



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health & Social Care

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

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).