracker how many confirmed and suspected COVID-19 cases they had, although the total is likely to be higher as not all providers completed the tracker. Between 20 April and 15 May, the reported number of COVID-19 cases increased most days, from 4,526 on 20 April to 9,622 on 15 May.

3.18 From 13 April, the home care tracker collected data on confirmed and suspected COVID-19 cases in domiciliary care, although the total is likely to be higher as not all providers completed the tracker. The weekly number of confirmed or suspected cases reported between 13 April and 17 May ranged from 4,204 to 6,917.

Discharge from NHS hospitals into care settings

3.19 The 17 March letter to NHS providers (paragraph 1.13 and Figure 5) stressed the need to discharge urgently all hospital patients who were medically fit to leave (paragraph 2.5). The government published more detailed guidance on 19 March which said hospitals must discharge all patients as soon as they are clinically safe to do so to ensure there is capacity to support those with acute healthcare needs. Due to government policy at the time, not all patients were tested for COVID-19 before being discharged, with priority going to those with respiratory illness or flu-like symptoms. Guidance from 2 April stated that care homes needed to make their full capacity available and that they could admit patients with COVID-19. The Department did not collect data on the extent to which care homes successfully isolated staff with confirmed or suspected COVID-19 and did not require local authorities to collect data either.

3.20 On 15 April, the adult social care action plan confirmed a new policy of testing everyone prior to admission to care homes. On 16 April, NHSE&I issued instructions to hospitals, community health providers and clinical commissioning groups. Up to this point, between 17 March and 15 April, around 25,000 people were discharged from the NHS to care homes. (This compared with around 35,000 such discharges over this period in 2019.)[32] Not all patients were tested for COVID-19 before discharge, with priority given to patients with respiratory illness or flu-like symptoms. It is, therefore, not known how many of those discharged to care homes had COVID-19 at the point they left hospital. From 15 April, the NHS has been responsible for testing all patients discharged from hospitals. The action plan advised care homes to isolate those discharged from hospital but still waiting for test results, in the same way as COVID-positive residents. If a care home could not safely isolate patients, local authorities were instructed to provide an alternative.

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[32] This represented a year-on-year fall of 29% for hospital discharges to care homes, compared with a 45% fall in all hospital discharges (see paragraph 2.5). The proportion of discharges from hospital to care homes rose from 2.2% in 2019 to 2.8% in 2020.
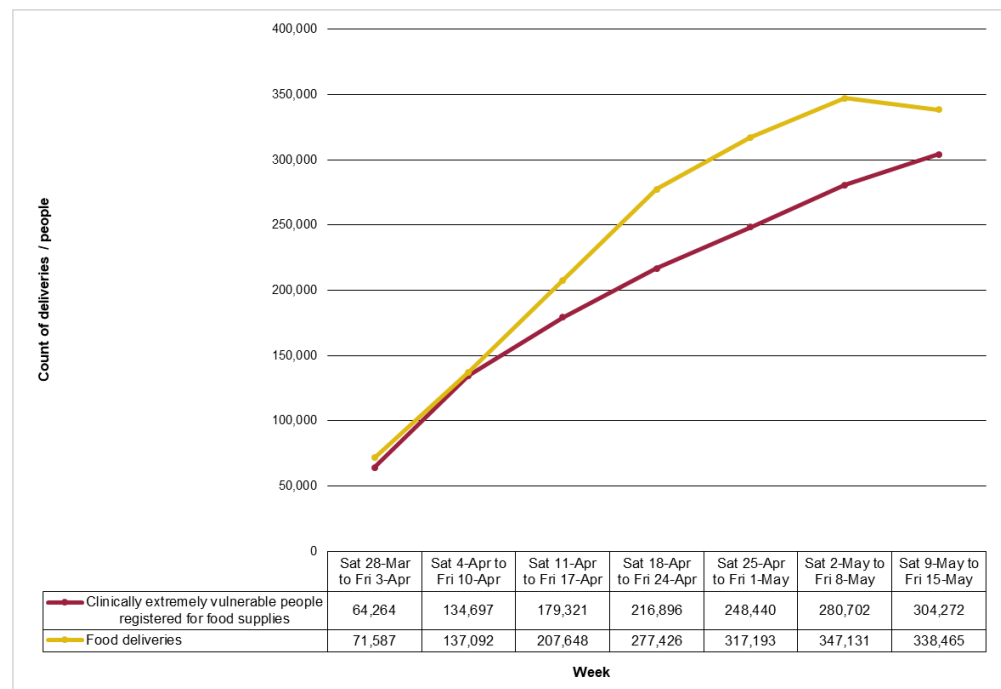
Shielding the most vulnerable

3.21 The 17 March NHS letter reiterated responsibilities for supporting older and vulnerable people who are being shielded at home. The Ministry of Housing, Communities & Local Government (the Ministry) and local authorities have lead responsibility for providing support. Overseen by local resilience forums, (LRFs), 132 local authority-led hubs were formed across the country to provide help and support for the most vulnerable. Hubs coordinate local care and support, including food and social contact, working with the NHS and the voluntary sector.

3.22 The NHS maintains the list of clinically extremely vulnerable people. As at 15 May 2020, 2.2 million people were on the list, of which 1.1 million had registered for support (324,000 of these requested food supplies). On 28 March, national deliveries of weekly food boxes to those clinically extremely vulnerable who registered to receive food supplies began. Figure 17 shows the number of people who registered and the number of deliveries.

