

# All Party Group on Coronavirus: inquiry on the UK's handling of the coronavirus outbreak

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 £87bn of annual expenditure and employing more than one million staff.

## Key points

- The health and care system was already under severe strain before COVID-19 struck, with growing demand for healthcare, workforce shortages and insufficient levels of funding.
- The pandemic has shone a light on the need for reform and sustainable funding of our social care sector. Although emergency funding has helped in the short term, it is not enough to undo years of underinvestment in the sector.
- The outbreak revealed that the UK was not sufficiently prepared for a pandemic, with levels of Personal Protective Equipment (PPE) running dangerously low at some points.
- Black, Asian and minority ethnic staff in the NHS have suffered disproportionately as a result of the pandemic. The link between systemic race inequalities and health inequalities should be addressed as an urgent priority.
- Despite the challenges faced by NHS trusts since the outbreak of COVID-19, trust leaders are proud of what has been achieved, from expanding critical care capacity to creating mental health A&E's for patients in crisis.

## Overview

1. COVID-19 has placed the NHS under unprecedented strain at a time when demand for health and care services was already at an all-time high. Prior to the pandemic, NHS trusts were 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 and staff exhausted after coping with year-round levels of 'winter' demand. Despite treating record numbers of patients, trusts in the acute sector were recording their lowest results against performance standards in elective surgery and emergency care in over a decade. The challenges facing trusts in the acute sector were replicated across community, mental health and ambulance services, which were similarly stretched to capacity during the first wave of the pandemic. Continued underinvestment in mental health, both in services and in the mental health estate were brought to the fore during the pandemic, highlighting the need for urgent investment.
2. Alongside the challenges facing the NHS, the pressures on social care are well documented, and yet [funding for social care remains below 2010/11 levels](#). [The Health Foundation](#) estimates that the social care funding gap will be between £2.1bn and £12.2bn by 2023/24 while a report by the [Institute for Fiscal Studies and the Health Foundation](#) calculated that social care funding would need to increase by 3.9% a year. This lack of investment, coupled with the failure by successive governments to reform social care, has meant that the care home sector suffered considerably during the pandemic, with high numbers of excess deaths. Emergency funding has been essential to support the sector in the immediate term but is insufficient to repair the damage caused by years of underinvestment.
3. Despite these challenges, trusts across the acute, community, mental health and ambulance sectors achieved an extraordinary amount over the last few months. From expanding critical care capacity and the number of staff who can look after critically ill coronavirus patients and diverting planned care for patients, to placing services online, creating 'mental health A&Es' for patients in crisis and swiftly developing capacity to support rapid discharge of medically fit patients into the community, trust leaders are rightly proud of the significant transformation by the NHS to meet the demands the pandemic has placed upon it.
4. What is clear is that the health and care system was already facing major challenges before the outbreak of COVID-19. The scale of the challenge presented by the pandemic meant that both national and local trust leaders were confronted with difficult choices and the need to make

decisions at speed. From the timing of lockdown, PPE supply and distribution, test and trace to the disproportionate impact of COVID-19 on Black, Asian and minority ethnic groups and the discharging of residents into care homes, this timely inquiry by the APPG on Coronavirus will be able to explore what lessons can be learnt and what measures should be put in place to mitigate the impact of any future waves or new pandemics.

## Lockdown and easing of restrictions

5. The introduction of a **national lockdown on 23 March** helped protect the NHS and control the spread of the virus. Throughout the pandemic, NHS Providers argued that any easing of restrictions should be in line with a full test, trace and isolate infrastructure being in place, with clear rules on social distancing in order to minimise the risk of a second spike in transmission. We note that at the end of May, **senior scientists expressed concern** about the government lifting lockdown restrictions while the number of new coronavirus cases recorded each day remained relatively high and the test and trace system was not fully up and running.
6. Given the spike in cases in a trust in the South West of England in late May and a local lockdown in Leicester at the end of June, it is clear that COVID-19 remains a serious threat, with further spikes possible in the coming months. The risks of a second surge in cases continue to be a concern for trust leaders; going forward, local teams must have access to the information and support they need to be able to respond quickly and efficiently to local outbreaks of COVID-19.

