How fit were public services for coronavirus?

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About this report

Public services have been at the frontline of the response to coronavirus. While some have been able to draw on well-understood command structures, experience of responding to emergencies and extensive plans, many have struggled. This report – produced in partnership by the Institute for Government and the Chartered Institute for Public Finance and Accountancy (CIPFA) – assesses the preparedness and resilience of nine key public services in the years running up to March 2020 to assess how fit they were to tackle the pandemic. It then offers our recommendations on practical and relatively cheap steps the government could take now to ensure that public services are in a better position to respond to future shocks.

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Contents

List of figures

Summary

Public services – hospitals, general practice, adult social care, children's care, schools, the police, criminal courts and prisons – have been at the frontline of the response to coronavirus. Most staff have gone the extra mile in extraordinarily difficult circumstances, but despite their efforts some public services have struggled. Communication and co-ordination between No.10, government departments, local authorities and the NHS have often been poor. Operations have been delayed, and critical day-to-day services suspended. Elsewhere, children have gone without education, and justice has been delayed for victims and defendants alike.

Public services have been able to draw on well-understood command structures, experience of responding to emergencies and extensive plans, enabling hospitals to quickly repurpose wards, the police to redeploy staff and prisons to effectively lockdown in attempts to tackle the pandemic. However, many plans had important gaps and government had failed to learn key lessons from the last major exercise to prepare for a pandemic. Public services were also weakened after a decade of budget pressures in which quality declined, staff became more stretched, buildings were poorly maintained, and vital equipment went unbought.

Government cannot comprehensively prepare for every possible incident and must always balance funding current priorities against building resilience for future emergencies. But there are practical and relatively cheap steps that past governments could have taken that would have improved the response to coronavirus and that the current government could take now to ensure that public services are in a better position to respond to future shocks.

This paper asks how fit public services* were for coronavirus by analysing their preparedness and resilience before the crisis began. To analyse preparedness we look at the quality of plans – whether they were sufficiently detailed, relevant and flexible – and the ability of public services to implement them – that is, whether they had suitable command and decision making structures and whether staff understood their responsibilities. To analyse resilience we scrutinise performance in the years running up to the crisis; staffing numbers, skills and flexibility; availability of appropriate equipment; and the condition of, and spare capacity in, public buildings such as hospitals.

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*   For each service, we look only at the parts of the UK where responsibilities have not been devolved. As most public services are devolved to the nations of the UK, most of the chapters in this report only cover England. The exception is the chapter on the criminal justice system, which covers England and Wales.

Emergencies such as the coronavirus pandemic are unpredictable and will inevitably cause disruption, but high-performing public services that are well-staffed, use modern facilities and have suitable plans and experience will be able to manage more effectively. These qualities are however far from uniform and the coronavirus crisis places different pressures on different public services, at different times. A service that was fit to manage the initial lockdown will not necessarily cope as well as restrictions are eased. This paper assesses the fitness of public services for both periods.

While this paper focuses on the preparedness and resilience of services when the crisis began, our judgement on deficiencies also includes assessment of how easily those services were able to rectify problems as they dealt with the first months of the pandemic. A second report to be published in the autumn will assess in detail how well public services coped in the crisis.

Our findings are based on extensive desk research, analysis of government data and interviews with civil servants, front-line staff, representative bodies and other experts.

Public services benefited from the existence of emergency plans and command structures

All services had plans for dealing with emergencies. Although they varied greatly in detail, focus and adaptability, they were helpful in all cases.

Some of the most useful plans were held by police forces, local authorities and NHS trusts which are designated as 'Category 1 responders' under the Civil Contingencies Act 2004, and therefore have a duty to maintain plans on how to continue to perform their normal functions while responding to emergencies. Planning is done through 42 Local Resilience Forums (LRFs) which bring these and other organisations together. LRFs have improved the co-ordination and implementation of local plans for responding to the coronavirus emergency.

Some services also benefited from the existence of well-developed command structures that enabled quicker decision making, implementation and reporting. These all take a strategic/tactical/operational approach, with clear roles, responsibilities and accountability at each level. In the police, criminal courts and prisons, as well as LRFs, this is codified as a gold/silver/bronze command structure, but a similar approach is taken in the NHS. These structures were activated relatively quickly and helped central government to disseminate information and instructions, particularly in the early stages of the crisis. In contrast, the more fragmented structures in schools and adult social care were less effective.

Some services benefited from experience of responding to emergencies, planning exercises and preparation for no-deal Brexit

Some services were able to draw on recent experience of responding to emergencies or exercises simulating similar potential incidents. For example, prisons regularly manage outbreaks of infectious diseases such as flu and norovirus. Those services most practised at dealing with emergencies – the police, prisons and hospitals – were able to manage the initial lockdown most successfully due to a combination of training, experience and culture.

More widely, the response of public services was improved by recent preparation for a possible no-deal Brexit. In the Ministry of Justice, the senior civil servant who led no-deal planning was appointed to run the department's coronavirus taskforce. And no-deal planning by the Department of Health and Social Care meant it better understood how supply chains would be disrupted in a pandemic and had improved its stockpiles of some drugs. Locally, planning for potential food shortages meant that it was easier to ensure vulnerable people who were shielding had access to food, and had helped strengthen relationships on LRFs between local authorities, NHS trusts and the police.

Public services were hampered by poor communication by ministers

Ministers have not always made use of well-established command and control structures, or forums for bringing together different levels of government. Announcements by No.10 and other senior ministers, including those in the daily press conferences, were often made without consultation with those who would be affected and with little consideration of how they would be implemented. For example, the announcement of changes to visitation rules and personal protective equipment (PPE) usage in hospitals on 5 June was made before NHS England guidance was available. This meant that frontline staff had to redesign services and explain important changes to the public without clear guidance.

Some of the poorly communicated changes may have been due to excessive ministerial churn over the last four years. For example, many in the cabinet have less than one year's experience in their current roles, and have not taken part in live planning exercises or built strong relationships with stakeholders beyond the department.

Emergency plans had important gaps

Despite these advantages, plans across all services had important gaps. Nationally and locally, pandemic influenza was considered a much greater risk than other pandemics. While this was a reasonable assumption, and much of the planning was relevant for any pandemic, it meant that key parts of plans were inappropriate for a novel coronavirus such as Covid-19.

The possibility of 'social distancing' is covered only briefly in the government's 2011 *Influenza Pandemic Preparedness Strategy*[1] and none of the services assessed had given proper consideration to how they would operate in such circumstances, be that police officers and GPs working from home, or the closure of criminal courts and schools. Similarly, planning for a flu pandemic meant that PPE stockpiles were missing critical equipment.

For example, the central Public Health England stockpile of PPE did not contain gowns or visors, which are of less importance with an influenza pandemic but vital for preventing coronavirus transmission. The 2011 plan did provide details of how to organise testing during a pandemic, but insufficient thought had been given to how testing arrangements would work for frontline staff in the police and adult social care.

Lessons from the last major pandemic planning exercise were not published and key recommendations were not implemented

Government pandemic planning recognised the importance of conducting regular exercises to test how plans functioned in practice and how different organisations would work together.[2] The last major national one was Exercise Cygnus – which simulated a flu outbreak – in 2016. But as the government did not publish its findings, many stakeholders, including private care home providers, were unaware of it and so unable to learn of its lessons.

As a result, and despite Exercise Cygnus identifying it as a risk, inadequate consideration had been given to communication and co-ordination between different levels of government, and across different sectors. During the crisis, this has been a major problem in adult social care, which is both highly dependent on decisions taken in the NHS and much of which is delivered by thousands of – often tiny – private and voluntary sector organisations.

The findings of other, smaller exercises, conducted across public services have also not been published, meaning that other important recommendations will likely also have gone unheeded due to a lack of transparency.