Figure 17

Number of extremely clinically vulnerable people registering for food supplies, and the number of food deliveries, each week in England between 28 March and 15 May 2020

The number of food deliveries rose each week until early May

	Sat 28-Mar to Fri 3-Apr	Sat 4-Apr to Fri 10-Apr	Sat 11-Apr to Fri 17-Apr	Sat 18-Apr to Fri 24-Apr	Sat 25-Apr to Fri 1-May	Sat 2-May to Fri 8-May	Sat 9-May to Fri 15-May
Clinically extremely vulnerable people registered for food supplies	64,264	134,697	179,321	216,896	248,440	280,702	304,272
Food deliveries	71,587	137,092	207,648	277,426	317,193	347,131	338,465

Week

NOTES

1. We only include food deliveries to clinically extremely vulnerable people.

2. Food deliveries include both successful and unsuccessful deliveries. The government estimates that around 6% of deliveries have been unsuccessful.

3. Data on the number of deliveries are collected by day and have been grouped into weeks, running from Saturday to Friday.

4. For the number of extremely vulnerable people registered for food supplies, we have used the figure recorded on the middle day of each week (Tuesday).

5. Based on data downloaded on 21 May. If a person subsequently deregistered or said they no longer wanted food supplies, their registration was removed from all prior weeks in which they were registered.

Source: National Audit Office analysis of Government Digital Service data

Part Four

Expanding, supporting and equipping the health and adult social care workforce

4.1   This part examines the main actions the government has taken during the COVID-19 pandemic in respect of the health and social care workforce, including:

• expanding the workforce;

• supporting staff to stay healthy and at work; and

• equipping staff with Personal Protective Equipment (PPE).

Expanding the number of staff providing direct care and support

NHS workforce

4.2   In January 2020, there were 117,400 doctors, 313,700 nurses and midwives and 69,400 allied healthcare professionals (full-time equivalent) working in NHS hospitals and community health services. This was below full staffing levels. For instance, between October and December 2019, NHS trusts reported vacancy rates of 11% for nursing and 7% for medical staff.

4.3   The 17 March letter (paragraph 1.13 and Figure 5) set out several actions, and was followed by emergency legislation, to increase the NHS workforce available to respond to the surge in COVID-19 patients, including:

• asking former healthcare professionals, (nurses and midwives, doctors, allied health professionals, healthcare scientists and pharmacists) who had recently relinquished their licence to practice to return;

• deploying medical and nursing students, where possible. Nursing and midwifery students in the second and third year of their degrees could increase the time they spent on clinical placement. Final year medical students were permitted to graduate early, while others could volunteer in roles relevant to their knowledge and skills; and

• asking doctors, nurses, midwives and allied health professionals in non-patient-facing roles to support clinical practice.

4.4   **Figure 18** shows that by end of April 2020, an extra 18,200 staff were deployed in clinical and support roles. The largest single group was nursing and midwifery students (around 7,000), followed by medical students (2,900), with around 8,000 returners to NHS work. As part of its deal with the independent sector (see paragraph 2.6), the NHS also gained access to around 10,000 nurses, 700 doctors and 8,000

other clinical staff, but it is not yet clear how many of these staff have been involved in treating NHS patients.

Figure 18

Number of additional staff deployed to support the NHS in England, as at 30 April 2020

An additional 18,200 staff were deployed to support the NHS, with nurses and midwives comprising a majority
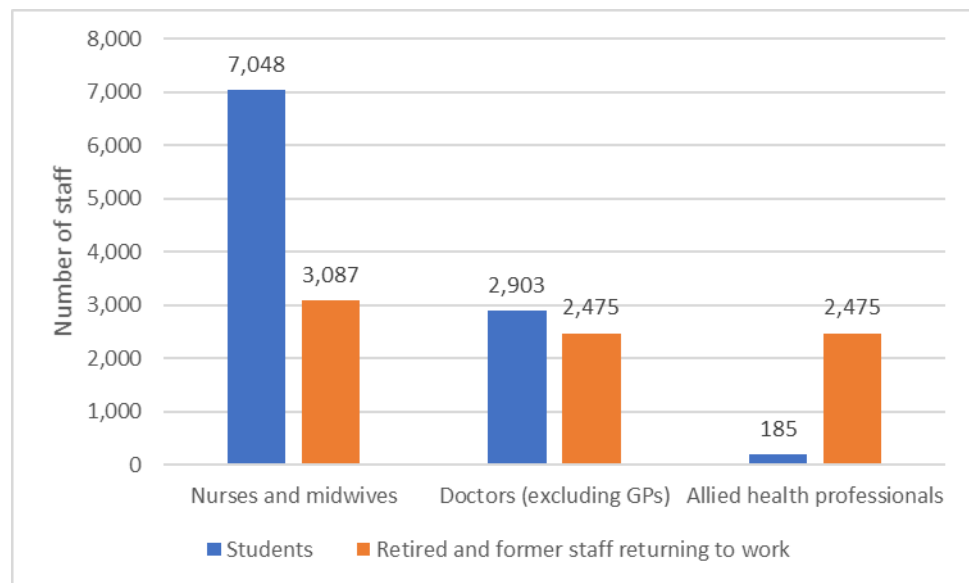
NOTES

1. Medical students comprise final year students, allocated to trusts as of 30 April 2020. Nursing and midwifery students comprise second and third year students, actual starters as of 30 April 2020. Data for allied health professional (AHP) students were only available from 15 May and indicate actual starters.

