



Health and Social Care Committee

Oral evidence: Preparations for coronavirus, HC 36

Thursday 26 March 2020

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Members present: Jeremy Hunt (Chair); Paul Bristow; Amy Callaghan; Rosie Cooper; Dr James Davies; Dr Luke Evans; James Murray; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Questions 189-331

Witnesses

I: Professor Yvonne Doyle, Medical Director, Public Health England, Dr Katherine Henderson, President, Royal College of Emergency Medicine, Dr Chaand Nagpaul, Chair, British Medical Association, and Dr Paul Tanto, Registrar in Emergency Medicine, Northwick Park Hospital.

II: James Bullion, Vice-President, Association of Directors of Adult Social Services, Professor Martin Green OBE, Deputy Chief Executive, Local Government Association, Emily Holzhausen OBE, Care and Support Alliance, and Sarah Pickup, Deputy Chief Executive, Local Government Association.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]



Examination of witnesses

Witnesses: Professor Yvonne Doyle, Dr Katherine Henderson, Dr Chaand Nagpaul and Dr Paul Tanto.

Q189 Chair: In this morning's session we want to focus largely on two issues: first, testing; and secondly, personal protective equipment, or PPE, for NHS staff. I thank Andrew Latham and the technical team at the House of Commons who have made this happen for the very first time. Also, to anyone watching this at home, I apologise if occasionally we have a technical glitch, because this has not been done before.

Let us start by focusing on coronavirus testing, which obviously has been much on people's minds over the past week. I will put some questions to Professor Yvonne Doyle, Public Health England's medical director. Professor Doyle, may I first thank you and all the PHE staff who have been working unbelievably hard? People often thank NHS staff, but the PHE staff have been under equal pressure and are doing an extraordinary job. I know that the whole Committee would want to ask you to thank them, and to give our very best wishes to Duncan Selbie, the chief executive of Public Health England, who was due to give evidence but is self-isolating and not feeling well. We wish Duncan and his family well.

Before we get to some questions on testing, may I ask you for some of the latest medical opinion, if I may put it that way? For how many days do we think people might be able to spread the virus while they are still asymptomatic?

Professor Doyle: Thank you very much for your acknowledgement of our wonderful teams, who have now been working seven days a week for nearly nine weeks. I will convey that to them and I know that they will be very pleased. Also, thank you for your good wishes to Duncan, who is recovering.

On your question about how many days, we know that the incubation period ranges between three and five days. For people who are asymptomatic, they may have been asymptomatic for some period before symptoms appeared. We are still learning—this is a crucial issue for us—about those who are asymptomatic and never develop symptoms. We think that about 30% of people may be in that category. They have harboured the virus, but we do not know whether they adequately or effectively can transmit. Three to five days is when we begin to see people becoming unwell.

Q190 Chair: When you say that the incubation period is three to five days, what you are saying is that people could be spreading the virus to others for up to five days before they show any symptoms?

Professor Doyle: Yes, that is correct. As I said, we are still learning about that. It ranges over quite a long range, but in the majority of cases that we are analysing, about five days is the period.



Q191 **Chair:** Yesterday we read about the tragic death of Chloe Middleton, who was just 21. Just to get a sense of the extent of the spread, could you tell us how many other people getting care from the NHS have no underlying health conditions, and how many are getting intensive care?

Professor Doyle: On our dashboard, our deaths numbered 400 yesterday. More have come in overnight, which would probably bring us to 500 or thereabouts. We have analysed the first 386 deaths to understand a little more about these questions. Some 98% of those who died had some form of other condition, so at the moment it is very rare for people who do not have some other condition to die. There are a couple of cases that are unknown, but the overwhelming message is really that the deaths affect those who have other conditions, and they are much more likely among those who are admitted to ITU.

Q192 **Chair:** Just doing the maths, if 2% of deaths are people who do not have an underlying condition, that means that about 10 people without underlying conditions have died so far.

Professor Doyle: Three definitely did not have underlying conditions, and we are still following five to understand whether or not they did. Age is a major determinant in every question about the clinical profile of cases, and about those who get unwell and those who die.

Q193 **Chair:** Could you give us an idea of how many doctors and nurses are currently in intensive care units with covid-19?

Professor Doyle: I cannot give you that information, because what we get is a line listing from the Intensive Care Society, which gives us information about age and sex, but does not give us more detail about the actual people. We will be able to get to that point at some stage. I asked my colleagues about this yesterday, and their view is that it is very rare at the moment for healthcare workers to get seriously unwell—I am not sure that there are any in ICU—but we have had some clusters.

Q194 **Chair:** I have a final general question. Yesterday, Professor Neil Ferguson said that, according to his modelling, we should have just about enough intensive care beds in the NHS to cope with the expected peak. Will that be the case in London according to that modelling?

Professor Doyle: As I understand it, at the moment there are about 570 people in ITU and there is much more capacity for ITU around the country, and indeed in London, but there is less in London. If we kept things the way they are, there would be less capacity in London.

Chair: There are 570 in London?

Professor Doyle: There are 570 people in ITU with covid-19 in London. There are hundreds more ITU beds. I said if things stay the way they are, but they have not, because there has been a transformation in the way that care will be offered—both in London and elsewhere—in escalating the amount of capacity per ITU. People will be particularly aware of the purchase of ventilators, but there are other aspects, for example the rate-limiting step being the number of staff who can adequately and



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appropriately man an ITU. I know that that has been looked at over recent weeks. Hospitals are moving to reallocate, reskill and reorientate staff who are most likely to be capable in ITU.

Q195 **Chair:** Just to go back to the earlier question, are you aware of any deaths of frontline NHS staff from covid-19 to date?

Professor Doyle: I can't say that. What I can say is that the deaths that we have had are very much influenced by age, particularly between 65 onwards and co-morbidities. I cannot say that there are no healthcare staff members in that group, but I can say that it would be very rare.

Q196 **Chair:** Thank you. I want to move on to the issue of testing, if I may, Professor Doyle. I want to start with some numbers. Over a week ago we were told that testing would go up from 5,000 tests a day to 10,000 tests a day within a week. I have the numbers here for the last four days: 5,500, 5,600, 6,500, and 6,500. We are nowhere near 10,000. What is the problem there?

Professor Doyle: At the moment we have capacity for about 7,000 between ourselves and the NHS. This was first-order work over the last month. We need to make sure that all our labs are working to full capacity, but we also need to recruit in a number of NHS labs. Now we will have labs going right down the spine of England, starting with Manchester and St Bart's, but also with many others coming in. By 30 March we expect to have capacity for nearly 12,000 tests a day. By the middle of April, or possibly a little later, we will be moving to 15,000 and 25,000. We are confident—we are watching this every day—that our capacity is going up as we have said it would.

Q197 **Chair:** When the Prime Minister talked about 250,000 tests a day, was that a plan or an aspiration?

Professor Doyle: There are four strands of work on testing. The element for which Public Health England has ownership with the NHS is the 25,000, to ensure that our sickest and hospitalised patients and those with outbreaks in the community are tested. That is happening right now and we are confident that it will continue to happen.

The 250,000 encompasses a number of other elements. There is the antigen testing of the 100K tests for healthcare workers, which will work through a system that goes through the midlands and will be enabled by other parts of the system, such as the national biological service and DSTL. We will all help there, but the responsibility for that lies with the Office for Life Sciences. That will really be first order for healthcare workers, particularly those in the most risky situations.

Behind that, there is a plan—we heard it précised on the media—for 1 million tests, which people can do themselves. The 1 million tests are for members of the public. In other words, they will be able to take a blood test, send it back in the post and get it analysed. That is an antibody test that tells you whether you have had the condition. It is absolutely critical for two reasons: to understand what is going on, but also to allow people



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to return to work. That test is well advanced but not yet ready. We need to be absolutely sure that it is a valid test. We expect that to come within a couple of weeks, but I would not want to over-promise on that. The chief medical officer has been absolutely clear about it being right before it is actually put out.

Q198 Chair: If I can just go through what he actually said yesterday: priority No. 1 was hospital patients, priority No. 2 was NHS staff, and priority No. 3 was the antibody test. Are we ever going to get back to testing and contact tracing in line with World Health Organisation guidelines so that every covid-19 suspected case in the community gets a rapid test and all their contacts are traced? Or has that ship sailed?

Professor Doyle: Let me answer that by explaining what we have done. Public Health England bore this burden for about six weeks. In the first phase of this, from mid to late January until the middle of March, this exactly was the strategy. We tried to make sure we had tested and contacted all positive test contacts. The aim was to disrupt transmission. We hoped that we could contain indefinitely, but we thought that was unlikely. The main thing was to move the peak out beyond the winter, but also to give the NHS some time to prepare for what we are beginning to see now.

At a point before we stopped that intensive contact tracing, it became clear to us that there were what I call dead ends of contacts where you had a case, you tried to find the contact, and it just was not possible, because that gave us the indication that there was sustained community transmission. Nevertheless, we did contact almost 4,000 people up to that point. That was from about 590 positive tests. The positivity rate at that point was 3%. It was a little bit higher for those where we suspected, but that method wasn't very efficient and it certainly wasn't, we thought, getting to the contacts, because the virus was out there, as you say.

In a sense, several weeks ago that ship had begun to sail. Nevertheless, we kept going until mid-March, until we were absolutely sure that contact tracing in that way would not work. Now we are seeing many more people coming into hospital, and community outbreaks in places where it is really quite important to contact trace instead and support the LRFs.

Q199 Chair: I think this is going to puzzle a lot of people, because countries that had an outbreak much worse than ours, such as South Korea, did not stop the testing and contact tracing; they kept it up. Korea is testing 10 times more people, per head of population, than us. It followed what the World Health Organisation guidelines suggested, which is that you keep testing, testing, testing and contact tracing. So why is our strategy different? Why have we said, "Actually, there is going to come a point when you just give up on testing and contact tracing"?

Professor Doyle: There is a core of activity that every country is undertaking at the moment. In the east, what was different about South Korea was that these were clusters of cases where the initial transmission was well understood, because they were in particular communities and



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actually it was quite regional. South Korea also did something that we have looked at carefully, which is that they used technology to contact trace. They were using people's personal details, including their bank accounts, and people were willing to convey that information in order to contact trace. It was quite personal information.

We have looked at that, and SAGE looked at it and felt that it was not appropriate here. However, we are still looking at applications that might be able to give us some information about conveying between people precautionary information: "You might have been in contact with me. Just take care of yourself. Look out for this." That is actually what was happening with qualified professionals some months ago; that was the nature of contact tracing. The difference was that it was easier to identify the context. The modelling now says that, if you are getting into the third generation of contacts, you will actually be looking at close on six-figure sums to try to find the number of contacts, with the kind of social networking that was going on.

There is one other element to this. The other element of breaking transmission isn't just contact tracing and isn't contact tracing in this phase; it is about social distancing and shielding. All countries are involved with this, but we have particularly, as you know, taken that as an effective way of breaking transmission, which is the issue about contacts. But we are still continuing to contact trace. We do actually follow up outbreaks in the community.

Q200 Chair: What is puzzling is that South Korea is a democracy. SAGE took a decision—you have just said that doing contact tracing in the way they do it in South Korea would be too intrusive. But because they were prepared to take those measures in a democracy, they are actually able to keep all their restaurants and shops open—your temperature is checked before you go in. So in fact they have avoided much more intrusive changes to daily life by keeping up the testing and contact tracing.

I suppose the thing that is worrying a lot of people is that it isn't just South Korea, because countries such as Austria, Germany and Sweden are also doing a lot more testing than we are. How did we allow ourselves to get behind so many other countries? I appreciate that we are ahead of other countries as well, but we are certainly not at the front of the pack when it comes to the numbers of tests we are doing.

Professor Doyle: I would probably separate testing and contact tracing at this point, because the contact tracing is clear at the moment—the rationale for doing it or not doing it is this. Is it effective? Is it actually an effective way of breaking transmission? Also, is it an effective use of staff? There is limited capacity in the field service to contact hundreds of thousands of people for a positivity rate of 3% when it was actually much more precise.

In terms of testing, I acknowledge that testing does need to increase. This is why there are four strands of work on increasing that. The other issue I would raise here is that there is global competition for some of the



materials, the equipment and so on for very large amounts of testing. It is not a good reason for not doing it, but we are in a competitive market. I think calls to industry and very close alignment with SAGE and with Government have led us to identify the ways in which testing will be most useful to flatten the peak and push out the epidemic into a better time of the year.

Q201 Chair: But just to be clear, you are acknowledging that even though the WHO is saying that testing and contact tracing should not stop, we took a decision that it was not practical—indeed, we did not have enough testing kits to do it—and so we moved away from testing. Do you think we are going to get back to testing and contact tracing in the community at all, or is it now just too late?

Professor Doyle: If I could just go back to the WHO—this is not to sound in any way defensive or excusatory—the WHO is speaking to the world, and where the other countries may be still in the containment phase, testing and contact tracing in that environment would be exactly the same as the messages we took on board and did during the containment phase. However, here we are in this phase of delay where there is sustained community transmission. Now, this is under review every day of the week, and if there are effective ways that actually will help to further reduce transmission that technology can offer when people are now social distancing, I think that will be, and is being, looked at carefully.

Q202 Chair: I just do not understand why other countries that have had the virus worse than us, or are closer to China—Taiwan, Singapore, Hong Kong; not just Korea—have not stopped the contact tracing and testing. We have stopped it. That does seem to be a very different strategy, and that does not seem to be what the World Health Organisation is recommending.

As my final question, can I just put to you what some chief executives of trusts have been saying to the *Health Service Journal* in a survey that was released yesterday? This is from the chief executive of a London acute trust: “We have a huge surge in London. We are going to run out of staff because of self-isolation, plus some staff are now sick.” In the Midlands, a chief executive said: “A lack of testing capacity is the biggest issue we face. Instead of growing it, we burn hours on debates about who should get the test.” Are we, any time soon, going to have instant testing for NHS staff who are currently self-isolating? This is a huge source of frustration.

Professor Doyle: I would just say again that we have not stopped testing and contact tracing. Over 80,000 tests have been done to date, and quite a lot of those have been done in the past couple of weeks, but yes, one of the strands of work led by the Office for Life Sciences is about getting antigen testing out to healthcare workers, particularly frontline ones, as quickly as possible. I agree with you that that is very important.

Q203 Chair: Thank you very much indeed. I am now going to bring in other members of the panel. We will start with Chaand Nagpaul from the British Medical Association. Thank you for joining us, Chaand. What are your



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comments on the testing issue?

Dr Nagpaul: I represent doctors across the UK, and this has been a source of real problems for our workforce. When the announcement was first made to stop testing and contact tracing and simply to self-isolate, I raised on behalf of doctors the impact that would have on our workforce. Literally the day after, we saw large numbers of NHS staff not coming into work.

Remember, at this time of year it is estimated that around 10% of the population could have a symptom of a temperature or a cough in a non-covid situation, so we had situations where many GP practices and hospitals were understaffed. The staff themselves who were self-isolating were telling us that many of them felt able to work but were following the guidance. If they were able to be tested, they would come back to work. We made that point right at the outset, and it seems counter-intuitive that we are reducing our NHS workforce at a time when we need them the most.

Then on 16 March we heard the Prime Minister's announcement that healthcare workers would be prioritised. That has not materialised. To make it even more difficult for us, the 14-day isolation has added to absence. We have many healthcare workers who are absolutely fine, but a member of their family—a child—may have a fever or a cough, and they are self-isolating for 14 days. I cannot overstate what this means on the ground. I know of practices where one doctor is trying to provide a service for 24,000 patients, and the same applies in hospitals. And it is not just doctors, of course, but nurses—those in the community, and those in hospitals. For us, this seems an illogical approach.