Public services were far less resilient after a decade of budget pressures

High-performing services, with spare staff capacity, the latest ICT equipment and spacious, modern buildings will find it easier to respond to crises while maintaining core services, than services that do not have these advantages. But a decade of budget pressures meant that public services entered the crisis with ailing performance levels, severe staffing pressures and having underinvested in buildings and equipment.

Even before the crisis began, public services had seen reduced access, longer waiting times, missed targets, rising public dissatisfaction and other signs of declining standards. Most notably, GPs and hospitals were missing almost all routine targets, while prisons had experienced a dramatic increase in levels of self-harm, violence and poor prisoner behaviour. This context made it far harder for services to maintain acceptable standards while also managing a disruption as wide-ranging and long-lasting as that wrought by the coronavirus.

The response has also been hampered by historic underinvestment in buildings and equipment. Government has consistently underspent its capital budgets, often using money that had been earmarked for long-term investment to cover holes in day-to-day budgets. As a result, public services have had to operate out of crumbling prisons, courthouses and hospitals that are difficult to clean or repurpose in line with coronavirus health measures. The sale of courthouses and police stations, and the

failure to build new prison places, have similarly made it harder to maintain social distancing. And inadequate ICT has reduced the ability of police officers and local authority staff to work from home, made it far harder for prisoners confined in cells for more than 23 hours a day to access training or speak to their families, and meant that schools, hospitals, GPs and criminal courts have all struggled at times to provide services remotely – even when greatly reduced.

Finally, spare staffing capacity in public services has been lost over the past decade, as government cut staff numbers. The coalition government also held down public sector wages to reduce spending, contributing to worsening recruitment and retention problems. In the initial stage of the crisis, this most affected the NHS, which had nearly 90,000 vacancies at the start of the crisis, of which 40% were for nurses. It has fewer of almost all kinds of staff per capita than comparable countries. Hospitals were only able to cope by relaxing regulations, allowing students to start early, retraining existing staff, encouraging recently retired staff to return, and buying private sector capacity. Such staffing problems are harder than equipment or building shortages to resolve quickly due to the time required to train critical staff, and are likely to become more problematic as restrictions are eased and demand for schools, courts, prisons and other services increases.

Recommendations

There is no doubt public services could have been better prepared for coronavirus. But government cannot plan comprehensively for every possible scenario and must be wary of tailoring plans to the most recent crisis. Equally, while public services could have been more resilient, that comes at a price – either spending more money or diverting resources from current priorities to future possibilities. There is no objective answer to the appropriate balance between efficiency and resilience.

Nonetheless, there are relatively simple and affordable changes that could be made which would improve preparedness and resilience, and help public services to respond to a range of emergencies. To improve preparedness in public services, we offer the following recommendations:

- **Government departments, agencies, local authorities, police forces, NHS bodies and other providers of public services ought to publish their plans for dealing with emergencies – currently only released in summary form, if at all.** They should also publish the key findings from planning exercises and implement them. They should report annually on progress implementing the key findings from these. In some cases, it may be necessary to redact or withhold information if publication would compromise national security, but overall better transparency would be beneficial.

- **Government ought to conduct more regular emergency planning exercises to assess the interdependencies between services and the extent to which plans take these into account.** Key ministers such as the prime minister and health secretary should take part in such an exercise within six months of taking office. Government must make efforts to improve planning and co-ordination between different levels of government, and with private and voluntary sector providers of public services.

- **Select committees ought to scrutinise departmental plans for emergencies and hold government to account for resolving shortcomings identified in major exercises.** Departments should provide annual updates to the relevant select committee on progress towards implementing key findings from major exercises.

- **The government ought to update the Civil Contingencies Act 2004 so that police and crime commissioners and multi-academy trusts are involved as standard in LRFs.** These organisations were created after the Act was passed, and are currently not consistently involved in LRFs despite the important role they play during emergencies.

To improve public services' resilience:

- **The government ought to analyse the resilience of public services when making spending decisions in the 2020 spending review.** This should include an assessment of the ability of staffing, equipment and buildings to cope with scenarios identified in emergency plans. If the government wants public services to be more resilient, then it needs to spend more.

- **Government departments ought to maintain an updated list of trained reserves, recent leavers and volunteers who are appropriately certified and can be deployed to key services in an emergency.** This would be a quicker and more effective than ad-hoc schemes at allocating appropriately skilled people to services in need of additional staff capacity.

- **Government departments ought to identify and fill data gaps that prevent them from making real-time assessments of demand and capacity in critical public services.** This is a particular problem in criminal courts – which lack data on the number of trials and defendants – and adult social care – where there is limited data on self-funders and domiciliary care.

Fitness ratings: our assessment of how prepared and resilient public services were at the start of the crisis
Fitness ratings for nine public services

Category		The NHS		Local government			Education	The criminal justice system		
		Hospitals	General practice	Local emergency support services	Adult social care	Children's social care	Schools	Police	Criminal courts	Prisons
Preparedness	Quality of plans	Yellow	Yellow	Yellow	Red	Yellow	Red	Yellow	Red	Green
	Ability to implement plans	Green	Red	Green	Red	Yellow	Red	Green	Yellow	Green
Resilience	Performance going into the crisis	Red	Red	Yellow	Red	Yellow	Green	Yellow	Yellow	Red
	Staff	Red	Yellow	Yellow	Red	Red	Yellow	Green	Yellow	Yellow
	Buildings	Red	Yellow	Grey	Red	Red	Red	Yellow	Red	Red
	Equipment	Red	Red	Grey	Red	Yellow	Red	Yellow	Yellow	Red

Source: Institute for Government analysis.

How we made our judgements

We summarise our conclusions from the following chapters in a 'fitness rating' – with a coloured rating for each aspect of preparedness and resilience. These ratings are for services as a whole and we recognise there will be considerable variation across the country. These are qualitative judgements, the basis of which is outlined in the table below.

Category	Criteria
Quality of plans	Green: Existing plans were helpful for responding to coronavirus.
	Amber: Existing plans were partially helpful for responding to coronavirus. Plans include4d good business continuity planning and planning for some specific aspects of this crisis.
	Red: Existing plans were not helpful for responding to coronavirus.
Ability to implement plans	Green: Service had a suitable command structure and staff who clearly understood their roles and responsibilities in an emergency.
	Amber: Service had a suitable command structure or staff who clearly understood their roles and responsibilities in an emergency; or service had a partially helpful command structure and staff who partially understood their roles and responsibilities in an emergency.
	Red: Service did not have a suitable command structure or staff who understood their roles and responsibilities in an emergency.
Performance going into the crisis*	Green: Service performance (scope, quality and efficiency) on the eve of the crisis was the same or better than in 2010.
	Amber: Service performance (scope, quality and efficiency) on the eve of the crisis was a bit worse than in 2010.
	Red: Service was performance (scope, quality and efficiency) on the eve of the crisis was much worse than in 2010.
Staff	Green: Service had enough staff to effectively respond to coronavirus while maintaining standards both during the initial lockdown and as restrictions are eased.
	Amber: Service had enough staff to effectively respond to coronavirus while maintaining standards either during the initial lockdown or as restrictions are eased; or service had enough staff to partially respond to coronavirus and partially maintain standards both during the initial lockdown and as restrictions are eased.
	Red: Service did not have enough staff to effectively respond to coronavirus while maintaining standards either during the initial lockdown or as restrictions are eased.

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*   This report does not assess in detail the performance of public services during the crisis and this will not always be directly correlated with performance pre-crisis. For more detailed analysis of how the performance of public services changed after 2010, see *Performance Tracker 2019*.