2. The figures for retired and former staff refer to the number whose details had been passed to trusts for redeployment as at 30 April 2020. A much higher number, around 24,400, expressed an interest in returning.

3. NHS England and NHS Improvement (NHSE&I) has confirmed that the number of medical and AHP returners was the same at 2,475.

4. The figure excludes a small number of healthcare scientists, dentists and pharmacists, who were redeployed.

Source: National Audit Office analysis of NHS England and NHS Improvement data

Social care workforce

4.5 To support and increase the social care workforce, the action plan for adult social care of 15 April (paragraph 1.15 and Figure 6) set out:

• an ambition to attract 20,000 people into social care over the following three months. On 23 April, the Department of Health & Social Care (the Department) launched a new national recruitment campaign, 'Care for Others. Make a Difference'. It aims to attract former staff back to the sector as well as new starters;

- an aim to support professionals such as occupational therapists and social workers to return to the sector, with a target for 8,000 returning social workers. Returning nurses and student nurses would also be used to support social care;

- plans to use some of the 750,000 people who signed up to be NHS Volunteer Responders to carry out tasks in social care; and

- plans to streamline recruitment and make it easier for new staff to access rapid online induction training.

The Department does not currently know how it is progressing against these parts of the action plan.

4.6   In 2019, there were an estimated 1.5 million jobs in the adult social care sector, including managerial roles, regulated professionals like nurses and occupational therapists, and care workers.[33] Of these, 1.2 million provided direct care to people. There are also an estimated five million informal carers in England, providing unpaid care to family or friends.[34]

4.7   We have previously reported on the high turnover and vacancy rates in the adult social care workforce. In 2018-19, annual turnover was 31% across all roles and 40% for care workers. In the same year, the overall vacancy rate was 8%, and highest for registered managers, at 11%. In a survey of the sector in late March, 34% of providers responded that they urgently needed more staff.[35] Skills for Care estimates the vacancy rate has fallen from around 8% pre-COVID-19 to 6.5% in May.[36]

4.8   Meanwhile, in a survey by Carers UK in April 2020, 70% of respondents reported providing more unpaid care than normal due to COVID-19. Over one-third of unpaid carers said they were having to provide more care because local services had reduced or closed.[37,38]

Supporting health and social care staff to stay well and at work

4.9   Both the 17 March NHS letter and the 15 April adult social care action plan set out measures to support workers to stay well and at work during the pandemic. Specific actions focused on protecting members of NHS staff (Figure 19) and advising the care workforce to follow guidance on self-isolating and shielding, while noting the

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[33] This information refers to the adult social care sector as those 1.52 million jobs in local authorities, the independent sector and jobs working for direct payment recipients. Those working in the NHS are not included in these workforce estimates.

[34] Office for National Statistics, *2011 census analysis: unpaid care in England and Wales 2011 and comparison with 2001*, February 2013, available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/2011censusanalysisisunpaidcareinenglandandwales2011andcomparisonwith2001/2013-02-15#key-points

[35] Skills for Care's analysis of Care Management Matters COVID-19 Survey looked at the impact of COVID-19 on the adult social care workforce. The survey was completed on 31 March 2020 by 211 adult social care providers.

[36] Based on data from around 450 providers.

[37] Carers UK carried out an online survey between 3 April and 14 April 2020. 4,830 carers and 217 former carers across England, Scotland, Wales and Northern Ireland responded.

[38] Carers UK, *Caring behind closed doors: forgotten families in the coronavirus outbreak*, April 2020.

financial support available to those unable to work.[39] The letter and action plan also set out arrangements for testing NHS staff and care workers. Wider measures to support staff well-being included:

- NHS providers ensuring enhanced health and well-being support for front-line staff;

- a dedicated support package for registered managers in social care;[40]

- temporary changes to the NHS terms and conditions to support staff; and

- helplines, a text message service and a dedicated website to aid physical and mental well-being.

Figure 19

Steps NHS organisations are required to take to protect staff

The 17 March letter to the NHS included measures to protect members of NHS staff

Staff group	**Steps NHS organisations should take**
Staff at higher risk of severe illness from COVID-19, and staff required by Public Health England (PHE) guidance to work from home.	Arrangements to allow staff to work remotely. For clinical staff this includes the use of remote consultations.
Staff at increased risk according to PHE guidance (including pregnant women).	Adjustments to enable staff to stay well and at work wherever possible. These could include working remotely or moving to a lower-risk area.
Staff affected by PHE's 14-day household isolation policy.	Offers of alternative accommodation in NHS-reimbursed hotel rooms to allow staff to continue to work.
Staff showing symptoms of COVID-19 and therefore liable to have to self-isolate for seven days.	Offers of testing for COVID-19.

