NHS Providers' submission to the House of Lords Public Services Committee inquiry:
Public services: lessons from coronavirus
9 June 2020

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Key points

- Trusts and the wider NHS have worked incredibly hard to meet the unprecedented challenge presented by COVID-19. All sectors have worked together to create capacity for critically ill patients.
- Trusts were presented with two immediate challenges at the onset of the pandemic: the supply and distribution of Personal Protective Equipment and testing.
- The care home sector has suffered considerably during the pandemic, with high numbers of excess deaths and emergency funding unable to repair the damage caused by years of underinvestment.
- The pandemic has highlighted the need to respond to the needs of the Black, Asian and Minority Ethnic (BAME) workforce and the need to go further in tackling systemic racism
- COVID-19 has presented health and care with the opportunity to drive innovation in the health and care sector. For example, moving many services online at pace, providing mutual aid and rapidly implementing new policies has helped to relieve pressure on services and allow staff to care for patients.
- The COVID-19 outbreak has underlined the need for better coordination from central government with Arms Length Bodies (ALBs) and the NHS frontline.

What have been the main areas of public service success and failure during the Covid-19 outbreak?

Public service successes

1. The outbreak of COVID-19 and the task of treating those seriously ill with the virus presented an unprecedented challenge for trusts and the wider health and care system. Prior to the pandemic, NHS trusts were already grappling with rapidly growing demand for healthcare. The NHS was facing its longest and deepest financial squeeze in NHS

history with over 100,000 workforce vacancies in the trust sector alone and staff exhausted after coping with year-round levels of 'winter' demand. Despite treating record numbers of patients, trusts were recording their lowest results against performance standards in elective surgery and emergency care in over a decade. Community, mental health and ambulance services were under similar pressure. The challenges in social care have also been well documented with the Association of Directors of Adult Social Services estimating the sector has had to make £7 billion of savings since 2010[1].

2. In this context, the fact the NHS has created sufficient extra capacity at speed, to successfully manage the first peak of the virus, must be viewed as a key success. Trusts significantly expanded their critical care capacity by repurposing wards and theatres and, in some cases, literally moving units to other parts of the hospital to create critical care capacity for extremely ill patients. For example, one hospital moved their entire paediatric intensive care unit to a completely different part of their hospital with no loss of bed space. Trusts providing community services implemented a new 'discharge to assess' model within days, deprioritising some services and creating capacity for step down beds and rehabilitation outside of hospital settings. Trusts providing mental health services created 24/7 helplines within weeks, and established emergency care and support to ensure those with mental health issues did not have to attend traditional A&E settings. The ambulance service and 111 response to these unprecedented pressures and operational challenges included finding a means to deep clean each vehicle after transporting patients. All trusts worked with partners to accelerate the use of digital technologies.

3. The incredible response from frontline staff to respond to the demands placed on them is, without doubt, another key area of success for trusts and the wider NHS. Staff were quick to reorganise workstreams and have been extremely flexible in order to provide continuity of care to seriously ill patients. Trusts increased the number of staff able to care for critically ill COVID-19 patients, redeploying staff to care for patients outside of their usual specialties with appropriate training.

4. Without a flexible reconfiguration of facilities and the dedication of staff to care for patients outside of their usual specialities, the NHS would not have had the capacity to treat the thousands of patients in intensive care settings who required care because of the Covid-19 pandemic.

Challenges

5. The provider sector has faced significant challenges during the outbreak, with the supply and distribution of Personal Protective Equipment (PPE) and capacity for testing being particularly problematic. While we understand from most trusts that they are now regularly receiving the right PPE when they need it, there are still a number of issues and

[1] Association of Directors of Adult Social Services, June 2019, ADASS Budget Survey 2019

supply isn't as consistent and reliable as it needs to be. This is all the more pressing given the secretary of state's announcement on Friday 5 June that all NHS staff, including back office workers will be required to wear type 1 and 2 masks. This will not be possible unless government acts to secure a sustainable supply of masks. The difficulties experienced throughout the pandemic in obtaining certain items for frontline staff has highlighted that the stockpile in the UK was not fit for the coronavirus pandemic.

6. The testing regime is another area where, despite the hard work of trusts and the wider health service, the UK has struggled to develop a clear strategy, a coordinated approach, and sufficient capacity. Despite the introduction of Track and Trace, the UK's system is still a long way from being fit for purpose.