Buildings	Green: Service had enough buildings in suitable condition to effectively respond to coronavirus while maintaining standards both during the initial lockdown and as restrictions are eased.
	Amber: Service had enough buildings in suitable condition to effectively respond to coronavirus while maintaining standards either during the initial lockdown or as restrictions are eased; or service had enough buildings in suitable condition to partially respond to coronavirus and partially maintain standards both during the initial lockdown and as restrictions are eased.
	Red: Service did not have enough buildings in suitable condition to effectively respond to coronavirus while maintaining standards either during the initial lockdown or as restrictions are eased.
	Grey: Insufficient information to make a clear judgement.
Equipment	Green: Service had suitable ICT and sufficient PPE and other equipment to effectively respond to coronavirus while maintaining standards both during the initial lockdown and as restrictions are eased.
	Amber: Service had suitable ICT and sufficient PPE and other equipment to effectively respond to coronavirus while maintaining standards either during the initial lockdown or as restrictions are eased; or service had partially suitable ICT and partially sufficient PPE and other equipment to effectively respond to coronavirus while maintaining standards both during the initial lockdown and as restrictions are eased; or service had suitable ICT or sufficient PPE and other equipment to effectively respond to coronavirus while maintaining standards both during the initial lockdown and as restrictions are eased.
	Red: Service did not have suitable ICT or sufficient PPE and other equipment to effectively respond to coronavirus while maintaining standards either during the initial lockdown and as restrictions are eased
	Grey: Insufficient information to make a clear judgement.

The NHS

Good planning ensured that hospitals could quickly increase intensive care capacity to treat an influx of patients, but crisis response plans did not foresee some of the specific problems that coronavirus posed. Plans were well rehearsed and there were clear command structures to distribute instructions from NHS England to both NHS trusts and GPs.* NHS command structures were helpful in the initial phase of the crisis, but they have become increasingly less appropriate as decisions have had to reflect local circumstances and capacity.

The NHS was not resilient going into the crisis, however, and had limited capacity to respond to a major shock without putting emergency measures in place. On 17 March, NHS England told trusts to postpone all non-urgent elective activity from 15 April for a period of at least three months.[1],** The NHS's lack of capacity didn't affect the initial decision to shut down some routine services – countries with greater resources also shut down services in light of uncertainty about the how transmissible and how fatal coronavirus would be. But lack of capacity will limit the NHS's ability to respond to coronavirus and run normal services at the same time.

How prepared was the NHS for the crisis?

Hospitals and GPs were, in theory, well prepared to respond to emergency shocks and had well-established command structures to distribute guidance. But the specific plans used in the crisis leaned too heavily on plans for pandemic influenza, and the command and control structures useful at the start of the coronavirus pandemic have proved less useful as the crisis moved past providing care to the initial surge of patients suffering from Covid-19.

NHS England and NHS trusts had clear plans in place to respond to crises

NHS England and NHS trusts as a whole were well prepared to respond to crises. NHS England had a clear plan for responding to shocks – its national *Incident Response Plan*[2] – which sets out its responsibilities in a health emergency and allows it to take control of NHS resources.

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*   This chapter focuses on the preparedness and resilience of GPs and NHS trusts in England. There are five different types of NHS trusts in England: acute, ambulance, community, mental health, and specialist. This chapter specifically focuses on acute and specialist trusts – which govern what most would consider hospitals – which provide short-term treatments such as diagnostic services, emergency treatments and surgeries, and have been at the forefront of the initial response to coronavirus.

**   This was subsequently superseded by an NHS England letter on 29 April which asked trusts to begin restarting elective activity: www.england.nhs.uk/coronavirus/publication/second-phase-of-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/

NHS trusts also had crisis response plans. NHS trusts are designated as 'Category 1 responders' under the Civil Contingencies Act 2004,[3] which requires them to have major incident plans. These plans set out how trusts will respond to an emergency, what the command structures are, and who is responsible for different tasks. They also require involvement in Local Resilience Forums (LRFs), which bring together emergency services and local authorities within police boundaries to respond to local crises. Emergency preparedness roles alternate on a rota between clinical staff within trusts,[4] so whoever is on duty when an incident happens will take on their operational, tactical or strategic management role in a short-term crisis. These roles have since been formalised for the longer period of this crisis.

Interviewees told us that trusts regularly run 'tabletop exercises'* to test these major incident plans, which are self-assessed and assured by NHS England's regional teams at least once each year.[5] Interviewees told us that trusts were able to implement these plans quickly during this crisis because almost all officials will have had emergency preparedness training at some point, and emergency preparedness roles are clearly demarcated.

One interviewee summarised simply by noting that the NHS in England was well prepared because emergency planning is "embedded in the health service".[6] As the NHS often has to deal with localised emergencies, another noted that the Emergency Preparedness Resilience and Response group within NHS England is "almost always managing an incident".[7]

GPs had fewer, less detailed plans but had begun to think more about risks to service provision

In contrast, GPs had less extensive crisis response plans than NHS trusts because they are not designated as either Category 1 (responding bodies) or Category 2 (co-operating bodies) responders in the Civil Contingencies Act, putting fewer obligations[8] on them to prepare for emergencies. GPs are also not formal partners in LRFs – though interviewees told us that GPs had participated and collaborated in practical planning on, for example, setting up integrated home-support teams for patients who need support at home after hospital discharge.

GPs were better prepared for this emergency than they would have been a decade ago, due to a change in the Care Quality Commission inspection framework which has since added business continuity during disruption as an inspection criteria.[9] Interviewees thought that this had ensured that most GPs had thought about how to provide services during a shock when faced with higher demands and fewer staff – although caveated that they thought some business continuity plans were "somewhat superficial" – copied and pasted from online forms, and not tailored to the practice in question.

All interviewees thought that most GPs had given little consideration to how to provide the majority of services remotely, although NHS England had set a goal for all practices to offer virtual and remote appointments within the next five years in the

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* A tabletop exercise involves relevant people meeting to discuss their roles and responsibilities in various simulated emergencies.

HOW FIT WERE PUBLIC SERVICES FOR CORONAVIRUS?

2019 *NHS Long Term Plan*.[10] According to Dr Jenny Harries, the deputy chief medical officer in England, the public sector in the UK had not thought much about how to use IT to deliver services during crises – how to "link up digital progression and opportunity in some of [its] preparedness planning".[11] One interviewee argued that the nature of this crisis was so different that there was not much overlap between pre-existing business continuity plans, and how GPs had to respond to the pandemic.

Despite limited preparation, GPs were able to rapidly increase online and video consultations during the pandemic. Some 85% of practices offered online consultations at the end of May,[12] which interviewees told us was a significant increase from less than 30% of practices at the end of March.

No-deal Brexit preparations improved stockpiles and local co-ordination

NHS plans were strengthened by recent work by the Department of Health and Social Care (DHSC) to prepare for a potential no-deal Brexit, which had forced the department to consider factors that were also relevant for coronavirus. Many officials who worked on preparations for no deal were moved to coronavirus teams, while Professor Keith Willet – NHS England's director of acute care, the strategic incident director in charge of the coronavirus strategic response – was previously the body's EU exit strategic commander for no-deal Brexit planning.

No-deal planning helped the government prepare for possible medicine shortages, as work done by DHSC on securing supply chains could be repurposed for coronavirus. No-deal stockpiles[13] helped meet the impact of high demand for particular drugs,[14] such as anaesthetic medicines[15] used in intensive care (although stockpiles of some of these drugs have now been exhausted).[16]

Interviewees also told us that health organisations' involvement in LRFs, which had been actively planning for the consequences of a no-deal Brexit such as food shortages and civil disobedience, had been helpful in re-establishing contact between NHS trusts, local authorities, and the emergency services.

The NHS was able to quickly respond to the emergency thanks to clear command and communication channels

There is a clear command and control structure in the NHS for responding to crises, overseen by NHS England's Emergency Preparedness, Resilience, and Response (EPRR) team that is responsible for ensuring that "there is a comprehensive NHS EPRR system and assure itself and [the Department of Health][*] that the system is fit for purpose".[17] The *Incident Response Plan*, mentioned above, meant that there were command structures and communication channels in place for NHS England to disseminate guidance to NHS trusts quickly. For any major incident, NHS England and NHS trusts set up and staff strategic, tactical and operational management – this works similarly to the gold/silver/bronze command used in other services.