Source: 17 March letter to the NHS from the chief executive of the NHS and its chief operating officer

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Staff absence

4.10 In normal times, sickness absence rates in the NHS are a little higher than average. The *Interim NHS People Plan*, published in 2019, reported that NHS sickness absence was typically around 2.3 percentage points higher than in the rest of the economy. During the COVID-19 outbreak to date, the absence rate for NHS acute hospital staff has almost doubled (Figure 20), peaking on 4 April 2020, when 13% of staff were absent (ranging from 10% in the East of England to 15% in London, the

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[39] This includes Statutory Sick Pay from the first day of sickness or isolation; increased Universal Credit and Working Tax Credit; and the option to furlough social care workers unable to work for a long period of time.
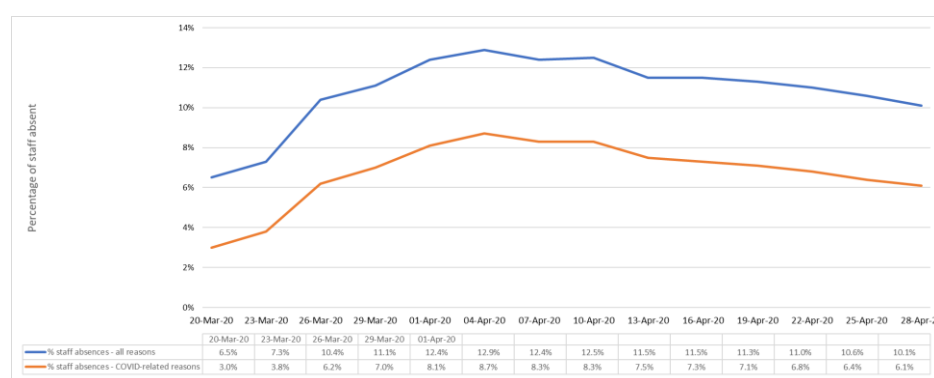[40] In development by Skills for Care at the time the adult social care action plan was published.

Midlands and North West). More than half the absence, 9% in total, was related to COVID-19 (ranging from 6% in the South West to 11% in London and the Midlands).[41]

Figure 20

Absence rate for NHS acute hospital staff in England, 20 March to 28 April 2020

The absence rate for NHS acute hospital staff peaked on 4 April 2020 at 13%, with 9% absent for reasons related to COVID-19

	20-Mar-20	23-Mar-20	26-Mar-20	29-Mar-20	01-Apr-20	04-Apr-20	07-Apr-20	10-Apr-20	13-Apr-20	16-Apr-20	19-Apr-20	22-Apr-20	25-Apr-20	28-Apr-20
% staff absences - all reasons	6.5%	7.3%	10.4%	11.1%	12.4%	12.9%	12.4%	12.5%	11.5%	11.5%	11.3%	11.0%	10.6%	10.1%
% staff absences - COVID-related reasons	3.0%	3.8%	6.2%	7.0%	8.1%	8.7%	8.3%	8.3%	7.5%	7.3%	7.1%	6.8%	6.4%	6.1%

NOTES

1. This shows the absence rate on each particular day for NHS staff working for acute hospital trusts with Type 1 accident and emergency departments.

2. Absence may be due to sickness or self-isolation.

Source: National Audit Office analysis of NHS England and NHS Improvement data

4.11 Skills for Care estimates the percentage of days lost due to sickness in adult social care, which includes absence for reasons such as shielding and self-isolation, was 3% before the pandemic and 8% in March and April.[42]

4.12 The Department recorded absence rates, using the care home tracker (paragraph 3.8). The average absence rate between 20 April and 15 May was 10% with no significant regional variations.

4.13 The Care Quality Commission (CQC) started collecting information on staff absence in domiciliary care from 13 April. Nationally, domiciliary care providers reported that between 10% and 13% of staff were not working each week due to COVID-19 between 13 April and 17 May.

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[41] All figures in this paragraph refer to the rate of absence for NHS staff working for acute trusts with Type 1 accident and emergency (A&E) departments.
[42] Information was taken from raw data in Adult Social Care Workforce Dataset (ASC-WDS). Data taken from February represent the period pre-COVID-19 and are compared to workers with a change in sickness days in March and April 2020. The sample includes around 6,000 workers from 245 establishments.

Testing staff

4.14 The 17 March NHS letter stated that testing for NHS staff with symptoms of COVID-19 would be established as testing capacity increased.[43] The Department told us that testing was initially restricted to critically ill patients in hospitals and up to five symptomatic residents in any one care home. On 27 March, the government announced that it was starting to roll out tests to healthcare staff with symptoms, beginning the following week with NHS staff in critical care and emergency services. However, the Department told us that, as the testing system expanded, there were challenges in matching local demand and available capacity, with reports of some healthcare workers wanting but not being able to get a test in April.

4.15 There were further changes to health and social care staff's eligibility for testing throughout April, as shown in Figure 21. These included extending testing to symptomatic social care staff on 15 April and to their households on 17 April, and to asymptomatic health and social care staff on 28 April. From 28 April, all care home staff were eligible for tests, but the Department capped the daily amount of care home tests at 30,000 (shared between staff and residents).

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[43] Public Health England (PHE) told us that the original reference in the 17 March letter that NHSE&I would ask PHE to establish staff testing was incorrect as the NHS was to use its own laboratory capacity to do this.

