HOUSE OF COMMONS

# Public Accounts Committee

## Oral evidence: Readying the NHS and social care for the COVID-19 peak, HC 405

Monday 22 June 2020

Ordered by the House of Commons to be published on 22 June 2020.

Watch the meeting

Members present: Meg Hillier (Chair); Olivia Blake; Sir Geoffrey Clifton-Brown; Peter Grant; Mr Richard Holden; Sir Bernard Jenkin; Mr Gagan Mohindra; Nick Smith; James Wild.

Gareth Davies, Comptroller and Auditor General; Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury; Adrian Jenner, Director of Parliamentary Relations, National Audit Office; Aileen Murphy, Director, National Audit Office; and Tim Phillips, Director, National Audit Office, were in attendance.

Questions 1-121

### Witnesses

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

HOUSE OF COMMONS

# Report by the Comptroller and Auditor General

Readying the NHS and adult social care in England for COVID-19 (HC 367)

## Examination of witnesses

Witnesses: Catherine Frances, Professor Paul Johnstone, Professor Steve Powis, Amanda Pritchard, Rosamond Roughton, Sir Simon Stevens and Sir Chris Wormald.

**Chair:** Welcome to the Public Accounts Committee of Monday 22 June 2020. Today, we are considering work that the National Audit Office has done on the preparedness of the NHS and the social care sector for the peak of covid-19. I want to put on the record the Committee's thanks to the witnesses and the organisations they represent for the enormous amount of work that has gone into preparing for the covid-19 peak.

The first case of covid-19 arrived in the UK, or was diagnosed, at the end of January. The national health service announced its strategy to combat the outbreak on 17 March, and the plan for social care followed in the middle of April, once we had already locked down. That included, of course, the Nightingale hospitals, postponing non-urgent operations, testing, supporting those discharged from hospitals into care homes, and trying to tackle the challenging issues around providing personal protective equipment—the stockpile that was originally there ran down as time ran on. We want to hear from the officials in front of us today about how the co-ordination for dealing with it worked, what lessons were learned, what new measures have been put in place since those first plans, and what you are doing to plan for a potential second wave of infections.

I welcome our witnesses. We have Sir Chris Wormald, who is the permanent secretary at the Department for Health and Social Care; Sir Simon Stevens, the chief executive of the national health service; Amanda Pritchard, the chief operating officer for NHS England and NHS Improvement, or NHSE&I, as it is sometimes known; Rosamond Roughton, who is the director general for adult social care at the Department for Health and Social Care; Catherine Frances, who is the director general for communities at the Ministry of Housing, Communities and Local Government, representing her accounting officer as well as herself; Professor Paul Johnstone, the national director for place and regions, and deputy senior responsible owner for the covid-19 response at Public Health England; and Professor Steve Powis, who is the national medical director, and is recognisable to everybody from the 5 o'clock briefings, as are many of you.

Thank you all for coming. We won't be hearing from all witnesses on every question. I want to welcome you, and I repeat our thanks for the hard

work you have done, but we now need to be reassured that you have learned lessons about what didn't work. Hopefully, you will acknowledge what has not worked, and will answer questions from us about how you are preparing for the next stages. I will ask Peter Grant to come in on what is happening on today's news. Mr Grant, over to you.

Q1 **Peter Grant:** Good afternoon to all our witnesses. It has been widely trailed by the Government that tomorrow the Prime Minister will announce a reduction in social distancing requirements from 2 metres to 1 metre. Is it the intention of either the Department or Public Health England to publish a risk assessment at the same time, so we know that the Government can be held to account for their management of the inevitable risks that will follow any reduction in social distancing?

***Sir Chris Wormald:*** I am afraid you will have to wait for what the Prime Minister says. I do not think it will surprise you that I will not preface anything that the Government might or might not announce in the future. On your general point, it is of course very important that we are held to account for everything we do, as we are through these hearings, NAO Reports and otherwise. I agree with your general point that the Government has to be transparent and accountable, but I am not going to say anything further about what they might or might not do in coming days.

Q2 **Chair:** Does Professor Powis want to come in on the wider issue of the difference between 1 metre and 2 metres?

***Professor Powis:*** No, I don't think I would want to add to what Chris has said. Clearly, as has been reported, SAGE has summarised the scientific evidence, but it is for the Government, as in all matters, to decide policy.

Q3 **Chair:** Professor Powis, we have heard a lot about the Government relying on the science. Do you think that it is always categorically science, or is it often a matter of judgment?

***Professor Powis:*** Well, the job of SAGE is to assess scientific evidence and to provide advice on the basis of an analysis of that evidence, and also to point out where evidence is not strong, and occasionally to help with seeking new evidence where it is required.

Q4 **Peter Grant:** For the avoidance of doubt, I am not asking Sir Chris or anyone else to tell us what is going to be in the Prime Minister's statement. I am just asking for an assurance, given that it is the job of Parliament to hold the Government to account, on the way in which they follow the science. We can only do that if we get told what the science is—not necessarily before the announcement is made, but as soon as possible afterwards.

***Sir Chris Wormald:*** Yes, and of course the Government has been publishing the advice it has received from SAGE, but just to emphasise Professor Powis's point, SAGE advice is exactly that: advice. It is then for Ministers, quite properly, to balance that advice against their wider view of the public interest, and to take decisions accordingly. To state the obvious, science does not deal in categorical yes/noes. It is quite clear that there is

very little difference between 2 metres and 1.99 metres. There is not a yes/no answer to a lot of these questions. As you see when you read the science advice published by SAGE, it sets out a series of balance of risks, and then, as is perfectly proper, Ministers weigh that balance of risks and decide where the public interest lies.

Q5 **Olivia Blake:** I thank all the witnesses for their time this afternoon. First, I want to ask a couple of questions about the NHS volunteer scheme. I want to ask Sir Chris Wormald, and perhaps Simon Stevens as well, what the costs to the Department were of the NHS volunteer scheme, and whether you feel that this is value for money.

***Sir Chris Wormald:*** Sorry, I don't have that number with me, and I don't think it's in the NAO Report. I don't know whether Simon—

**Chair:** Sir Simon Stevens, if you have the figure, that would be helpful.

***Sir Simon Stevens:*** The point of the volunteering scheme is that although you need to put an infrastructure in place to support it, by definition volunteers are giving of their own free time, and the support that the Royal Voluntary Service has provided to more than 600,000 volunteers who have stepped forward has been magnificent. In terms of the grant that the RVS and others are getting to support that volunteering, I am happy to write to the Committee, but I think the key take-home is that this has been an overwhelming response by the public. Those volunteers have been useful not only, for example, in delivering medicines to people at home, like in the pharmacy scheme I saw in Brixton on Friday, but in supporting a much wider range of public services. It may well be that if you have colleagues from the DCMS or the Ministry of housing and local government, they want to chip in, because part of the shielding support that people have been getting has also relied on volunteers.

Q6 **Olivia Blake:** How many of the 600,000 people who signed up were actually deployed as volunteers? Also, does Catherine Frances think that this could have been better organised, and perhaps better value for money, if it had been run through the MHCLG hub scheme?

***Sir Simon Stevens:*** My understanding is that, to date, over 300,000 volunteering tasks have been completed; and progressively, the range of people who can request help from a volunteer has expanded.

***Catherine Frances:*** Perhaps I could come in on the issue of local authority hubs. Local authorities have been able to access the central NHS volunteering mechanism, like other organisations and other charities in their area. It has been an additional resource for them to use, and they have made good use of it, but it has not supplanted other organisations that are operating locally, as you would expect, in individual areas where they may have support networks and charities that work in each part of the country. It has been an effective additional string to their bow.

Q7 **Olivia Blake:** You do not think that the infrastructure that local authorities have for this sort of work would have been quicker at getting

volunteers on the ground, and probably more successful?

***Sir Simon Stevens:*** I personally do not. I think this is "both…and", in the way Catherine has described, and local authorities have had the ability to task the volunteers who come forward with helping in their areas. However, the reality is that a lot of people responded because they wanted to help the country and the NHS at the time of coronavirus, and their doing so in a nationally co-ordinated way meant that we got far more people coming forward than we have ever seen for any volunteering opportunity in the past. That is not cutting across the work that organisations such as St John Ambulance, the Red Cross and Age UK have also been doing, together with local volunteering networks.

***Catherine Frances:*** I do not have much to add to that. I think the 132 hubs across the country have made use of what is available to them. In some cases, quite rightly, that is a very localised set of volunteers depending on their local area, but in many areas they have accessed either local volunteers or other organisations via the centrally organised scheme. I do not think it is for us to say centrally what would necessarily have been the best combination of those things in each place.

Q8 **Chair:** Ms Frances, we have had another letter from your Department about the money available to local authorities. We will be pursuing it further in writing; it didn't give much more information. Was money provided to local authorities specifically to deal with the number of volunteers? Some had large numbers in their area, and then were asked to absorb a number of the national volunteers. Going through the checks, allocating tasks and keeping people in play was quite a big task, so did they get any additional funds specifically for volunteers?

***Catherine Frances:*** The shielding local support that councils had to give, both to corral any volunteering efforts and to support and contact individuals, was one of the areas of expenditure that we expected councils to meet from the £3.2 billion allocation. Some of the material we have published this weekend about how they have spent that funding has set out the money they have used on shielding locally.

Q9 **Chair:** What you are saying, really, is that there was nothing specifically for managing the volunteer hubs locally. Councils could take it out of their share of the £3.2 billion, if they wanted.

***Catherine Frances:*** Exactly. The £3.2 billion was there, among other things, for that purpose.

**Chair:** Because it has been quite costly for some boroughs. I am going to move on, because we have a lot of ground to cover regarding the vital issue of what was happening in adult social care and in our care homes during this period. As I highlighted, the plan for social care followed a month after the NHS plan; I am sure that was for reasons that you will explain, but it would be helpful to find out more about that. I am going to ask Sir Geoffrey Clifton-Brown to lead on the questions about adult social care.

Q10 **Sir Geoffrey Clifton-Brown:** Sir Chris, good afternoon. As the Chair said in her opening remarks, the first case of covid was reported on 31 January. The NHS declared a level 4 incident the day before, on 30 January, yet proper guidance was not given to the NHS and its hospitals until 17 March. What was going on between the two dates?

***Sir Chris Wormald:*** With the NHS?

**Sir Geoffrey Clifton-Brown:** The NHS, yes.

***Sir Chris Wormald:*** I will ask Simon to comment on that, but in general—this goes for both the NHS and social care—the action plans that we published were not the beginning of our activity. We were issuing guidance, and were in dialogue with both sectors, way before we were formally publishing guidance. I will ask Simon to comment specifically on the NHS point.

***Sir Simon Stevens:*** Good afternoon, Sir Geoffrey. As you say, on 30 January we declared a level 4 national incident, which is the highest level of emergency response the NHS can provide. That was coincident with the World Health Organisation declaring a public health emergency of international concern on the same day. The next day—31 January—we were preparing to receive, if you remember, the repatriation flight of people to Arrowe Park Hospital in the Wirral.

On 3 February, we opened our incident co-ordination centre for London, given that we could see that a heavy impact was likely there. On 6 February, we began weekly briefings for NHS clinical directors and leaders through the covid response webinars. On 7 February, we wrote, with the Department of Health and Social Care and Public Health England, about the case definition and the handling of suspected cases. On 10 February, we commissioned extra high-consequence infectious disease capacity.

On 18 February, we strengthened the national oversight. On 2 March, we sent the NHS preparedness and response letter, which was followed, as you say, on 17 and 19 March with more details. It would be wrong to begin the chronology on 17 March because, as I have demonstrated, in the prior six weeks, we had our sleeves rolled up and were preparing for the impact of coronavirus.

Q11 **Sir Geoffrey Clifton-Brown:** That is very helpful. Sir Chris, Sir Simon set out clear advice on the NHS on 17 March. It was not until 15 April, some seven weeks later, that proper advice was sent out to the care sector. Throughout all of this, was not the care sector the forgotten cousin?