[*]   NHS England's *Emergency Preparedness, Resilience, and Response Framework* was produced before social care was added to the Department of Health's title, in 2018.

For any national ('Level 4') incidents, NHS England can take command of all NHS resources in England, and issue directions to trusts through regional NHS England teams.[18] This helped in the early phase of the crisis when NHS England was remodelling and expanding existing services such as the NHS's non-emergency call line, 111,[19] and expanding capacity both by building new facilities (namely, the Nightingale hospitals) and providing guidance on how to optimise existing hospital facilities to safely treat patients with coronavirus symptoms.[20]

Similarly, in general practice, NHS England was able to distribute guidance to GPs quickly, although one interviewee described the volume of guidance as "relentless".[21] As most GPs are small independent businesses, some struggled to take in and implement all of it. One interviewee thought that well-established GP federations – groups of general practices forming organisations and working together to provide joint services and combine back-office functions – had proved useful in this crisis as they had the management capacity to summarise, plan, and implement NHS England guidance.

In some cases – such as changes to guidance for 'shielded' patients on 1 June[22] and changes to visiting and personal protective equipment (PPE) usage in hospitals on 5 June[23] – the government did not properly utilise the communications structures mentioned above, making announcements prior to NHS England guidance being available. This caused difficulties for clinicians left to redesign services or explain what changes meant for patients with no guidance on what to do. Some of the poorly communicated changes may have been due to excessive ministerial churn over the last four years.[24] For example, many in the cabinet have less than one year's experience in their current roles,[25] and have not taken part in live planning exercises or built strong relationships with stakeholders beyond the department.[26,27]

The government's focus on planning for pandemic influenza was a weakness of pre-crisis planning

In addition to generic resilience planning and no-deal preparations, DHSC had developed a specific strategy for responding to pandemic influenza (flu) in 2011,[28] which the government had classified as one of the most likely (and most impactful) of the risks on its national risk register.[29] In May 2015, the NHS England website stated that "pandemic influenza remains the top risk for England and the UK".[30]

There were some benefits from the planning that had been done for pandemic flu. Interviewees told us that most trusts conduct tabletop tests of their pandemic flu plans each year, which gave them "a really good headstart" for this crisis. Alongside the 2016 Exercise Cygnus, the government-led live exercises where various services simulated responding to the seventh week of a flu pandemic,[31,32] the amount of preparation individual trusts had undertaken meant that the NHS was well prepared to deal with a flu pandemic.

But many of the assumptions in the flu pandemic strategy – from assuming a vaccine would be available within four to six months[33] to expectations about how long people would be infected and ill, as well as, crucially, how contagious and deadly the virus would be[34] – proved too optimistic when applied to coronavirus.

The government adapted its plans in light of new information from around the world, and the initial response, when little was known about Covid-19, had to be based on assumptions.

As the risk assessed as having the biggest impact on the government's risk register,[35] flu was a reasonable choice to base the response on, and indeed one interviewee told us that "the playbook [for the initial response] was pandemic flu planning".

But while the pandemic flu plan was helpful in some ways, it was not a Covid-19 plan. This caused problems later, when it took the government a long time to divert from the pandemic flu plan towards a Covid-19-specific one.[36]

The delay in imposing movement restrictions and the decision to abandon community tracing in March, for instance, appear to have been driven by the previous plan. The 2011 strategy asserts that "it will not be possible to halt the spread of a new pandemic influenza virus, and it would be a waste of public health resources and capacity to attempt to do so".[37] The UK was not the only country to make these assumptions. New Zealand's equivalent pandemic flu plan also asserts that "once pandemic influenza has entered New Zealand, the need for highly accurate testing will diminish",[38] for example. Given the uncertainties about the novel coronavirus in the early phases of the pandemic, the focus on the flu plan is understandable but in hindsight following it so closely to begin with was a mistake.

The assumption that pandemic flu was the biggest risk facing the UK also proved influential in DHSC's decisions about which drugs and equipment to include in the Public Health England (PHE) pandemic stockpile, and where to build additional capacity. While some decisions – such as increasing the number of critical care beds after 2010[39] – improved overall resilience and helped prepare for a novel coronavirus as well as pandemic flu, decisions not to stockpile certain items such as swabs for testing[40] made the UK less prepared than it otherwise would have been.

Similarly, the central PHE stockpile of PPE was designed for a flu pandemic and did not contain gowns or visors – which have proved crucial to protecting NHS frontline staff during the Covid-19 crisis, as that virus can be spread easily by coughing and breathing.[41] The Theresa May government chose not to procure visors or safety glasses for all staff due to concerns about the high cost and seemingly low benefits of stockpiling eye protection equipment for similar reasons.[42] According to Bill Morgan, former special adviser to former health secretary Andrew Lansley, the government "continued to rely on the assumption that the pandemic we had to worry about was a flu pandemic even though SARS and MERS were coronaviruses. This perhaps led us to take comfort in the antiviral stockpile [of drugs aimed at treating flu] a little too much".[43]

The command and control system has become less useful as decisions have become more complex

In most cases, the command and control system has been effective at implementing consistent changes across the NHS,[*] but there will be greater need for flexibility as restrictions are eased and the NHS restarts routine care. The continuing effectiveness of the command and control system depends on NHS England not being too prescriptive and allowing trusts and GPs to respond to variations in local capacity and circumstances.

As one interviewee noted, any guidance on re-establishing routine care while maintaining capacity to treat Covid-19 patients will necessarily involve local areas designing services around their specific staff and estates, and corresponding ability to see patients. London NHS trusts, for example, have worked together to establish a hub of cancer services at the Royal Marsden hospital in order to offer cancer services in one wholly Covid-free location.[44] One interviewee told us that GPs felt "energised" from the freedom to develop a local response which did not have to fit within standardised central planning guidance.[45]

NHS England has recognised the importance of not being too prescriptive, with a letter sent to trusts on 17 March providing trusts with flexibility to "use your discretion to do the right thing in your particular circumstances".[46]

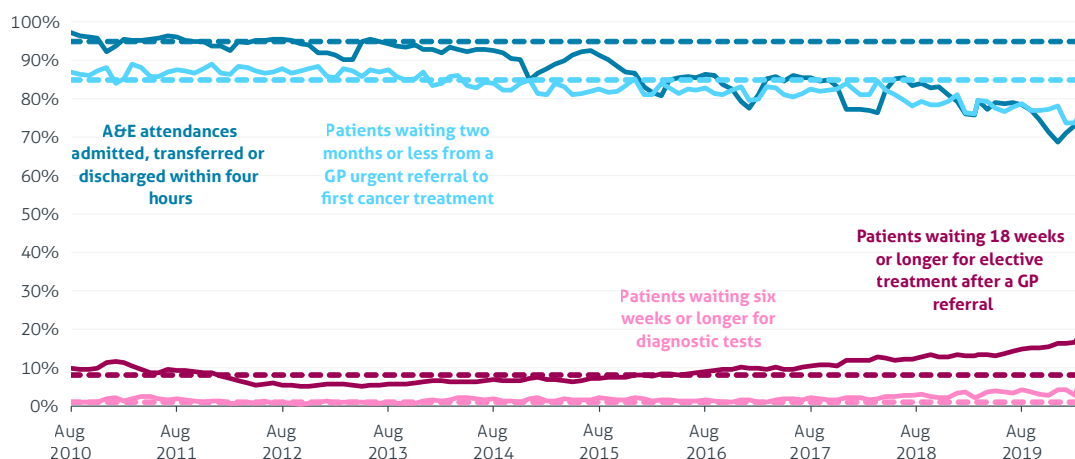## How resilient was the NHS going into this crisis?