Figure 21

Number of NHS staff, key workers and their household members tested, and timeline of changes in testing eligibility in England during April 2020

On 27 March, the government began rolling out tests to NHS staff with symptoms, extending this to social care staff on 15 April
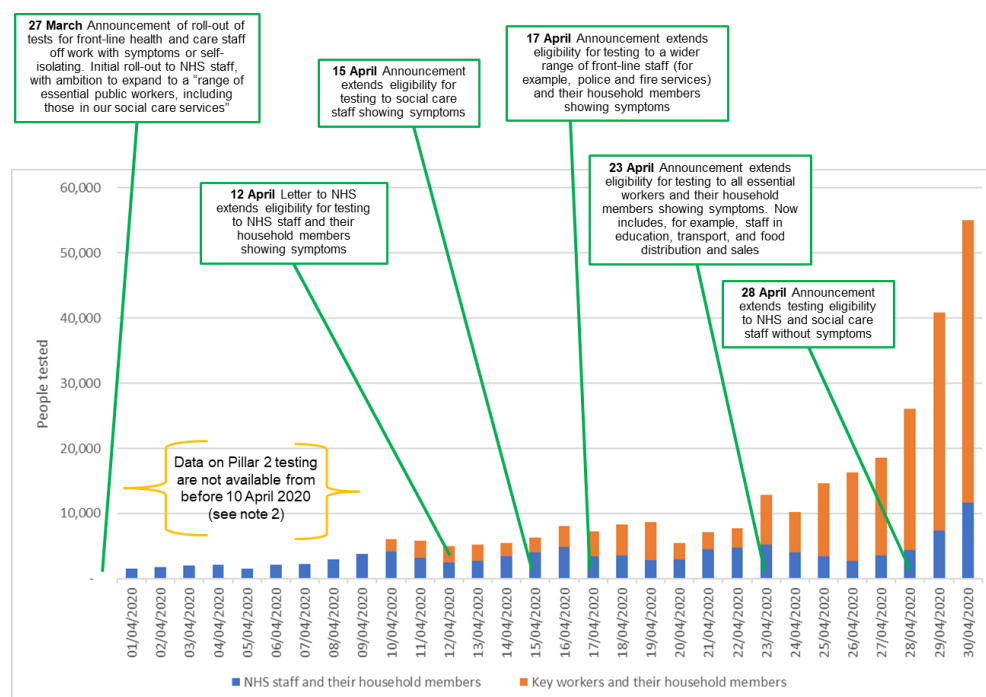
NOTES

1. Testing is currently organised under five "pillars". For this graph, figures for NHS staff and household members are based on data supplied by NHSE&I under Pillar 1 (testing for those with a medical need and the most critical key workers by NHS and PHE laboratories). Some non-NHS key workers may have been tested under Pillar 1 but are not included in this table. Figures for key workers and their household members are the totals published for Pillar 2 (testing for critical key workers in the NHS, social care and other sectors, mainly by commercial and university laboratories) which may include NHS staff and their household members, in addition to social care and other key workers.

2. Data are not available on the number of key workers and household members tested before 10 April 2020, as Pillar 1 and Pillar 2 data were not disaggregated before this date.

3. Exploratory testing of a small number of social care workers took place by invitation from 8 April.

Source: NHS England and NHS Improvement (NHSE&I) data and Department of Health & Social Care data, as well as National Audit Office summary of government announcements and NHSE&I letters to the wider NHS

4.16 At the time of this report, the Department was not able to provide the total numbers of NHS staff and care workers tested each day. For tests carried out in commercial laboratories, the Department holds some (self-reported) data to identify the sector in which people worked, but this only applies to tests ordered via a dedicated key worker portal, and does not separate out staff and household members, or, for example, distinguish between NHS and non-NHS healthcare staff (see note 1 of Figure 21). The Department was also unable to provide a breakdown of data on the

split between care home staff and resident testing as it is still in discussions with the UK Statistics Authority on the reporting of testing data. Figure 21 shows that the number of key workers and household members tested each day using commercial swab tests increased from 1,800 on 10 April to 43,400 on 30 April. For NHS swab tests, NHSE&I provided estimates of the number of NHS staff members and household members tested each day, which increased from 1,500 on 1 April to 11,500 on 30 April.

4.17 When health and social care staff cannot get prompt tests, this can have several adverse consequences, including potentially unnecessary absence from work, personal anxiety and increased spread of the virus. Even as testing eligibility increased during April, some staff, particularly in the social care sector, reported being offered tests in inaccessible locations and others reported that they continued to be unable to get tests. In a British Medical Association (BMA) survey of doctors from 14 May, 71% who had needed a test in the preceding week reported that testing had been accessible, timely and convenient, but 29% reported it was not. Provider organisations told us they were concerned that there was still no programme in place to enable comprehensive, routine and regular home testing for staff and residents in care homes. The Department said it had sought to improve testing for all these groups through increasing the number of home testing kits, mobile testing units and regional test centres and designating a certain number of tests for care home residents and staff.

Personal Protective Equipment

4.18 Personal Protective Equipment (PPE) is any equipment that protects against health and safety risks. In the health and social care sector it ranges from basic items, such as aprons, gowns and disposable gloves, to specialised items, such as face shields and respirators. From January to April, the government published a range of guidance on the PPE that health and social care workers should use in different settings when caring for people with COVID-19 (Figure 22). There have been several significant changes to the guidance over time, which affect the PPE staff were expected to use when caring for patients, and the amounts that health and social care providers needed to procure.