***Sir Chris Wormald:*** No, not at all. I will ask Ros, in a moment, to set out what we had done with care before the action plan was published. As a general point, we have been learning about this situation and this disease the entire time. It is not a situation where Government can issue a single piece of guidance and that is that. In both sectors, the picture was building over time. As we learned more, we advised more.

I do not agree that we left out social care. We did a lot of work with social care over this period. However, as I said at the last hearing on 22 May, it is clearly more challenging for us to act in the social care sector, given its fragmentation, than in the NHS. I do not deny that it was considerably more difficult for the Government to take the actions they did in the social care sector, due to the nature of the sector, but I do not agree that we in any way left it out. Ros, would you like to set out the actions that we took?

***Ros Roughton:*** We began work on this well in advance of the action plan of 15 April to which you referred. On 25 February, through Public Health England, we set out advice for people working in residential settings. On 13 March, we issued guidance to residential care settings on home care provision and on people in supported living environments. That marked the change from the "contain" to the "delay" phase of the pandemic. That guidance gave advice to care home providers about what they could do. It also set out steps that the NHS and local authorities would take to support care homes.

We followed that on 19 March with funding to local governments, working with colleagues in MHCLG and the Treasury, and we began the first issue of PPE from the pandemic flu stock the following week. We took a number of steps in advance of the action plan being published on 15 April.

Q12 **Sir Geoffrey Clifton-Brown:** Sir Chris, far from building your policy on the emerging disease, I would say that you did not give that advice on 15 April to care homes until the pandemic was almost at its peak at the end of April. Was that not pretty negligent?

***Sir Chris Wormald:*** No, I do not agree with that at all, for exactly the reasons that Ros has just given. If that action plan had been the first thing that we had done in the care sector, that would be one thing, but as Ros has set out clearly, there was considerable advice and considerable investment in the care sector before that date.

I return to the beginning of my answer. This is not a situation where you publish an action plan on a day and that is that. The action plan we published was the bringing together and the enhancement of a lot of advice and support that we had been putting into the sector already. As Ros set out, the Department started action on that considerably before the action plan was published.

Q13 **Sir Geoffrey Clifton-Brown:** Sir Simon, two days after his advice on 17 March, advised NHS hospitals that all patients who were clinically fit to do so should be discharged, presumably most of them to care homes. On 2 April, care homes were asked to ramp up their capacity to take those people. That was reinforced—I know it was in Gloucestershire—by the local authorities pressurising care homes to take people, and if an individual care home would not take them, they would find another care home that would. That was at a point where the testing was pretty well zero—five people per care home were allowed tests at that point—they did not have adequate PPE; there was not adequate testing; and they did

not have adequate training at that time. How can you say that that was not negligent?

**Chair:** Sir Chris?

***Sir Chris Wormald:*** I thought that was aimed at Sir Simon.

**Sir Geoffrey Clifton-Brown:** You are responsible for care homes. Sir Simon is responsible for the NHS.

***Sir Chris Wormald:*** We will set out the position on discharge. Professor Powis will lead off on that and then Ros will add.

Q14 **Sir Geoffrey Clifton-Brown:** Professor Powis, could you also cover the fact that there was pretty little testing when care homes were being asked to take those patients from NHS hospitals?

***Professor Powis:*** There are a number of important points to make. First, at that time, in the first few weeks of March, the number of identified cases in the UK was not high, as you said earlier—it was the start of the epidemic in the UK—but we could quite clearly see from the modelling that was being undertaken that there was likely to be a large increase in the number of cases that the UK would see.

The modelling predicted that many thousands, and indeed hundreds of thousands, of patients in an unmitigated epidemic—in other words, in an epidemic where measures were not put in place—would occur and that that would overwhelm the NHS. The figure in the NAO Report talks about it being eight times greater than the capacity we had in intensive care beds. In our general beds, we have about 100,000 general and acute beds in the NHS normally.

It was clear from the reasonable worst-case scenario that SAGE was working on that the NHS would quite simply be overwhelmed by the epidemic that it looked as if we were facing. Of course, at the same time, we were seeing health systems elsewhere in Europe being overwhelmed.

Q15 **Sir Geoffrey Clifton-Brown:** Can I stop you there, Professor Powis? Is it not the case that, all along, the policy was driven to stop the NHS being overwhelmed and that there was not the same degree of care, if I can put it that way, for the care homes that had to deal with those patients?

***Professor Powis:*** The first point that I was making was not to underestimate the potential effect on the NHS. Many of the patients—we have now managed more than 100,000 patients with covid in the NHS—are elderly and vulnerable patients who unfortunately caught covid-19.

The second point, as you said in the introduction, was that the ask was to discharge people who were clinically fit to be discharged. We always wished to discharge individuals who no longer needed to remain in hospital. This was the discharge of those whose medical treatment work was complete—

Q16 **Sir Geoffrey Clifton-Brown:** I am sorry to interrupt you again,

Professor, but how do you know that they were clinically fit to be discharged and did not have covid, because you did not test them, did you?

***Professor Powis:*** Because there are processes in place in hospitals to ensure that people who no longer require medical treatment in hospitals, including people such as this, would be discharged. It has always been the case that we would want to discharge people who are clinically fit. Of course, for the elderly, staying in hospital when they are medically fit for discharge can be harmful. I have spoken and written about that in the past. It was always our aim—

Q17 **Sir Geoffrey Clifton-Brown:** Professor, you have not answered my question. How did you know that they did not have covid when you discharged them, because you did not test them?

***Professor Powis:*** We were following the testing advice that PHE provided at the time, so they were discharged in accordance with PHE policy on testing at that time. Indeed, remember that the vast majority of people who caught covid-19 in the UK have not been treated in hospital. They have been managed, or managed for themselves—

Q18 **Chair:** Professor Powis, can I chip in there? You said that they should not be discharged from hospital unless medically fit, so are you saying that the hospitals should have tested people for covid-19 before release, in order for them to be clear that they were medically fit for discharge?

***Professor Powis:*** No, because we followed the guidance on testing that was extant at the time—

**Chair:** Okay. I just wanted to be absolutely clear on that. Sir Geoffrey—

***Professor Powis:*** The point I was making is that the vast majority of people who have contracted covid-19 have not required hospital treatment, so it is wrong to equate hospital care and treatment with infection.

Q19 **Sir Geoffrey Clifton-Brown:** Professor, paragraph 15 on page 11 says very clearly that outbreaks in care homes peaked at just over 1,000 homes per week in the first week of April. This was the very week that the NHS had told care homes to ramp up their capacity to take patients being discharged from hospital. You already knew that there was a considerable problem in care homes, and you were discharging patients into homes with some of the most vulnerable people in society. This was surely absolutely reckless, was it not?

***Professor Powis:*** As I said, we were following the testing strategy that was extant at the time. I am sure that Professor Johnstone will be able to come in and describe the testing situation at the time, which of course was being led by my colleagues at PHE.

Q20 **Sir Geoffrey Clifton-Brown:** Let us hear from Professor Johnstone.

***Professor Johnstone:*** Good afternoon, Sir Geoffrey. At the time, about 3,500 tests a day were available nationally. In agreement with the NHS,

the CMOs and the devolved Administrations, we categorised three situations in which tests should be deployed, given the limited number of tests. That included very sick patients on ITU; other patients in hospitals who needed a differential diagnosis and who had a respiratory infection; and testing in care homes to diagnose outbreaks. They were the three top categories for testing.

Q21 **Sir Geoffrey Clifton-Brown:** Sir Chris, you were discharging them from hospital into care homes when care homes were already in dire trouble and home to some of the most vulnerable people in society. The testing wasn't available, the PPE wasn't available, the training wasn't available. Wasn't this a pretty reckless policy by the Government?

***Sir Chris Wormald:*** No; for the reasons my colleagues have described, we do not believe that. As Professor Powis described, at that point, covid was not considered to be widespread in the community. We knew we were going to get into hospital a large number of covid patients, and the—

Q22 **Sir Geoffrey Clifton-Brown:** Sir Chris, I am sorry to interrupt you, but I must come back to this point in paragraph 15. At the beginning of April, just over 1,000 homes had already had cases of covid, so it was clear that there was an emerging problem in social care sector.

***Sir Chris Wormald:*** No, sorry—just to be clear, the point when the NHS issued its guidance on discharge was before the period that you are talking about. As I say, I am not denying that we had challenges in care homes, but on the specifics of discharge, the NHS advice, as you described it, was earlier, and at that point covid was not widespread.

Q23 **Sir Geoffrey Clifton-Brown:** I am sorry, Sir Chris; I am going to have to stop you again. That is because paragraph 3.19 on page 47 of the NAO Report makes it very clear: "Guidance from 2 April stated that care homes needed to make their full capacity available and that they could admit patients with COVID-19." So, you were sending people from hospitals, in quite large numbers, into the care home sector, which you knew was already facing a substantial and increasing number of covid patients of their own. They did not have sufficient PPE; they did not have sufficient testing and they were the most vulnerable group in society. How could that have made any sense whatsoever?

***Sir Chris Wormald:*** For the reasons that Professor Powis set out, you do not want to keep in hospital patients who are clinically fit for discharge. Now, in the way that Ros Roughton described earlier, we were putting a range of protections in care homes, but as Professor Powis has set out, what you don't want to do is to keep in hospitals, which we knew were going to receive large numbers of covid patients and would have infection challenges of their own, people who didn't need to be there.

Now, in terms of the care homes outbreak—and Professor Johnstone and Ros may want to say more about this—the clearest correlations we have between social care outbreaks and other issues are related to staff, not the admission of residents into care homes, and that has been one of the big focuses of policy for us.

As I said at the beginning, we are not disputing, and no one would dispute, that we have had huge challenges in care homes. We have learned an enormous amount about this disease and how to deal with it, and we have made considerable progress. So, just for the avoidance of any doubt, I am not here to say that there were not big issues with care homes—we have learned a lot and we need to do more, both now and in the future. That is all common ground. What I am saying is that the decisions that we took around discharge, which were all based on clinical advice at the time in the way that Professor Powis and Professor Johnstone have described, were rational, given the evidence that we had on the table at that time.

So, as I say, I am not denying that there were big problems, but I don't accept, for the reasons that the two professors have set out, that the decisions were not soundly based in science at the time.

Q24 **Sir Geoffrey Clifton-Brown:** Can I move to you, Professor Johnstone, and talk about testing? What were PHE and NERVTAG—the New and Emerging Respiratory Virus Threats Advisory Group—doing between 31 January and when the tests were altered to just two people in care homes? Why did it take so long to get the testing regime ramped up to a level that would not only cope with the NHS but with care homes as well?

***Professor Johnstone:*** Thank you, Sir Geoffrey. I will just make it clear that PHE runs specialist reference laboratories, which are not the large-scale pathology laboratories that were needed. But what we did do very early on—in late January—is that we were able to identify the recipe for a test, working alongside international scientists and the WHO. As a result, we were able to distribute this recipe, so that by the end of March 40 NHS labs could test for covid-19. That is the fastest deployment of a test in the UK that we have ever done.

The wider testing strategy, which the Government announced in April, was about bringing in other players to ramp up the testing. We achieved the target of what we called pillar 1 tests—the swab tests. The remaining tests, led by DHSC—the so-called pillar 2 tests, the drive-in tests and so on, were also ramped up during April. From PHE's perspective, we did more than we were asked to do. We worked internationally, we got the recipe, we deployed it, we got the tests out to 40 NHS labs, and we supported the lighthouse mega-labs programme as part of the national testing strategy led by DHSC.

**Chair:** Which we know. Thank you for that. Sir Geoffrey.

Q25 **Sir Geoffrey Clifton-Brown:** Sir Chris, paragraph 3.16 on page 47 states: "In the period up to 15 April, up to a maximum of five symptomatic residents would be tested in a care home." Given that you were discharging all these patients into care homes, could you not have prioritised the care homes to get a little more of the tests that were available, given that it was limited?