Hospitals and GPs were not resilient in March 2020. They entered the crisis with limited spare capacity, large numbers of staff vacancies, buildings increasingly in need of repair, and missing almost all routine performance targets.

The NHS entered the crisis following years of worsening performance

Disruption as wide-ranging and long-lasting as coronavirus will inevitably have a detrimental impact on the accessibility of health care. A better-funded health service able to meet performance targets by providing care to the rising number of people in need of it[47] in normal times would have been in a better starting position to maintain acceptable standards during a crisis. But the NHS in England entered this crisis missing all routine performance targets for access to care, with a particularly sharp decline since 2015.

Figure 1 **NHS performance against key targets**

A&E attendances admitted, transferred or discharged within four hours

Patients waiting two months or less from a GP urgent referral to first cancer treatment

Patients waiting six weeks or longer for diagnostic tests

Patients waiting 18 weeks or longer for elective treatment after a GP referral

Source: Institute for Government analysis of NHS England, A&E attendances and emergency admissions, Cancer Waiting Times, Diagnostic Waiting Times and Activity, Consultant-led Referral to Treatment Waiting Times.

While there have been some nominal improvements during the pandemic such as shorter waits in A&E[48] and faster ambulance response times,[49] in most cases this has been due to the sharp decline in patients coming forward – from emergency department attendances to outpatient appointments. This is potentially storing up problems for the future as individuals in need of treatment have not sought it during the crisis.

NHS trusts entered the crisis with too few staff to provide routine medical care as well as care for an influx of coronavirus patients

The UK health care system has fewer of almost all kinds of staff – from doctors and nurses to pharmacists and physiotherapists – than comparable countries, although England has a middling number of GPs. The difference is most stark in nursing numbers – where the UK was the only OECD or EU country to see a decrease in the number of nurses per capita between 2010 and 2017.[50] While low staff numbers mean the NHS operates more efficiently than most other health systems,[51,52] it makes it less resilient when crises occur.

Hospitals had large and increasing numbers of permanent staff vacancies at the start of the pandemic. The latest available data shows that the number of adverts for vacant NHS jobs[*] rose by 14.7% between March 2016 and March 2019, from 78,112 to 89,589, with over 70% of this increase accounted for by nurses.[53]

These shortages left trusts less able to handle staff absences due to illness or isolation than they would have been a decade ago. According to the chief medical officer, Chris Witty, during the first peak of coronavirus cases "things [in the NHS] may be under pressure, some things may be postponed, and certain things may be considerably less well done than we would hope... nobody would claim that we will have the optimal number of nurses to manage this over this period of time".[54]

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[*]   These vacancies were partially filled with bank or agency staff, or existing staff working overtime.

Staff shortages at the start of the crisis were exacerbated by lack of testing capacity available to test staff in March,* which made it harder for trusts to know which of their staff could safely return to work.**

Staff shortages will limit how quickly routine care can be restarted, in particular because many staff will require time to rest after the winter and first peak of coronavirus cases.[55] Interviewees also told us that the NHS's increasingly specialised medical workforce[56] made it harder than it otherwise would have been to redeploy staff during the pandemic as most had to be retrained on how to care for patients in different wards.

Figure 2 **Percentage of physicians who are specialists**
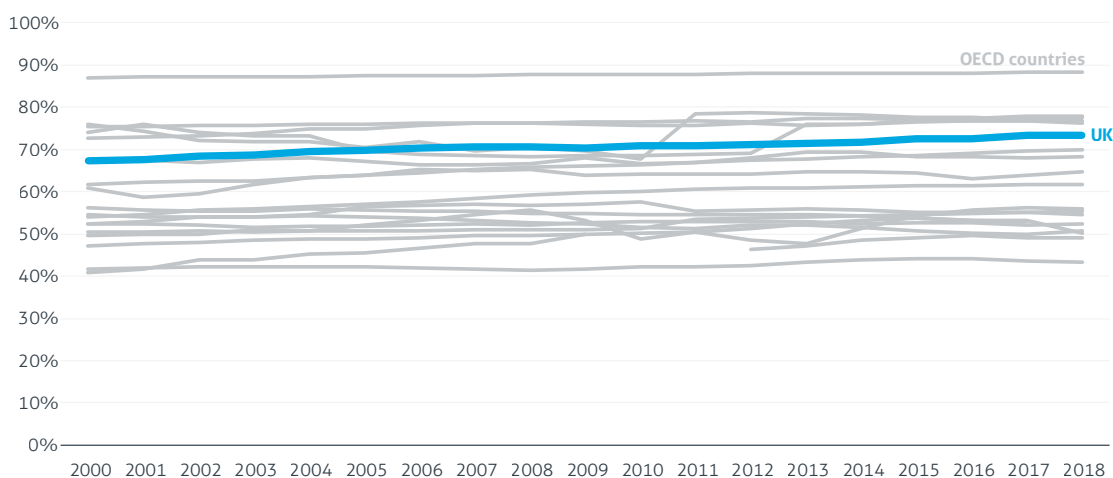
Source: Institute for Government analysis of OECD, Health Care Resources, Physicians by categories.

NHS trusts had to implement short-term measures to manage staffing shortages

NHS England implemented five policies to help NHS trusts manage higher staff absences from coronavirus, whether due to self-isolation, inability to combine work and caring responsibilities, or illness during the peak weeks: retraining existing staff; relaxing staff:patient ratios; allowing new health staff to start early; encouraging recently retired staff to return; and buying independent sector capacity. These policies have helped manage the peak,[57] but the pressures of responding to coronavirus increased staff stress,[58] and are, understandably, likely to affect the quality of care staff are able to provide.[59] These policies are not sustainable.

To prevent intensive care units (ICUs) from being overwhelmed, NHS England worked with professional bodies to give trusts the ability to relax staffing ratios if they needed to. Relaxing staff:patient ratio guidance and retraining staff helped but, according to one doctor, "definitions of safe [were] redefined [and] our need to relearn forgotten skills [has made] for uncomfortable times".[60] In evidence to the Health and Social Care

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* NHS England subsequently allowed 15% of Trust testing capacity to be used for staff on 29 March, see: www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/covid-19-testing-and-staff-retention-letter-29-march-2020.pdf, and removed the cap on 1 April: www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/covid-19-testing-letter-1-april-2020.pdf

** Testing is beyond the scope of this report but will be covered in more detail in forthcoming IfG work.

Select Committee, the Faculty of Intensive Care Medicine noted that "in order to meet the increase in demand we have had to change those ratios... we have had to spread ourselves more thinly".[61] The British Association of Critical Care Nurses agreed that the relaxations were necessary but worried that they would dilute the standard of care.

The guidance on intensive care was first to change, but the guidance for other professions changed too. NHS England told community nurses to consider how to prioritise urgent care needs on 1 April,[62] and the Royal College of Nursing told the *Health Service Journal* that community trusts have been training up healthcare assistants to provide some of the nursing care that nurses would typically provide.[63]

The government also allowed student nurses, doctors, and other health professionals to start work early[64] and NHS England ran a programme to encourage retired staff to return.[65] By the end of April, an extra 18,200 staff were deployed in clinical and support roles.[66] If these staff worked full time, this would have amounted to an almost 4% increase in staff. Our interviewees told us that this system worked reasonably well, with people successfully deployed to the NHS 111 phone service in order to minimise their exposure to coronavirus. However, we were also told that not all staff reached hospital wards and that the nationally run scheme resulted in trusts managing people who volunteered but weren't suitable. As part of efforts to increase capacity, NHS England also agreed a three-month contract with independent hospitals to provide services for NHS patients starting on 23 March,[67] which gave the NHS access to around 10,000 nurses, 700 doctors and 8,000 other clinical staff.[68]

Policy interventions meant there were enough staff to deal with the immediate crisis: there were no situations where staff couldn't provide the care they wanted to for coronavirus patients because they didn't have enough staff. But this is not sustainable. As one interviewee noted, the current staff structure "required extraordinary things to happen" and cannot and should not continue, noting that it would neither be logical or useful to have "orthopaedic surgeons working as assistants in [the ICU] on an ongoing basis".[69] A larger workforce or one that could more easily be redeployed could have reduced the need for these trade-offs.