Figure 22

Main guidance applying to use of Personal Protective Equipment for health and social care settings, January to April 2020

There have been three significant announcements and several updates regarding Personal Protective Equipment (PPE) guidance

Date	Guidance	Content
Issued 10 January	COVID-19: infection prevention and control guidance	General infection control guidance covering a range of matters, including PPE. Other aspects included general hygiene (for example, hand-washing), segregating patients, and managing visitors. In January (and up to 19 March), COVID-19 was classified on an interim basis as a high-consequence infectious disease (HCID) – see paragraph 1.1. At this stage, the guidance recommended a higher level of PPE. For example, as at 15 January, recommended PPE for people entering the room of a patient in isolation included: gowns, gloves, respirators and eye protection. The Department of Heath & Social Care highlighted to us two particular updates to this guidance. On 6 March, the guidance no longer recommended the use of enhanced PPE for contact with suspected cases other than for aerosol-generating procedures (AGPs) such as ventilation. On 13 March the guidance no longer recommended the use of enhanced PPE for contact with confirmed or suspected cases unless doing an APG.
Issued 2 April (updated nine times up to 3 May)	COVID-19: personal protective equipment	Revised guidance on the use of PPE, superseding all previous guidance. Specific and 'enhanced' recommendations for a range of health and social care contexts. Changes included approving 'sessional' use of some PPE (for example, masks and visors) which means the same clothing could be used throughout one person's shift instead of solely for one patient or procedure. The guidance now specified minimum levels of protection for those providing direct care (within two metres). For example, in hospital inpatient areas or care homes with possible or confirmed cases of COVID-19, staff providing direct care were told to use gloves, aprons, face masks and (dependent on risk in care homes) eye/face protection. Higher standards were advised for certain tasks: AGPs such as ventilation required gowns, gloves, respirators and eye/face protection in any setting.
Updated 17 April	Consideration for acute personal protective equipment (PPE) shortages	Additional guidance in the event of severe supply shortages, reinforcing advice on 'sessional' use of PPE, and approving reuse of PPE (by the same worker) or the use of alternative PPE to recommended ones (for example, disposable, non-fluid-repellent, or washable surgical gowns where fluid-repellent hospital gowns are not available).

NOTES

1. The table shows the main updates to PPE guidance rather than an exhaustive list.

Source: National Audit Office summary of Gov.uk information
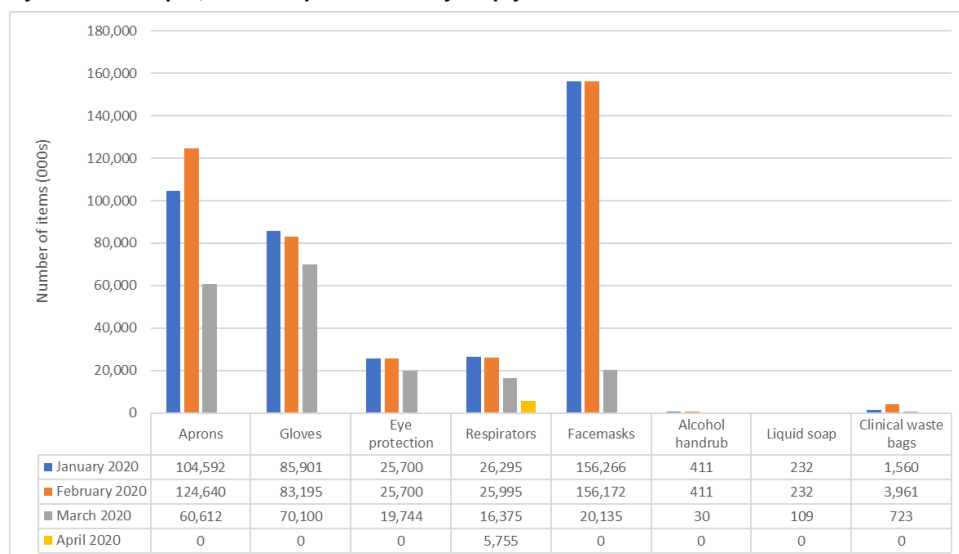
Central stockpile of PPE

4.19 For many years, Public Health England (PHE) has managed a PPE stockpile as part of the UK's contingency planning for a pandemic flu outbreak. The Department approves the contents of the stockpile, following advice from the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG). This was the only central stockpile available to meet increased demand for PPE in the early stages of the COVID-19 outbreak.

4.20 Figure 23 details the PPE stockpile that PHE held from January to April 2020. The only categories of item which increased in volume between 24 January and 21 February were aprons and clinical waste bags. At no point did the stockpile contain gowns or visors. In June 2019, NERVTAG had recommended stockpiling gowns, with a sub-committee confirming specifications for these in November 2019. The Department told us the procurement of gowns was planned for early 2020. For eye protection, NERVTAG recommended a switch from glasses to visors when glasses next required reordering.

Figure 23

Stock of Personal Protective Equipment (PPE) held by Public Health England, January to April 2020

By the end of April, the stockpile was nearly empty

	Aprons	Gloves	Eye protection	Respirators	Facemasks	Alcohol handrub	Liquid soap	Clinical waste bags
■ January 2020	104,592	85,901	25,700	26,295	156,266	411	232	1,560
■ February 2020	124,640	83,195	25,700	25,995	156,172	411	232	3,961
■ March 2020	60,612	70,100	19,744	16,375	20,135	30	109	723
■ April 2020	0	0	0	5,755	0	0	0	0

NOTES

1. The table reflects PPE stocks on 24 January, 21 February, 31 March and 24 April.

2. Gloves are counted per item (not pair). A single item of liquid soap was 1 litre in volume. A single item of alcohol hand rub was 500ml. All eye protection consisted of safety glasses and there were no eye visors in stock.