***Sir Chris Wormald:*** Again, we acted on the clinical advice that we had at the time. The NAO Report sets it out extremely clearly in figure 2 on page

17, which shows the build-up of our testing capability. As is clear, particularly during March, in that early period our number of tests was quite limited and much smaller than we would have wanted, as the chief medical officers and others have made clear. Within that limited capacity, we took clinical advice on where that capacity was best deployed, and it was then, as Professor Powis has already said, top of the list. It came to people who were in hospital where their treatment depended upon a covid diagnosis—Sir Simon might say more about this in a moment—and that was our top priority. We had a priority for care homes, but our capacity was limited. As I say, we acted on clinical advice in helping to get out limited capacity. Again, I am not here to be defensive. We have learned from our testing experience. It is an area that, as the NAO Report sets out, we have evolved most over the period of this terrible epidemic. So that is the rationale for the decisions we took at the time. It became clear to us, as you know, that ramping up testing was an absolute priority for the management of the disease.

Q26 **Sir Geoffrey Clifton-Brown:** We have got the gist of that, Sir Chris. Up to 5 April, it was limited to five patients in care homes who were showing symptoms. There was no thought to giving tests to the staff in care homes, who had limited PPE, limited training and no testing.

***Sir Chris Wormald:*** That is not exactly true. I will ask Ros to set out the position on testing in care homes. The reason for the five was that, basically, once you have got an outbreak in a care home, you know you have to go in and do infection control and all those sorts of things, knowing that there is 10 rather than five. If we had had the capacity, we would clearly have wanted to do that, but once you have got five you know you have got an outbreak, so the actions you then need to take into that care home are not dependent on *[Inaudible]* tests, and that is why it was done in that way.

Q27 **Sir Geoffrey Clifton-Brown:** But the question was about the staff, not the patients.

***Sir Chris Wormald:*** Yes, I was simply explaining the five as you had raised that. I will now ask Ros to comment on staff testing, which we also ramped up. Ros.

***Ros Roughton:*** As other colleagues have already said, we had limited testing capacity at the start. As that grew, we made more testing available both for residents and staff. As soon as we had the facility for the drive-in testing, we opened that up to all care staff. Because that was spread out across the country, we got a lot of feedback about the difficulties for some staff in accessing that. As a result, as we have got even more testing capacity, we have been able to send out test kits to every care home across England that has ordered them for them to test all their staff and all their residents. So, as our capacity has grown, we have been able to test more and more people.

Q28 **Sir Geoffrey Clifton-Brown:** Can I change the subject and come to Catherine Frances? Is the additional £3.2 billion of funding that you gave

to local authorities sufficient to enable them to properly ensure the sustainability of the care home sector?

***Catherine Frances:*** The data that we have so far, about which we spoke in an earlier hearing, shows that we have put £3.2 billion into the sector. Your question was on social care; we have not ring-fenced that for social care, because we think that local decision makers are best likely to know their own market and where funding is most needed. We have urged councils to prioritise social care spending. The monitoring returns that we have got show that they have spent just over £500 million on social care from that funding, in addition to other funding that has gone into the system, such as the infection control grant.

We have asked councils if they could consider increasing the fees that go to care home providers or putting cash payments up front. We have now asked them to publish data on their websites about the support that they offer care homes in their area. So far, the data has shown, as I said, that they have spent £500 million on social care, and in aggregate, the council sector has spent £1.25 billion of that £3.2 billion overall spending.

Q29 **Sir Geoffrey Clifton-Brown:** Given that you provided that £3.2 billion, and an extra £600 million for infection control, are you satisfied that they have so far managed to spend only £500 million of £3.7 billion?

***Catherine Frances:*** I think that those things are for slightly different purposes. The infection control grant is for exactly that: infection control in care homes. There are quite specific conditions on councils to try to get that funding out as quickly as possible, and to pass a large chunk of it directly on to care homes—Ros Roughton will be able to comment on that.

Adult social care has received the largest portion of councils' expenditure of the money so far. They have spent £1.25 billion overall, and £500 million has gone on adult social care. Given that they have not yet spent all the money that they have been given, we do not necessarily have any evidence that not enough funding has gone into the system—let's put it that way—but we are keeping that under constant review, and we have said that we will very shortly come forward with a plan for councils' funding for the whole year. Our priority has been to get the money out to the sector, and to urge it to use it where local market conditions suggest that it should use it.

Q30 **Sir Geoffrey Clifton-Brown:** Sir Chris, I am sorry; I was rather brutal to you earlier, because anything to do with the care home sector upsets me. I can be less brutal on the funding. How many care home providers are at risk of failing, and how much capacity do you risk losing?

***Sir Chris Wormald:*** I will ask Ros to answer that. On your first point, which was very kind of you, I would say that on social care, we challenge ourselves every day about whether we are doing enough. We are not attempting to avoid scrutiny, and your questions are exactly appropriate.

**Chair:** Can we perhaps cut the niceties, and cut to the chase?

***Sir Chris Wormald:*** Ros, would you like to answer the specific question?

***Ros Roughton:*** I will just link up the previous question about the funding, and then come to provider viability. On the funding, the feedback that Catherine referred to will not yet include the £600 million infection control fund, so in future data from MHCLG, I would expect us to see that that will have been spent. On that first tranche of funding, the Secretary of State for Health and Social Care wrote to local authorities on 19 March, setting out some of the things on which it could be spent. That included helping providers to meet costs associated with enhanced infection control and protection of staff. It is important to see the infection control fund as something that was additional; it was not the first tranche of money that local government got to help with infection control.

On the provider viability point that you asked about, Sir Geoffrey, as you will know, in adult social care, there is an open and competitive market, and there has been for more than 30 years. We know that there are both increased costs to that market, which is why we are providing extra support, and the impact of reduced demand in some parts of the sector. We are seeing a little reduced demand for care homes, but we are seeing, in other parts, increased demands. There are different circumstances for different care providers.

For the large providers, we have a well-established, tried-and-tested regime for monitoring that through the Care Quality Commission's market oversight regime, which looks at the 25%—the biggest providers in the market. For smaller ones, we are looking very closely at the evidence base. We are getting submissions from the care provider associations to make sure that we have the clearest possible understanding of the uncertainties and challenges posed by covid. We are working with local authorities at the moment to look at how we get the balance right between supporting providers and supporting people when care providers go out of business. Every year, we have a flow of entry and exit from the market.

**Chair:** We have covered that in previous reports. We would love to get into it more today, but I think we need to move along. We have looked at the Department's management of the care market, and the supply of medicines for Brexit and for care homes. We will touch on a bit of that a little later.

Q31 **Mr Mohindra:** First, I declare that I am a councillor, for the record. Going back to the stress test for care homes, there is a perception that the social care side of the Department is not treated as well as the NHS. Could I get your views on that statement, Ros Roughton?

***Ros Roughton:*** I believe that we have had all the support that we require from across the Department, and from partners across Government—and indeed from local government and the care sector—to deal with this, but as I think Sir Christopher said at the start, this is a different context from the NHS. Unlike the NHS, we are talking about thousands of small, independent providers with a mixed funding model. That has made it a very challenging and tough context for responding to covid; it is different from the way in which the NHS operates.

Q32 **Mr Mohindra:** Sir Chris, we have heard a lot about the evidence base determining decision making. Do you think that there was sufficient data to drive some of the clinical decisions put forward by PHE and your officers?

***Sir Chris Wormald:*** There are several ways of answering that question. Would we have wanted more data and more information about the disease when we took decisions? Undoubtedly, yes. One of our huge challenges is, of course, that this is a very new disease, and at the beginning of the outbreak we were in a position where we had to take decisions, for many of the reasons that Sir Geoffrey was setting out, on the basis of imperfect knowledge, and we are still acting on the basis of imperfect knowledge.

Some absolutely key things, particularly around the role of asymptomatic patients and the level of immunity that you get from having had covid, are still medical and scientific unknowns. We were undoubtedly in the position—I think I said this in one of my answers to Sir Geoffrey—of needing to take decisions on the best evidence available on that day. That was the right thing to do, but I would not at any point claim that that was perfect information.

To emphasise something that Ros said, it is simply a statement of fact that we have much better, much more timely information in the NHS than in the care sector. That is due to the structure of those two things.

Q33 **Mr Mohindra:** Has not the fact that more testing was done in the NHS and in hospitals than in care homes inadvertently meant that the data was better on the NHS side?

***Sir Chris Wormald:*** As I say, decisions about how to use our limited testing capacity were based on clinical advice, and just as a statement of fact, the people who needed testing most were people being admitted to, or in, hospital, who were showing symptoms that might or might not be covid. That was at the top of our priority list and it was a clinical priority, and in my view that was correct. As we set out in previous answers, we were testing in care homes. That was one of our priorities, and as Ros described, as our testing capacity increased, we have massively increased the testing of both staff and residents in care homes.

Q34 **Mr Mohindra:** Can I direct my question to Professor Paul Johnstone? Sir Chris and others have said that it was based on PHE guidance. Obviously, there was a limited supply of testing. Did you feel you had sufficient information to make the judgment call—and it would have been a judgment call—between frontline NHS staff and patients versus those in the care sector?

***Professor Johnstone:*** I would like to answer the question about whether we had sufficient information about the tests for outbreaks in care homes. When it comes to the difference in weighting between NHS and social care, perhaps I would like to pass that back to Chris.

We have for years been supporting outbreaks of all infectious diseases in care homes. Our local health inspection teams know the care home sector,

and the same would go for covid as for previous examples, such as norovirus outbreaks or seasonal flu: the care manager, on suspicion of an outbreak, would phone the health protection team, and the health protection team would arrange those five tests that we have heard about. The five are about being clear about the diagnosis. From that, PHE local teams would provide advice on infection control; isolation of patients, if needed; the correct PPE and general cleanliness; and disposal of waste. I think we had sufficient data and information to manage those outbreaks in real time.

**Chair:** Thank you. Mr Mohindra, could you lift your head a little, or move your screen? We can see the top of your head only some of the time.

Q35 **Mr Mohindra:** Going back to Sir Chris, hospitals got a stress test before the peak in infections. Why did this not happen in the adult social care sector?

***Sir Chris Wormald:*** I am not quite sure I understand the question.

Q36 **Mr Mohindra:** It is about stress testing. This was done in hospitals before the peak in infections, but it did not seem to happen in the care sector. I just wanted to know your views on that.

***Sir Chris Wormald:*** I will ask Ros to comment, but we have set out already the measures that we took in care homes and why. Given the differences between the sectors, and our leverage in them, that was what we felt at the time was commensurate with the needs in the two sectors. Ros, would you like to add to that?

***Ros Roughton:*** The only thing I would add is that this is also a reflection about the different context. We have a local government and a national Government role in the care sector. So many local authorities will have stress tested their business continuity plans, and over the past year there has been quite a lot of work done on that anyway, for the care sector, in respect of leaving the European Union. What we were getting ready for was a surge of demand, so that we had the data around capacity, if we needed to get more capacity in the care sector. Pandemic flu planning was one of the things that had been highlighted that we might need to be thinking about. What we do not have is oversight of what every local authority and the NHS may have done at a local level, in terms of testing those plans.

Q37 **Mr Mohindra:** The frustration for the Committee is the perception that we do not have all the data to ensure that we can accurately measure the impact of your decision making. I know there will be subsequent NAO Reports on PPE and the like; hopefully, they will flesh out some of the concerns that I have. The NHS and social care appear to be on twin tracks. In hindsight, do you think there should have been a system-wide approach, incorporating care homes, social care and the NHS?

***Sir Chris Wormald:*** Just as a statement of fact, as this Committee well knows, there are significant differences between how the NHS is run and how social care is run.

Q38 **Chair:** Sir Chris, we need to cut to the chase. The Committee does know that, as you say. Perhaps you can answer Mr Mohindra's question.

***Sir Chris Wormald:*** Yes. In this crisis, we have taken a more national and more interventionist role in social care than we ever have before. There has actually been a considerable amount of excellent working between local government and the NHS to deal with the issues that are arising. We cannot get around the fact that these are very different sectors with different statutory bases; one is a public service, and the other is a number of independent providers. The approach we took was certainly to look across the piece at what we needed to do to deal with the infection as a whole, and then to be considerably more interventionist—in terms of both funding and guidance, and other interventions—than we ever have been before on social care, while promoting joint working between social care and the NHS. As I say, we have probably seen more excellent joint working between local government and the NHS over the last six months—

Q39 **Chair:** That is talking about the specifics. Mr Mohindra was particularly asking about a system-wide approach more generally. We have talked to you twice before—at least in my memory as Chair of this Committee—about your role in shaping the market for social care, and about your role in supplying medicines if there was a no-deal Brexit. We have also been looking at this issue, so there are three areas where, as a Department, you would acknowledge that there has been a divide between what is happening in social care and what is happening centrally and nationally through our NHS. We could list some others as well.