The NHS used emergency funding to implement the policies to manage workforce pressures. But no amount of money would have been able to fill all the vacancies that the NHS had at the start of March 2020. There would not have been enough trained staff (at least within the UK) to hire.[70] With international recruitment likely to be more difficult after Brexit, the government will have to improve workforce planning – a longstanding problem for the NHS – if it wants to ensure the NHS can draw on more staff in future pandemics. Before the current crisis, Health Education England, the non-departmental public body responsible for workforce planning, had published an 'interim people plan' in 2019 which set out how the NHS intended to ensure it had enough staff in future. The final version was repeatedly delayed, eventually being published at the end of July 2020, having originally expected at the same time as a spending review in spring 2020.[71]

GP staffing has had fewer problems so far due to the fall in demand for appointments

As general practices are independent businesses, the government does not collect data on vacancies, but the government has persistently missed its own GP recruitment targets since 2015.[72] This suggests that it has not recruited as many GPs as it thinks it needs. During the last decade, the number of GPs per capita fell for the first time since the 1960s.[73]

Workforce pressures in general practice have not yet caused major difficulties in responding to coronavirus because fewer appointments are taking place[74] and the initial stage of the crisis has mostly required more intensive care support, which is given in hospitals. However, workforce pressures and lack of clarity on how to care for recovering patients in need of rehabilitation may make it harder to provide support as lockdown restrictions are eased.

The government's supply chains and PPE stockpile for health care staff were not resilient

The UK government – like many other countries including France, Germany, and the US[75] – did not have sufficient stockpiles, resilient supply chains, or distribution channels to provide health care staff and other key workers with PPE during the pandemic.

At the start of the outbreak, NHS England said, on the basis of advice from DHSC, that it had enough PPE from flu pandemic and no-deal Brexit stockpiles to keep staff safe, and that shortages were due to local distribution problems.[76] But the problems proved to be greater than this.

The main stockpile was designed for pandemic flu and did not contain the fluid-repellent gowns and visors necessary to prevent coronavirus transmission[77,78] (DHSC had planned to procure gowns in early 2020, prior to the pandemic).[79] The stockpile was also small relative to the NHS's needs, which disrupted health care provision when trusts, GPs, and other providers struggled to obtain PPE through their normal channels. In a survey of 34 NHS trust chief executives at the end of March, 68% reported that PPE shortages were one of their biggest concerns in responding to the coronavirus outbreak;[80] by the start of April, PHE's pandemic flu stockpile was almost empty.[81] According to the National Audit Office (NAO), over 80% of LRFs reported that PPE shortages were having a disruptive impact in their area between 6 April and 19 May.[82]

Alongside well-documented PPE problems in hospitals, securing PPE has been a big problem in general practice. One witness at the Health and Social Care Committee observed that PPE availability "is an issue less in hospitals and more in our ancillary services and in the primary care setting, where PPE is not being distributed quite as efficiently [i.e. quickly] as it could be".[83] PHE packages for GP surgeries, for example, included gloves, masks and aprons but not goggles, despite its own guidance that GPs should have eye protection to prevent infections from droplets if they come within a metre of patients.[84]

This lack of resilience led some doctors to fear that PHE guidance on PPE usage in March was based on the availability of equipment rather than on what was needed.[85] In evidence to the Health and Social Care Committee, the health secretary, Matt Hancock, said that the guidance – before it was updated to World Health Organization (WHO) standards on 2 April[86] – was "in part… about the PPE stocks that had been built up, and fitting the proposals of what people should wear when to what the stocks are".[87]

Difficulties securing and distributing PPE illustrate the lack of resilience in the UK's supply chains. Before the pandemic, the UK had primarily relied on getting PPE through 'just-in-time' supply chains from suppliers in East Asia. A *Financial Times* investigation found that NHS Supply Chain – an arms-length body of DHSC that procures goods for NHS trusts – had little experience of directly sourcing PPE and was accustomed to securing it through UK-based intermediaries.[88] The UK's domestic capacity to produce PPE was similarly limited and had to be set up on an ad-hoc basis.[89] The 2011 pandemic flu plan contained only one reference to PPE and only mentions supply chains in reference to supply chain companies.[90] Consequently, some NHS trusts took procurement into their own hands, only for NHS England to subsequently restrict them from procuring certain kinds of goods on 1 May in order to reduce competition for scarce equipment.[91]

Shortages of adequate PPE have made it hard to prevent the spread of coronavirus in hospitals and contributed to high infection and transmission rates there.[92] A leaked report from PHE in May[93,94] estimated that 20% of coronavirus infections among hospital patients and 90% of infections among hospital staff may have been caught in hospital,[95] due to a mix of inadequate PPE, an old estate which made social distancing difficult, and a lack of testing that allowed for asymptomatic transmission between patients and staff.[96,*]

Hospitals and GPs entered the crisis with limited capacity to deliver services remotely

The crisis disrupted routine care services – such as GP appointments and outpatient consultations – due to social distancing requirements and the repurposing of hospitals to treat coronavirus patients. Staff worked hard to set up remote working incredibly quickly[**] but neither hospitals nor GPs entered the crisis having invested enough in ICT to deliver a high volume of services remotely.

NHS England estimated that trusts spend less than 2% of their total expenditure on IT, which is considerably less than former health minister Lord Darzi's recommendation in 2018 that trusts should spend 5% of their turnover on IT by 2022.[97] A 2019 survey of 186 IT leaders in NHS trusts found that 77% thought that their IT budget was insufficient to meet business priorities.[98]

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* NHS England has since collected further data on infection rates that show that the percentage of hospital coronavirus infections caught in hospital is now less than 20%, and reducing: https://committees.parliament.uk/oralevidence/607/html

** For example, 46% of outpatient services were delivered virtually in March and April 2020, compared to 6% in February and March 2020, and by June the level of virtual outpatient coverage exceeded the goal that NHS England had set for 2020/21: https://www.england.nhs.uk/wp-content/uploads/2020/06/item-4-BM2012Pu-ongoing-covid-response-and-recovery.pdf, p. 3.

As a result, some NHS trusts were working on outdated systems when the crisis hit. Interviewees told us that some trusts are working on technology that would be considered out of date in the previous century, such as Windows 95.[99]

Similarly, in general practice, interviewees told us that GPs had been resistant to remote working such as online patient triage or telephone and video appointments. Recent policy initiatives[*] meant that many GPs had installed the software and started – albeit slowly in many places – to offer digital consultations. The quick distribution of laptops by clinical commissioning groups (CCGs) has, however, allowed GPs to work from home and to conduct a large number of consultations remotely. As of May 2020, online consultations were available in 85% of practices,[100] compared to less than 30% of practices live with an online consultation system at the end of March.[101]