7. The care home sector has clearly suffered considerably during the pandemic, with high numbers of excess deaths and emergency funding unable to repair the damage caused by years of underinvestment. A public inquiry into the UK's response to COVID-19 will need to examine why this was the case. Throughout the crisis, trusts have been committed to supporting their partners in the care sector, who look after the most vulnerable members of society, and this commitment has never been stronger than during the COVID-19 pandemic. Trust leaders strongly refute the suggestion that they "systematically" discharged those known or suspected of having COVID-19 into care home settings; discharge procedures were agreed on the basis, as they always have been, of a measurement of the overall balance of risk to individual patients, taking into account that acute hospitals are not safe environments once they have recovered.[2]

8. Overall, we feel there has been a lack of strategic overview and sufficient planning from the government in terms of making decisions and announcements, and putting these into operation. Throughout the pandemic, trust leaders have felt that there have been a number of announcements which have come with little or no consultation and without plans in place to ensure they can be carried out effectively.

How have public attitudes to public services changed as a result of the Covid-19 outbreak?

9. Since the outbreak of the pandemic, we have seen health and care workers going above and beyond to care for critically ill patients. The public response has been positive, as we have seen from the Clap for Carers initiative and various fundraising efforts for the NHS.

10. However, there is also an indication that during the outbreak, some people have become more wary of accessing health services when they need them, either because they fear catching the virus or because they do not want to overburden the service during the pandemic. Trusts have seen an unprecedented fall in the number of people accessing their services and are concerned at the marked drop in demand for key

[2] NHS Providers, 19 May, Spotlight on recent NHS discharges into care homes

services such as A&E, cancer diagnostics, neurosurgery and urgent cardiology services. In mental health, GP referrals and patient presentations have dropped since the start of the pandemic with fears that those who need care might not be accessing services until they are at crisis point. The Royal College of Psychiatrists has reported increased numbers of people needing urgent and emergency mental health care, alongside a reduction in routine care, especially for older adults, for children and young people, and within general hospitals.[3] Decisions not to seek help could lead to a delay in diagnosis and a deterioration in people's overall health, which could lead to poorer outcomes. Furthermore, delays in seeking help now may lead to a spike in pent-up demand of more complex and advanced needs which risks overwhelming trusts when the lockdown is eased.

Did resource problems or capacity issues limit the ability of public services to respond to the crisis? Are there lessons to be learnt from the pandemic on how resources can be better allocated and public service resilience improved?

11. PPE and testing are two key areas where resource and capacity issues presented challenges for NHS trust leaders. Looking first at PPE, it is important to emphasise that NHS procurement and supply chain management was centralised over the last decade. The supply chain in recent years has served the NHS well, with just in time delivery of goods and supplies based on a stable and predictable pattern of demand. In addition, the UK held a significant reserve of equipment ready for distribution in the case of a pandemic. At the outbreak of COVID-19, demand for some items increased by 5000% overnight, and naturally every trust had a much higher demand for PPE and all wanted it at the same time.

12. Huge logistical challenges were presented when trying to distribute the amount of PPE needed across the country which led to NHS leaders mobilising help from the army and UK logistics industry quickly, as well as changing the way in which items were distributed. Added to logistical issues was the overwhelming worldwide demand for PPE. At certain points during the first peak, trusts came dangerously close to running out of certain items of PPE, with gowns being in particularly short supply. At this time, trusts worked with other local providers to ensure that gown stock was shared wherever possible. Trust leaders believe it is vital to involve them in finding solutions to these problems at an early stage – they would prefer to know if there is going to be a shortage of a particular item well in advance so they can work with others to mitigate any risks.

13. Nothing is more important than ensuring their staff have the personal protection equipment they need to keep themselves safe. It is a priority for trust leaders to ensure that frontline staff can have confidence in their own safety as they treat and care for patients. This is of particular concern when it comes to protecting Black, Asian and Minority Ethnic (BAME) staff. Trust leaders are working hard to take appropriate steps to

[3] NHS Providers, 3 June 2020, Spotlight on the impact of COVID-19 on mental health trusts in the NHS

ensure the safety of BAME staff and those staff who are most at risk, by following updated guidance from NHS Employers[4].

14. Despite all the work delivered by trusts and the NHS, the health and care system has struggled to develop an effective, coordinated approach to testing. This is clearly one area where trust leaders would have liked the health and care system to have been able to perform better as part of the response to COVID-19. Initially, NHS trusts were facing unprecedented staff absence rates due to staff either being sick or needing to adhere to self-isolation rules in the absence of sufficient testing. By the end of March, national leaders allowed 15% of trust capacity to be used for staff testing and this revealed, as trusts had argued, that a significant number of staff were self-isolating unnecessarily and were able to return to work.