3. Source: National Audit Office analysis of Public Health England data

PPE requirements and national distribution

4.21 Prior to the outbreak, NHS trusts and care providers could procure their own PPE supplies independently or through NHS Supply Chain.[44] The Department told us that the manufacture and supply of PPE has for many years been based on 'just in time' procurement and manufacturing principles. From 1 April, new, additional arrangements were put in place for core PPE items to meet the urgent volume requirements, with a dedicated central supply route established (the Parallel Supply Chain).[45]

4.22 The Parallel Supply Chain's primary focus is on supporting NHS trusts. The service operates a 'push' model, with essential equipment being issued to NHS trusts. Initially the focus was on addressing immediate shortages. NHS trusts could still procure their own PPE in addition. On 1 May, the Department wrote to NHS trusts setting out that PPE was among a list of supplies now being centrally managed; that

[44] NHS Supply Chain is a brand which covers the sourcing, delivery and supply of healthcare products, services and food for NHS trusts and healthcare organisations across England and Wales. Supply Chain Co-ordination Limited (SCCL) manages the NHS Supply Chain operating model for the NHS. It is a limited company wholly owned by the Secretary of State for Health and Social Care.

[45] The new Parallel Supply Chain consisted of the Department, NHSE&I, NHS Supply Chain, the Ministry of Defence and Unipart Logistics, supported by Clipper Logistics. A new central procurement cell, comprising staff from across government, took on responsibility for the availability of PPE products.

they should flag any significant PPE procurement in progress to central teams for diversion to central stocks; and they could continue purchasing their own PPE directly from "new, small, local suppliers". This was in order to prevent NHS organisations competing on the open market for the same supplies.

4.23 Social care providers were expected to source their own PPE supplies, and have been advised to continue ordering through their wholesalers. The government centrally supplied around 60 million items direct to adult social care wholesalers to distribute. Social care providers had access to some stock through their local resilience forums and they could make emergency requests for items to the National Supply Disruption Response (NSDR) system. 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.

4.24 For the period 20 March to 9 May, Figure 24 sets out the number of items of PPE that were distributed from central procurement services ('central stocks'), and the percentages these made up of the modelled requirement for key items of PPE, as modelled by the Department.[46] The distribution figures therefore do not include PPE that providers already held or bought themselves. The modelled requirement assumes a "reasonable worst-case scenario" for the pandemic's progression, and assumptions have been continually refined as circumstances changed. [47]

4.25 Between 20 March and 9 May, the amount of central stocks distributed to health settings – largely NHS trusts – exceeded the modelled requirement for face masks and clinical waste bags. For all other items the amount distributed from central stocks was lower than the modelled requirement, particularly for gowns (20% of the modelled requirement was met from central stocks), eye protectors (33%) and aprons (50%). During April and May healthcare stakeholders (for example, the BMA and the Royal College of Nursing) raised concerns about PPE shortages.

4.26 Between 20 March and 9 May, central stocks distributed to social care settings accounted for 15% or less of the overall modelled requirement for any item of PPE, apart from face masks. The items with the lowest levels of distribution from central stocks compared to modelled requirement were gowns (0% of the modelled requirement was met from central stocks), eye protectors (5%) and gloves (8%). Many bodies have raised concerns about PPE supplies to social care providers: for example, on 27 March, the Association of Directors of Adult Social Services and the Local Government Association wrote to the Secretary of State for Health and Social Care about the issue.

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[46] By central stocks, we include all supplies from all NHS central procurement services and the Public Health England central stockpile

[47] The models are influenced by scientific advice, official guidance and assumptions about the restart of suspended services. For more details on assumptions, see notes to Figure 24.

Figure 24

Number of Personal Protective Equipment (PPE) items distributed from central stocks, and percentage of the modelled requirement distributed from central stocks for health and care settings in England, 20 March to 9 May

Between 20 March and 9 May, the amount of central stocks distributed to health settings exceeded the modelled requirement for face masks and clinical waste bags

	Health settings		Care settings	
	Number of items distributed from central stocks (million)	Percentage of modelled requirement distributed from central stocks	Number of items distributed from central stocks (million)	Percentage of modelled requirement distributed from central stocks
Aprons	120	50%	45	9%
Body bags	<5	56%	<5	No forecasted requirement
Clinical waste bags	20	>100%	0	No forecasted requirement
Eye protectors	20	33%	5	5%
Face mask FFP3	15	>100%	<5	36%
Face mask IIR	100	>100%	25	26%
Gloves	460	76%	80	8%
Gowns	<5	20%	0	0%
Hand hygiene	<5	82%	<5	15%

NOTES

1. The modelled requirement was for the highest priority PPE/stock items only. Eye protectors include visors and eyeglasses. Gloves are counted per item (not pair). FFP stands for filtering face piece. FFP3 hoods provide the highest level of protection. FFP IIR masks are fluid resistant surgical masks.

2. It assumes PPE guidance from Public Health England is followed and does not assume waste, leakage, or over-usage

3. The modelled requirement figures are based on the Department of Health & Social Care's retrospective forecast of UK demand for the period 20 March to 9 May. It is based on a reasonable worst-case scenario and the assumptions that fed into the model were as at 10 May. One of the assumptions was that all care homes were using PPE throughout the period.

4. The distribution data cover all centrally held PPE stock, including that held by NHS Supply Chain, Public Health England and Parallel Supply Chain.

5. We adjusted the modelled requirement for the whole of UK to reflect the population of England only, based on Office for National Statistics 2019 UK population mid-year estimate. We have excluded any distribution to devolved administrations (15 million items).

6. Under Health settings, we include distributions to wholesalers for GPs, pharmacies and dentists (five million items) and a small amount of stock distributed to other government departments and the National Supply Distribution Response system. We also include part of a distribution to primary care and adult social care providers (62.5% of 20 million items) as these went to primary care providers.