Figure 3 **Weekly GP appointments by type**
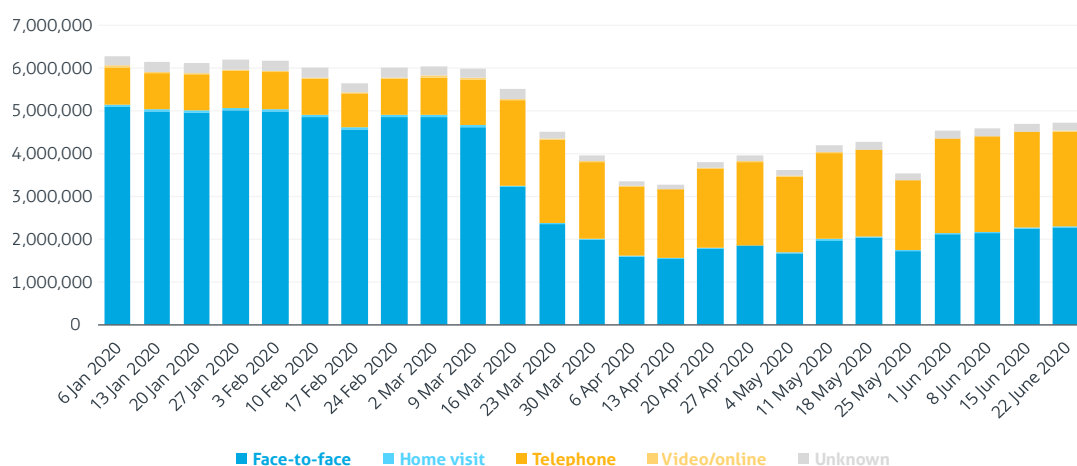
Source: Institute for Government analysis of NHS Digital, Appointments in General Practice

The shift to remote working in general practice was made possible by some software providers offering their services for free[102] and NHS England funding for IT hardware.[103] If the government expects GPs to offer more remote services, they will have to provide GPs with the funding to cover the ongoing running costs of this technology.

The drive to make NHS beds, wards and buildings more efficient made it harder to treat and isolate hospital patients

Alongside most other wealthy countries, the NHS has reduced its number of beds over the preceding 20 years to try to maximise efficiency and provide more care outside of acute hospitals. The NHS now has fewer hospital beds per capita than comparable countries. Importantly for this crisis, the NHS entered with fewer critical care beds – beds in ICUs that could be used to provide ventilated support for patients.[104]

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[*]   For example, NHS England's plan to encourage digital patient triage in the 2019 *NHS Long Term Plan* and the requirement in the 2019/20 GP Contract that all practices must offer patients an opportunity to book a minimum of 25% of all appointments online.

Figure 4 **Hospital beds per 1,000 people**
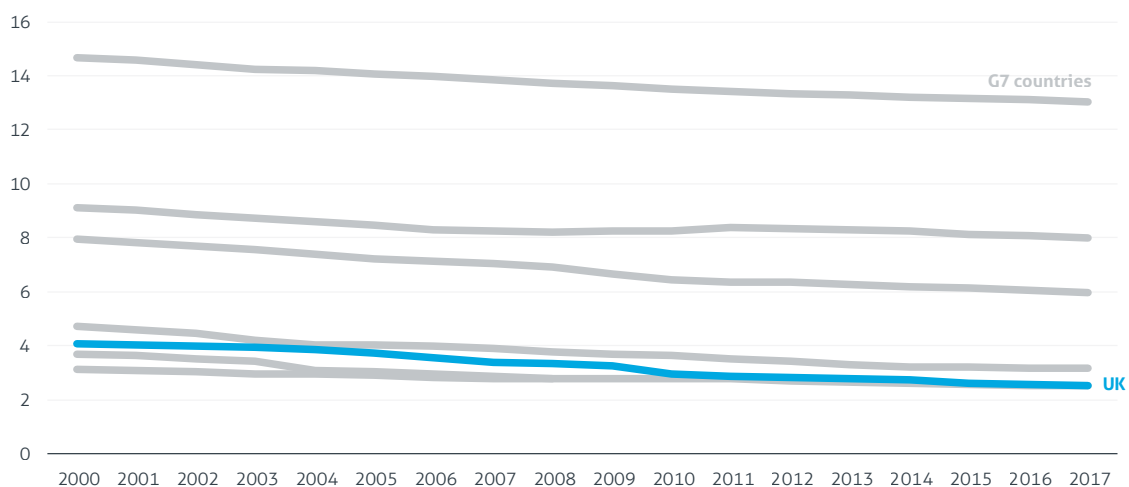
Source: Institute for Government analysis of OECD, Health Care Resources, Hospital Beds.

By early March, as was the case in most countries, the number of beds was insufficient to meet demand without other interventions to reduce the number of coronavirus patients presenting at hospital.[105] In evidence to the Health and Social Care Committee in mid-March, NHS England chief executive Simon Stevens stated that NHS England's focus was ensuring that beds and intensive care capacity were "expanded to the greatest possible extent so that in the NHS we do all we possibly can".[106] This focus[107] during the initial stages of the crisis did successfully increase the number of available beds by building 75% more critical care beds in two months,[108] but the additional critical care beds were ultimately under-utilised because using them required diverting staff from other areas.[109]

Between 17 March and 15 April, NHS England also advised trusts to discharge medically fit hospital patients even if testing was not available,[110] which may have inadvertently contributed to the spread of Covid-19 in care homes. The government's focus on NHS critical care capacity came at the expense of attention on other areas such as social care, where problems have since emerged.[111]

Limited beds have also made it harder to separate and isolate patients.* This has contributed to high transmission rates within hospitals and will make it harder to treat coronavirus cases and provide routine care at the same time. PHE researchers modelled that allocating suspected coronavirus patients to separate rooms or bays while awaiting test results, instead of being grouped together, could halve transmission within hospitals.[112]

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*   Increasing the number of beds is, however, only one solution to slowing the spread of a virus. Greater and earlier accessibility to community testing centres and home test kits could have reduced the spread of coronavirus, removing the need for the additional beds, and preventing transmission within hospitals.

The drive for greater efficiency over the last decade has also reduced resilience of wards. NHS trusts redesigned and increasingly sold[113] parts of their estate to maximise the number of patients treated within particular wards. This included putting most beds in shared accommodation, often with access to one ward coming through another. This limited the options for isolation and meant that wards had to be reconfigured to separate coronavirus patients from those with other conditions.[114,115]

There has been a similar trend towards more efficient use of space in GP practices over the last decade. Over 1,000 GP practices closed or merged between 2013 and 2018, and the remaining practices have a larger number of GPs. Between March 2016 and March 2019, the share of practices with five or more GPs increased from 45.8% to 48.8%, while the number of practices with more than 10 increased from 7.0% to 10.1%.[116]

It may be harder to maintain social distancing in a smaller number of larger practices as communal areas become more congested. However, estate rationalisation in general practice may be less of a problem than in hospitals if GPs can continue to provide a substantial amount of care remotely.

One interviewee noted that the government's policies to extend GP practice opening hours under the coalition and subsequent Conservative governments[117] led some CCGs to create "extended access hubs" – facilities where patients can go for appointments at times GPs do not typically offer – which have proved helpful during the current crisis. Interviewees told us that local areas which had more hubs were able to convert some of them into 'hot hubs' (where GPs can see patients who may be infected face to face)[118] relatively easily, as these larger hubs had more space for putting on and taking off PPE. Interviewees told us that areas with GP federations were able to set up hubs particularly quickly because of a sustained government policy over the last five years to promote local practice collaboration (whether through federations or primary care networks), which proved beneficial during the coronavirus response.

The NHS could have entered this crisis with a more resilient health infrastructure if it had invested more in recent years

Spending on buildings, equipment and other assets has consistently been lower in the UK than in other comparable countries. The UK only exceeded the OECD country average investment in health infrastructure in three years between 2000 and 2016, and the value of the UK's health capital is actually lower now than it was in 2000.

The difference between the UK and other countries has become increasingly pronounced over the last decade. DHSC's annual capital budget was cut substantially after 2009/10, and as of last year was still 20% lower than it was at the turn of the decade.[119] In NHS trusts, where data is only available after 2013/14, spending fell each year between 2013/14 and 2017/18, rising in 2018/19 because of investment in new buildings.[120] In 2018, the last year in which most OECD countries submitted data returns, the UK was in the middle tier of health capital spenders alongside Iceland and Ireland, and far behind Austria and Canada, spending 0.4% of its GDP on health capital.