Q204 **Chair:** Have you noticed it getting better in the last week at all?

Dr Nagpaul: No. In fact, each day that goes by, there are more staff who are self-isolating, because the symptoms—a cough or a temperature—are quite prevalent. I do not know what proportion of those symptoms are due to Covid. Even in a normal situation at this time of year, up to 10% of the population will be estimated to have such symptoms.

Q205 **Chair:** Thank you, and it goes without saying that we all want you to pass on our thanks to your members and to the people you represent for the incredible work they are doing.

Can I bring in Dr Paul Tanto, who is a registrar at Northwick Park, where there were particular pressures over the weekend? Thank you for joining us. I know you are not on shift at the moment, so we are not taking you off the frontline by having you here. We really appreciate you giving up the time. Just talk to us, first of all, about your experiences on the frontline. We will come to PPE later, but particularly with respect to testing, are there any thoughts that you have?

Dr Tanto: I certainly echo what Chaand has just been saying about the non-knowledge of testing and diagnosis of whether staff members have Covid-19. To get into the vernacular, if you have a cough and a fever, do you have Covid-19, or do you have an upper respiratory tract infection? At

this moment, we do not know. The former requires the seven-day isolation; the latter, not necessarily. We have lost members of staff in departments across London who have had to self-isolate for reasons of their symptomatology. With the increase in work with Covid, that has an impact on the efficiency of our departments.

We have seen a concurrent decrease in non-Covid presentations to our emergency departments, which has helped, but the work required for a Covid patient has increased, compared with non-Covid, so any decrease in numbers of attendances has been more than offset by the individual work per patient required.

The decrease in staff is putting pressure on emergency departments, but it cascades to the rest of the hospital too, as members of staff in the ward areas are also going off sick with self-isolation requirements because of potential Covid symptomatology. If we knew somebody had Covid, fine; if we knew they did not have Covid, we would not need the seven days and we would have less sick time, and that would change our staffing issues within hospitals. I echo Chaand's comments.

Q206 Chair: Thank you very much. I will come to you a bit later about the general situation in Northwick Park, but can I bring in Katherine Henderson from the Royal College of Emergency Medicine? Thank you so much for joining us. Can you give us your comments on the testing issue?

Dr Henderson: We are very keen to get staff tested as soon as possible. I currently have six members of staff off with symptoms, and 10 members of staff off self-isolating. It would be really helpful to get those people back on the frontline. The ability to put people into hotels when they discover that a household contact has symptoms has been helpful. We are managing to do that, but not everyone, obviously, has the possibility of going to a hotel if they have family responsibilities.

From our point of view, and round the country, everyone is saying that rotas are becoming more challenging because of this. That being said, given that we are not quite sure about asymptomatic transmission, we need to continue with the quarantine arrangements—the self-isolation arrangements—until we actually have the ability to do the testing. We are not pushing for bringing back people early just because they feel okay. We would be pushing for having people back early because we have tested them.

Chair: Thank you very much indeed. I am going to bring in my colleagues from the Committee, starting with James Davies and then going on to Amy Callaghan. James, who would you like to ask a question to? Please fire away.

Q207 Dr Davies: Professor Doyle, if that's okay, at least initially. In terms of testing, particularly of key workers, we have heard that more sites around the country are being brought on stream, but that there are issues with acquiring elements of the test kits, and we may not be top of



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the list internationally. Where would you place the various factors that are limiting the ramping-up of the testing? Is it the sites, or is it the equipment? If so, why are we unable to put ourselves above some of the other countries that are perhaps doing better in that respect? I also wondered whether there was any data from other countries that are doing more testing on the number of asymptomatic patients out there.

Professor Doyle: To answer the question, there are three active elements and a surveillance element to the testing. The one that Public Health England works with the NHS on is moving to 25,000 a day, which will be for patients and for outbreaks in the community; if there is spare capacity, absolutely the next priority behind the patients is the frontline staff. But we understand that that will not be enough for frontline staff, so the Office for Life Sciences has been asked to develop much greater capacity, and we are supporting that. All I can say is that that is progressing, but I am not able to give you the absolute day that that will come up to 100,000 antigen tests.

Yes, we are in touch with other countries; in fact, we ring all our contacts around the world several times a week, including in the east, and we know the differences and why certain countries have taken the line that they have, and how they are actually measuring what they are doing. We are well placed, because of our scientific base and our contacts through that with industry, to get the kind of equipment and materials that we need. All I would say is that it is a global market, and everybody wants that at the moment. I know that the WHO is also concerned about that.

Chair: Thank you. James, any more questions from you?

Q208 **Dr Davies:** I did have one further question about the home test kits. There has been a suggestion that people will perform these on themselves, and that they will sometimes give readings there and then. For the purposes of recording in medical records, is it suggested that we should rely on self-reporting of tests, rather like we do for pregnancy test kits or for blood glucose monitoring?

Professor Doyle: As you say, self-testing is not new and is well understood in other areas, and I think there has been fast learning about how that works. The most obvious one is the pregnancy test, but there are other areas as well, and the intention is to allow people to do as much of this as they validly can. The validity of the test is important if we are asking people to self-test, but it is by far the most efficient way, if the technology will support it.

Chair: I will come on to Amy and then Rosie Cooper. If colleagues have more than one question on testing, could I suggest that they ask them all together? Make sure you say who you are directing the questions to. Amy first.

Q209 **Amy Callaghan:** Thank you so much. I would like to echo the Chair's thanks to the panel for answering our questions today; it is really helpful. I have one question on testing, and it is also around the home testing kit. Professor Chris Whitty has stated that the second priority behind testing



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those in hospital is testing NHS frontline staff, and the third priority behind that is potentially the home testing kits, but 10 days on from the Prime Minister's announcement of testing for frontline NHS staff, we still do not seem to be much further forward. I am wondering what the reality of those home testing kits coming into fruition any time soon would be. I think that is probably directed to Yvonne Doyle again—sorry.

Professor Doyle: I understand why. This is not my responsibility, I have to say, so you will have to take it that this is what I am informed of, but I know that healthcare workers are absolutely the priority now. This is very active. I am unwilling to give a day when this is coming on, but it is imminent. The kits are certainly available and the testing is understood, and the intention is to get it ramped up as fast as possible. I do understand what other members of the panel have said, and we are experiencing this ourselves in our interactions with the NHS, so I fully understand and accept that.

Q210 **Rosie Cooper:** My question is directed to Professor Doyle. Despite the fact that case finding and contact tracing in the community is known to be best practice—even the Government published a paper demonstrating the effectiveness of these methods—we seem to have totally disregarded that and are on a path all on our own. I have heard from other MPs that they have manufacturers in their constituencies manufacturing tests, and they were absolutely astounded that they were exporting these tests around the world, yet no contract had been placed by the British Government. Is that correct? Do you know about that? I suppose the next bit of that is: when was the first major contract for testing kits placed?

I am going to speak rather strongly: a lot of people, both NHS workers and members of the public, have expressed the view to me that the Government have lost control of this, are completely overwhelmed, are bunkering into the bits they can do, and have stopped dealing with best practice. They are horrified at where we are.

Professor Doyle: For the part of the testing that Public Health England and the NHS are responsible for, we have been able to give a commitment that those 25,000 tests a day will be on stream by mid-April—

Q211 **Rosie Cooper:** No, no. That was not my question. My question is: when did you place the orders? Why are we so far behind the curve? Did we actually export tests from this country without the British Government having placed those contracts for us?

Professor Doyle: I cannot answer about contracts being placed by the Government, I am afraid, but what I can say is that—

Q212 **Rosie Cooper:** Or NHS England, or whoever?

Professor Doyle: I understand, and we work together. Let me tell you what I can tell you: a call to industry has gone out, some time ago, and did get a good response. This is not to do with money, and it is not to do with trying to bunker down. It is about whether the responses will deliver what we need to happen, which is a huge increase in the capacity for



testing, which we know about, and about the way in which it is done. All of this is done in conjunction with the scientific advisory committees and it follows their clear advice. That is in progress—that is all I can say—and it is promised as imminent.

Q213 **Rosie Cooper:** So we know better than the World Health Organisation, and better than public health professionals right across the board, who are astounded by and disappointed in our response?

Professor Doyle: I do not think we are trying to say that we know better. We are in regular touch; we were in touch with the WHO only yesterday, and several of our people are working on this with the WHO—

Q214 **Rosie Cooper:** So which bit of “Test, test, test” didn’t we get?

Professor Doyle: I am sorry, but I cannot answer that question specifically. If you wish, we can take that away and request the parts of Government that might know the answer to provide it for you. I am happy to do that. But in terms of the WHO, I say again that at the moment there is a profound attempt to reduce transmission. That has been informed not by trying to bunker down, but by the information we have had from SAGE that this is the most effective way to protect the most vulnerable. Contact tracing continues for outbreaks where it is extremely important, and where people are contained—for instance, in nursing homes and prisons. We do follow as best we can where it came from, and we do something about it. That is active at the moment. We have not diverted from the WHO; we are simply in a phase where this is the most effective way of—

Chair: Rosie, Chaand wants to come in on that point.

Dr Nagpaul: Literally three weeks ago, we had about 20 cases. We now have several thousand; it probably doubles every few days. I just want to understand how valuable it will be for this to come on stream in the middle of April. That is three weeks away, by which stage the numbers we are likely to see will have grown exponentially. I just want to understand how it can be of value for healthcare staff to be waiting for that period of time, while at the same time we are being told it will be imminent. I am just not clear about the timescales, because I am hearing the middle of April, but we will be in a completely different situation then; many healthcare staff will have been affected by that stage. I am not sure how contact tracing or testing at that stage will be as effective as doing it now. I accept the logistical issues.

Q215 **Chair:** Professor Doyle?

Professor Doyle: So far as tracing goes, I again say that we continued to contact trace long after it was felt to be effective. I repeat what we found, which was that the actual positivity in the contacts was 3% of the thousands we followed. It would be much less now. However, we continue to look at whether contact tracing has a place at this point of transmission.

This is not simply something we made up to be convenient for staff. It has been modelled that the gaps between the number of cases now and where they might have got that, up to the point of social distancing, are almost



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unknowable, because of community transmission. To some extent, although we are very positive about what happened in the containment phase, the fact is that containment cannot run down to ground every contact, as we are now seeing.

Chair: Thank you. I am going to bring in Paul Bristow and then Dean Russell.

Q216 **Paul Bristow:** Thank you, Chair, and thank you to all of you, especially the frontline NHS workers, for what you are doing at this time. I will ask two questions. If a hospital does not have its own testing facilities or laboratories, how long does it take to get test results back? If there is a capacity issue, might you explore that?

Secondly, I understand that some hospitals are refusing to test patients for a second time, regardless of a change in their symptoms. That is from direct feedback that I received. I ask that question because if a patient is suspected of having Covid-19, they are placed on a bed next to patients who definitely have Covid-19, and are then moved on to a clean ward after a negative result, which might come several days later, despite their being next to those other patients for a considerable period of time. I am just interested in your view of whether that policy is happening throughout the NHS, and perhaps the views of some of the NHS frontline workers on whether they have seen this activity.

Professor Doyle: If you wish, I will answer first and then pass over to colleagues. The testing continues. As I say, 80,000 tests have been done, and much of that is hospital-orientated. Who to test would be a clinical decision. We have provided advice, through the Scientific Advisory Group for Emergencies—SAGE—and our infectious disease consultants who watch this, on what is worth knowing about testing, such as when it is worth doing several tests, and when testing really cannot tell you much more.

That is being done in conjunction with increasing knowledge about the clinical profile of this condition. We know that the majority of people will be better in seven days and less likely to transmit. That is not the case for people who get severely ill and who have to be cohorted into the intensive treatment unit, where 14 days onwards is much more likely.

Understanding more about the clinical profile informs when to test and the best way to test, but it would be a clinical decision. That is what the testing capacity is being increased for, but maybe I can pass to one of my colleagues.

Q217 **Paul Bristow:** On the specific question of how long it takes, if you are in a hospital that does not have it, how long would it take for that to come back to that hospital?

Professor Doyle: That might vary by region, but the test was taking up to five days to come back with a result, which I have to say was too long. That is why it is important that we increase the efficiency of getting results.

Q218 **Paul Bristow:** What is the capacity issue here? Is it an issue with the



microbiologists? Why is it taking so long?

Professor Doyle: I don't think that initially it was because of the time it took to do the testing, because at that point Public Health England was doing all the testing and it was done in four hours. We did analyse this, and we found that much of it was about the time it took to get to the hospital or to get back, and at that time there were quite complicated ways of informing people: it went through various databases and so on, and it had to be validated, because the worst thing would be to give people the wrong result. It was about the days on either side, particularly after the test was done, and we have really worked to try to improve that, but I accept that it was too long.

Q219 **Paul Bristow:** I am sorry to labour the point, but what about laboratory opening hours? Are they open 24 hours a day? Have we done that? What about weekend working, because I know that was an issue before covid-19, for example with sepsis? Because of this particular emergency, are labs now open all the time?

Professor Doyle: I can speak for our labs, and they have been open seven days a week for the whole period—they moved very quickly to a seven-day week—and they do work overnight; the tests are actually done overnight.

Q220 **Dean Russell:** I have two related questions for Professor Doyle. First, I have been speaking extensively to pharmacists across my patch in Watford, but also in Hertfordshire and more widely, and they are really concerned that they are not being tested, despite being very much on the frontline. A lot of GP surgeries are only taking calls from patients, before they can walk in, whereas people can walk into a pharmacy and speak to a pharmacist directly, and there is a real worry about that. Are you considering pharmacists and also dentists within that frontline group?

Secondly, on the previous question about testing, we have put out a call to factories for ventilators, so I do not understand why we are not putting out a call across the country for more organisations to help support the testing by building testing kits. I understand that will be more complicated, but my grandmother helped to build Spitfires during the second world war, and I am sure that she did not know how to do that beforehand. I am sure that people could learn how to do the testing, which would allow us to do even more than 25,000 a day, because it seems to me that this could help us more immediately.

Professor Doyle: On pharmacists, again the NHS would be well informed about this, but I do know that they are considered as key workers. We have provided guidance, which is part of our responsibility, to advise frontline workers, including pharmacists and dentists, on what they need to do to keep safe and to protect their patients. I know that pharmacists are considered to be very much part of the solution, and an element in how we get through this epidemic. The NHS might want to elaborate on that, but we have certainly been involved in providing the guidance—

Q221 **Dean Russell:** I am sorry to interrupt, but I want to ask specifically about



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testing. As we can ramp up the amount of testing that we can do, will pharmacists be considered part of that first tranche of frontline NHS staff?

Professor Doyle: Very much so. If they are involved in the covid-19 response, then yes.

As far as the call to industry is concerned, that is absolutely what we would love to see, and calls have gone out to invite anyone really. We get a lot of people approaching us and we put them through to the right quarters to make sure that their offers are duly considered. There is a great willingness to get solutions. That also needs to be balanced, as the chief medical officer would say, with making sure that what we are offering is valid and works in this situation.

Q222 **Dean Russell:** Has that call gone out not just to business but to universities, because there are universities up and down the country with quite impressive laboratories—as a former physicist, I used to work in some of them? I just wonder whether those are being activated to enable testing, because I can imagine there are an awful lot of medical students across the country, who could become an army of people building and performing the tests.