15. We have welcomed the appointment of Baroness Dido Harding to lead the testing response and have highlighted the following challenges to her:

    - Issues still exist with obtaining routine tests for staff and patients. Without systematic testing of patients and staff, it will not be possible to safely get services up and running for patients who need physical treatment on an NHS site.
    - Trust leaders remain unsure as to how the new NHS Test and Trace service, which requires individuals who have been in contact with a person who tests positive for coronavirus to self-isolate for 14 days, will apply to NHS staff who work in environments with COVID-19 patients. This could result in entire teams being off work for weeks, thereby jeopardising service delivery.

16. Trusts leaders tell us they need the following:

    - external testing support and details on when this will happen and how quickly.
    - clarity on when the turnaround for test results to be processed will routinely be 24 hours for symptomatic patients and staff – currently the turnaround time for some health and care providers is three to seven days
    - clarification on when local test and trace operations will be ready to cope with significant local surges in activity.

17. Many of the problems around testing have been exacerbated by dispersed and unclear accountability between a number of different ALBs and different parts of government. It is essential to reflect on how the lessons learnt from this experience should impact ways of working in the future.

Did workforce pressures preceding the crisis, such as difficulties in the recruitment or retention of workers, limit the ability of public services to meet people's needs during the

[4] NHS Employers, 28 May 2020, Risk Assessments for Staff

lockdown? How effectively, if at all, have these issues been addressed during the Covid-19 outbreak? Do public services require a new approach to staff wellbeing?

18. NHS trusts were already grappling with rapidly growing demand for healthcare before the COVID-19 crisis started. After the longest and deepest financial squeeze in NHS history, the service entered the pandemic with over 100,000 workforce vacancies in the trust sector alone. Despite treating record numbers of patients, trusts were recording their lowest results against performance standards in elective surgery and emergency care in over a decade. Community, mental health and ambulance services were under similar pressure.

19. Trusts have been creative and proactive in redeploying staff to cover the areas of greatest need from the beginning of the outbreak. The bolstering of the workforce with early qualification of healthcare students, returned retirees, and support from the private sector was helpful in this effort, alongside guidance from professional regulators and other national bodies assuring trusts and staff of their ability to work outside of their traditional specialties and professional boundaries.

20. Recently, NHS England and NHS Improvement (NHSEI) reported a significant reduction in the number of NHS vacancies[5]. As such, workforce pressures appear to have been eased to a degree. However, this is likely to be linked in part to a different approach to traditional recruitment efforts in the early stages of the pandemic.

21. The health and care sector needs a constant and growing focus on staff wellbeing. This was made clear in the findings of the latest NHS staff survey: while small improvements were seen in some wellbeing indicators from previous years, there are still major concerns. For example, over 40% of staff reported feeling unwell due to work-related stress over a 12-month period, and far too many staff are working significant additional hours[6]. NHS Providers has been clear that initiatives to improve NHS staff wellbeing must be complemented by action to address persistent workforce shortages.

22. Work to investigate the impact of COVID-19 on BAME NHS and care staff is ongoing, but initial analysis points towards a significantly elevated risk of death for these groups. Through our daily engagement with trust leaders, we have heard their observations, concerns and activity in relation to their BAME staff. Themes included enhanced support in the form of letters to BAME staff, promoted activity on trust's BAME networks and groups as well as listening events with trust leaders. Details of the risk assessment process were also compared across trusts and systems, with a number of examples of seeking to work collaboratively on the response to this challenge across the health and care landscape. While there has been some discussion in the media about the potential for automatic mass re-deployment of BAME staff away from patient-facing activity, new guidance provides a steer for individual organisations to approach these challenges in a manner which responds directly to identified risk within their organisation and, crucially, the expressed wishes and feelings of their BAME staff.

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[5] NHS Digital, 28 May 2020, NHS Vacancy Statistics

[6] NHS England Survey Coordination Centre, February 2020, NHS Staff Survey 2019

23. In the forthcoming NHS People Plan, we hope to see innovative ideas to help trusts consider ways to improve the wellbeing of their workforce, alongside local initiatives they are already taking forward. However, until NHS workforce supply is increased to match ever-growing demand, there will be considerable limitations on the impact that any reforms to staff wellbeing can have.

Why have some public services been able to achieve goals within a much shorter timeframe than typically would have been expected before the Covid-19 outbreak – for example, the increase in NHS capacity? What lessons can be learnt?