## Personal protective equipment and stockpiles

7. Ensuring the effective supply and distribution of Personal Protective Equipment (PPE) has been a significant challenge for the national NHS bodies during the COVID-19 pandemic, creating challenges for local trusts and their partners. The overwhelming worldwide demand for PPE was compounded by the huge logistical challenges of trying to distribute volumes of PPE across the country. At certain points during the first peak, trusts came dangerously close to running out of certain items of PPE, with gowns and visors being in particularly short supply. This demonstrated the fact that the stockpile in the UK was not fit for the coronavirus pandemic. These shortages led to NHS national leaders quickly mobilising help from the army and UK logistics industry, encouraging trusts not to purchase a number of items of PPE themselves and moving to a 'just in time' distribution method. Alongside this, trusts worked with neighbouring health and care providers to ensure PPE stock was shared when possible – this mutual aid being a key benefit of being part of a National Health Service.

8. The domestic shortage of PPE, coupled with global competition for items, highlighted the need to ensure contracts for equipment are secured without delay. We welcomed progress from the government in developing the manufacturing capability for several items of PPE within the UK, given the challenges we have seen in securing PPE from other countries. This included [the announcement on 26 May](#) that the government had signed deals with over 100 new suppliers worldwide and has started to increase domestic production of PPE, signing contracts to manufacture 2 billion items. We also welcome moves by the government to secure extra PPE, [including the manufacture of 70 million FFP1 and FFP2 masks in the UK over the next 18 months](#). However, given the rate that trusts will go through masks, it will be vital to ensure sufficient supplies are available when trusts require them.
9. The difficulties with PPE supply and distribution demonstrated how vital it is to involve trust leaders, and other frontline organisations, at an early stage to help find solutions. In the case of PPE, trusts needed to know if there was going to be a shortage of a particular item well in advance so they can work with others to mitigate any risks. Trusts must also be consulted ahead of any national decisions affecting their operation. For example, the requirement for all hospital staff to wear masks was communicated to trusts by a letter from NHS England and Improvement on 9 June, with no prior warning. Associated guidance was published on 12 June – just three days before action was required. NHS Providers [responded to this with a letter](#) to the Secretary of State, asking for due notice and consultation with NHS trusts on future announcements.
10. When looking to future planning for pandemics, it is vital that we properly take stock of what happened during the first peak of the pandemic with regards to PPE supply to avoid similar errors in the future.

## Testing strategy

11. 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.

12. Many of the problems around testing have been exacerbated by dispersed and unclear accountability between a number of different Arms Length Bodies (ALBs) and different parts of government. For example, Public Health England, the Office of Life Sciences, the Department of Business, Energy and Industrial Energy and Cabinet Office have all had involvement in the role of testing.
13. Alongside this dispersed and unclear accountability, excessive focus on a blunt national target to reach 100,000 tests a day by the end of April and 200,000 by the end of May might have had a helpful, galvanizing effect to start, but proved to be a distraction from developing the required capacity in all areas of the country and slowed down the development of the test and trace scheme. Trust leaders really need to know whether those staff and patients who need tests can get tested as and when required, with swift return of the results - not whether an arbitrary target has been met. The NHS stands ready to play its part on delivering the test and trace strategy, but it is essential to reflect on how the lessons learnt from this experience should impact ways of working in the future.
14. Looking to the future and how the health and care system could be better prepared, we believe that a fit for purpose test and trace programme is vital to guard against a second spike in cases as lockdown restrictions are eased; we still need to see improvements in the current test and trace system before it can be called "world class" . Currently, challenges remain to ensure rapid, regular and reliable testing for all patients and staff as part of restarting NHS services, and to create local surge capacity that can respond effectively to protect local communities in the event of local outbreaks.
15. Alongside this, the government continues to face criticism from local authority leaders over insufficient sharing of local testing data. Despite reports on 1 July that agreements had been signed between the government and local authorities for postcode level data, there remains frustration over the lack of information on pillar 2 testing, in particular, available to local leaders seeking to prepare for or manage localised outbreaks.