7. Under Care settings, we include distributions to wholesalers for adult social care (60 million items) and distributions to local resilience forums (90 million items). Stock distributed to local resilience forums was forwarded onto a variety of settings, not just social care providers. We also include part of a distribution to primary care and adult social care providers (37.5% of 20 million items) as these went to social care providers

8. For presentational purposes, we have rounded the distribution to the nearest 5 million. For percentage distributed, ">100%" indicates at least 100%.

Source: National Audit Office analysis of Department of Health & Social Care modelled requirement and stock data

4.27 The Department's view is that actual shortages would be less than those implied by Figure 24 as providers could purchase their own PPE and the modelled requirement was based on the 'reasonable worst-case scenario'. The Department told us that, throughout this period, it ensured that the NSDR had access to emergency stocks, but to achieve this it sometimes had to supply trusts and other providers at levels below modelled requirements.

4.28 Between 25 March and 22 May, the NSDR system logged 27,230 individual action requests relating to PPE from health and care providers. The Department told us that at times some items, including body bags, gowns and extra-large gloves, were only available through the NSDR system. Throughout 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.

Staff well-being

4.29 By its nature, the COVID-19 emergency is placing great additional stress on health and social care workers. Before the outbreak, the 2019 *Interim NHS People Plan* recognised that staff were overstretched and experiencing stress and burnout, and, as outlined in paragraph 4.7, turnover and vacancy rates among social care workers have been high.

4.30 In May, some 45% of doctors responding to a survey by the BMA reported suffering from depression, anxiety, stress, burnout, emotional distress or other mental health conditions relating to or made worse by their work. Similarly, some registered managers in social care reported the mental health of workers was under massive strain, with individuals particularly concerned about getting ill and unknowingly passing the virus on. Given the stresses that staff were experiencing before the outbreak, and the additional pressures caused by COVID-19 since, it is likely that the after-effects of responding to the pandemic will be substantial and, for some people, long-lasting. In response, NHSE&I told us they will establish outreach, screening and intervention via resilience hubs and are working to support the mental health of all keyworkers delivering health and care.

Appendix One

Our methodology

Scope

1   Following the first confirmed cases of COVID-19 in England in January 2020, 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. On 17 March, NHS England and NHS Improvement (NHSE&I) set out in a letter to the NHS the measures that national and local NHS bodies should take to prepare for the outbreak. On 15 April, the Department of Health & Social Care (the Department) published an action plan for adult social care.

2   This report sets out the facts about government's progress in preparing the NHS and social care for the COVID-19 outbreak in England, with a focus on:

- actions set out in the 17 March letter to the NHS, and the 15 April action plan for adult social care. It also documents what is currently known about additional funding for health and social care.

- actions taken at a national level by health, adult social care and local government bodies in England. The report does not cover providers of children's social care, as this was not the focus of the adult social care action plan.

- the period from the start of the outbreak to at least the end of April, when the government announced that the UK was "past the peak". Depending on data availability at the time of writing, we have sometimes been able to provide information up to mid-May.

The report does not assess the value for money of the measures adopted by government or the effectiveness of its response. The report does not comment in detail on the government framework for pandemic planning that existed before the outbreak, nor does it set out in detail local responses to COVID-19.

3   The aim of this report is to provide a progress update on the initial actions identified for the health and social care sector. Events are moving quickly and the UK government's response to COVID-19 is evolving, including in health and social care. As a result, there are limitations and uncertainty in the information available.

4   This report draws on a wide range of activity, performance and cost information. Where possible, we have made use of published data, supplemented with unpublished data from public bodies, requested under our statutory audit powers. We have not audited the data used in this report for completeness or quality, but relevant bodies have reviewed and confirmed the accuracy of the information relating to them.

However, the data are mostly from live administrative systems collected to inform operations and, while reflecting the position to the best of our knowledge at the time of this report, they will be subject to revision in future as better and more complete data are collected, compiled and reported. In addition, much information, particularly in relation to costs, is not yet available or finalised as the UK government's response continues.

Methods

5   We have produced this report after collecting evidence between 27 March and 30 May 2020. We:

- reviewed announcements made by the government in response to COVID-19;

- reviewed key documents and guidance published by the Department, NHS England and NHS Improvement (NHSE&I), the Ministry of Housing, Communities and Local Government (the Ministry), Public Health England (PHE) and other government bodies in response to COVID-19;

- analysed data published by government bodies and on gov.uk, including in relation to testing, hospital admissions and critical care capacity. We also used data published by the Office for National Statistics on mortality related to COVID-19;

- drew on discussions with officials from government bodies about their operational response to COVID-19, and the data and intelligence they used to monitor progress. This included: the Department, NHSE&I, PHE, the Medical Healthcare products Regulatory Agency, NHS Digital, the Ministry and the Care Quality Commission (CQC);

- analysed additional data provided by the Department, NHSE&I, PHE, the Ministry, NHS Digital and the CQC. This included data related to health and social care capacity, activity, staff and procurement of support and equipment; and

- drew on discussions with and information from health, social care and local government stakeholders. This included: the Local Government Association, the Association of Directors of Adult Social Services, Care England, Skills for Care, Carers UK, Laing Buisson, the National Care Forum, Care Provider Alliance, NHS Providers, the British Medical Association, the Royal College of Nursing and Healthwatch UK.