***Sir Chris Wormald:*** I have never denied this, and they are services that, as you know, operate on a different funding basis and a different statutory basis. What I am saying is that, actually, those divisions over the last five months, while we have been dealing with this set of questions, have been considerably less than previously. I am not going to claim that we run them as a single national system, because clearly we cannot, but we have pushed the limits of what we are able to do, in terms of bringing the two together.

Q40 **Mr Mohindra:** To go back to my earlier question about the stress testing of care homes, you correctly pointed out, Sir Chris, that this is a very fragmented market. Wouldn't a stress test allow you and other policy makers to realise where the weaknesses are in the system and what intervention is required? You have intervened at certain points in the system, but not at others. We are just trying to get a clear rationale. What was the decision making behind that?

***Sir Chris Wormald:*** As you correctly pointed out earlier, we were and still are, in terms of social care, working with imperfect data, so we would not be happy with that at all. That is actually an ongoing debate with local government and with the sector. As Ros pointed out, the way stress testing works is that it is basically a local government-managed service, as opposed to being managed by the NHS; it is fundamentally different. The stress testing that is done, in terms of social care, goes mainly to local

authorities, which have the primary statutory duty, and then local resilience forums. That is the system on that side of the house. Obviously, the NHS is very different. As part of the arrangements that Simon and Amanda put in, a lot was done at the national level. There are systems on both sides of the house, but they are very different. Ros, do you want to add to that?

***Ros Roughton:*** Yes. At a local level, emergency planning is done as a system. We reminded local authorities in March that, by drawing on their pre-existing plans for influenza pandemics, they should take a number of measures, including testing their business continuity plans, taking stock of how to maintain viable care home provision, looking at how they work with the NHS to support care providers, and having a plan for how and when that will be triggered.

The thing we did not have on 13 March, when we issued that particular advice, was a way to get all that back in. Now, every local authority across England has sent us their care support plans, and we can see, looking through that, how far back some of it goes. That is what we would expect. We have stepped in much further than we would have done normally in relation to local government as this has gone on.

Q41 **Mr Mohindra:** My next question is to Catherine Frances. We have just heard from colleagues at the Department of Health and Social Care that the onus was on local government to check whether care homes had sufficient capacity and stress testing. Can I get your views on that?

***Catherine Frances:*** Yes, of course. I may come back to your earlier question about joined-up planning, alluding to the point that Chris Wormald made about LRFs. On the role of local government, the key point is that local councils have statutory responsibilities to manage their market and ensure that they have continuity of provision. They play a lead role, in terms of the local infection teams working with Public Health England and others, in getting out there among care homes normally.

What central Government have asked councils to do is essentially a sort of extension and lean-in to that role. We have worked with them and supported them quite heavily in doing that. When they look at their local plans for social care, they are really bringing together all the local parts of the jigsaw. They are confirming whether the NHS is playing its role in care homes as expected, whether the funding is flowing through and whether the infection plans are in place. They bring that together, and we have tried to resource them to do that.

On your point about joined-up planning, Chris Wormald alluded to local resilience forums. It is important to note that all parts of England have resilience forums in place, which, as you probably know, bring together the NHS, local government and all the category 1 responders. The Government work with LRFs in each place. They have all had plans in place, and we have had very close contact with them throughout this crisis to hear the key messages that they are feeding back to the centre and

where they are requesting help. That has helped to form the Government's response and policy in areas like PPE.

Q42 **Chair:** We are going to touch on PPE later, but my local hospice was in the pipeline to receive PPE through NHS Supply Chain, and the plug was pulled on that suddenly. Care homes and hospices were suddenly unable to access it through that direct route. Why was that, Sir Chris?

***Sir Chris Wormald:*** I will ask Ros to answer that.

**Chair:** If it is Ros Roughton that I should be directing that to, I will direct it to her.

***Ros Roughton:*** At no point has there been an instruction for the NHS to be prioritised over the care sector. Every time that has been raised with us—I think I have had three or four cases directed to me or our Ministers—we have looked into it, and it has not been that things were redirected to the NHS away from the care sector. With PPE, we have provided some emergency lines for the care sector through the National Supply Disruption Response centre and LRFs. Through our procurement, we have also sold on to wholesalers for care providers to access PPE—buy PPE—in business as usual. We have not issued any instructions to prioritise the NHS—

**Chair:** Ms Roughton, one of the things here is that hospices were downgraded to the level of care facilities, rather than hospitals, because of certain standards they have to reach. I will write to you about this. What you are telling me is not the experience of St Joseph's Hospice, on the ground, or of other hospices around the country. It is important that lessons are learned from this, but it would be helpful to take that offline.

Q43 **Nick Smith:** I have a follow-up question for Sir Chris Wormald, please. I want to return to this issue of discharging from NHS hospitals to care settings. On page 47, paragraph 3.19, the Report states: "Guidance from 2 April stated that care homes…could admit patients with COVID-19." Given what we knew at the time about what was happening in places like Italy in care homes, do you now accept that that was high-risk and wrong guidance?

***Sir Chris Wormald:*** I will ask Ros to answer—

**Nick Smith:** No, Sir Chris.

**Chair:** He wants you to answer, Sir Chris.

***Sir Chris Wormald:*** I will ask Ros to comment afterwards—

**Chair:** That, Sir Chris, is a matter for the Committee and the Chair to decide, but you think she has something to contribute—we hear that.

***Sir Chris Wormald:*** Sorry, Chair. As I have said before, we believe that we took the right decision, based on the right clinical evidence at the time. I am thinking through my answer carefully here for the reason that I said before, that we are both undefensive and reflective on what we have

done, in the NHS and in social care, so I will not say that every single piece of our guidance was correct. We are in a process of learning as we go along about these entire issues. I am confident that, based on the information that we had at the time, our guidance was correct; that is not the same as saying that we would do the same again. If the Chair allows, I will ask Ros to add to that.

Q44 **Nick Smith:** May I come back to you, Sir Chris, to answer my question? Given that there were 400,000 vulnerable residents in care homes, do you think that the guidance that care homes could admit patients with covid-19 was high risk?

***Sir Chris Wormald:*** There are clearly risks in whatever you do in these circumstances, so I am not going to deny that there were risks. All our guidance is very carefully considered and based on the best clinical advice at the time, but that is not the same as there being no risk. As Professor Powis set out earlier, there were considerable risks to people staying in hospital, both outside a covid outbreak and within it. When we are setting our guidance on all these issues, we have to take balance-of-risk judgments where there is no no-risk option. We acted on the clinical advice that we had at the time. As I said in my previous answer, that is not the same as saying that we always got things right—

**Chair:** We have got that message, that you say you didn't always get things right. We accept that.

Q45 **Nick Smith:** Sir Chris, you said the advice came through from Public Health England—

***Sir Chris Wormald:*** No, I have not said that. I want to be very clear that I am not in the business of seeking to push responsibility for decisions on to other organisations. There is no sense of that here—

**Chair:** Okay, thank you. Mr Smith.

***Sir Chris Wormald:*** I will just explain what happens with clinical advice. Clinical advice comes from a range of clinical sources, two of which are at this Committee today, but which also includes the CMO and his team of deputy CMOs. They talk all the time, and the clinical advice that the Government as a whole act on is the best clinical advice available from a range of sources. As I say, we are not in the business of saying, "This organisation said that and therefore responsibility goes elsewhere".

**Chair:** Thank you.

***Sir Chris Wormald:*** The Government as a whole act on the clinical advice that people like Professor Powis give.

**Chair:** I think we understand that. We need to cut back on the explanation of how things work. We have prepared the report and we cover this area quite a lot. Mr Smith?

***Sir Chris Wormald:*** It was only because the issue was directly raised.

**Chair:** Okay, point taken, but we need to have quick questions and quick answers, and Mr Nick Smith is going to be an exemplar in that, I know.

Q46 **Nick Smith:** My next question is to Rosamond Roughton and it is about data on deaths in care homes. In south Wales, I have found it difficult to get up-to-date information on deaths in care homes and in particular settings. I have been told by local government and locally that daily information on deaths in care homes would help with providing PPE, pushing towards improving the testing regime and providing support for care homes. Do you think the data on deaths in care home settings is sufficient to support the residents and the care home organisers?

***Rosamond Roughton:*** I think it has improved since the start of the pandemic. It is awful information, looking at it, and we look at it every day. What we have now got, through CQC collecting it, is data about when they are notified of a death in a care home. That information is published each week, broken down by local authorities. That is now available.

Q47 **Nick Smith:** Do you think you could do a better job if that were produced by care home, by day?

***Rosamond Roughton:*** In order to manage the outbreak, it is important that local systems know where they need to give support and, clearly, as soon as there is an outbreak in a care home, then that feels like the most important information. Is the question you are asking about whether that information is made public?

Q48 **Nick Smith:** It is, really. I can understand why Public Health England and Wales would be afraid of scaring communities and unsettling residents. That is the last thing that anybody wants, but I have had local authorities tell me that information has been too slow on deaths in care homes and, maybe, support for care homes could have been improved if there had been increased transparency to allow local authorities and other services to help sooner rather than later.

***Rosamond Roughton:*** As soon as there had been an outbreak in a care home, then local system leaders would have had that data straightaway, to help them manage the position. In terms of the public, I think that transparency is always helpful, generally, but the information that is provided is a matter for care homes. Certainly, with the care home providers I have spoken to, they know the families of existing residents have taken a very deep interest in what is going on and what measures they are taking to manage covid in their care homes. We are at the stage where the majority of care homes have not had an outbreak. That is testament to the fact that many care homes have well-established infection prevention control procedures and have been supported in taking steps.

Q49 **Chair:** Professor Johnstone, you talked earlier about PHE going in and advising care homes about this. Do you have enough staff on the ground to do that properly? Was that an issue?

***Professor Johnstone:*** We have 360 staff across nine teams in our local health protection teams.

Q50 **Chair:** Is that enough? That seems very thinly spread to advise care homes.

***Professor Johnstone:*** It was certainly enough in the early stages when we had a lot of work on containment. Given where we are in the pandemic now, with the test and track part of the programme, we are ramping up the personnel in our local health protection teams to work with the joint biosecurity board.

Q51 **Chair:** When you say "ramping up", are you getting more staff in to do this?

***Professor Johnstone:*** We are, yes.

Q52 **Chair:** From where?

***Professor Johnstone:*** We have had a good response from people who have retired. We need a range of people, including consultants, nurses and phone operators, and we are moving very quickly towards having over 1,200 staff ready for the test and track programme.

**Chair:** If you could write to us to tell us a bit more about where they have come from, that would be helpful.

Q53 **Mr Holden:** Ms Roughton, you mentioned that a majority of care homes in the country have not had incidents of covid. That is not the case in County Durham, where I am from: the majority have had covid cases.

I have two very quick points. First, the council has consistently said that its policy has been based on the guidance it received from the Government, yet it initially tied funding for coronavirus-related costs to homes being willing to accept those who tested positive for the virus or were untested. Was it ever the Government's guidance that more money should be given to those willing to accept patients from hospital who either had tested positive or were untested?

***Ros Roughton:*** No.

Q54 **Mr Holden:** That is good to know. Secondly, I have looked at your reports and the guidance you issued in March, and the two sets of guidance in April. During an investigation, the BBC were told that there was a conference call between a care home association in County Durham and council officials, in which the council was told that releasing patients into care homes without testing would be "disastrous", and the local association offered to find specific homes or homes where covid-19-positive or untested patients could be cared for, separate from the rest of the network. Having looked at the Select Committee's report, it looks like that guidance on keeping separate only came through from the national level in April. Was that your guidance before, to keep them separate, or did that only come later?