## Social care and hospital discharges into care homes

16. 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. As part of its inquiry, the APPG on Coronavirus may wish to examine why this was the case, but we can see that the failures of testing to date and the supply of PPE have hit the care sector particularly hard and remain problematic. Workforce

issues are also likely to have played a part, with agency workers transmitting the virus when moving between different care homes. We also note the care sector's view that the government did not focus on its concerns sufficiently or soon enough, and that additional funding took too long to get to the frontline.

17. 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. There is much to be learned from the tragic deaths in care homes during the pandemic. However 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.
18. With hindsight, it seems clear that everyone discharged from hospitals into care homes should have been tested for COVID-19 at an earlier stage. However, this was not possible as the UK's testing capacity did not allow for this at that time; it is also likely that community transmission reached care homes faster than expected.

## International comparisons of COVID-19 death and infection rates

19. Now that we have passed the first peak of the pandemic, the numbers of excess deaths in hospitals and care homes have fallen significantly. It is too soon to be able to draw reliable international comparisons of deaths involving COVID-19 (excess death rates will provide a clearer international comparison) but these figures are a further reminder of the terrible impact of this virus. While the NHS has managed to cope with the increased pressure on hospital capacity better than other countries, questions must be asked about the higher death toll than other European countries and clarifications about the differences in international reporting methods urgently sought.
20. [Evidence given to the Health and Social Care Committee](#) on 19 May highlighted the fact that there had been no deaths in care homes in South Korea or Hong Kong, and only 3,000 in Germany due to each country taking tougher steps against the virus, including isolating cases sooner in quarantine centres and having sufficient PPE earlier on in the outbreak. We would suggest that the APPG looks into differences in reporting COVID-19 mortality rates and fully examine the reasons why the UK appears to have fared less well compared to some other countries.

## Disproportionate COVID-19 death rates in Black, Asian and minority ethnic groups

21. It is crucial that the disproportionate impact of COVID-19 on Black, Asian and minority ethnic (BAME) groups, which has become increasingly clear since the outbreak of the virus is thoroughly examined through the work of this inquiry. Looking at all staff employed by the NHS, individuals from BAME groups account for approximately 21% of the overall workforce, with approximately 20% of nursing and support staff and 44% of medical staff coming from a BAME background. **Analysis suggests** BAME individuals account for 63% of all NHS staff deaths from COVID-19, including 64% of deaths of nursing and support staff and 95% of deaths of medical staff.
22. Trust leaders are deeply concerned by the shocking statistics around the impact of COVID-19, which point towards a significantly elevated risk of death for individuals from BAME backgrounds. Since evidence of the disproportionate impact of COVID-19 on BAME staff first began to emerge, trusts have been working to protect both their staff and patients, recognising their responsibilities as leaders and employers through undertaking risk assessments for their BAME employees and carrying out other measures. For trust leaders across England, nothing could be more important than ensuring the safety of staff; they remain committed to understanding the disproportionate toll this pandemic is taking on BAME groups and why.
23. A report from Public Health England (PHE) on 16 June found that as well as BAME groups being more likely to work in occupations with a higher risk of COVID-19 exposure, historic racism and poorer experiences of healthcare may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about PPE or risk.
24. The disproportionate impact of COVID-19 on Black, Asian and minority ethnic (BAME) staff across the NHS has shone a harsh light on the inextricable link between systemic race inequalities and health inequalities. We believe that in light of these findings, there is an urgent need to take action to transform the culture of all our public institutions from top to bottom, and we would urge the APPG on Coronavirus to look into this as a matter of priority.



## Conclusion

25. The NHS responded at speed to the unprecedented demand placed upon it by COVID-19, working across different sectors to increase capacity and staffing to care for the most critically ill patients. Trusts now face the challenge of resuming day-to-day services as well as coping with potential further waves of the pandemic, as well as preparing for the flu season and typical winter pressures. It is vital that key issues which emerged during the first wave of the pandemic, such as shortages in PPE, mortality rates in care homes and the disproportionate impact on Black, Asian and minority ethnic communities, are thoroughly examined to ensure the NHS and society as a whole can learn lessons and ensure we are prepared for any subsequent waves of the virus or future pandemics.