Professor Doyle: I understand that not just retired people, but medical students and nurses in their last period of training, have been invited to contribute in the most appropriate way. The Office for Life Sciences, which is involved in some of these testing processes, is very well connected to the universities, and the universities have certainly been mentioned as part of the possibility of offering solutions, if they are set up to do so.

Chair: Could I possibly just ask my colleagues—because I am very keen to have enough time to talk about PP equipment, which is so important for staff—to ask all your questions in one go, so that we can make sure we have enough time for the protective equipment discussion?

Q223 **Dr Evans:** Thank you very much. My questions are to Yvonne Doyle. They are quick-fire questions, if that's all right. Is a PCR cheek swab still the main testing we are doing?

Professor Doyle: Yes, it is a throat swab, actually.

Q224 **Dr Evans:** Thank you. How much does it cost?

Professor Doyle: The test that we do is very cheap, but the kit and delivery—I cannot give you an exact figure, but I know it is considerably more. It is somewhere in the order of £70, but I would have to find that out; it is an NHS number.

Q225 **Dr Evans:** If we assume it is close to £100, doing 25,000 tests gets close to costing £2.5 million a day. Whose budget is that coming out of, and have you got enough there?

Professor Doyle: There is a national covid Government budget, which everyone has been invited to avail of—obviously with the right governance. That is certainly what we do at Public Health England, and



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we are not concerned about budget cuts in this particular incident.

Q226 Dr Evans: In terms of resilience, the key thing is being able to do the test by having the staff to do it. What have you got in place? If you lose 20% of your lab technicians or histopathologists, how are you going to cover that?

Professor Doyle: Yes, and this is a big project across Government: to understand what we would do for business continuity in the context of losing 20%. That was understood very early on from the modelling. It is a massive assessment of skills, deployment of skills and flexible ways to be as close to the frontline—certainly in my organisation—as we can safely get people. It is a huge endeavour, and you are absolutely right to say that the workforce is a great limiting step.

Q227 Dr Evans: My final question then. Guy's, King's and Tommy's have released a research app. You report on the day that you are well or have symptoms. This seems a very sensible way of being able to track the spread if we get people to use it voluntarily, giving some updated data. Have you any thoughts on that? Has there been any discussion about possibly rolling that out on a wider scale to see how the virus spreads, and about people self-reporting?

Professor Doyle: These are parts of the offers that we really welcome, and I am certainly aware of King's and Guy's having offered us something, as have many others. I never ignore those; if they come to me, I make sure that they go through the portal, where these are examined as to what utility they might have and whether they are the right thing to use. We welcome the app, and these are where the solutions will come from.

Q228 Taiwo Owatemi: My question is directed to Professor Doyle. Just two weeks ago, I had to self-isolate because I had some cold symptoms. I contacted NHS 111 and was told I would be contacted by Public Health England; that took about two days. I was told to go to the drive-through facility, it took about five days to get my results back. Has the process improved? It took about seven days in all for me, from reporting to getting my results.

Professor Doyle: I hope you are recovering, and thank you for sharing that. It is important to hear this. I will not try to say that the process taking seven days is a good experience. Part of my answer is that we really need to get much faster about getting the results back. I will take back your experience of it taking Public Health England two days to contact you; it may have been that there was a lot of activity going on and a relatively small team. We had 70 people and about 120 more around the whole country trying to do this up to the middle of March—small numbers of people, but very committed to getting to you. I am sorry it took two days, but I know they were committed to doing it.

As for the five days afterwards, I would much rather this happened within 24 hours. I would like to see that happen, and I hope that as we move to bigger capacity, and perhaps quicker technology, we will be able to do that. It is not the test itself that is taking the time. I know it is frustrating

to say, but it is the logistics of what happens particularly after the test has occurred.

Chair: Okay, thank you. Taiwo, do you want to come back on that, or are you happy for us to move on?

Q229 **Taiwo Owatemi:** I just wanted to ask what information is being provided to the public to put them at ease, especially if you have to wait a couple of days to be contacted by someone. NHS 111 were not as helpful as I thought they could have been. I understand that they do not necessarily have the information to provide.

Professor Doyle: I am glad to get this feedback. At the moment, our helpline is getting about 25,000 calls a day, although it varies and sometimes that comes to NHS 111, so it is a diverted line. It could have been NHS 111 itself—I know it gets huge numbers, depending on what comes on the media on the particular day. I would like the experience always to be better, so I am glad to hear that, and I will feed that back.

Q230 **Laura Trott:** I have one specific question. Many of my colleagues have talked about the length of time it takes for the tests to come back. Professor Doyle, there is a point of care test, which is with the MHRA at the moment, that will allow clinics to test at the bedside, and the results will come back in about an hour. What is the delay in this being approved, and how quickly can that be forced through? It is something that a number of clinicians in my patch are asking for.

Professor Doyle: Again, it is something I will need to request from the NHS, because we are not the people who do the point of care testing or response, though the NHS will be. Ms Trott, I am sorry I cannot answer you directly, but I am happy to come back to you on that through the NHS.

Laura Trott: Thank you.

Q231 **James Murray:** Professor Doyle, there seems to be a disparity between the WHO instruction to test, test, test and the approach we are taking here in the UK. I would like to understand more where that different approach has come from. Is it entirely down to capacity? Hypothetically, if we had unlimited capacity in terms of how many tests we could do, would we be aiming for more than 25,000 quicker?

Professor Doyle: We are aiming for more than 25,000 quicker, and in the circumstance of increasing capacity rapidly, we had to prioritise where the testing was the most important and how quickly. The intention, as we have said, is to get the healthcare workers next in line, and then—critically—to understand what is going on. This technology still has to be fully validated, but the most critical—the game changer—will be the antibody tests that tell us which parts of the population are immune. On that, we are in complete agreement with the WHO.

Q232 **James Murray:** I appreciate absolutely the prioritisation of patients and NHS workers in terms of the testing that is available. I guess that my question, just so I can really understand where the decisions are coming



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from and on what basis they are being taken, is: are the decisions about testing limited entirely by the capacity to test more, or are other decisions being taken—for clinical, strategic or political reasons, and so on—to have a particular approach in terms of the testing numbers?

Professor Doyle: The approach through this whole epidemic is always influenced by the modelling and the science in the first instance, and then senior clinical advice and Public Health England's guidance. That is what directs us as to what we do at any particular phase. And the numbers, of course—this is a critical thing. Our surveillance will tell us what is actually going on in the population at any time and, in the light of that, what interventions are most likely to be effective.

I continue to say that testing is part of a general approach to this. The whole epidemic will not be sorted simply by testing everybody. I understand what people say about the east and so on, but in China and Singapore—we are in touch with them—and in Korea and Japan as well, testing is part of a portfolio of interventions, most of which you are seeing at the moment. Yes, undoubtedly we would like to have more capacity, and that is something I think has very clearly come out this morning. That is the intention: to have more capacity to test. But on its own, testing, or indeed just contact tracing, is not, in an epidemic, going to actually protect the population to the maximum effect.

Q233 **James Murray:** Just to conclude, I want to make sure that I have understood correctly. You are saying that you would like more capacity, but that the decision around the testing strategy is not driven entirely by capacity—it is also driven by other decisions, whether they be the overall clinical priorities, political decisions or a decision about what strategy to take, irrespective of what capacity is available. Is that correct?

Professor Doyle: Yes, and in this order: the science, the clinical reasoning, the surveillance and the numbers first; and then the decisions about what is the best thing to do at that time. It is also very much about what is realistic. We have had a very coherent cross-Government approach to this, which really is a whole-country attempt to do the best that can be done under the circumstances of what the numbers are telling us.

Chair: Thank you, James. Last but not least—thank you for being patient—Sarah Owen.

Q234 **Sarah Owen:** Thank you, Chair, and thank you to the panel. I have two questions for Professor Doyle first. The first is about NHS workers. I am really relieved to hear that frontline workers will be treated as a priority for testing. I want to clarify whether that includes ambulance and paramedic workers, as well as social care workers.

The second is about the antibody tests—you alluded to it just then. If you have caught the covid-19 coronavirus and you test positive for the antibodies, what evidence do we have that that actually provides immunity, and how long will that immunity last for? If we don't know, what purpose are these antibody tests actually providing?



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My second batch of questions goes to Dr Nagpaul. Earlier, Professor Doyle repeated that age is a factor. If the Government are asking retired doctors, nurses and healthcare workers to come back and play their part, what risk is that causing for your members? Have you had conversations with the Government about that?

The last one is about pregnant healthcare workers and doctors. We are seeing a large number of reports of pregnant healthcare workers feeling pressured to go back to work, or to continue working, when the Government advice is actually for pregnant mothers to isolate.

Professor Doyle: Yes, ambulance workers and paramedics on the front line, dealing with people in the community and in hospital, are very much part of the worker priority.

On the question about immunity, it is a novel virus, so we have to really model it and learn about it clinically on the basis of three previous viruses. First and foremost is pandemic flu. You will also have heard of SARS—because it is of that family—and the middle eastern virus, which is mainly, as its name says, contained in the middle east, but has been quite severe and has appeared in other countries. What we have learned from that is that immunity is certainly strongest in the first while—in the first few months. We can say with some confidence that people would be immune at 28 days. It is not possible to say at the moment whether they would be immune in a year or two's time. It is one of the important scientific questions that SAGE—the Scientific Advisory Group—is looking at.

To answer your question on what antibody testing tells us, it will tell us two things. It will tell us who—I will not say “cannot”, because we are still learning—is highly unlikely to transmit infection, which is important because it allows people to get back to some form of normality, including work. It also tells us about what is going on in the population, in terms of zero prevalence. That is not the sole purpose of doing antibody testing, but a proportion of the testing will look at what is going on in the population so that we understand much better what this epidemic is doing.

Dr Nagpaul: On the question about age and retired doctors, about 15,000 retired doctors were written to by the General Medical Council, and they have been put on to the medical register unless they wish to opt out. Significant numbers—more than 2,000—have indicated that they wish to support the NHS at this time. As you mentioned, it is really important that they are protected, because they are in an age group that puts them at higher risk, and many will have other medical conditions.

There are significant areas of work that are non-patient facing. For example, in general practice, we are able to manage a significant number—maybe over half—of our patients through telephone consultations. You heard about NHS 111 having, in my patch at least, a five-hour delay for a response. Retired doctors could be very useful in providing medical expertise in that sort of area and, of course, many other patients in hospitals are also increasingly managed in a non-patient facing



way, with video consultations and follow-ups remotely, so there is a role for them to play.

Having said all that, where they are going to be treating patients—this will be the second part of the questioning, of course—it is vital that they have the right protective equipment, as must doctors and all healthcare staff. I know we will be coming on to that shortly.

Q235 Chair: Thank you very much indeed, and thank you to everyone for those questions.

I just have one final question on testing to Professor Doyle. I am sorry that you have been getting nearly all the questions, but you will appreciate what an important issue this is.

At the start, you said that you could pass on the virus when you are asymptomatic, for potentially up to five days. Does that mean that, today, NHS staff are likely to be passing on the virus to their patients?

Professor Doyle: This is something we are learning about. In theory, when people are incubating viruses, they can be infectious. We still have to chart the nature of this virus, and how infectious it is and at what point. We are working on first principles that it could be, and that is the precautionary principle.

People tend to most infectious—we have noticed this from the testing, and indeed from the clinical feedback we are getting from colleagues—at the beginning of this disease, particularly if they are severely unwell, and that does tail off. That is the issue about what happens between seven and 14 days; other important things do happen between seven and 14 days with those who are hospitalised.

So, the answer in theory is yes, and at the beginning, particularly when people are symptomatic at the beginning, they may be at their most infectious, but we are still learning.

Q236 Chair: If the answer is yes, can you give us some date at which we will be able to introduce for sure rapid testing for all NHS staff? Is there something you can say to NHS staff today that would give them some comfort that, by this time next week, everyone will be able to have tests on a regular basis and we will be able to turn around tests for NHS staff in 24 hours? Is there something you could say—a message you could give them—that would give them some comfort on that?

Professor Doyle: The comfort I can give them is that this is the most active work that is ongoing. As I say, unfortunately I am not the NHS; it probably would be good if the NHS were alongside us here. What I can do is to ask that question to the NHS—would they wish to give that assurance? I am sure that as soon as they have a time that this can be put into the public domain, they will do so. It is very active. It would be disingenuous of me, not in the NHS, to give a date and a time which simply would raise people's hopes and then might be found to be inaccurate.



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Q237 **Chair:** Okay, I understand that. I mean, Public Health England is in charge of testing, which is why we think it is reasonable to ask you that question. We are not party to the discussions that you are party to. Can you not give us any sense of when it feels to you like NHS staff will be able to get immediate tests?

Professor Doyle: In the first instance, our labs do about a third of the testing of the 25,000. The NHS is the major capacity in testing, even within the system that we are describing. Then we are talking about adding on further capacity from industry. I am not trying to excuse this, but we are a small partner in the actual testing. We are also, of course, having to test for many other infections. Our labs are not just waiting for Covid. They are very busy all the time as, indeed, I am sure the NHS is. We are partnered with the NHS. We do provide the advice, the technology and the knowhow, but the capacity is something that the NHS really brings to the table.

Chair: Thank you very much.

I am going to move on now to the issue of protective equipment for staff, which has obviously been very hotly debated in the last week. I think I will start by asking Dr Paul Tanto to talk about his experiences on the front line, and what his colleagues are saying to him about PPE?

Dr Tanto: Of course. I am keen to point out, as is my trust, that I speak in a personal professional capacity as a doctor working rather than speaking for the trust.

We have had several iterations of advice on the appropriate PPE to be wearing. Obviously, this is a novel virus and an unusual situation. Most of us have never worked in a pandemic situation before, so there is a degree of learning as we go along about what is the appropriate level of PPE. The fact that this has caused a certain degree of confusion is inevitable, and I think sometimes the communication about what we should be wearing has been a bit slow in coming forward to frontline NHS staff. Thus, at the start of our preparations, we were using Ebola-type PPE, whereas now we have downgraded to more appropriate PPE on the basis of the infectivity of covid-19.

Availability has been mixed. It is largely present in terms of the appropriate PPE, but there are certainly occasions when we run short of equipment. Visors certainly were an issue initially, although I gather that, with the establishment of the central distribution mechanism, that is no longer a problem. Gloves and gowns—not so much. It is an issue less in hospitals and more in our ancillary services and in the primary care setting, where PPE is not being distributed quite as efficiently as it could be. Staff are rightly concerned about the degree of infectivity that may occur with PPE, but we are reassured by our occupational health teams and our infectious diseases teams that what we are wearing is appropriate to prevent onward transmission from patients to us and vice versa, where that occurs.



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As ever, it is a communication issue. Divergent messages create difficulties, because people will always look to what suits their own perspective on the situation whereas if we have an unambiguous message—"This is the equipment you require"—and it is an absolute across our service, that will reduce instances of, "I don't have appropriate PPE." I think we have all seen some of the PPE discussions on social media, with some people saying, "I don't have appropriate PPE," yet it is the PPE that is appropriately deployed in other environments. It is primarily the continuity of communication.

Q238 Chair: Thank you very much. Can I bring in Professor Henderson to talk about what your members are saying at the college?

Dr Henderson: Thank you. You have just promoted me to Professor, so that is very nice. I am a mere doctor, I am afraid.