***Ros Roughton:*** I think it was only later. I think it was something we had discussed with care home providers, but it is not possible to do that in every care home, so mandating it would create different sorts of risks. We

really talked about isolation, rather than doing separate care homes at the outset. That was a later proposition, I think.

Q55 **Mr Holden:** Sorry, but early on—in your earlier guidance in March—you talked about isolating patients away from general communities.

***Ros Roughton:*** Yes, dedicated isolation facilities were what we recommended.

Q56 **Mr Mohindra:** I am going to move on to talking about caring for people in hospital and direct my question to Amanda Pritchard.

I think we would all agree that the provision made by the likes of the Nightingales was excellent and ensured the NHS did not fall over, but what lessons have we learned from that? Based on history, we are expecting a second wave. A lot of frontline staff will be exhausted from doing the first wave, and we have a backlog of non-covid-related operations required. What plans are in place at the moment?

***Amanda Pritchard:*** Thank you for that question and your reflections on the Nightingales. I think the comments made about the experience of staff in the past few months were well made. Currently, we are trying to find—this is in the letter that Simon and I wrote on 29 April—the right balance. On the one hand, we need to give clear instructions to the NHS, which say, "We now need to operate in a with-covid environment." Our first priority is to keep patients and staff safe as we continue to have a certain amount of coronavirus with us, and we expect to do so for a considerable period of time. On the other hand, we also want to ensure that people are supported to re-start critical services. We have seen emergency and critical services, such as cancer, maintained throughout, but we now can increase some of the proactive offer of those services to people who need them.

The third component is ensuring that we have carefully thought about what flexible capacity we must have available, as we head into autumn and winter, to respond to potential further demands from coronavirus into the winter. We are planning now to maintain the Nightingale facilities, for example, on a stand-by basis. We do not need them now, but to bring them back into operation in a matter of a few days would give us flexibility.

Q57 **Mr Mohindra:** Building on that point, we expect seasonal winter pressures. How is that being planned for? The concern I share with NHS Providers is that there is so much incapacity in the system that if we experience multiple demands, it may fall over. What planning are we doing now—in peacetime, so to speak—to ensure that we are ready for the battle ahead?

***Amanda Pritchard:*** Very active discussions are underway now with colleagues in DHSC and the Government more widely about exactly that issue. Part of the answer, as I say, is that we hope to maintain the Nightingale flexibility and we are in active conversations now about having continued access to the independent sector, to provide us with some of

that additional headroom, which we think we will need for the rest of the year.

There are a few other things worth mentioning. First, on staff and our ability to support the workforce, given the extraordinary response we have had over the first few months of the pandemic, we need to ensure we can give people a bit of breathing time by encouraging people to take leave, so that they are refreshed going into the autumn and winter, as well as encouraging people who have returned to stay with us and those who have volunteered to continue to offer their support.

Finally, we are also trying to emphasise the flu vaccination campaign this year. Anything we can do to ensure that we keep the population of people who might be at risk safe through winter will clearly help us to be more resilient.

**Chair:** Absolutely.

Q58 **Mr Mohindra:** Amanda, you referred to working across Government. Please talk about the co-ordination between Government Departments. How is that working? In hindsight, we can look at the first phase of covid. What, in your view, went wrong?

***Amanda Pritchard:*** Structurally, right from the start, we have had a co-ordinated approach in responding to the pandemic. For example, our most senior governance group internally has had representation from DHSC right from the beginning and vice versa. We have already talked about the daily clinical meetings that have been taking place in England and across the four nations. There are lots of examples of planning and execution being done in a strong partnership right from the start.

On your point about learning, I hope what we would say is that we are learning continuously. As colleagues have said throughout this hearing, a lot of the things that we have been doing over recent weeks and months are of course based on the very immediate feedback loops that we have had in place. As data has improved and we have learnt more about the virus, we have been able to put additional measures in place to strengthen and support our response; and our intention will be absolutely to continue to do that.

Q59 **Mr Mohindra:** Going back to my other question, about the pent-up demand for non-covid-related procedures, I think the figure for April, year on year, is down 74% on elective procedures. That is quite significant and may entail further attendances at A&E and the like. This is about a stitch in time versus nine stitches later. So, what plans do you have in place to unlock the non-covid-related procedures, to ensure that the system does not fall over?

***Amanda Pritchard:*** As I said earlier, one of the things that we have been very careful about doing is maintaining the access for critical services throughout. In terms of a safety-first approach and a clinically led approach, that has been very much at the heart of the NHS response.

The letter that Simon and I sent at the end of April I can very much reinforce, but also I give clear encouragement to now start to proactively stand up services and go as far as possible, where people can, to start to very much get, exactly as you say, into some of those more elective areas of service. It is where, I think, we would say the partnership with the independent sector can now be regeared. It was originally very much focused, of course, on supporting us through that first phase response. There is potential now to see that gearing around also helping us with some of the—

**Chair:** Yes, we are going to come to that; thank you. Mr Mohindra.

Q60 **Mr Mohindra:** Can we think about the wider healthcare system? We have obviously focused a lot on hospitals and care homes, but what about things like dentistry and osteopathy? If certain conditions, like mouth cancer, are not treated early, they can quickly spiral out of control. What are we doing to ensure that people have some guidance that these other services are coming back online?

***Amanda Pritchard:*** We have now written out, for example to dentistry, just very recently and have been very clear what the restart arrangements in place are for dentistry. Again, of course what we focused on over the first phase was the continuation of urgent dental care, but we are very much with you in thinking that—

Q61 **Mr Mohindra:** Just on that, Amanda, I have some personal history there in terms of a family member. Wasn't it only if effectively you needed a tooth pulled out? Nothing else was going to be done. It was very much a black-and-white decision: "Either you get the tooth pulled out or we're not seeing you."

***Amanda Pritchard:*** That has been very much, as you would expect me to say, clinically led—on what the safety equation was around all the clinical services that we have been seeking to maintain. That is equally true of dentistry as it would be of anything else. So, weighing up for individuals—and it has got to be, of course, a local clinical decision. That is why the triage arrangements around dentistry were put in place to support the urgent dental centres. We have done over 800,000 virtual triage appointments for dentistry, and for those where the local clinical judgment was that the balance of risk was such that it was preferable for somebody to come in for a face-to-face appointment rather than being managed remotely—that was the purpose behind setting up that network of urgent dental centres, to try to guide people appropriately.

**Mr Mohindra:** Just one statement before I hand over, Chairman. Amanda, you mentioned virtual triage. I think that is definitely the way forward. I know my local acute hospital, Watford General, had a very successful 1,000-bed virtual hospital. I look forward to seeing future plans.

Q62 **Sir Geoffrey Clifton-Brown:** I would like to turn to Sir Chris, in the first instance anyway, on PPE, and go back to the level 4 incident declared on 30 January. What did PHE do to start ramping up their supplies of PPE after that incident was declared?

***Sir Chris Wormald:*** It is not a particular PHE responsibility. The business as usual position on PPE is that institutions both within the health service and within the social care sector are responsible for procuring their own PPE. That is what happens in the normal course of events. Public Health England maintains what is known as the PIP stockpile—the pandemic influenza preparedness stockpile—which was begun in 2009. That is PHE's specific responsibility.

What we did essentially in this crisis, beginning really in late January and then ramping up, was to increasingly make the provision of PPE a national responsibility, both within the NHS and the social care service. We put together—this is something that Simon and I did—effectively a joint cell between our commercial operations in the Department and the NHS. They increasingly became responsible, working with the Foreign Office and others, for sourcing international supplies of PPE, and delivering it both to the health sector and to social care.

Q63 **Sir Geoffrey Clifton-Brown:** Sir Simon, you went out to the private sector and procured a contract for 8,000 beds. It was procured on 21 March and it runs until 28 June. Will it be renewed after that?

***Sir Simon Stevens:*** As Amanda Pritchard said a moment ago, we expect that we will want to make use of independent sector capacity for the balance of the year in order to give more buffer for routine surgery, cancer care and other conditions, but the basis on which we are contracting with the independent sector is likely to change, in that in the first several months the purpose was essentially to have reserve capacity in the event that the forecasts that were given to us showing a huge increase in the number of in-patients came to pass. We would have needed to use those beds for that.

Now, in the next phrase, we want to use them specifically for elective care, diagnostics, cancer and so forth. We are in discussion with Government about that, but my hunch is that we will want to sustain the relationship with the independent hospitals.

Q64 **Sir Geoffrey Clifton-Brown:** How much has this contract cost to date, and what discussions are you having on how much money you will need in order to do what you have just said for the next phase of the contract?

***Sir Simon Stevens:*** The contract to date has been on an at-cost basis, with open book accounting and independent audit. Those figures are still in the process of being trued up, so I do not want to give an unaudited number today, but the basis on which we would expect to proceed hereon in will be a different type of arrangement, probably following a competitive procurement.

Q65 **Sir Geoffrey Clifton-Brown:** Will this open-book arrangement that you have negotiated hitherto be fully open and transparent, because we are hearing stories of high interest rates on loans being charged, and of bonuses to directors and others being charged. Will the basis of it be totally transparent?

***Sir Simon Stevens:*** Yes, with independent audit. The contract explicitly prohibits compensation for bonus payments or executive pay beyond that which would have been accepted through the NHS. Indeed, it contains caps on the profits that can be in dividends and other aspects of what would be a normal cost structure for those providers.

Q66 **Sir Geoffrey Clifton-Brown:** One final question. Given Mr Mohindra's questions on getting back to the NHS as normal on elective surgery, how will these hospitals be allocated to each health trust to carry out their elective surgery if the phase 2 contract is negotiated?

***Sir Simon Stevens:*** I do not want to pre-empt the discussions that we are having with the independent hospitals and, indeed, the Government, but essentially, we will be making that capacity available to networks of hospitals and GPs in an area. The exact mechanism by which patients choose to have their operations there will be negotiated over the coming weeks.

Q67 **Chair:** Simon, while we are on this subject, could you tell us how many of the 8,000 beds that you commissioned in the private hospitals have been used at any time to date? What has the capacity been?

***Sir Simon Stevens:*** Remember that the reason we block-booked those beds was not solely to use them for hospital admissions; we actually redeployed a number of staff—

Q68 **Chair:** That was not my question. How many of them have been used for anything at all? You paid for them—we paid for them—so how many have been used?

***Sir Simon Stevens:*** Several hundred thousand patient treatments—

**Chair:** Sorry; I did not hear that. Several hundred thousand or 700,000?

***Sir Simon Stevens:*** Several hundred thousand patient treatments, which is a combination of operations and outpatient spells, such as for chemotherapy treatment or diagnostic tests. In addition, we pulled staff out of those hospitals and used them where they were needed across the NHS. We also deployed equipment from those hospitals to where they were needed as well. This was not, principally, an activity-based contract but a capacity—

Q69 **Chair:** No one disputes that. I am just wondering how many of the 8,000—some of them would have been day cases. Some of them would have been people in hospital residentially, for operations. It would be very helpful if you could supply us with some of that data, because I think it is really useful to know, when that resource was pulled in, how much of it was used. That is all I am asking. You are telling me that there were several hundred thousand patient experiences?

***Sir Simon Stevens:*** Yes.

Q70 **Chair:** But you cannot give any more detail than that. Can you write to us with that?

***Sir Simon Stevens:*** As I said, it is a combination of diagnostic tests, chemotherapy, outpatients and day cases, with variance between sites. That is not the principal metric on which to judge the use of this capacity hitherto. It has been the use of the staffing that was there, as well as the equipment.

Q71 **Chair:** But it is useful to know, given what taxpayers spent on that, what we got back. That is all I am asking for. Could you write to us with that information?

***Sir Simon Stevens:*** Yes, absolutely. We got back more than that kind of patient treatment. We got staff as well.

Q72 **Chair:** Thank you very much. When you talk about the costs that you are negotiating—it has not been audited yet—can you give us a ballpark figure of what it is in the region of?

***Sir Simon Stevens:*** I would rather wait until we have that audited data, and then I will be happy to write to you with that.