24. The NHS has been front and centre of the NHS response to coronavirus. Given the NHS' key role in delivering critical care for patients ill with COVID-19, many of whom need expert care and treatment, trusts and health leaders worked to ensure the NHS was as prepared as possible to cope with the first wave of the virus. A number of measures allowed the NHS to react quickly to outbreak. NHSEI wrote to health services on the 17 March[7] asking them to enact measures to help them to cope with the predicted increase in demand. This included postponing all non-urgent elective work, urgently discharging medically fit patients from hospital, and freeing up community hospital and intermediate care beds. The NHS successfully transformed it discharge policy to allow this rapid discharge process and thanks to the work of NHS community and mental health trusts, local government and social care, record numbers of patients were discharged to intermediate care beds or to their homes with rehabilitation support in record time when they were medically fit to move to different care settings.

25. Trusts in the acute sector were supported by national modelling, analysis and intelligence, worked hard to estimate what the likely pattern of extra coronavirus related demand would be. The modelling predicted overall demand, ventilation requirement, mortality rates and length of stay so trusts had a fair idea of what to expect. This modelling is a key advantage of our state funded and nationally coordinated NHS and it would be helpful to see the approach rolled out for mental health and community services in the near future.

26. To protect patients and save lives, trusts worked hard to reconfigure their services as speed. At the start of the outbreak, Nightingale Hospitals, and the Seacole Hospital were created extremely quickly, freeing up capacity for trusts to look after the most severely ill patients.

27. The ability of the NHS to adapt certain regulations was a key factor in helping the NHS to achieve its goals in a much shorter timeframe than would normally be expected. Although its vital to recognise that healthcare carries risk and therefore some level of regulation will always be needed, a more flexible approach to regulation without a

[7] NHS England and NHS Improvement, 17 March 2020, Letter from Sir Simon Stevens and Amanda Pritchard

doubt enabled the NHS to react at speed. The NHS was also fortunate to have support from a range of partners, such as the army and volunteers, to help it react rapidly.

Has the delivery of public services changed as a result of coronavirus? For example, have any services adopted new methods of meeting people's needs in response to the outbreak? What lessons can be learnt from innovation during coronavirus?

28. On 17 March, NHSEI wrote to NHS bodies asking them to enact a number of measures to free up capacity to cope with the unprecedented demand caused by COVID-19[8]. To implement this, many trusts delayed core services, such as non-urgent elective care, in order to look after critically ill patients. With other planned care, such as routine appointments and follow up appointments, trusts and the wider NHS have been able to deliver care in a different way, either by speaking to patients over the phone or online. A significant amount of healthcare provision, such as GP appointments, outpatient appointments and basic consultations have been moved online at record pace.

29. The outbreak has demonstrated what can be achieved when digital transformation is prioritised and funding is made available for it. For example, GPs have been asked to include additional COVID related information in patient records which gives clinicians better medical information about COVID patients when they are treated. NHSX and NHS Digital primarily used GP records to compile the Shielded Patient List and GP connect (a tool that allows GPs to share patient information and gives patients greater access to local primary care) is being used to notify local primary care systems of patients suspected of suffering from COVID.

Are there any examples of services collaborating in new and effective ways as a result of Covid-19? Are there lessons to be learnt for central Government and national regulators in supporting the integration of services?

30. COVID-19 has accelerated innovation and collaboration across the health and care system, helping to meet unprecedented levels of demand. This progress has made particular strides in areas where the groundwork of system working and integration had already been laid. Sustainability and Transformation Partnerships and Integrated Care Systems have fulfilled the role of convenor, facilitating planning across the local health and care system and mutual aid schemes for PPE, supporting trusts and other providers in their delivery roles. Reduced governance burden during the pandemic has facilitated rapid decision-making between different health and care organisations, often led via the new leadership cells in which providers have a key voice.

31. NHSEI's letter on 17 March[9] suspended contracting between providers and commissioners, so collaboration has effectively replaced competition. This has enabled providers to deliver services in new, effective ways. For example, reconfiguring services

[8] NHS England and NHS Improvement, 17 March 2020, Letter from Sir Simon Stevens and Amanda Pritchard
[9] NHS England and NHS Improvement, 17 March 2020, Letter from Sir Simon Stevens and Amanda Pritchard

into COVID and non-COVID sites, CCGs and trust teams supporting care homes with Integrated Personal Commissioning and redesigning pathways through mental health and community services. Well established Primary Care Networks (PCNs) have been coordinating shielding patients. Community, primary and social care providers have flexed to work in expanded multidisciplinary teams to support care homes via virtual ward rounds, workforce support to stop providers with high turnover or vacancy rates from becoming overwhelmed.