We really want to stop the chain of transmission. That is the really important thing, and we are very worried that the situation that we are in is not stopping the chain of transmission with a group of patients who are potentially at risk. We have heard from Professor Doyle that there is the possibility of asymptomatic patients, which means that any patient who is unwell enough to come into an emergency department needs to be considered as having covid-19 until proved otherwise. In that case, even in cold zones in our low-risk areas where patients are coming in, say with abdominal pain, we should be wearing some form of protection and they should also be wearing a mask. This would be the same feeling of concern that primary care carers and district nurses have. We should institute an attempt to break the chain of transmission by putting in both the masks and the attitude around hand hygiene, surface cleaning and all the rest of it.

We then come to our other big concern, which is the higher-risk patients: patients in our "suspect but don't know yet" category, because we cannot get a testing result within the timeframe of an emergency department visit. We have patients when, to be absolutely honest, it is blindingly obvious that they have got it; we are still not perhaps as well protected as we should be. We need to be able to wear what are called FFP3 masks and the visor that Paul mentioned to absolutely prevent healthcare workers being affected. We understand high-risk areas in ICU and HDU—that makes sense, and we would not want to downgrade that concept at all—but by that time very often the patient's result is known and you know the risk you are dealing with, and we understand ventilator disconnection risks, but in an emergency department when you have got a coughing patient, an agitated patient and a patient who does not understand wearing a mask, you have the risk of a mixed environment where you are putting healthcare workers at risk.

It has got to be the primary responsibility of everybody to make sure that we maintain our workforce in this difficult time, that they are absolutely protected, and that they also do not become a cause of transmission themselves by working when they have picked something up but are asymptomatic, and going off only when they finally develop symptoms.



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Q239 **Chair:** Chaand, you are obviously getting a lot of messages from your BMA members. What is your perspective on where we are at?

Dr Nagpaul: We are flooded with anxieties and concerns by doctors. It is the single biggest issue at the moment. We have two concerns. One is the actual supplies themselves. I know we have had assurances around deliveries being escalated, but we are still finding far too many of our members telling us that that has not translated on the ground. Even this morning I have had emails from doctors saying that masks have run out, that they are having to wear them for longer than they should and so forth. So there is the issue of supplies. In general practice, when we run out and we ring up the helpline, we are told to buy them ourselves—that is the advice we are getting. So there is a still an issue of supplies, but I accept that there is an increase.

The other issue is about the adequacy of protection. If you look at the World Health Organisation's recommendations for any healthcare worker—I also speak for nurses and ambulance crew, because they have the same concerns—as a minimum a healthcare worker should have their eyes protected, because we know that these droplets can be absorbed through the mucus membranes of the eyes, and also have a protective gown. We have neither of those in general practice in the community; nor, for that matter, do frontline staff in A&E. We are given a plastic sleeveless apron. I wear normal clothes at work, and my clothes are exposed—they could be infected. I take off the apron and see another patient; I may be harbouring infection. This does not seem to be the standards we should be adhering to.

It is not just the WHO; UEMO and the European Centre for Disease Prevention and Control are all recommending the sort of protection that the WHO speaks of. So we have concerns on both fronts—adequacy and supplies.

Q240 **Chair:** Thank you very much. I am sure that we will bring you back, but may I ask Professor Doyle to clarify that point? Is Public Health England guidance on PPE weaker or the same as World Health Organisation guidance?

Professor Doyle: The vast majority of the guidance is consistent; It does differ, though. We have done an analysis of the coherence of our guidance with the guidance from the WHO, the CDC in Atlanta, and the European Centre for Disease Prevention and Control. There isn't agreement between those agencies on much of the equipment that should be used, particularly in the most risky settings. There is a problem about everybody agreeing what the right thing to do is, but the guidance here, which has been inputted by the NHS, penned by clinicians, and advised by our advisory groups on dangerous pathogens and emerging viruses, is more protective in the most risky environments than what the WHO recommends.

There is a difference in other settings. The reason for that is that the guidance has been written on the basis of best infection control advice, which has served this country for many decades. The issue that comes up



occasionally is “bare below the elbows” and the apron versus the gown. The reason for that is that we want to ensure that it is not another hospital-acquired infection that kills the patient. There is a balance between what we are doing for coronavirus, and what good infection control has told us works for all infections in hospitals.

That is building on experiential evidence, but I would not try to pretend that there is a huge amount; there is a literature review, and we have got it, but it is not as definitive as people might think on what exactly to do in each setting. What the WHO recommends is a proportionate, rational approach to infection control.

The third element of this is that just having a piece of equipment is not going to protect people fully, including patients. There should be a whole-system approach to best infection control, as people have mentioned—I do not need to labour that point. We are noticing that this has not been at the top of people’s minds up to this year. People are very anxious, which I absolutely accept; we are hearing that as well. As well as the question of having the piece of equipment that people think will fully protect them, we have a training issue here, and a communications issue, as Chaand has mentioned.

Q241 Chair: This is what the chief executive of an acute trust in the midlands told the *Health Service Journal*: “There is near revolt amongst my clinical staff about the national guidance on use of surgical masks for non-aerosol generating work...They see hazmat suits and FFP3”—the highest grade of masks—“being deployed in all scenarios in western Europe and want to know why we aren’t doing the same.” That is not an unreasonable thing for staff to feel, is it?

Professor Doyle: Absolutely. I accept people’s anxieties, but I do not know the circumstances in which the hazmat suits were sought. I come back to the point that the guidance, which was written and cleared by people who live infection control every day of the year, is proportionate and protective for the most risky environments. In this circumstance, I fully accept that the guidance is under review. In the light of people’s anxieties and the full package of the problems that are emerging—which are not about just one issue, really—we are keeping that under active review, right now.

Q242 Chair: Let me ask you about something that is in your guidance. You are now very clear that if there is a risk of spray—of someone, for example, coughing droplets—the healthcare worker should wear goggles or other eye protection. At the moment, there could be up to 500,000 people infected around the country, if it is still about 1,000 cases for every death. That is a lot of people. This would apply not just to people in ICUs or the covid-19 cohort areas; it would apply to GPs, district nurses and people in A&Es as well. They should be wearing eye protection—is that correct?

Professor Doyle: Again, this depends on the clinician doing the risk assessment in their setting of the exact likelihood of droplet infection in



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the procedures that they are undertaking. Yes, if an aerosol-generating process is being undertaken in that setting, the right equipment should be used, for sure.

Q243 Chair: You are a doctor, and you are the medical director of Public Health England, so it is not unreasonable for me to ask you, given your knowledge of the work done by people done in A&E departments, whether they should be wearing goggles.

Professor Doyle: Certainly they should be undertaking a risk assessment as to the likelihood that they will be within a metre of someone, because that is the droplet distance—a metre is the distance that a droplet travels in. Obviously, doctors who are at close quarters need adequate protection for that, but that depends on the risk. It is not a unified—

Q244 Chair: They are going to be within a metre, and a GP is going to be within a metre of a patient, and a community nurse is going to be within a patient when they visit them, aren't they? So they should be wearing goggles. Can you just give a straight answer, because that is your advice—that there is a risk of droplets. So, just for those three examples—community nurses, GPs and A&E doctors—should they be wearing goggles?

Professor Doyle: If they are in a situation where transmission is likely to occur, of course. Droplets, aerosol and touching are the three ways in which this particular virus is transmitted, and the highest—

Q245 Chair: Okay. Can I just ask Chaand then—I am so sorry—have they got those goggles, those three categories, to your knowledge?

Dr Nagpaul: No. So, the Public Health England pack that GP surgeries have received is comprised of gloves, a mask—a paper surgical mask—and a sleeveless apron. There are no goggles provided. In fact, there are many GPs who are trying to get hold of them online, but the stocks have run out.

As I said earlier, not only that, but we have no other covering of our clothing, and my own practice, as well as others, has tried to buy some online—some surgical scrubs. That is the sort of desperation that we feel, because we have risk-assessed and we believe that we are at risk, and we are risking the health of patients if we are not at least covered and we do not have our eyes protected.

Also, as you said, many GPs are visiting patients at home, very close by. We have now got GPs going into what are called covid hub centres in the community, where patients with suspected covid symptoms are being seen, and they do not wear gloves; we are not even being provided with them.

Q246 Chair: Dr Henderson, do your members have the goggles they need?

Dr Henderson: It is very variable. Rather than wearing goggles, we are wearing visors, and at the moment visors are being worn when we are very close up to a patient in our resus rooms, but we are not managing



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that in our high or intermediate-risk areas. We feel that that would be the most sensible thing to do.

We feel that we need to do this at a higher level than maybe the evidence gives us. We recognise absolutely that the evidence is difficult; we also recognise completely the logistical problems of all of this. But it would be good to hear about the production, and call for manufacturers to be making face shields, visors—whatever you call them—and masks, in the same way that we are hearing about ventilators.

If we can stop the train of transmission by getting all these bits right—we absolutely recognise that it is not just about single items. It is about the whole system. It is about how we take our things on and off, and prevent ourselves from getting infected, and how we use our gowns, how we wash our hands and arms properly, and how we cohort our areas.

Increasingly our A&E departments are pretty much full respiratory. My department started out with a minor division. Now, the whole of our majors area is a respiratory area, and our old observation ward is, in theory, our clean, non-respiratory area. That is not going to last. We just need to assume it is everywhere. We need to have some degree of protection and, in the highest-risk areas—bearing in mind the logistics, that we are in this for the long term and that we need to keep stocks—we should use as high a grade of protection as we possibly can, and absolutely ramp up the production of it.

Q247 Chair: I will bring in my colleagues, but I just want to ask Dr Tanto, if I may, about eye protection. What is your experience on the front line in terms of the availability of eye protection in the work that you do?

Dr Tanto: It is similar to what Dr Henderson has just been saying. For the higher-risk patients, there is an availability of visors—some staff members have used goggles, but visors are the recommendation. There have been issues with the supply of visors, certainly in the early stages of covid-19. I think that is starting to ease.

Much like Dr Henderson's hospital, we are also a major part of the respiratory division in the A&E in the hospital, and the other part is non-respiratory. And much like Professor Doyle was saying, we make a risk assessment of the likelihood of the severity of covid in patients who come in with respiratory symptoms. Those who are walking in are probably seen by doctors not wearing visors, whereas those who are conveyed by ambulance to the hospital with more severe symptoms are visor-greeted.

It would be welcome—I echo Chaand as well—to have a surplus of visors so that we are not having to make risk assessments for the use of visors. It would be nice just to have visors for everyone with respiratory symptoms in the initial stages until we get greater clarity on who is and is not covid-positive.

Chair: Dean wants to come in to ask about eye protection.

Q248 Dean Russell: I was going to make a similar point about whether



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pharmacists and other groups—supermarket workers, for example—who are going to be seeing lots of people should have eye protection. My other question relates specifically to the creation of eye protection. I have seen people popping up on Facebook saying that they are going to Hobbycraft to buy materials so that they can help to make visors and so on. When I have gone into B&Q for DIY stuff, there used to be stocks and stocks of goggles for DIY. Is there any initiative to look at not only going out to factories, of course, but getting people to help from home? They could get the raw materials for building very basic visors, or even donate goggles they have. I appreciate that they would need to be cleaned and properly evaluated, but surely we could get an army of schoolkids who are at home to do a bit of DIY work and build very basic visors, and so on, to help so that we have a surplus. It is the classic thing where it doesn't need to be perfect—it is good rather than great—but even if it is not for the NHS workers, at least it could help the wider groups with visors or goggles.

Chair: Just before I ask Professor Doyle and Chaand Nagpaul to answer those points, Laura also wanted to ask about eye protection.

Laura Trott: Thank you, Chair. I want to echo the comments made by others about the availability of eye protection, particularly for GPs, and I want to be clear that GPs in my constituency at the moment have not received any form of eye protection. When are they going to get this?

Chair: Thank you. Professor Doyle first.

Professor Doyle: Just to go back on a couple of points, the guidance will support the use of eye protection, with a risk assessment as to whether you are likely to get droplets into your eyes, and I continue to support that. I understand the points about, “Could we not just get more supplies?” I know that there is work in hand to ensure that there are supplies and there are millions of these respirators available at the moment, but in the light of what is coming back from the field, this may, again, be an NHS issue that will have to be assessed, but I do not think there will be a lack of willingness to hear those concerns.

In terms of making them, there is another element about this, which is that people do need—as I understand it—proper training to fit them adequately, particularly the ones in the highest-risk settings. If they are not properly fitted and not properly designed for fitting in the way that they are intended to, they do not protect. But I think it is very welcome, again, if people are offering to help and support with this.

Dr Nagpaul: So the difficulty we have is that the World Health Organisation—I have a piece of paper sitting in front of me—is very clear that a healthcare worker like a GP or a primary care physician should be in receipt of protection comprising eye protection, a gown, gloves and a mask. The supplies, as specified by Public Health England and as supplied by the NHS, do not include any eye protection for GPs or primary care workers and they do not include a gown. I know that we are speaking about eye protection, but let us not forget that our clothing also transmits



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and can be a carrier of infection. We are not receiving—it is not even specified that we should receive the protection of the World Health Organisation’s recommendations. For that matter, the same applies in Europe—they made the same recommendations as the WHO—so we seem to be an outlier here, and naturally, not just GPs but nurses in the community are very, very worried that they are not adequately protected.

Chair: I am going to bring in Sarah Owen next and, after that, James Murray.

Q249 **Sarah Owen:** These questions relate to the concerns that Dr Nagpaul and Dr Henderson have raised. The first one is for Professor Doyle. There is clearly a mismatch now between the more optimistic messages coming from the Government and their briefings, to the reality of what is happening on the ground, in terms of the supply of PPE. Chris Whitty had said that supply chains were an issue. How far are we away from clearing up those issues and how is it being prioritised in terms of who gets the PPE first? Is it hospitals? Is it the dedicated covid-19 centres that we are seeing set up? Is it GPs or paramedics? As Dr Henderson said, it is really important for social care workers and primary care workers to have access to PPE. Who is taking the decision on how PPE distribution is being prioritised?

You are the Government representative here, Professor Doyle, so that is why you are getting the questions; we appreciate that. Some of the questions will be outside your area, but if you could help us as much as you can that would be much appreciated.

Professor Doyle: I do welcome this; I will certainly convey it to colleagues who need to hear it as well. To go back to Chaand’s points about the guidance, I accept them entirely. This is not an attempt to undermine general practice. The guidance is more orientated towards the context of what is being done, where the risk is and, particularly, where the procedures with the highest risks are. Whoever is involved in that higher risk, the guidance is very supportive of them having the appropriate protection. It keeps coming back to what one of the other speakers said, which is that risk assessment is very important.

I accept the issue about supplies as well, and the priority there. It is understood that there is a lot of anxiety, not just in hospitals but in the communities and in social work. We accept that those who are at any risk in the community should have equivalent access to protective equipment. It is not as if the health system in a particular setting is more important than the social care setting. That is definitely a challenge, but it is an accepted one.

Chair: Okay, thank you. James Murray and then after that Rosie Cooper.

Q250 **James Murray:** I would like to ask two questions. The first question is to Dr Tanto, particularly given his experience working at Northwick Park. Northwick Park serves many people in my constituency, so a particular thanks to him and his colleagues for the work that they do there. We know that Northwick Park declared a critical incident at the weekend and



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that on Tuesday over a quarter of the deaths registered in England from covid-19 were in the London North West Trust. From Dr Tanto's experience on the frontline, does he have a view on why the numbers from Northwick Park and from the trust that it is part of are so high? Obviously, that is a concern for people living locally. What can we learn from that in terms of the general response to the covid-19 outbreak?