Q73 **Chair:** Okay. When will you expect to get that audited data?

***Sir Simon Stevens:*** As Sir Geoffrey said, the first round of the contract expires on 28 June, but there will be a short extension while the reprocurement—selectively—is occurring. Certainly, within the next several weeks, I should imagine.

**Chair:** I am sure our colleagues at the National Audit Office will be keen to look at that.

Q74 **Sir Geoffrey Clifton-Brown:** Can I ask one final question to Sir Simon please? Simon, it is my impression that some of these private hospitals have not been used all that much. Is the basis of this open-book arrangement on this first phase of the contract such that, if the hospital is not used, it is not paid, or would it expect to get a certain amount of its overheads under the contract, irrespective of whether it is used or not?

***Sir Simon Stevens:*** During the block booking phase, we would essentially be compensating at cost, with an offset for any private patients that they took through those facilities, which then offsets our costs. For this next phase, we are likely to prune the list of facilities based on expected usage for the balance of the year.

**Chair:** So, you have learned from what has happened? That is good. We look forward to the figures.

Q75 **Mr Mohindra:** My questions will be about PPE. This is notwithstanding a future report that I am sure the NAO will do. My question is to Professor Paul Johnstone. If you look at the NAO Report, section 4.19 downwards on page 58 refers to the New and Emerging Respiratory Virus Threats Advisory Group's warning, this time last year, that certain stockpiles of PPE were not sufficient. Can you run us through what happened, and why we did not have sufficient PPE when we needed it for covid?

***Professor Johnstone:*** Thank you for the question. I would like to start with what the Permanent Secretary said on this about PHE's responsibility for PPE. We have two clear areas of responsibility: first, to hold the stock on behalf of DHSC and secondly, to receive, where there is advice from NERVTAG, commissions from the DHSC to go through a procurement exercise to change or adjust stock.

Q76 **Mr Mohindra:** Therefore, the actual policy decisions would have been via Sir Chris or Sir Simon, so I ask the same question to you both. This time last year, there was an independent report suggesting that we needed an increase in PPE. What was done between then and say, the beginning of this year, to fill that gap?

***Sir Chris Wormald:*** I will take this. I think it is exactly as set out on page 58 of the National Audit Office Report. There was an outline NERVTAG recommendation in June 2019 to add gowns to the stockpile. We then received the technical specifications from a further NERVTAG report in November 2019 and procurement was planned for early 2020. That was of course overtaken by events and we went over to buying for immediate delivery, rather than for a future stockpile. But the story is exactly as set out by the National Audit Office.

***Sir Simon Stevens:*** Chris has explained the situation. As I understand it, NERVTAG made the recommendation and the Department was in the process of responding at the point that coronavirus hit, as Chris has just said.

Q77 **Mr Mohindra:** Sir Chris, obviously you were still Permanent Secretary four years ago when we had exercise Cygnus, which was to do with a pandemic and specified that we did not have sufficient PPE. What was done in those four years? There seems to be a history of red flags that it may have been an issue. Obviously, we are benefiting from hindsight, but I am trying to understand the rationale for why it was not addressed four years ago or in the intervening period.

***Sir Chris Wormald:*** The whole of Operation Cygnus was addressed, including what it said about PPE, but it did not cover the issue that we have just been discussing. As set out in the NAO Report, that was a considerably later recommendation. Basically, what happened with Operation Cygnus was something that was done with the Department and by the Department. There was a series of recommendations to put it in a better place, which were implemented. A number of those have played out in how we have responded to the coronavirus crisis.

What I would say is that it was a test of a pandemic flu, which has a series of clinical differences from the pandemic we are currently facing, including—my medical colleagues will be better placed to comment, but I will give you the summary—the fact that coronavirus turns out to place considerably more stress on PPE, due to the hospitalisation rate and the need for PPE in other circumstances, than we had projected from pandemic influenza.

The stockpile that we had built up, which was begun after the swine flu issues, has been completely invaluable in dealing with coronavirus. We have used it intensely, as the NAO Report sets out, but it was not specifically designed for this type of pandemic.

**Mr Mohindra:** I appreciate that it was not exactly the right type of pandemic—

***Sir Chris Wormald:*** I am not being defensive about it; I am simply stating a fact as to what the stockpile was for. On your basic question, we followed up all the recommendations about Operation Cygnus.

Q78 **Mr Mohindra:** We are still anticipating a second wave, until we find a cure for covid-19. Where are we in planning to make sure that we have sufficient PPE to match that? I have alluded to the fact that we are currently seeing the back end of the first wave. Now is the time to ramp up manufacturing or supply. Do we have that in place? What reassurance can you give the Committee that we are on top of that?

***Sir Chris Wormald:*** You are exactly right. Obviously, it is not certain that there will be a second wave and we certainly hope that there will not be, but our planning needs to be on the basis of a reasonable worst-case scenarios. As I described to the Committee last time I was here, the PPE position, for a variety of reasons—mainly to do with international supply—was extremely tight indeed. We are pleased that we are now in a considerably better place. To give you a sense of where we have moved from, at the height of our challenges, our planning window was up to seven days—

**Chair:** We know that from the previous hearing, so can you cut to what you have learnt from that?

***Sir Chris Wormald:*** We are now in a position where we are looking 90 days ahead—we have plans for that—and right now we are putting in place plans to go beyond that. I am not saying that we have everything in place that we want to cover—

Q79 **Chair:** You said that you have a 90-day plan. Could you just explain precisely what you are doing to make sure that you have got PPE 90 days out? One of the things that we have discovered from previous sessions and from the frontline is that you had supply coming in but not enough understanding of the demand in the very different sectors that needed PPE. What are you doing to plug that gap?

***Sir Chris Wormald:*** As I think the questioner pointed out, the NAO is doing a full study of that so I expect we will debate it in considerably more detail.

**Chair:** Will we? We still want you to tell us now.

***Sir Chris Wormald:*** In a summarised version, we are doing two things to put us in a position where we have a line-of-sight 90-day supply and can then go further. One is certainty of overseas supply and the longer-term

contracts that we are signing with suppliers. The second, as we discussed previously, is to really expand what we make domestically, which is at the moment a small proportion of our supply. We want that to be increasingly important going forward. Those are basically the two ways that we can get PPE—as part of our plan, Lord Deighton is leading on our looking at both.

A third aspect is to better understand demand and ensure that our internal logistics match—I will not repeat what I said in a previous hearing about that. Putting those three things together—understanding of demand, longer-term contracts for international supply and increased domestic provision—is putting us in a better place. As I said—as, I am sure, would Lord Deighton if he were here—we have more to do to move on from the 90-day plan into the long-term.

Q80 **Mr Mohindra:** Sir Simon, could you answer the same question? From my understanding, if we are looking to get all non-covid-related operations back up and running, we will need double the PPE that we are using currently. What plans have you got to make sure that is in place before we open the floodgates?

***Sir Simon Stevens:*** We have, as the NHS, provided the central PPE team at the Department, under Lord Deighton, with the expected demand volumes that would be required, as you just pointed out, Mr Mohindra. They are seeking to source that volume, for 90 days and beyond, in the way that Chris Wormald just described.

Q81 **Peter Grant:** Can I ask Ros Roughton, at what point did it become clear that there was going to be a serious issue with the supply of personal protective equipment in the care home sector in particular?

***Ros Roughton:*** When we first got the advice about the use of face masks, that was something that was new, on the whole, for the care sector. Gloves and aprons are things that care providers have always used and in normal times, as you will know, care providers have a multitude of wholesalers or retailers from which they get their supplies. So, we did issue that initial drop to get people over that very first hump when we issued the guidance on face masks. And I think that in those first couple of weeks, it was very, very tight, and—

Q82 **Peter Grant:** I am sorry—could you tell us what dates you are talking about there, please, in the first couple of weeks?

***Ros Roughton:*** Sorry—I think that on 13 March, when we issued the guidance around use of face masks, and that is when we made the initial drop from the pandemic flu stock of PPE, with face masks to go alongside that. I think then on 2 April, when we changed the advice around using PPE for care home residents who were not necessarily symptomatic—so, kind of widespread use—that was something that very much increased the demand beyond what we had originally anticipated.

Q83 **Peter Grant:** Why was there such an under-anticipation of the need for protective equipment in care homes when we knew that there were around 400,000 vulnerable people living in them? Why did nobody spot

that danger until it came and hit us?

***Ros Roughton:*** I think it was not to do with the care homes but to do with the nature of the transmission. So, the amounts of PPE used for this particular virus—the advice, which has changed throughout the course of this as people have got to understand it better—that was something that we had not anticipated.

Q84 **Peter Grant:** Does that mean that you had not anticipated the nature of transmission, and a virus that could be spread so easily by particular methods, or had you just underestimated generally the R number of this virus?

***Ros Roughton:*** I think I would ask Professor Johnstone to comment on the kind of planning around what kinds of virus and the transmission rates, and methods of transmission.

***Professor Johnstone:*** The nature of this virus was not clear to the whole of the world when it started; it is a new virus. What was becoming clear in the back-end of March and certainly from the beginning of April was that there was an asymptomatic phase, which means that people can transfer the virus without ever having symptoms, or a significant pre-symptomatic phase, which is where the virus could be shared and then someone would—

Q85 **Chair:** Yes. We understand the terms. Thank you.

***Professor Johnstone:*** Yes. And this was learning throughout the pandemic globally. Therefore, the advice on PPE that was changing reflected the most up-to-date advice that we learned from WHO and others.

Q86 **Peter Grant:** The NAO Report points out that the stockpiles did not significantly increase during January and February. By that time, weren't we picking up information or at least learned that this virus was not going to behave the way we had expected it to when we did the previous exercise?

***Sir Chris Wormald:*** That is because we were already beginning to give out material from the stockpile from late January. So, of the three actions that we took before the clinical position was absolutely clear, two were at the end of January. We began international purchasing towards the end of January, and we began to release from the PIP stockpile towards the end of January. And then we stood up the national supply disruption response hotline from mid-March. So, we were already taking action to deliver PPE into the health and care sectors before we were clear on the clinical need that Professor Johnstone has just referred to and said changed.

Sorry—I may just have to check the date on one of those answers. I will come back on that if I need to.

**Chair:** Okay. You can write to us, or we can pick it up at the end.

Q87 **Sir Geoffrey Clifton-Brown:** Two questions for Sir Chris. You had two

and half months from the first coronavirus case to the appointment of Lord Deighton on 19 April. How was it that you were running into significant shortages of PPE up to the time he was appointed? In about six weeks, he was able to boost your supplies from about a billion to about 5 billion items. Why couldn't the NHS, and particularly PHE, have managed that much more quickly?

***Sir Chris Wormald:*** I will correct my previous answer, now I have the opportunity: it was in February that we began international buying. The story of PPE is one of continuous advancement. We were boosting our international supply throughout that period. Lord Deighton has done a brilliant job and has boosted it yet further. But in the way I have just described, we were very active on PPE right from the outset. As I described in a previous hearing, our challenges have been twofold. The biggest has been that world demand outstripped world supply. We have seen countries all over the world, including some of those who are said to have managed the virus extremely well—

**Chair:** There is no need to list them.

**Sir Chris Wormald:** They have been reporting similar challenges with PPE.

Q88 **Sir Geoffrey Clifton-Brown:** But Sir Chris, if anything, the situation had got tougher when Lord Deighton was appointed, because the whole world was wanting PPE, yet he still managed to increase the quantity very significantly.

**Sir Chris Wormald:** Yes, and I am not going to underplay what Lord Deighton has achieved at all. At the same time, however, as you would expect, world supply increased as demand increased. We have seen fewer challenges in sourcing our international supply as time has gone on and world markets have adapted. That is not to downplay at all what Lord Deighton has achieved. As you say, it has been excellent.

Q89 **Sir Geoffrey Clifton-Brown:** Final question, Sir Chris, because time is moving on. I have taken part every single week in conference calls with our health chiefs in Gloucestershire, and I am sure that Gloucestershire is not unique in what I am about to say, which is this: the guidelines on the use of PPE were constantly changed. It seemed to the health chiefs and to me that they were changed without regard to the supply situation in the country, thereby exacerbating the whole shortage of PPE. Supply did not match the guidelines—was that the question?