32. Other innovative partnerships include Barbour producing fluid repellent gowns for trusts in the North East. Overall, relaxing the regulatory and funding barriers around NHS Continuing Healthcare has been incredibly welcome. The rapid discharge to assess model (which was already in place in some areas of the country) has meant that hospital bed occupancy rates have decreased.

33. Trusts were able to innovate and work collaboratively thanks to a more light touch approach to regulation. While this approach would not be suitable in "normal" post-COVID provision, we believe that a system which facilitates more local autonomy and avoids duplication would be advisable.

What does the experience of public services during the outbreak tell us about services' ability to collaborate to provide "person-centred care"?

34. The outbreak of COVID-19 and the introduction of social distancing and shielding for the most vulnerable has led to NHSEI advising people to limit visits to patients, and to consider other ways of keeping in touch. Trusts have worked hard to support patients and service users to maintain contact with loved ones, in particular for those who are particularly vulnerable or at the end of their lives, prioritising visits for those individuals and helping visitors to visit family safely. Frontline staff are focussing their efforts on being there for the people they care for and providing them with any extra support they need while restrictions on visiting are in place. Mental health trusts are working with primary care, community health and acute trusts to get the best solution for patients and have adapted services to deliver them remotely where possible.

35. Trusts are taking an active role in signposting and sharing with patients, service users and their families and carers up-to-date information on COVID-19. Trusts are keen to see the development of communication materials that they can share with patients and families in languages other than English.

36. We have seen 24/7 mental health emergency service access lines rapidly established to cover all areas of the country to children and adults in crisis. Mental health trusts have also set up mental health A&Es to help those in crisis and to ease pressures on emergency departments. These initiatives demonstrate how collaboration between different sectors (including the voluntary sector) is having a positive impact on delivering person centred care.

How well did central and local government, and national and local services, work together to coordinate public services during the outbreak? For example, how effectively have national and local agencies shared data?

37. The fact that the NHS is a national system, supported by national infrastructure was a strength of the collective response to the pandemic. Trusts supported the easing of various aspects of national regulation and bureaucracy during the outbreak. They welcomed clear, regular and timely communications, and efforts from national bodies to offer clear direction while allowing local trusts and their system partners to work out the practicalities without too much prescription. The suspension of usual financial rules also facilitated system working and allowed for a swift response to the crisis. Many trusts benefitted from a nationally negotiated deal with the independent sector to increase capacity and supported the delivery of the Nightingale and Seacole hospitals.

38. However, challenges have remained despite best efforts locally and nationally. As outlined earlier, the supply and distribution of PPE has been problematic, but trusts understand the importance of a nationally co-ordinated system during the early stages of the pandemic, and of moves to prioritise the distribution of key equipment including ventilators. Trusts would have welcomed a much more coherent and co-ordinated strategy for testing earlier in the outbreak, or indeed in preparation for COVID-19 hitting the UK. However, they have also welcomed the recent focus on local co-ordination of NHS Test and Trace.

39. In the early phases of the NHS response to the pandemic trusts have told us that NHSEI offered a set of clear national "must do's" without being prescriptive as to how these should be achieved locally. As the virus becomes more contained, and as we progress through the pandemic, trusts are now keen to move away from a rigid 'command and control' structure to ensure they best serve their local community needs.

40. Many trusts have told us that the experience of the pandemic has galvanised integrated working within local systems and strengthened relationships. However, we know that this is largely dependent on local relationships. It is certainly possible that the NHS 'machinery' was in some ways better set up to deal with a national crisis on the scale of the pandemic. While trusts have offered mutual aid and support to colleagues in the care sector, we know that many colleagues in social care felt left without sufficient information and support during this critical time.

How effectively has the Government worked with the private sector to ensure services have continued to operate during the Covid-19 outbreak?

41. Extra staff, equipment and beds were made available to the NHS following a **c**omprehensive deal with the independent hospital sector to use their capacity to treat both coronavirus patients and to help the NHS deliver other urgent operations and cancer treatments. Trusts have welcomed this supportive and collaborative partnership with the independent sector. We believe there is a strong argument to contract this capacity for a further period of time, particularly as we approach winter and the

possibility of a second peak. Trusts recognise their responsibility to ensure capacity is used to best effect if contracted for a further period.