Dr Tanto: I think there are two issues about the statistics. The first is a hospital issue and the second is a geographical or territorial issue. The hospital issue is that Northwick Park is a centre of specialty for infectious diseases. There are some notable clinicians who work there. The consequence of that is that Northwick Park has taken covid patients from other parts of the country to Northwick Park for infectious diseases treatment. I think, by definition, they will be more ill than elsewhere. As we all know, patients who are more ill have a higher risk of mortality.

In terms of territory and geography, the Harrow-Brent area of north-west London has a significant number of houses in multiple occupation. With that, you have non-family households in probably small-ish housing stock, with people at Heathrow and in service industries. There is a lot of comingling. There is also quite a large number of intergenerational households, where you have grandparents, parents, children and grandchildren all living together. Again, there are the confluence points of interdependence of exposure to covid in the community, mixing in the housing and out from that. Those issues allow for greater penetration of covid in the area resulting in a greater number of covid patients presenting at Northwick Park, which is the hospital there.

We also have quite a high degree of frailty in our community of Harrow-Brent. There are a lot of patients with heart and lung conditions. We have a respiratory team of excellence at Northwick Park. People who already have respiratory conditions will be slightly more vulnerable to covid infection, and that adds to the statistics. The critical incident happened because there was a surge requirement for intensive care beds. The hospital is making more intensive care beds available from its baseline. As that comes on stream, we should have less of a surge, but there will certainly be increased demand over the next weeks to a month for intensive care beds, so we are in a difficult situation.

Q251 **James Murray:** I have a quick question for Professor Doyle. We heard from Keith Willett last week about the NHS being able to draw on the pandemic influenza stockpile for certain elements of PPE. Thinking about his comments, it struck me that if you had such a stockpile, you should naturally have a distribution chain to get that out quite rapidly, but the problem seems to be the lack of that rapid distribution. Why would we have a pandemic stockpile of certain elements of PPE, but not the distribution chain to go with it?

Professor Doyle: That is correct; the pandemic stockpile is being used. This is complex logistics, and I do not pretend to fully understand the answer to your question. I think it is partly about the uneven distribution of the cases themselves. We now concede that the analysis of both cases



and deaths by region shows different patterns at the moment. It may simply also represent where trusts particularly needed additional supplies that perhaps they had not realised they needed before. It is difficult to answer the question, but there is a distribution chain, and in fact, press releases went out saying, "This is how it's going. If you can't get access, ring this number." I think that improved matters, but we are still not completely there.

Q252 **James Murray:** That was very helpful, but just to understand a very specific point, there is this pandemic stockpile of certain items of PPE ready to go; was there a special rapid distribution plan for that stockpile?

Professor Doyle: Yes, I believe so. Again it is something that I am not involved with day to day. It would work through the NHS, but yes. I think the distribution was ramped up considerably when it was realised that certain places were not getting what they needed.

Q253 **James Murray:** Okay, so there was a rapid distribution plan, it just has not worked.

Professor Doyle: There was a distribution plan, but no plan survives battle when it becomes clear where there are different levels of supply already in stock. I think that is maybe what happened, but I cannot answer any more than that I'm afraid.

Q254 **Dr Evans:** I have two questions. The first is for Chaand and the second for Yvonne. Chaand, I spoke to my CCG yesterday, and there seemed to be some confusion from GPs about the best models. Does the BMA have any suggestions on whether hub and spoke models/PCN models should be working? Do you feel that the guidance is clear enough about how to use resources? If you had three practices close by, setting one up as the covid centre with PPE may well allow you to carry on normal GP activity and also covid-19 activity. Does the BMA have any position or thoughts on the continuity of the message that is coming through?

Dr Nagpaul: It is so good that someone has raised the fact that there are many ill people out there who are not covid sufferers, and the health service must provide its services to all of them. We think it is important for GP practices to be clean areas so that the patients who come into our surgeries feel safe and that they are not mixing with ill patients with respiratory symptoms. In that sense, a "hot hub" is a very sensible model, which I would support. We do not have a BMA position on it, but we certainly have a position on having clean and hot hubs, so to speak. That goes back to the protection. The GPs in my patch, where we have just set up a hub, are worried about the PPE. It goes back to that. If we could provide those GPs with the eye protection and the gowns to enable them to feel that when they were doing their jobs they were protected, that would enable those hubs to take off. I absolutely agree with you about separating clean and dirty areas.

Q255 **Dr Evans:** Thank you. My second question is to Yvonne Doyle. There are two parts to this. The first is advice on high-risk people. ENT specialists, dentists and ophthalmologists are very close to people's eyes, nose and



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face, obviously. Is there any different advice for them, and special precautions? They really are right on the frontline.

Professor Doyle: Sorry, I was frowning because our fire alarm just went off. Yes, aerosol-generating procedures are reckoned to be part of dentistry; indeed, there is a list of procedures, and it would include anything in ENT involving suctioning and certainly anything respiratory—a list of respiratory procedures that are reckoned to be very high risk. In those circumstances, the full PPE should be worn, including FFP3.

Q256 **Dr Evans:** Thank you. To follow that question up, because I think this one is really important, can you be clear on the advice? If someone is exposed front-up—a GP looks into someone's throat and that person does have covid-19—what should be that clinician's response? Are they to self-isolate for 14 days? Are they to go for seven days? The worry is that the workforce do not know how to react to this, and I am not sure that the message has been clear. I was on a phone call with the police yesterday. They face a similar thing; they are getting people spitting at them, saying, "I've got covid-19." I do not expect you to comment on the legal aspect, but if this is happening, what is the advice for someone who has been exposed? What is significant exposure, and what should the advice be?

Professor Doyle: Droplets and aerosols are significant exposure, for certain, as is touching with hands that may be contaminated, which is where the washing hands thing comes in. For healthcare workers, people do not isolate unless they have symptoms. If they have symptoms they definitely need to isolate, and they isolate for seven days. The 14-day period is where families are in touch—I do accept that this can be confusing. It does take people out of the situation, and it comes back to the issues of testing, which we fully accept. Fourteen days is when a member of your family has been exposed and is symptomatic. The reason for that is that by the time you actually get to be in contact with them, you may be incubating the condition yourself, and that gives you another seven days. It does end at 14 days. But for people in healthcare settings, the advice is: if not symptomatic, don't isolate.

Q257 **Dr Evans:** Can I be crystal clear on that? If I am a GP and I see a patient who gets confirmed covid-19, what is the procedure that I should follow?

Professor Doyle: There is a risk assessment. If the person has been deemed positive, you will need to be followed up carefully to ensure that you do not develop symptoms. I think the advice would be to watch for symptoms, and the most important symptoms are fever and cough. At that point, the assumption is you should immediately self-isolate.

Dr Evans: Thank you. I think Chaand wanted to come in.

Dr Nagpaul: I just want to understand the logic there. We have had many doctors who have been worried that they have been in contact with covid-19 patients without protection—the example you have given. If you are waiting for the symptoms, in that intervening period you could be passing on that infection in the incubation phase. How does that tally with



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the advice we are giving around self-isolation if a member of your household has symptoms, let alone being covid-19 positive? Is this not resulting in the risk of spread by healthcare workers who do not self-isolate after contact with proven covid-19 patients?

Professor Doyle: Again, I understand the difference here. This is a balance between the healthcare worker's understanding the level of risk and remaining at work. We have certainly taken advice from clinicians on this. Somebody in the lay community may not, and we are overly precautionary, particularly in the family setting. But I do understand that it sounds different.

If people are uncomfortable—certainly if they are at high risk—about continuing to work, and certainly if they are developing symptoms, they should self-isolate. So this is not absolute; it is the best guidance in circumstances where we are learning about how the virus behaves, particularly before people are symptomatic.

Dr Henderson: I have enormous sympathy for the GPs' position, but to a certain extent a GP's surgery can decide what rules it is going to play by and what kit it is going to get; I know that some stuff is being sent out, but the surgery can make certain decisions. Emergency departments at the frontline of the NHS have to follow the central guidance.

We have hospitals where it is being said: "You must follow the current guidance." We do not have the option to risk-assess, perhaps, in quite the way being described. We have the kit available—that is the kit you have got available. We are to a certain extent trying to make sure that when there is a risky situation we get kit that is appropriate, but basically we have had people being told that there will be serious consequences if they do not follow PHE guidance as regards kit.

We do not have the luxury to go, "Oooh—this is a bit more high risk." We need to just protect everybody as much as possible proportionately from the beginning, so that everybody has something, and then be able to ramp it up when infection becomes apparent.

Currently, the resus room of an A&E department is not even thought of as a high-risk area unless there is an aerosol generating procedure going on—at which point, yes, everything is being followed. But we are not doing those in single rooms; these are now in open areas.

So there is a problem with proportionality, with risk assessment and with how we communicate to staff how at risk they are. We need to be able to know that there is going to be some protection for everybody who is coming into a hospital or having an encounter with a healthcare worker, and we need to understand that the nervousness that we could become part of the problem as well as of the solution is real.

Q258 **Paul Bristow:** There has been a recent downgrade in PPE requirements from WHO standards, and this is outlined in a document called "COVID-19: Guidance for infection prevention and control in healthcare settings".



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If the evidence for the downgrade is there, why do you think so many NHS staff are unhappy? Why do they not believe Public Health England?

Professor Doyle: Thank you; that is a really key question. The downgrading was not an attempt to underestimate covid itself, but was really a learning about how it is behaving, which looks much more like flu than some conditions like Ebola—initially, people were not certain about how that virus behaved.

The assumption has always been that 80% of people will actually get better, and very quickly—from seven days onwards—and that there would then be a severe tail. When that was better understood, the four countries—it was not Public Health England but the four devolved Administrations and the NHS, in conjunction with the right expert committees—took the view that it was proportionate and reasonable to change the status from high-consequence infection to the status it has at the moment. But the equipment and guidance in relation to that does still very much approach where the risk is likely to be.

We have taken advice collectively between the NHS and Public Health England on that again, and we will continue to do so. So it is a risk-based approach.

Sorry, your question was—

Q259 **Paul Bristow:** It was about why so many NHS staff don't believe you. I can tell you first hand what I have heard. Quite honestly, people believe that Public Health England, or at least the NHS, realised that there was not enough FFP3 kit to go around, and that was the reason for the downgrade.

Professor Doyle: That is very helpful to say, because that was not the reason for the downgrade. Again, this is a learning experience for everybody, and I absolutely accept that how the public behave and what they are feeling anxious about is something we have always felt would be part of the learning from this epidemic. That continues. This is not for ever. The guidance is reviewed regularly in the light of practice, and I am sure that will continue to be the case.

Why are people anxious? I think there is a complex set of reasons for that. Partly, it is the unknown; partly, it is the real problems that people have experienced, maybe in getting supplies; and, partly, it is unfamiliarity with day-to-day infection control.

Q260 **Dr James Davies:** My question is about communication above all else. I read the documentation from the public health bodies of the UK, but a lot of people out there, in the community in particular, do not really know what they should be wearing. For instance, occupational therapists are still wearing their usual uniform, with no form of protection—admittedly, this is in north Wales, not in England—and community nurses are doing the same. They feel very much on their own. What I have not seen is simple guidance, with a flow chart or graphical illustrations, for the hundreds of thousands of people going into homes daily, for social care



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and so forth, so that those people know whether they are doing the right thing. Are they being given the support they need from those around and above them? They are in a different position from those in hospitals, where there are often supported teams and infection control support to hand. That question is to Professor Doyle but does Chaand Nagpaul agree?

Professor Doyle: Absolutely. Actually, Public Health Wales was involved with the guidance and will continue to be so. This is absolutely right: communication, training, and making it easy for people to understand what to do, rather than every profession having to have bespoke guidance. Trying to get out there what circumstances, in your professional practice, you could you be at risk in is by far the better way to do this, but it needs much more education and opinion leadership than we have at the moment anticipated. I completely accept that, and I think that the clinicians involved in all this would accept that too.

Public Health England has commissioned some support to add to other training, and it has done posters on donning and doffing—the greatest risk is taking things off, so taking it off in the wrong way and self-contamination. That is stuff on which we will continue to offer support. I accept your point—I think it is right. Communication is paramount.

Dr Nagpaul: I wrote to Public Health England yesterday, and I maintain that the guidance and equipment offered in low-risk situations—if we can call general practice and A&E front-end low risk—is still not the same as that recommended by WHO. I would like a clear answer to that.

I also agree with the comment that we are working in a health and social care system. The plans, increasingly, are for patients to be seen in the community—to discharge from hospital earlier—and I worry about our community nurses, and about the volunteers and social care workers. They also must have proper protection. They are equally at risk, not just themselves, but also of spreading infection.

When I speak about protection, I am speaking for doctors, but I am also speaking for the wider healthcare and social care communities, who have expressed exactly the same concerns.

Q261 **Chair:** That is a very good point. Will Professor Doyle tell us about that, because this is the question that Taiwo Owatemi wanted to ask: what are we doing to keep those 400,000 volunteers safe, in terms of protective equipment? Also, a question from Sarah Owen: what work are you doing with care companies and care homes to ensure that they get the right advice and the right equipment for their work in the community?

Professor Doyle: If the volunteers are for the NHS, I think the answer to that is that the NHS, with our support, will need to consider in what circumstances the volunteers are deployed, what the risks are, and indeed what the protection for them will be. That would be a huge and massive logistics exercise, to make sure we get that right and to give people the confidence to keep volunteering when they generously offer to do so. That will be work in hand, because this is very recent. It comes back to the

circumstances of exactly what they are being asked to do, how risky that is, and how much risk that incurs for them.

We have provided guidance on social care, for people working in the social care setting and, indeed, for informal care. As I said before, we accept entirely that social care needs good consideration, according to the risks that they have, alongside other frontline workers. There is plenty of advocacy for that within the system, so I assure you that we do not lose sight of that. Again, it is what is appropriate for the risks that they are facing, particularly in care homes. I understand that point.

Chaand, yes, just to acknowledge, we did receive your communication, and we will be responding appropriately and fully to that. Thank you for it.

Q262 **Chair:** I want to wrap up, because we need to move on to our second panel. I have one last question. I know that you cannot give me an answer now, Professor Doyle, but will you make a commitment to get back to us by the end of tomorrow on when GPs will get eye protection in particular, but also the gowns that they need, so that we can get to the bottom of it? This is obviously a huge concern. We also want to know about community nurses and other healthcare professionals, but particularly for GPs—not just because Chaand is a GP, but because it has been raised by so many people. Will you talk to your colleagues in the NHS and in the Department of Health and Social Care, and get back to us with a very specific answer about when we will ensure that all surgeries have all the equipment, including the eye protection, that they need?

Professor Doyle: Yes, Chair, I will do that.

Chair: Thank you. It has been a longer session than we planned, but these are very important issues. On behalf of the Committee, I thank you, Professor Doyle, for answering so many questions on such important issues. Thank you for your patience in answering those questions. Dr Nagpaul, Dr Tanto and Dr Henderson, thank you, too, for joining us—very important questions. We will now take a five-minute break.

Examination of witnesses

Witnesses: James Bullion, Professor Martin Green OBE, Emily Holzhausen OBE, and Sarah Pickup.

Q263 **Chair:** Welcome to the second session of our Health and Social Care Committee sitting focusing particularly on testing and PPE. For the second half of these proceedings, we are looking particularly at the social care sector. We are extremely grateful to have Sarah Pickup from the Local Government Association, Professor Martin Green from Care England, James Bullion from the Association of Directors of Adult Social Services and Emily Holzhausen from the Care and Support Alliance.