**Sir Chris Wormald:** Now, the way we set the guidelines has to be the interaction of two things. One is what is clinically appropriate, clearly. As Professor Johnstone described earlier, that has changed over the course of the virus as our understanding has changed. Clearly, our guidance has to keep track of that. The second thing is supply. It is not entirely driven by what is available, and it should not be. What we try to do as we update our guidance is put out guidance that is clinically appropriate and that matches the supply. That is a balance of those two factors, and that is how the guidance is set. I am not going to deny that the guidance has

changed. We did it quite deliberately as our supply changed and as our understanding of the clinical nature of the disease changed.

Q90 **Sir Geoffrey Clifton-Brown:** I am afraid I must come back on Sir Chris. One final question on that. What on earth was the point in changing the guidelines? At one point, the guidelines said that every single new patient whom an assistant in a care home visited had to have new PPE—each time they visited a different patient. This caused considerable anxiety in the social care sector. Surely there was no point in changing the guidelines, even if the clinical need altered, until you were sure you had sufficient supply.

**Sir Chris Wormald:** The changes we made were away from that provision, for the reason that you say. That is what we try to do as we update our guidance; we are trying to match clinical need with what we can supply.

Q91 **Sir Geoffrey Clifton-Brown:** Sir Chris, you can't get away with saying that the guidelines were away from that provision when you put that guideline in place in the first place.

***Sir Chris Wormald:*** That was the original advice about what should be done. As I say, we can't simply be driven by supply in this case, because the two interact. What we ask our commercial teams to go out and buy is based upon our assessment of what is clinically needed at the time.

**Chair:** Sir Geoffrey raises an important point, which the NAO will no doubt look into when it looks at procurement and whether the guidance or supply was first. We will come back to that in a future hearing because it is a knotty point. I am going to bring in Nick Smith and then Olivia Blake.

Q92 **Nick Smith:** This is a question to Sir Chris. Parts of the care sector are under huge business pressures. Do you expect to have to rescue failing care home providers in the weeks ahead?

***Sir Chris Wormald:*** I refer you to the answer that Ros Roughton gave earlier. We have a regime for assessing the viability of care homes. It is partly national, in relation to the biggest care providers, but it is mainly a statutory duty, certainly within England—I couldn't comment on Wales—on local authorities.

The point of our regime is to ensure the continued provision of services to individuals. That is not the same as rescuing individual providers. That may be the appropriate course of action or it may not. The decisions are taken based on securing provision of supply for individuals. We have seen examples recently of one provider taking over the provision of another that has gone out of business. As I say, our decision making is based on what maintains the provision of supply, not what is good or not for companies.

Q93 **Nick Smith:** Sir Chris, given that the sector is foundering at the moment—it is saying that costs are up and income is down—do you expect to have to rescue any of the groups that are large national providers over the coming weeks?

***Sir Chris Wormald:*** I am not going to comment on individual cases. I have explained the failure regime that we have in place. As Ros described, we are in constant dialogue with the sector on questions of viability and funding. I am not going to speculate about what we might do in the future.

Q94 **Olivia Blake:** I have some quick questions for Amanda Pritchard. What proportion of the 18,200 increase in staffing was from student and pre-reg nurses? Do you hold that data?

***Amanda Pritchard:*** The figures that we have are a little more up to date than those in the National Audit Office Report. We originally had about 30,000 nursing, midwifery and AHP students come forward and offer to move into formalised placements, of whom roughly 20,000 have been working in practice. About 25,000 were able to be deployed and about 20,000 in practice have taken up those placements.

Q95 **Olivia Blake:** Has the NMC temporary registration for students and pre-registered nurses ever opened? I think the original letter mentioned it. Could you update us on that?

***Amanda Pritchard:*** I don't want to give you the wrong answer on that one. What I can say is that, with the support of the NMC and others, we have tried to make sure we are not putting students in a position where they are unsupported. They have moved into positions where, rather than being supernumerary, they are still supervised. That is quite an important distinction in terms of making sure that people were not working outside their comfortable scope of practice. In terms of the temporary registration, I will have to come back to confirm that.

Q96 **Olivia Blake:** It has been in the news that the programme for student nurses has been cut short. What is the reason for that?

***Amanda Pritchard:*** There was, regrettably, some confusion over the actual nature of the arrangements that were put in place. It is worth saying that it is an enormous contribution that all of those students have made in supporting the NHS. It has been invaluable in giving that resilience that we talked about earlier. The intention was always that the third-year students, once they had competed their training, would be able to move into substantive positions, because they would reach a point where they were then qualified. Those people have been working in band 4 positions. Once they are qualified, they can then move into band 5 positions. It would not be that there would be a premature end; it would be more that they were then moving into substantive placements at a more senior grade.

It is slightly more complicated for second-year students. At the point where they have completed the hours required in clinical practice, we then provide the right support for them to move back into the academic part of their courses. It is obviously right that they continue their education so that, ultimately, we are not depriving people of that opportunity when they have put themselves forward to take on this role.

Q97 **Olivia Blake:** Do you envisage an operational impact if there is a second wave or a loss to the workforce? Also, are there are any plans for more financial support for student nurses?

***Amanda Pritchard:*** We would be enormously disappointed if people felt undervalued as a consequence of the way that this has been played out. My colleagues in HEE and NHSE&I are committed to sending out some further clarification and guidance imminently to try and give people a bit of support and greater clarity on the arrangements for them. Part of what they will be saying is how very grateful we all are for what people have done. Getting the right balance between education and service is something that they will be thinking hard about as we go into the autumn. The aim has been, as I said a moment ago, to find the right balance on supporting people to take on additional clinical practice, but not outside of an appropriate scope. As we go into winter, we are keen to make sure that people are not deprived of that educational experience.

Q98 **Olivia Blake:** Moving on to testing, Sheffield started testing their staff in the NHS trust much earlier, using local provision. Why was that not encouraged in other areas, and why was testing in care homes capped?

**Chair:** That was about availability. We covered the capping. Can I bring in Ros Roughton?

***Ros Roughton:*** On the care home testing, we made tests available as the testing capacity ramped up. I think we are now at about 70,000 a day in care homes. It is simply a matter of prioritising testing across the whole country.

Q99 **Olivia Blake:** Why weren't other NHS trusts encouraged to do what Sheffield did?

***Professor Powis:*** Shall I come in on that? We have been increasing testing of NHS staff. Clearly, in the NHS the priority is always, as you heard earlier, to test the patients who come in with symptoms and who were sick because of covid, and that has stayed the same. We have also started testing all patients who come in as emergencies as we have heard more about asymptomatic transmission in individuals. We have also started testing staff who are asymptomatic, particularly where we see hospitals that are managing a lot of infection. We continue to evolve that. Different trusts have been asked to review that locally, and where they see a need for more tests, and particularly of staff who do not have symptoms, they will do that. As, of course, the science evolves, we will continue to guide trusts.

The final thing I would say is that Public Health England has set up a large study, called Siren, which is asking NHS staff to join that study, which will sequentially test staff with the antigen test—that is the test that determines whether you have got it—and an antibody test. That is the test that tells you whether you have had it. It is that sort of academic endeavour that will actually give us the answers to a lot of the questions that we are struggling with, and some unknowns, such as the role of asymptomatic testing and also whether immunity develops, and how long

it develops for. So, much in the way that the NHS has led the world on dexamethasone, and learning how to treat, doing these sorts of large-scale academic study in the NHS will give us more information on how and when best to test.

Q100 **Olivia Blake:** Two more questions. This is to Professor Paul Johnstone and Ros again, if that is okay. Why have there been no excess deaths in hospices, compared to the 20,000-plus in care homes? Does this show any difference in the way staff have been treated? This is according to the report on disparities released by Public Health England. *[Interruption.]*

**Chair:** Who was that to, Ms Blake? With the bell going I could not hear.

**Olivia Blake:** Professor Paul Johnstone.

***Professor Johnstone:*** It is quite early to make great pronouncements about test numbers, but care homes have clearly been a high risk, and that reflects the higher numbers. I am not sure if Ros wants to make another comment.

***Ros Roughton:*** I do not know the reason for that, but it is something that we definitely want to look at, to learn from.

Q101 **Olivia Blake:** I was just going to finally ask, what is the current availability of testing for— *[Interruption.]*

**Chair:** Could you repeat the question? It is difficult to hear, with the bell. Now it has gone.

**Olivia Blake:** How available is testing now?

***Ros Roughton:*** For care staff? We have basically been doing a kind of sweep, of offering blanket testing to all care home staff and all residents, and we have just been taking advice, and will be making decisions shortly about what policy will be, going forward, around repeat testing—what the frequency would be and where the priorities should be, in the care sector. So, we will have more to say later.

**Chair:** Thank you. I am sure we will have more to ask later, too. I am going to bring in James Wild MP and then Sir Bernard Jenkin.

Q102 **James Wild:** I know from talking to nurses and doctors at the Queen Elizabeth Hospital in King's Lynn how affected they have been in dealing with the emotional trauma of treating patients with covid, and being with them in their final moments, so I want to ask a bit about mental health. Sir Simon, how is the NHS looking after the mental health of its employees?

***Sir Simon Stevens:*** You are quite right about that. This has obviously been a period without parallel in the professional and personal life of everybody working in the health service—particularly those people who have looked after more than 101,000 mainly older people who have had emergency hospitalisation for coronavirus. So, part of the response has

got to be ensuring that there is targeted psychological and mental health support available for staff across the health service.

Last year, for the first time, we introduced a dedicated practitioner mental health programme for doctors, but we are asking for those supports to be extended more widely by trusts and into primary care. Then, for particular staff groups, where their experience may have been different as well—for example, nurses from a Filipino background—we have been nationally putting in place particular helplines and support for them as well. But nobody has been unaffected, untouched, by this. That is true in our personal lives as well as our professional lives, and you are quite right to point that out.

Q103 **James Wild:** How are you tracking that picture across the NHS and what kind of picture do you have at the moment? What is your forecast in terms of cases of PTSD? What proportion of the workforce do you think might come forward with it?

***Sir Simon Stevens:*** I was talking about that very topic on Friday with Professor Sir Simon Wessely, who is regius professor of psychiatry at the Institute of Psychiatry, King's College London. I think it is fair to say that, on the one hand, there is an expectation that there will be increased anxiety and mental distress as a result, but PTSD in particular is a very diagnostically precise term, and the advice from some other equivalent areas is that it might not be PTSD specifically that we need to respond to. Part of what people like Professor Wessely and others are doing is tracking mental distress as distinct from mental disorder on the part of staff across the NHS, so that we can better design a mental health support offering, which my colleague Claire Murdoch is working on doing.

Q104 **James Wild:** Even before the crisis hit, mental health absence was an issue. You paused the people plan back in March. Do you have a date for when that is going to be published?

***Sir Simon Stevens:*** In a sense we have been getting on with a number of the building blocks, or elements, of the people plan regardless. One of the consequences of coronavirus over the past three months has been that we have fast-tracked a lot of the things that we were planning on doing in the health service in a very flexible and agile way.

The people plan is not just about support for our current staff; it is also about the funding that we discussed last time, I think, for education and training expansions that Health Education England will bring about. That is obviously a discussion that we are having with the Department of Health and with Government. Those aspects of the people plan that we can get on with, as the NHS, we are getting on with.

Q105 **James Wild:** That is good to know, because the interim plan did not refer particularly to mental health. It talked about shortages in mental health services—nurses and other professionals—but there was not a particular focus on treating mental health. Turning to the wider population, like other MPs I get a lot of emails from constituents who are shielding and struggling with loneliness and other challenges. What is your assessment

of the problems that we are going to see in wider society from mental health issues? Do you think that this is just a temporary thing, and once the lockdown lifts people will be healthy again?

***Sir Simon Stevens:*** Again, the gold standard for mental health research in this area is doing interviews rather than online surveys. A lot of the reports to date have been quite small-sample online surveys, so I do not think that there is a good empirical fix to answer the size and shape of the problem, but we believe that there will be extra pressure on mental health services. As a result, we are going to need to fast-track some of the service expansions that were already in hand as part of the long-term plan.

Q106 **Chair:** I think we have lots to focus on there in future—where you are going to get all those people from, for a start. Sir Simon, you were allocated £6.6 billion by the Treasury as part of the funding that you needed to tackle this emergency. Can you break down how that has been spent so far? What is it being spent on?

***Sir Simon Stevens:*** I think it was laid out in the NAO Report that we discussed last time.

Q107 **Chair:** Well, that was then. Do you have an update? Let me drive at the point. Some of the money has been spent to support the peak, but, because of the time it took to spend it, the peak has passed, so you have people in temporary roles, reallocated, retrained, etc. How much of that is money that is well spent, which will have a dividend in the future, and how much of it is what I think the Treasury would tend to call dead-weight money, because it is not actually delivering anything that you need right now? We expect in a crisis that the planning will not always quite align, but have you done any analysis of that, so that you can plan for any future peak?

***Sir Simon Stevens:*** That is the discussion that we are having with Government as we speak, for reasons related to the question that was asked earlier about planning for a possible second peak and dealing with the overhang of services that had to be deferred during the first peak. It is worth saying that people are now taking it for granted that the NHS was not overwhelmed during this first period. In fact, that was anything but certain. All the evidence pointed to the fact that there would potentially be millions of people requiring hospital care, as we saw in Wuhan, northern Italy and so on. The investment we made in capacity was entirely appropriate.

Q108 **Chair:** Sir Simon, I get that. You can sometimes plan, but things don't always line up. You recruit people but cannot get them in time. Now you have people in position—out of retirement, retrained or temporary staff—and a cadre of people potentially able to help. Some of them are on short-term contracts. How will you ensure that the money invested in that solution, which will all get used, is ready and waiting on the stocks if we hit a second peak?

***Sir Simon Stevens:*** That is what we want to do, and we are in dialogue with colleagues about what the right level of resourcing for that looks like for the balance of the year. One thing that will be important is ensuring that we in the NHS get a clear early signal from the new monitoring apparatus, the surveillance system and the Joint Biosecurity Centre that is being created, which gives us at least several weeks of advance notice of whether there is an emerging spike in a particular geography.

Q109 **Chair:** You had the Nightingale hospitals. You had the private sector hospitals. You suggested that you used a lot of their staff. Did you have enough staff to deliver the care you were buying in, whether from those two places or elsewhere, and do you have enough staff ready and available for any potential second peak to actually do this work?

***Sir Simon Stevens:*** We went into the coronavirus emergency with a gross 100,000 staff vacancies across the NHS, as you know. Some of those were being covered by people working extra shifts, including temporary staff. As it happens, we have seen a fantastic response both from those who have come back to the NHS and those who have started their career early. Yes, under highly stressful circumstances, the NHS was able to cope.

I will not deny the fact that it was pretty scary at times. On 17 March, we had a few hundred coronavirus patients; a week later it was 3,500; a week after that it was 11,000 in hospital beds; and a week after that it was 18,000. It is easy to forget precisely how sharp the increase in demand on staff and capacity was from mid-March through to the peak in mid-April.

Q110 **Chair:** I ask that question partly because we have acknowledged that the NHS coped, in a sense, in that people bust a gut, worked long hours and put in the time, but, as Mr Wild has highlighted, that came at a great personal cost. The question is whether they could do that again without it being at such personal cost that it is not possible.

***Amanda Pritchard:*** I think that does build on what Simon was saying earlier about the number of different initiatives that we have tried to put in place to support staff health and wellbeing. At the moment, we are focusing on ensuring that the primary responsibility of all health service leaders to the safety of their staff and patients—

Q111 **Chair:** That is the theory—I am not knocking it—but the practical thing now is that having gone through hell on earth on a critical care ward or having been redeployed elsewhere and worked like crazy to support our country, NHS staff are on their knees. They now have a gap where they must treat all the patients in the backlog, and then there could be a second peak. The theory is there, but in practical reality, what precisely are you doing to ensure you are ready to cope with personnel in the next peak, if it happens?

***Amanda Pritchard:*** There are several different strands to this. First, this is top of mind, because having physical capacity is useless unless you have the workforce to enable it to be used to look after patients. There are

a couple of things It is absolutely about the health and wellbeing points that colleagues have made. That was a critical theme through the people plan and has remained a primary focus for us nationally, regionally and locally.

Every time I talk to colleagues in the health service—I talk to them all the time—the first thing they will talk about is how they can make sure that they are supporting their own staff and colleagues. The second thing is, again, also a very practical one. The thinking that we are doing is, of course, about all those people who have so generously offered to return to the NHS. Let's try to make it possible for them to stay. Let's think really creatively about different models of—

Q112 **Chair:** That is great. You want them to stay, but you won't have the money. We in this Committee have looked often at the money that is available to trusts. There is not enough at settlement day to actually pay for it. Why were those vacancies there? They were not there by accident; they were often there because there is not enough money to pay for them. The money that you were given for the emergency—you still have not got a guarantee that you will get the next wave. Can you afford to staff the NHS at a higher level than you have been doing, in order to cope not just with the next peak, but more generally with the pressures that the coronavirus has thrown up?

***Amanda Pritchard:*** That is obviously one of the things we are actively discussing with colleagues in DHSC and in Government at the moment, but many of the vacancies were previous to covid; they are still there now. It was to do with the supply of staff, not with a lack of resource. It is both/and. That is why we are trying to make sure that, as I say, we are doing the things that are within our control, which is very much about supporting the people who we already have working with us and continuing to look at the more creative, radical ways that we have encouraged people to come back to stay with us, and thinking also about more flexible ways to use the workforce. One of the things that we are clearly being asked to do by colleagues across the NHS is to continue to build on the multi-disciplinary working and the more flexible deployment model, which for many people has been a really energising thing to do. Those are the sorts of things that we have made it clear we need to do to make sure that we are supporting the NHS to be ready for winter, regardless of whether there is a second wave or not, while we continue to work this way.

Q113 **Chair:** I would just contend that there is going to be an issue if you cannot afford to pay for them, but we have not got time to go into that more; we look at that regularly on this Committee, anyway. I want to ask Sir Chris something before I pass to Peter Grant and then to Sir Bernard Jenkin. Sir Chris, if you could send us the monthly figures for PPE procured and distributed since the end of January, that would be very helpful. Is that something you can provide us with?

***Sir Chris Wormald:*** I will need to go and consult our PPE team, but I will look at what we have done on that.

Q114 **Chair:** Figure 23 in the NAO Report lists items. For ease of recording, it would be helpful to go with those categories, if that is okay.

***Sir Chris Wormald:*** I am sure we can do that.

**Chair:** Thank you. We will look forward to hearing from you on that. Let's go to Peter Grant, and then the last word will go to Sir Bernard Jenkin.

Q115 **Peter Grant:** I want to pick up on one of the recent comments about the fact that, if the precautions that we took in the middle of March had not worked, we would have been facing—I think the witness said—potentially a million or more people being hospitalised. I might be remembering incorrectly, but in answer to a previous question about the difficulty in anticipating the demand for some protective equipment, I think part of the answer was that the virus was landing more people in hospital than we had anticipated. Unless I have completely misremembered the answer, it seems that we have a virus that on the one hand puts far more people into hospital than we had expected, and on the other hand puts far fewer people into hospital. Is there a contradiction there, or is there something I am missing?

***Sir Chris Wormald:*** No, there isn't a contradiction there. The numbers that Sir Simon is quoting are what the reasonable worst-case scenario would have been if the actions that the Government and the wider society took, in terms of non-pharmaceutical interventions and social distancing measures, had not worked. Sir Simon may like to add to that, but the basis of our concern in March was what would happen to the health service and elsewhere if the measures that we put in place did not cause the flattening of the peak and the decline that we have in fact seen. There is a separate thing, which we did not know at the beginning of the outbreak and which we have learned as we have gone on: it is about where PPE is required due to the concerns about asymptomatic transmission. Those are two separate issues, but Simon, that was the point you were getting at, wasn't it?

Q116 **Peter Grant:** That suggests to me that whatever was planned for in advance was not a reasonable worst-case scenario. Was the planning done on the basis that it was something that would be as bad as, or worse than, the 1918-19 flu epidemic? Isn't that what the reasonable worst-case scenario should have been?

***Sir Simon Stevens:*** If you look at the SAGE papers and the modelling, which have now been published, you will see quite clearly that in mid-March, there was a very dramatic shift in the forecast as to what might happen as a result of coronavirus. That showed that potentially over 4% of the population might be hospitalised, and 30% of those would require critical care. The reason I say this was a very scary time for everybody in the NHS is that if you look at the minute published by SPI-M, the modelling group, on 20 March—several days after we had pulled the trigger on freeing up NHS capacity—it said, "It is very likely that we will see ICU capacity in London breached by the end of the month, even if additional measures are put in place today."

Q117 **Chair:** The problem is, Sir Simon, we have not seen who this group is. We do not see these figures; if you could supply them to us, that might be helpful, but it is difficult when you introduce it in the middle of a meeting.

***Sir Simon Stevens:*** It is on the SAGE website, and it is 20 March. I am just pointing out that hindsight bias is a wonderful thing, but that is not what was actually going on at the time.

**Chair:** The last word goes to Sir Bernard Jenkin.

Q118 **Sir Bernard Jenkin:** I will be as brief as I can, and I am very grateful, having missed a certain amount of this meeting because of other duties. Forgive me for that, but I have been listening to the last hour and a half of this, at least, and there is a mismatch between being so ready for some eventualities and not ready for others. How clear was it who was responsible for ensuring we had sufficient beds and ventilators?

**Chair:** Who is that to, Sir Bernard?

**Sir Bernard Jenkin:** Whoever wishes to answer.

***Sir Chris Wormald:*** That was one of the curious bits. The NAO Report sets out the various responsibilities that, in the NHS, are very clear indeed. What I will say is that how we dealt with this crisis in the early stages was to not particularly worry about whose job was what. This was done jointly.

Q119 **Sir Bernard Jenkin:** This is the interesting question. I asked who was made responsible for making sure we had enough beds and ventilators.

***Sir Chris Wormald:*** The provision of hospital care is quite clearly the primary responsibility of NHS England and Improvement. What I would say is that this was a giant cross-Government—

Q120 **Sir Bernard Jenkin:** I understand that, but I am asking what we have learned about accountability and responsibility. What body had equivalent responsibility for the safety of people being transferred to care homes from hospitals?

***Sir Chris Wormald:*** As I described earlier in this hearing, it is not a secret to anyone that statutory responsibilities in social care are spread between national Government, local government and individual providers. How we acted, however, was to essentially nationalise a lot of questions.

I have never denied that there is considerable ambiguity in how social care is managed, and I have discussed that with the Committee before. What national Government did, within the powers available to us, was to push the limits of what we could do in order to address the questions you are raising. As I said right at the beginning of this hearing, no one is denying that the challenges in social care because of those structural questions were particularly huge, compared with the clarity on the NHS side.

Q121 **Sir Bernard Jenkin:** The creative question to ask at the end of this, then, is: what is going to change so that in future, there is comparable clarity—as NHS England has for beds and ventilators—for the safety of people in

care homes and the provision of PPE in those homes?

***Sir Chris Wormald:*** That is not a question I can answer. We operate within the laws and statutory framework that Parliament gives us. I do not think I am straying beyond my civil service neutrality if I say that I believe there is a considerable consensus in Parliament and elsewhere that there needs to be change, and our experiences with covid heighten that need. However, as I say, the approach we took at the beginning of covid was to do the things we thought were necessary, regardless—I am not going to say, "regardless of the statutory position", but pushing the statutory position to its limit.

**Sir Bernard Jenkin:** I have the utmost sympathy for everybody on the frontline of the NHS, but I imagine it was pretty torrid in the Department of Health as well at the bad moments, so thank you for everything you did.

***Sir Chris Wormald:*** That is very kind of you.

**Chair:** Thank you very much, Sir Bernard. Thank you to our witnesses and thank you to the Committee.