If I could start with a few questions, then I will pass on to my Select Committee colleagues. James Bullion, if I could start with you: what



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guidance has been issued to social workers about protective equipment?

James Bullion: Thank you for the opportunity to participate in the Committee's meeting. In terms of the pieces of information that have gone out to social care in general and social work specifically, we have obviously had guidance for home care, residential care and supported living settings, and we are currently finalising guidance for personal assistants—in other words, individuals who employ a PA themselves.

In all those sets of guidance, there is a section on local government and how care workers and social workers work with people in those care settings. In addition to that, in relation to the other major item of guidance relating to the Care Act and the Care Act easements, there is an ethical framework that we have published specifically in relation to how social work works.

In all four pieces of guidance that have been issued, there are sections on how to work and a little bit of information about personal protective equipment and what you should and shouldn't do. I have to say, though, that we have mainly referenced out from that guidance to the general Public Health England guidance on what you should and shouldn't do about infection control and PPE. I have to say, though, that the experience of councils and, locally, social care providers is that the delivery of PPE, as is well known, has been extremely erratic and difficult. We have sent guidance out, though.

Q264 **Chair:** Can I ask you a very specific question? Given the high risk and vulnerability of residents in care homes, and given that the people who are doing an amazing job looking after them are going home to their families at the end of the day, shouldn't care home workers wear protective equipment just as a matter of course, to avoid the risk of passing the virus on to highly vulnerable residents?

James Bullion: What we have tended to do is to follow the guidance from Public Health England, and so far that has not said PPE for general care—only for when either a person is symptomatic or there is another reason to do that in relation to other infectious illnesses that they might be working with. You mustn't forget that also out there at the moment is flu and other IC issues.

Q265 **Chair:** Do you feel comfortable that you have not had guidance for people in care homes to do that?

James Bullion: I certainly recognise that among both social workers and social care workers, and patients or service users, there is a certain amount of assurance required that PPE does deliver, but I have to say that, given the stocks that most councils and care providers have got, it might be impractical at the moment to go for that level of prevention or protection, if you like, which would be beyond the current guidelines.

Q266 **Chair:** Can I just bring in Professor Green? Public Health England say they are going to issue PPE free to support compliance with their advice. You speak, I suppose, for 300,000 care workers working in care homes. Have



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they received that equipment yet?

Professor Green: At the moment, we are in the process of it being rolled out. One of the concerns people have is that they are starting to receive the equipment, but they feel worried—when that equipment has been used, where is the next tranche coming from? We have also heard that the things some of my care members ordered some time before this crisis are being taken at the borders for the NHS.

We have a situation where even the normal areas of supply are not getting through, and the PPE that is coming through at the moment is only a short-term measure. For example, this morning I heard of one case where one of my providers got a letter from their normal suppliers saying that they would not be providing—[Inaudible]—anymore because those were all going to the NHS.

If we have a national stock, we must make sure that it is cascaded right across the system. Obviously, the NHS has needs, but so does social care. You made the point at the start, Chair, that the people in social care are all in the highly vulnerable category, so we have to focus a lot of our attention on social care services.

Q267 **Chair:** Let me ask you a question: in the session that we have just had, Dr Chaand Nagpaul of the BMA said how he felt very uncomfortable that the advice to doctors who have had exposure to a covid-19 patient was still to carry on treating other patients until they showed any symptoms. That advice is the same for the people working in care homes, so if a resident gets covid-19, the people who have been looking after that resident are, at the moment, still supposed to carry on working until or unless they show symptoms. Do you feel comfortable with that advice, given the vulnerability of care home residents?

Professor Green: I would not say I am comfortable with the advice, but I think we have to recognise that we are in uncharted waters and this is a complete emergency. If we have our staff going off and following the advice, which is to self-isolate, we will then have a major problem in care homes. This really plays into the fact that we need to have testing. We need to know exactly who has got covid-19 and who has not, so that we can bring people back into the workforce. You made the point at the start, Chair, and James made it as well, that this is also heavily reliant on having the PPE required, so that if people are in that category, they can make sure that they are able to have infection control.

Q268 **Chair:** I have a couple of brief questions for Sarah Pickup. Thank you for joining us, Sarah. Under the Coronavirus Act that is now becoming law—or is about to become law today, if it has received Royal Assent—as a local authority sector you will have the power to meet statutory care needs, but not the duty to meet them. Do you anticipate reducing the number of people that the local government social care sector will be helping?

Sarah Pickup: Thank you for the question. I do not think that we do. Obviously, the real issue here is that—[Inaudible]



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Q269 **Chair:** Sarah, I am so sorry; I think we are having a bit of trouble picking up your line. I am sorry, but we probably need to ask you to log out and log back in, because we cannot pick up what you are saying. I am very sorry about that.

Can I bring in Emily Holzhausen? What are your comments about the way your members are responding to the covid-19 crisis? Do you have any particular concerns?

Emily Holzhausen: Sure. Just to clarify, the Care and Support Alliance is about 75 charities, some of whom are providers of services—voluntary sector providers—and some of whom, like mine, do not provide frontline services but represent people who care. It is worth recognising the level of anxiety among disabled and older people and their families, trying to follow Government advice at a very difficult time.

I want to raise a number of things on behalf of disabled people, older people and carers. One of those things is that they are having to make some of the most difficult decisions of their lives. To give you an example, there might be somebody working in the NHS who has to come home to somebody who is on the shielding list, and they have concerns about PPE and about transferring it and infecting people.

People are wondering whether they should give up work to care for their relative, because they are concerned. People are very worried about people coming into their house and passing on infections. Of course, the services that are so important to people's lives are changing daily, because the availability of other staff is not there. Families and disabled and older people are having to deal with some quite complicated, difficult situations.

From a provider point of view in the voluntary sector, all our organisations are trying to respond as well as we can, with information and advice, to make sure that those really important messages coming through from the Government get through to families and disabled and older people. Most of our helplines are absolutely swamped and our local services are also under quite a lot of pressure in the same way that other services are trying to respond.

There are also some structural problems, such as cash flow, when local organisations have income from other sources and it has gone, and they are trying to manage care. Some have seen an increase in services. For example, if someone needs one-to-one support to go to a day service and that day service can no longer operate because of staffing levels and Government guidance, that person is not safe at home so they need the one-to-one support at home. That instantly changes the ratios and the cost goes up, because otherwise they would be extremely vulnerable.

Q270 **Chair:** Emily, may I ask you a specific question on the basis of what your members are telling you? If you take the most vulnerable people, many of whom, such as older people with underlying conditions and disabled people, will be in the shielding category, and their basic needs, such as



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being able to get up out of bed, being washed and being able to eat, are you getting any reports at this stage—this extreme policy came in only at the start of this week—of people who are not having those basic needs met?

Emily Holzhausen: I am going to go and ask that question directly of all the members. I have not had anything fed through directly. I know through Carers UK's services that people are having to change what they do rapidly, so, for example, with the withdrawal of nurses providing nursing care, the family has had to take over some quite complex procedures to keep somebody not at high risk of medical infection. They juggle work and care, so they do not necessarily live with them. We have other people who do live with them.

I think our worry is people who live alone, whom we do not know and have not necessarily told us. The other worry is how long people might have to manage for. I know people whose services have reduced who are thinking, "Okay, I can manage for a bit." The difficulty is that none of us can tell how long that will be.

I would be happy to go back and ask that specific question of CSA members and provide the Committee with a note.

Q271 **Chair:** Thank you. That is very good. I know James Bullion wants to come in, but do we have Sarah Pickup back now? We do not, so James, you wanted to make some points.

James Bullion: Yes, thank you, Chair. I want to come back to the issue about local authorities, the Care Act easements and the reduction of the duty to a power to provide care. From a social work point of view, in social services we see that as more of an enabling power, rather than a direction to us to cease providing care.

I would expect, as a jobbing director, in my case in Norfolk, that that power be used only where it is absolutely necessary to deprioritise somebody's care in favour of a new person with priority coming through the system, to allow me to act speedily not to have to do an assessment, for example, in a hospital and to not have to rely on a review for changing the level of package. But, all the time, we would expect social workers and other staff employed by the council to be taking a risk-based judgment about whether this is the right to do for this person.

Of course, the category of those most in need, and the shielded groups, will be at the top of our list, but typically, as Emily described, we have shut our local day services—partly for reasons of safety, but also partly as a prioritisation issue—so we need to make sure, as far as we can, that those people who might have a lower level of need none the less have some contact, and some eyes and ears, keeping them safe and keeping them connected to the community.

The power to avoid having to do an assessment is really meant to be enabling; it is not meant to be the scrapping of people's rights, but I absolutely understand, from an advocacy point of view and from a self-



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directed support and user control point of view, that those freedoms to control your own care were fought for very hard by the disability movement and by the carers' movement. As a director, I would only avoid those duties for this emergency. Although the legislation might have a two-year sunset clause, I would absolutely want them back as quickly as possible to get that self-direction and control back to people.

On the numbers issue you raise—will we serve fewer people?—I am not sure we know that. I would like to think we serve everybody in some way that we are already serving, and we may go further and serve more with the community response that we have. But, as Emily described, the nature of the care will need to change for some people, and most people have been very understanding about that change so far.

Q272 Chair: Thank you. We have got Sarah Pickup back, so I just want to give her a chance to come in on that. Also, very directly, the Government is giving local authorities £1.6 billion extra to deal with the social care needs of covid-19 patients. Is that enough?

Sarah Pickup: To answer that very bluntly, I do not think it will be enough in the long run. It is a really welcome sum of money and certainly will help—*[Inaudible.]*

Q273 Chair: I am terribly sorry. We are not able to hear you. I appreciate how infuriating that is, but this is the very first time we have used this technology in the House of Commons. Many apologies.

James, could you give us your take, from the ADASS perspective, about whether that £1.6 billion will be enough?

James Bullion: To echo what Sarah said at the beginning, I do not think it will be enough, but it is a good start. We very much welcome the £1.6 billion for local authorities, but also the £1.3 billion for the NHS. Between us, with one focusing on the "discharge to assess" spending, and the other focusing on keeping the care sector and community groups sustained, we will have a go with that amount of money. But it is already very clear, and I am sure Martin will want to come in on this, that the costs involved in providers taking on agency staff and dealing with sickness, PPE and all of that, are likely to be 30% to 40% higher than the usual rate that we would pay. We are going to have to pay our way out of trouble on this issue, and I think we might have to come back for additional funding.

I have to say that if the care sector was not so stressed by the last six or seven years of the funding regime that we have had, we would be in a much better state. If ever there was a demonstration that social care is our social infrastructure, then this period is a demonstration of that.

Q274 Chair: Thank you. I think we should use this moment to ask you to pass on to all the people you represent in the care sector our gratitude as a Committee for the work they are doing. We fully understand how incredibly important that is, alongside the work of their NHS colleagues, at this time.

I want to bring in Professor Green, but, Sarah, while Professor Green is



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speaking, if you could try to turn your video off, so you are just on audio, we might have a bit more luck. Professor Green, do you have a comment on the funding issues?

Professor Green: Yes. Thank you, Chair. I agree with what James and Sarah have said, but I also think we need to separate this out. For example, it would be much more helpful if we had an agreed figure from NHS England for people being transferred out of hospital who might not have coronavirus and might be ready to discharge, so that we could do that very speedily. Some of the extra money could then be for how we move beyond this particular crisis.

One challenge for care providers is in trying to deal with 343 local authorities, or 44 sustainability and transformation plans. However, in terms of the emptying hospitals bit, all we need NHS England to do is to agree a figure for discharges, and then we will work with colleagues in local government on what to do after that has ended its four weeks, or whatever timeframe is put on it. We have been trying to push for this from NHS England for about the last 14 days, and we still have not got the answer to that.

Chair: Thank you. I am hoping that we might now have Sarah again, with a bit more luck. Sarah, are you there?

Sarah Pickup: Yes, I am. Can you hear me now?

Q275 **Chair:** We can hear you beautifully, so please fire away.

Sarah Pickup: I switched off my wi-fi, so it may be better. It is really important to me that there are two strands of funding—the £1.6 billion going to councils and the funding going to the NHS CCGs to help councils with discharge. We have to think about the entirety of the people who need social care, not just those who need to be discharged from hospital.

We know that we need to work with providers to ensure that they can access staff for all those purposes. Even if we do not fully apply the Care Act, there are still a lot of people out there who cannot manage without support day to day. In agreeing any rates, we have to be cognisant of local differences, local workforces and the different purposes to which we need to put the care workforce.

It is absolutely vital that we all work together. We have been working with the NHS, the Ministry of Housing, Communities and Local Government, the Department of Health and Social Care and the provider sector to try to make sure that we are all sharing all these issues and trying to work through solutions. We have worked with the Care Provider Alliance, the Association of Directors of Adult Social Services and the Local Government Association to put together some guidance for commissioners to look at all these issues about funding.

It is about not just the rate but the speed of payment—payments up front, payment on plan and so on. We need to take a whole range of measures to support providers. It is absolutely vital, but it is unfortunately not simple. Guidance is coming out very rapidly. There is guidance on



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discharge, guidance for commissioners, and I think guidance on fees is coming shortly.

Chair: Thank you very much. I am sure my colleagues will have more questions for you, Sarah. I will bring them in now, starting with Rosie Cooper. Then I will go on to Luke Evans.

Rosie Cooper: Thank you, Jeremy. Sorry, I have been offline, so I am not quite sure exactly which part of the proceeding we are on. I apologise. I have lost you altogether now. I can hear you now. Sorry.

Chair: It is questions on social care provision, Rosie.

Q276 **Rosie Cooper:** Right. How are people in the community being reached? I know a number of people who are self-isolating who are immunosuppressed and have not been contacted by anybody thus far. They are isolated and do not know what is happening. Who is taking control of that? Is it local authorities? Social care agencies? How will that work?

Chair: I will bring in Emily or James. Did you hear that question, James?

James Bullion: Yes, I did, thank you very much. There are a number of ways into this. First of all, those people who already have a relationship with social services or social care are being prioritised, as it were, into groups that need to be contacted immediately or groups that we can work with, through existing providers, to make sure that they are cared for and that issues that crop up are picked up. That is people who have an existing local authority relationship, as it were.

Secondly, the NHS is in the process of identifying, through primary care and community health services, people who need to be shielded or who are vulnerable on the edges of that. That process is now under way, although my own feedback on this is that it is a bit patchy and variable around the country. That process is under way to identify those names and pass them on to local authorities through our local resilience forums for us to intervene with those people and organise the practical response to them, whether it is picking up shopping or prescriptions, or checking that they are okay.

Beyond those two categories of people—those who are known and those who are shielded—there is a broader community response being organised by councils. That is sometimes quite targeted, such as with rough sleepers and homeless people, and sometimes very broad, about encouraging community groups to pick up community needs. With everybody being at home, though, the complexity is how you get the names in one place and then triage them, so in every local resilience forum there is a kind of triaging going on.

Of course, the role of the VCS sector in this is absolutely critical, and I am sure Emily would want to say something about how we respond to that and the role of care providers themselves in reaching out where they can, too. There is a command and control structure around this, and there are the resources to do it—it is about £1.6 billion.



Q277 **Chair:** Emily?

Emily Holzhausen: Thank you, James. This is where the voluntary sector is also adding a bit of value, so I understand, Rosie. There are also a lot of people who are not necessarily in touch with services, as James said. Hopefully they are in touch with local voluntary organisations. I know people have been trying to reprioritise services where something has closed down: they have shifted, changed, brought volunteers in to start ringing round people and keeping in touch, making sure they are okay. My hope, too, is that they have really good links with the local resilience efforts and the forum, so that we can ensure that that is systematically fed in, and really clear routes for those organisations to flag risk where they see it coming in.

Of course, if you are telephoning people, it does rely on them on the other end to give you the answers that you need to know. One of our concerns, of course, is that if you phone somebody with dementia, you may not get a clear answer. It may be very hard to see what the answer is, whereas if somebody goes in regularly, they can see how people are, so it does need a mixed response. The same would be true for people with a learning disability. Organisations are trying to respond to that and ensure that no nobody falls through the net.

Our information systems and communication out from Government, using all the usual channels including radio, have been incredibly important to help translate some of those messages. Of course there is social media, but some of the media that are more traditional have been very important, especially local radio.

Chair: Thank you very much. Luke, and then I will bring in Amy from Scotland.

Q278 **Dr Evans:** My first question is to Emily, if that is all right. The Government put out a call for volunteers to come forward, expecting about 250,000. We have almost 500,000 and we are now getting close to aiming for 750,000. That is a lot of people coming into the service, and I just wondered how you are receiving it, how the people you work with are receiving it and how that is being structured. On top of that, what about things such as DBS checking? A lot of people may come forward. That is both a good thing and a bad thing. I would just like your comments on how you see that actually working on the ground.

Emily Holzhausen: I am really sorry, but I do not have a huge amount of detail about that. I will have to come back with the detail—but what a phenomenal response! It is absolutely incredible, and I am so pleased that people have put themselves forward. I will go away and ask my colleagues how they see that working. Of course things have to work quite quickly and there needs to be a proportionate response, making sure that the people we have operating are bona fide, but at the same time making sure that we get those volunteers out quite quickly. Of course, there will be a number who are already DBS-checked, which is important. Would you like me to come back with a note from colleagues on that?



Q279 Dr Evans: That would be very helpful. My second question is to James and then Martin. My concern is that, given that the people your staff look after are the most vulnerable—we are looking at a 10% to 15% death rate—that is very, very hard for staff to be dealing with. What mental health provisions are being put in place and talked about for people who will literally be seeing a huge amount of death in a care home? I am talking about carers, who may be on low wages. Do they have the resilience? What is in place to support them? If this goes as badly as it could, I am concerned about the effect on people who see this day in, day out.

James Bullion: First, there is a broader issue both with the volunteers and with the social care workforce. As Martin will no doubt say, in the social care sector there is already a vacancy rate of about 10% and a turnover rate of about 30% to 40%, so if we are expecting an expansion of care capacity in the next couple of months, as we deal with this in a sustained way, we will need to bring more workers into social care. Some of those could come from that volunteer pool, but many of them will just come from the employment market and, indeed, other sectors of the economy. So there is this broader issue about DBS checks for both volunteers and the social care workforce.

At the moment, we are working with a process of doing the minimum—making sure that there is an adult first check to exclude anyone on the register of barred individuals, and then getting in one good reference. We are working at a slightly high degree of risk, but none the less making sure that we recruit people in the best possible way. As Emily says, where there they are known to an existing organisation, that gives us a level of assurance.

There is plenty for the volunteers to do, even though the number is really high. Over the next two months, as well as the practical things we can think of like shopping and prescriptions, all kinds of stuff will happen around people's homes and houses that might need a bit of intervention or support from local voluntary groups or volunteers.

On the mental health issue and staff care, that is really important. We need to adopt an approach that is for the long term, as well as recognising the heroic efforts that people are making. We have switched to an 8 am to 8 pm, seven-day working week in most local authorities, and that means we cannot wear people out. We have put in place some resilience measures in local authorities around both counselling or debriefing for difficult situations, and trying to rota respectfully, so that we have a four days on, three days off type of approach.

Q280 Dr Evans: James, can I pin you down on that bit about the difficult situation? That is my concern. If you are working in a residential home, looking after 300 residents, all of whom are over the age of 80 and very vulnerable, and the virus gets in, a 10% rate will be very, very scary—and that is 10% generally, let alone for the people there. Could I press you a little on whether you have been given any provisions or anything about that aspect?



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James Bullion: In the guidance we have given ourselves, we have given a profile, as it were, of what the impact of covid-19 might be on people infected and the numbers of people who might die. The social care sector is used to dealing with these issues. Every year, we have about 600,000 deaths, so in our sector we are quite used to dealing with that. It is the compression of all of that and the changes in terms of dignity and bringing in other family members—the usual arrangements you might have around someone sadly passing away. It is more those issues that will be more difficult.

Chair: I am going to bring in Martin to answer this question, then go on to Amy.

Professor Green: Those two points are well made. Just as James has said, on issues around volunteering or indeed staff and DBS checks, we are not going down the road that we would normally go down, but we are taking every possible measure to make sure that people are safe. We are doing that quite reluctantly, but we feel we have to because there is a real need. We have also reached out to people like the retail associations and the hospital sector, because we know that there are people in those sectors who will quite happily transfer into social care, so we have been doing some of that. We have been trying to make those processes as seamless and as quick as possible, so that we can get the necessary people into care services.

The issue you raise about people's mental health and resilience is really important. As James said, we have done our level best to try to put in measures that will support people, but the reality is that we will probably be in a situation where we have lots of people who have built relationships with people who die. This is a challenge in social care at the best of times. People in residential care settings have co-morbidities. Many of them will be at the end of their lives, so people have that challenge on a day-to-day basis. I appreciate that it will be really compressed in this situation, so one of the things that we have to do is to get enough time for people to have support and to reflect, and, as James says, to look at the rota situation. We also need managers to be really mindful of identifying people who they feel might need extra support. There are things in place, but they are not going to be perfect.

Q281 **Amy Callaghan:** So the question I am asking is probably directed to both James and Emily; it would be appreciated if either can answer it. What is your view on visitors to care homes? I will frame that specifically with the notion of protecting the vulnerable residents of the care home and the staff working there, but also with the obviously very difficult situation of many people having relatives in care homes who are perhaps at the end of their life. They are really struggling with the idea that they cannot visit them.

Emily Holzhausen: I think it is one of the most difficult things that people have to deal with, and families are generally dealing with it and trying to keep contact. Care homes are also trying to keep contact with the families where they can, and some of them are being wonderfully



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innovative. Families are very aware and very worried about their taking something into a care home, and they are painfully aware of what reduced contact does for the health and wellbeing of the people who they love and care about. I know it is one of the most difficult times when they have to deal with such situations. I don't know whether Martin or James want to say anything more. We are dealing with unprecedented times.

James Bullion: As Emily says, I think families themselves have the greatest level of concern about not visiting their relatives. I suppose we need to enforce the measures that we have in place now. The Prime Minister was very clear about what families should and should not do. Having said that, however, we know in our hospitals whether someone is very ill and at the end of their life. Some innovation about how you bring people close but not too close—such arrangements have been utilised on occasions, and it is as much about protecting the family as well as the vulnerable person. It is a very difficult and unprecedented circumstance that we face.

Chair: Do you want to come back on that, Amy?

Amy Callaghan: No, I just want to thank our witnesses for all the work that they are doing to help families that are in this situation. It is much appreciated.

Chair: I am going to bring in Laura, then Paul Bristow.

Q282 **Laura Trott:** Even before this pandemic, one of the big issues—you all know much more about it than I do—was social care discharge. That will obviously need to be addressed, to a heightened extent, during this crisis. What needs to be done to facilitate that? This question is probably best directed to Sarah and James in the first instance.

Sarah Pickup: I think we covered a little bit of this earlier—I don't know whether you were able to hear it, Laura. What is really critical is the capacity in the care sector and looking at things that you would not normally be able to access. There are a number of things that will help. There is the funding that has gone through CCGs but is for joint use, which therefore takes away the dividing line about who is paying for what. There are the flexibilities from the Care Act, which mean that we do not have to do financial assessments or detailed care assessments. We can do work on payments to providers, to enhance fees—Martin has already talked about the importance of that—and to ensure that providers can get enough staff. And also to look to new sources—for example, there are a number of care home placements that councils do not normally access because the fees are too high, and we can work in this crisis to access those in the same way that the NHS is accessing private hospital beds. But I think the key really is to have staff to help people go home and to work with unpaid carers and families to make sure they have got the right support. The key thing is that we—the providers, the NHS and councils—have all got to work together to get people out fast. All the freedoms and flexibilities that have been put in place will really help with that.



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James Bullion: I absolutely echo what Sarah said around the funding, the flexibilities, the payment rate with providers and having a single model where everyone is joined up, and where the care providers are brought into that model as an integral part of it rather than just being transacted with. I think that will allow us to maximise what is out there in the market. I have to say, though, that during the time of surge—whenever that comes—the current capacity of the care market may not be enough on its own. So we may get into, and most local authorities are beginning to look at whether we should be thinking about, hotel facilities—or, in my case in Norfolk, holiday park facilities—where we may need to put people who can be competently cared for until the capacity in the care market is there again, because there is a high degree of compression in the discharge arrangements. But I have to say that NHS England, ADASS, DHSC and the Care Providers Association are working very well together on this model.

Q283 **Laura Trott:** As you outlined, there are clearly supply-side constraints, which are being dealt with through money and other aspects that you talked about. Sarah, you mentioned flexibility in the Care Act. Are there any additional administrative hurdles that should be addressed by Government? To give one example, I have been talking to doctors who have said that they need to give patients only one choice of discharge destination, but there is not clarity on whether they have the legal right to send patients to a care placement without a court order protection. Are there issues like that in the system that the Government need to address?

Sarah Pickup: I think there is clarity that the choice directive is essentially paused during this period and you can require people to move to a place where they can be safely cared for because you simply cannot have hospital beds used by people waiting—and on the whole, people will absolutely understand that. Of course, in the vast majority of cases, the place people will be going is home. The majority do not need a choice of bed; most people will be going home and will be cared for there, subject to the capacity in that care provider market. So we will need to keep an eye on those administrative hurdles and make sure we overcome them. Even where we have action in place, like the sharing of data around the 1.5 million vulnerable people, it is agreed, but it has not been done everywhere. So there is something about making sure that everything happens in every place and there are not some people lagging behind the curve in enacting what is available.

Emily Holzhausen: I just wanted to speak from the perspective of the people going through that process. The changes that the Government have made and the funding actually take away a lot of the complexities that families have to deal with at hospital discharge around financial assessment, which can be extremely stressful. In fact, making some of those services free at the point of delivery frees up some of that pathway. So we absolutely welcome that.

I want to say that these are people moving through. I very much hope that our colleagues in local government and providers will still try to take on people's preferences and views and make sure that they are involved



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as well as their family in the difficult decisions they might have at a very pressurised time, so that we get the best for people.

Professor Green: We have some new care homes coming on stream and we have been in touch with the Department, because some of those can be used as isolation units for people with coronavirus. We have linked to various hotel groups that have offered significant numbers of hotel beds, if those are necessary. Also, we have linked to people like Sixt car rental, who provide cars for transport. Oomph!, a group in the care sector that provides minibuses to transport people out of care homes, has turned that to be available to deliver staff if we have to move staff around. So there has been a really great effort by lots of different people in the system, by colleagues in the local areas and by businesses associated with the sector, which are coming forward to offer some really tangible resources.

Q284 **Paul Bristow:** I know we have touched on this already, but I want to talk again a little bit about PPE and testing in the care sector. I have been contacted by a hospice in my constituency on several occasions. They are telling me that they are still expected to admit patients with symptoms, but they have a very limited supply of PPE and no testing capabilities at all.

Do you accept this about PPE and testing? Is it your experience that they are really two sides of the same coin for social care staff? With rapid testing, staff would feel more confident about lower protection, and if everyone had the appropriate PPE, slow and patchy testing would be less of an issue.

Chair: Who do you want to put that question to, Paul?

Paul Bristow: I think that first and foremost Sarah Pickup would be good, and then anybody else who wants to chip in can do so.

Sarah Pickup: This is a really big issue, and I know Martin will want to say something about it. Access to PPE—we referred to this at the beginning—is insufficient in the care sector. The Government have been doing their best to get things out to people, but it is very, very difficult to have enough. If you think about a situation where you're a care home with a set of people—residents—who do not have the infection and you are at risk of bringing in someone who could bring the infection into the care home, and there is the lack of testing and the lack of PPE together, you can see why there could be some difficulty or reluctance to do that.

I have heard from care homes that have said, "Look, we can do barrier nursing if we have the kit and the testing and we know who is positive and who isn't. We can make that work, but it is a big challenge." We know that there is a lot to do and there are a lot of people in need of PPE, including people outside the care sector, like the police and mental health workers. We really have to get the flows of equipment going, and testing, as soon as that is practicable.

Professor Green: I absolutely agree with Sarah, because we have to have the testing and the PPE. If we have both, we will be able to balance

how we manage this process. For example, there are care homes that can really easily, if they have the right equipment, do barrier nursing and isolation. Within a locality, you could identify the number of care homes that were able to do that. But if we had testing, you would send people who had had the coronavirus to those care homes and send people who had not had the virus to other care homes. It would really help us to make sure that we had enough facilities and capacity within the local area. Both testing and PPE are essential. In a way, they sit hand in hand. We have to do both.

Chair: Paul, do you want to come back on any of those points?

Q285 **Paul Bristow:** Not specifically on those, but I do have a second question to ask, if I may, Chair. I am interested in how we improve the morale—I think Luke touched on this as well—of social care staff, because the staff who work in the social care system are at the frontline of the crisis and their morale is a key factor in ensuring the wellbeing of the people they provide for. Rather than just, obviously, saying thank you and making sure that we recognise everybody—today, at 8 o'clock, the country wants to have a clap for NHS staff—what we really need to be doing, I think, at the same time as doing that is to value the social care staff and the work that they do. That is not often put out there. Emily, you might want to comment on that. It's parity of esteem I'm looking for.

Emily Holzhausen: Absolutely; I could not agree more. Every time someone says, "Our NHS staff are doing an amazing job," I can hear myself saying, "And social care. And social care." I say to all of you, who are leaders and do quite a lot of media work, that just hearing that over the airwaves and seeing it in print and online, consistently, about the NHS and social care would make such a difference. Wouldn't it be fantastic if we could raise the profile like that, and even have a separate shout-out to all the social care staff who are supporting our families, disabled people and older people, and carers? It would really help to raise the profile.

Q286 **Taiwo Owatemi:** My question is also about testing. My major concern is what is being done to support staff and residents, and home carers, in terms of assessing the issue, and what support is being provided from local authorities to ensure that the staff and patients are safe?

Sarah Pickup: At the moment, there simply isn't access to testing for local authority staff, for care workers or for people resident or in use of social care. We know that the Department of Health and Social Care has got a priority order, starting with critical cases in hospitals and staff nursing those critical cases.

I also know from being in a conversation with the Secretary of State yesterday that there are a significant number of tests in the pipeline and then there is an order of priority. I know care workers and users of care services are on that list, but I go back to parity of esteem, in a sense, which the previous speaker mentioned. It is really important that those care workers who are in and out of people's homes or people's rooms in a care home, are protected and have access to testing. I don't think there is



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a lack of desire to do it; I think it is a capacity issue, but it needs to be recognised that, as and when that capacity is available, the care sector is one of the places where it is absolutely essential to get those arrangements in place.

Chair: Thank you. Taiwo, did you have another question?

Taiwo Owatemi: No, that was all.

Chair: Thank you. I will bring in Sarah Owen, and after that, James Murray.

Q287 **Sarah Owen:** Thank you to the panel for the information you have given already.

My first question relates to PPE. James, you mentioned already that guidance has been given to care providers, but I want to ask about the training, and how are we ensuring that the right level of training on how to use the PPE is being provided by the care companies or in care homes. We heard in a previous evidence session that this is not just about the PPE—it is also about how to use the kit.

Secondly, on disposal of equipment and PPE—I think this question will be for Sarah—are local authorities being given extra resources to ensure that the disposal of the PPE is being done correctly and to ensure that there isn't further contamination?

Lastly, a large number of the workers within the social care sector will be women and some of those will be pregnant women. What guidance is being given to pregnant social care workers about going into work, when the Government have told pregnant women that they should be one of the categories who are shielding?

Sarah Pickup: I am not an expert on what training is being given. I think there is some rapid training being put in place, particularly e-learning for new workers coming on board, around things like PPE. It is the kind of training that care providers would put on anyway, which Martin can comment on.

In terms of disposal, which is where the local authority role comes in, this is one of the issues we have flagged as having costs. Obviously, we have been provided with £1.6 billion. That is predominantly for adult social care, but it is for all services—it is intended to meet the beginning of all costs, which would include waste disposal.

My understanding with the disposal of PPE and other contaminated materials is that they should be double-bagged and then after three to four days, they are no longer contaminated, so you do not necessarily need additional disposal arrangements, except perhaps for some of the care homes and other providers of care, where there would be collections of clinical waste in any case. I think the funding is expected to come from the core funding.

Chair: Thank you. Martin, do you want to talk about the training?



Professor Green: Yes, thank you Chair. We should recognise as well that care homes do quite a lot around infection control in their daily work. For example, we have in place infection controls for norovirus and other things. A lot of staff are already trained in those aspects of it, and what we need is the equipment. I think that there is a good understanding within care homes, which needs of course to be refreshed. As we get new staff in, because of the fact that we have lots of staff off, we need to have clear and easy ways in which people can be trained to use this equipment. Of course, we do use it quite regularly anyway.

Chair: Thank you, and thank you very much Sarah. James Murray?

Q288 **James Murray:** Thank you, Chair. I have a couple of questions that relate to commitments that Ministers have made about some of the approach overall. I would like to ask the panel members whether, from their frontline experience, they have any view on whether they are being met or not. First, there was a commitment from Ministers to a target that the discharge of people from NHS hospitals into social care settings should make at least 15,000 hospital beds available by tomorrow. In my view, James is best placed to begin the answers, but obviously anyone who has anything to contribute is welcome to do so. Do you get the sense from conversations or feedback that we are on track to get those 15,000 beds freed up, and if not, what more help do you need?

James Bullion: Yes, the discharge to assess process is very ambitious and it does talk about 15,000 beds. If I take my local council as an example, which is Norfolk, we have identified 2,000 potential beds, hotel spaces or other spaces that might be able to cope with our need for an additional 650 beds in our area. I can see that authorities up and down the country will be doing the maths and trying to identify where that capacity will come from. I think that the limiting factor on our success will be the PPE and the providers feeling assured that they can take people either into care homes or back home for home care. That is the first limiting factor.

The second, though, will be the workforce and plugging the gap. There are currently 122,000 vacancies in social care—right now, today. That is a fantastic opportunity for growth, jobs and all of that—it is a good thing in a way—but because those vacancies are there and because we need to expand, they will be another limiting factor on making a success of discharge to assess.

Thirdly, and I will put this delicately, the flow arrangements within our hospitals are still not perfect. We have removed all the bureaucracy, we have removed the funding question, and we have removed some of the legislative factors requiring an assessment, a continuing healthcare assessment or a financial assessment—those are gone—but we still have this flow issue about identifying the people who are safe to discharge. Because those three limitations are there, I think that we will struggle to get 15,000 beds by tomorrow, if I am candid with you, but we will move—

Chair: Do you want to come back on that, James?



Q289 James Murray: I have another question to ask as well, but it is really helpful to understand how we are struggling to hit that 15,000 target, and that is quite a clear message from you, James, about the limitations. One limitation you mentioned was about PPE, and we spoke quite a bit about this. This question relates to a separate commitment that the Government have made to the sector about getting some of the fluid repellent face masks from the pandemic flu stock to care homes and home care providers, so that every such institution will receive 300 face masks by, I think, Tuesday of this week. Again, from your experience and the people you are speaking to, has that been met and how long will it last?

Professor Green: Well, I think it is on target to be met, but of course people are really concerned about the fact that it will not last very long. If we look at the numbers of people in care homes, 300 masks will not last very long, so we need some surety about where the rest of the supply chain is and how we can assure ourselves that we will get those things. There is a particular issue for example, in that there are masks, but there is also the issue of goggles and whether they are available. They seem to be in very short supply, both in the NHS and particularly in social care. This is another reason why we need to have testing. If we knew who had the virus or who was currently infected, we would be able to make sure that we used any of the equipment that we had in the most effective way, so we would use it for the people who were seen to have the virus and so on. Testing, again, is really important in relation to how we use the equipment. The short answer to your question is: a lot has gone out and I think we are on target, but it is the next tranche and how we ensure future supplies that is going to be the big challenge.

Q290 James Murray: Can I clarify that, just so I am really clear? You say that we are on target to meet that commitment for 300 face masks. My understanding was that that was supposed to have been completed by the Tuesday of this week, so, just to be clear, we haven't met that target. Obviously, there are limitations to how long it lasts, and the fact is that we are talking only about face masks rather than about all the other things and the supply issues that you mentioned earlier.

Professor Green: Certainly, we are probably on target for Friday, not last Tuesday.

James Murray: Finally, I have a request of the panel members—we probably don't have time to go into it today—about the Coronavirus Act provisions on the removal of duties and shifting over to a power. I know that a six-month review of the Coronavirus Act provisions will come back to Parliament in due course. From my point of view, it would be helpful if the witnesses attending today could let us know, if they have the capacity to do so, how they think the removal of those duties is playing out in practice and the issues that we will need to raise in a few months' time when it comes back for review in Westminster.

Chair: That would be very helpful indeed. I will bring in panel members in a minute, but I want to crack on, if I may, with Dean Russell and then



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James Davies.

Q291 **Dean Russell:** Thank you, Chair. First of all, can I echo everybody else's comments about social care workers being seen as having absolute parity with the wider NHS? My thanks go out to everyone. One of my relatives uses a carer every day and they do a fantastic job.

My question is about our care for people who are homeless. For a good chunk of the end of last week, I was working solidly with Ministers, Watford Borough Council and a fantastic local homeless charity called New Hope, to try to organise both the funding and the support to enable homeless people to get rooms, to self-isolate. A large chunk of that work was with local hotels. I was very pleased on Friday night when I got a wonderful call from Ministers saying that the money was coming through and the council was going to be able to support that. But now that we are trying to get rooms in hotels, even though I know that hotel chains are working very hard and are under an awful lot of pressure, the sense I am getting, if I am totally honest, is that hotels are probably open to helping NHS staff and people in care, but when it comes to helping homeless people, there is probably a fear that there might be damage to rooms or related problems. I wonder whether that is something that other people are hearing. While hotel chains are opening their doors in some instances—and I am very grateful for that—is there a resistance there?

Related to that, are there other options whereby some people in care homes could go directly to or move for a period of time into apartments in hotels—a lot of hotels have not just rooms but apartments—so that they can self-isolate but also have the workers with them so that they are all living in a similar place?

I have another, slightly different, question about technology. I have been working locally with a technology firm to develop a system so that we can help people on the ground. I manage their processes. We have launched this amazing volunteering assistance, and 500,000 are signed up. I am interested to know your views on the ground about how people are trying to organise, say, street-by-street volunteering support, especially in the social care space and for people who are in need of care, and how that will work and what the machinery of that is. Do we need other systems to latch on to it, like the one I have been working on, or will that all be rolled out over the coming weeks?

Chair: I will ask Sarah to answer the technology one, but James, do you want to come in first on the homeless issue?

James Bullion: This is a really difficult area of work, actually. I absolutely recognise the issue of hotels being somewhat resistant to this, and we have had examples up and down the country of hotels closing and causing homelessness in some circumstances, which is very distressing. Also, from an equalities point of view, rough sleepers and homeless people appear to be suffering from a disproportionate experience of infection and access to health services. The pre-existing inequality in access to services that rough sleepers or homeless people already have is made much worse by



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covid-19, by the perception of those people as well as the scarcity of the service. It is a real problem.

Through our local resilience forums in local authorities, we are beginning to pick this up and make sure that the best practice of some areas—your area sounds potentially like one of those—is moved around the country, but I still think we have further to go in terms of having a model in which people can self-isolate or can be cared for. It is an issue that is not yet cracked, because it is not a resource constraint; it is more of a model constraint about how to tackle an ingrained problem.

Dean Russell: If I may, I will use this opportunity to call out to hotels to please help on this. I was chatting to a homeless man just this week who was telling me they can't get access to public toilets, so they are having to use plastic bags. I mean, it is just horrific, and the reality is that from a health perspective, that is causing a whole load of issues. I would really love to see some collaborative efforts—because the money is there, the funding is there, and the will is there in local councils. We are just not seeing it on the ground or in those rooms, which I think is a real travesty.

Q292 **Chair:** Thank you. Sarah, do you want to address that technology point?

Sarah Pickup: I would just add on homelessness that there was a problem when there was the directive for hotels and hostels to close due to isolation, because that was when some homeless people were put out on to the streets. That has been corrected, and very close work is going on with the local resilience forums across the country to try to address this problem with hotel chains and others.

On the technology point and the NHS app, this is a very fast-moving time and things are happening at pace, not always as co-ordinated as you would ideally like. The NHS announcement about volunteers and how that was going to work was not entirely communicated to the social care sector and the LRFs beforehand. However, people are catching up. The technology behind that will allow matching of needs identified in local areas to volunteers who come in through the local hub, but of course, we have to work out how to tie that up with existing voluntary networks in local areas and all the work that councils have already been doing with their hubs and their helplines to attract volunteers.

What we have to do is work as best we can to use all the resources at our disposal, and make sure that the hubs have access to the volunteers who can help in local areas. I know that is what the app is designed to do, but we have yet to see how that works in practical application.

Q293 **Dean Russell:** Very quickly, am I correct in saying that people who previously perhaps signed up to local and county council volunteering systems should now shift fully to volunteering through the new NHS one?

Sarah Pickup: I hesitate to say they should shift fully before we know exactly how it is going to work, because I do not know whether, for example, councils or LRFs simply have to put a need on the system and then get matched to a volunteer, or whether they will have access to the



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list of volunteers. There may be things where they can deal with it more quickly by going to known and local organisations, so I think we might have—

Q294 **Chair:** Could you perhaps write to us on that one, Sarah? That would be very helpful.

Sarah Pickup: Sure.

Dr Davies: Could I just raise the plight of the over-70s and those in high-risk groups who are often at home and perhaps are not normally in contact with social services? Certainly based on my postbag—which I think has now exceeded 300 cases since this all began, probably a week or so ago—people are asking how they can get their medicines and how they can get their shopping when online supermarket offerings are limited, and perhaps non-existent in many cases. What do the panel feel is the current level of provision for those people? Who do they think should be taking the lead in relation to provisions for that group of people? Should it be top down, or should it be arranged at a local level only?

James Bullion: On the shielded group, those names will be very specifically handed over from the NHS, primary care and the registered lists to local authorities through the resilience forums. Formal contact will be made with those people to set up a regular pattern of checking and practical tasks, such as shopping, prescriptions and so on. They ought to be covered by that, although it will take time to roll out and a rhythm of implementation needs to be got right in some areas.

On the broader issue, the volunteering lists for the NHS scheme and local authority schemes are brought together as one in local resilience forums. We will have to let local areas work out an approach to how they will start to maintain regular contact with people and to put people in contact with others.

In addition to that command and control approach, it is quite heartening to see a kind of blossoming of WhatsApp groups and other local initiatives from people to set up arrangements for who will go shopping to pick up bits and bobs for others. I am sure that that will happen as well as the more formal system. Inevitably, as Emily referred to earlier, for some people—the “hard to reach”—it is hard to access that, for reasons of language, disability or other factors that mean that the usual technology might not work. We will have to do some doorstep work with people to try to ensure that they are okay. That will have to be done in accordance with the PHE guidelines. We cannot do all that on Alexa and over the phone; some of it will have to be in person.

Emily Holzhausen: One of the really important things that my organisation and others have been trying to look at is communications so that people know how medications can be delivered and can try to sort that out for themselves as far as possible, so we can then focus on those who are most at risk. That has worked pretty well for some people. We probably need to look at some of the processes, such as how many people



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can re-order medication and how many can do that online or over the phone. Those sorts of processes, which do not necessarily always go smoothly, probably need to be ironed out. Getting clear information to the public about what they can do for themselves is a really important part of the answer.

Q295 **Sarah Owen:** This question is probably for Emily and Martin. Women make up 80% of the social care workforce and a large number of them will be pregnant. We have seen, and I have had reports of, doctors and nurses who are pregnant being expected to go to work. Is that the same for care workers and is there currently enough guidance and support for pregnant care workers?

Emily Holzhausen: I am afraid that I am not an expert on that.

Chair: Okay, fair enough—thanks for letting us know. Martin?

Professor Green: That is a really important point, Sarah. I do not think that there is enough guidance. For example, some of my members have said to people that they understand that it is a risk so they should stay at home, but others are obviously in the same space as the NHS, saying that people should come to work, in line with the guidance. I think that the guidance needs to be much clearer, because a high proportion of women will be pregnant, so we need guidance on what people should do.

Chair: Thank you very much. I am very conscious that this second session started later than planned, so we kept our panel waiting at this very busy time. I know that the whole Committee would want to reiterate our profound thanks, on behalf of all parliamentarians, to everyone in the social care sector. We completely understand that you are every bit as important as our NHS colleagues, who are also working incredibly hard. We want to send that message through you to the entire sector. I give special thanks to Sarah, James, Martin and Emily for sparing your time this morning. I also thank my Committee colleagues for coming to these two very important sessions. Everyone is free to go, except Rosie, who wants to read a couple of her earlier questions into the record. To everyone else, thank you very much for joining us for this historic first remote Select Committee session.

Rosie, are you there? Do you want to read your questions into the record?

Rosie Cooper: I apologise to everybody because the internet went down a couple of times for me and it was a struggle to get back in.

During the first session, I wanted to ask how we were ensuring that community trusts, mental health trusts and healthcare in prisons are getting their fair share of PPE, because they are the areas that normally lag behind. For community trusts, the people who go into other people's homes are desperate for that equipment.

The second question, which I hope Public Health England and Government officials can also answer, is why Atlético Madrid supporters, who were banned from going to their own stadium, were allowed to travel to



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Liverpool for a match a fortnight ago, potentially carrying the infection to Liverpool? Two weeks later, in Liverpool we now have a spike of infections. I really want to ask: were they asleep at the wheel? It cannot have been a surprise, and it should have been dealt with and stopped.

Another question that I was going to ask—I sort of asked it in a confused way earlier—was about how we are dealing with the interface between the NHS and local councils for people such as cancer patients, who are supposed to be shielded. They cannot leave their homes for 12 weeks; they have no immune system. Is that interface working? My information is that it is not.

Chair: We have read them into the record. Thank you for staying on. We will get better at this as we get more used to the technology. Thank you for joining us, and I hope that you are well.

Rosie Cooper: Thank you—you too. Thank you for kindly letting me do that. God bless.

Chair: Thank you.