One major factor has been the health department's increasing tendency to use money originally earmarked for investment to deliver core services – it has done so every year since 2014/15.[121] This has reduced the amount of funding available for new facilities and equipment that could have enabled the NHS to provide better care during the pandemic. For example, the UK has fewer CT and MRI scanners than all other G7 countries.[122] It has also hindered its ability to quickly and efficiently set itself up to manage more services remotely, which has proved particularly important during the current crisis.

It also meant that NHS trusts entered this crisis in a poor state of repair, with a substantial and growing maintenance backlog. The cost of addressing this – calculated as being how much NHS trusts would have to spend in order for buildings to be sound, operationally safe and exhibiting only minor deterioration[123] – rose from £4.0bn in 2013/14 to £6.5bn, a real-terms increase of 47.4%.

Figure 5 **Cost of addressing NHS trust maintenance backlog, 2019/20 prices**
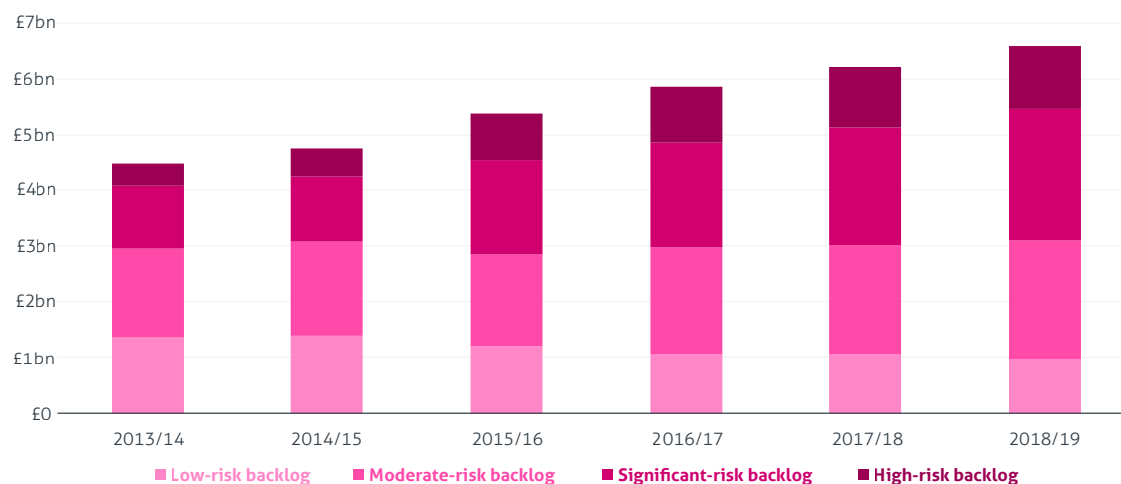
Source: Institute for Government analysis of NHS Digital, Estates Return Information Collection.

The poor state of buildings makes it harder to restart routine care services while continuing to treat coronavirus patients.[124] In June, NHS Providers, an NHS membership organisation, estimated that the social distancing requirements imply that the NHS will only be able to operate at 40% of capacity for the near future,[125] and any improvements or changes to allow patients and visitors to stay farther apart will require investment.

The government does not collect data on the state of the primary care buildings* so it is not possible to assess the physical condition of GP practices.**

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* However, collecting this data has been suggested to a NHS Property Board's recently established data collection project.
** NHS England is currently undertaking a primary care estates data collection project that will provide commissioners with more effective mapping tools and information to support more strategic planning.

Looking ahead

In the event of a second peak of infections, the NHS will be better prepared than it was first time around, with plans tailored for a coronavirus pandemic rather than flu. In some ways it will also be more resilient, with better access to PPE, greater ability to conduct remote consultations and appointments, and increased hospital bed capacity.

However, staffing resilience will be weaker, particularly in hospitals. To date, staffing shortages have been managed through the implementation of short-term measures, including relaxing staff:patient ratios and retraining existing staff. These measures are not sustainable and there is a risk of workforce burnout.

Even without a second peak, staff shortages and the poor state of buildings will make it hard for hospitals to fully restart routine services – never mind begin to tackle backlogs that have built up – while continuing to treat people for coronavirus.

Local government

Local government* had reasonably good plans for delivering emergency support in a crisis and could draw on well-established local relationships and command structures. However, central government plans for adult social care had not fully taken on board the lessons from the last major planning exercise, communication channels with local government – which commissions publicly funded care – were often poor, and the diversity of the adult social care market made it harder to implement plans quickly once the crisis began.

Most local services were also less resilient after a decade of austerity, and some aspects of performance had declined. Staffing weaknesses have caused problems for adult social care, in particular, while children's social care could well face workforce difficulties as coronavirus measures are further eased. Care homes, among other social care providers, have found it difficult to work effectively while observing social distancing, which has been compounded by a lack of investment in ICT in the last few years making it harder to operate remotely.

How prepared was local government?

Local authorities had good plans in place for delivering emergency support and maintaining essential services, some of which benefited from recent no-deal Brexit planning. However, national plans for adult social care were poor, and those for safeguarding children did not account for the severity of the lockdown.

In some cases, the response by local authority services was improved by the strength of existing relationships and decision making structures. However, communication channels between central and local government were often poor, and the diversity of adult social care providers made it harder to implement plans quickly and consistently.

Local authorities had reasonably good plans, but these were focused on an influenza pandemic

Local authorities were able to respond well in the initial phase of the crisis because they could draw on well-established plans. Like the NHS and the police, the Civil Contingencies Act 2004 designates local authorities as Category 1 responders. This requires them to undertake specific civil protection duties such as assessing the likelihood of certain risks, undertaking contingency planning, setting up business

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* Here we focus on local government services that play a part in responding to crises (such as providing food, shelter and information) as well as children's social care (services for looked-after children, safeguarding and family support services) and adult social care (the provision of support and personal care – as opposed to treatment – to meet needs arising from illness, disability or old age). Our coverage is limited to England. This chapter does not provide a full assessment of all local government services, such as libraries, food hygiene and safety, waste collection, and road maintenance.

continuity plans and advising local businesses about these plans. This planning is done through Local Resilience Forums (LRFs), which bring together local authorities with other responders, such as the emergency services, utility companies and transport providers. LRF plans are peer-reviewed for quality and cover a range of possible emergencies, including flooding, terror attacks and major accidents such as bridge collapses.

In 2013, public health teams were moved to local authorities, integrating directors of public health into the LRF structure. Interviewees told us that this transfer and the more prominent role directors of public health now play in local authorities improved local authorities' ability to plan for public health emergencies such as coronavirus.

Local plans for a pandemic were heavily shaped by central government guidance. The Civil Contingencies Secretariat in the Cabinet Office issues detailed guidance for LRFs on what is expected from their emergency planning. Critically, the guidance states that LRFs should develop multi-agency plans both for an influenza pandemic and "for infectious disease risks, which would require a response quite different to a response to an influenza pandemic".[1] However, both nationally and locally, pandemic flu was considered to be a greater risk than other infectious diseases. While publicly available material from local authorities indicate that they did treat the two as distinct threats,[2] interviewees told us that local authorities did less planning for non-flu pandemics.

Substantial cuts to the funding provided by central government to local authorities weakened councils' ability to plan for emergencies. Interviewees told us that during austerity, emergency planning functions were politically easier to cut than front-line services. As a result, local authority emergency planning expenditure in 2018/19 was 35% lower in real terms than in 2009/10. We were also told by interviewees that staff cuts, particularly in senior finance and governance roles,[3] hampered local authorities' ability to develop plans for emergencies, and to scrutinise and challenge them.

Figure 6 **Local authority spending on emergency planning, 2019/20 prices**
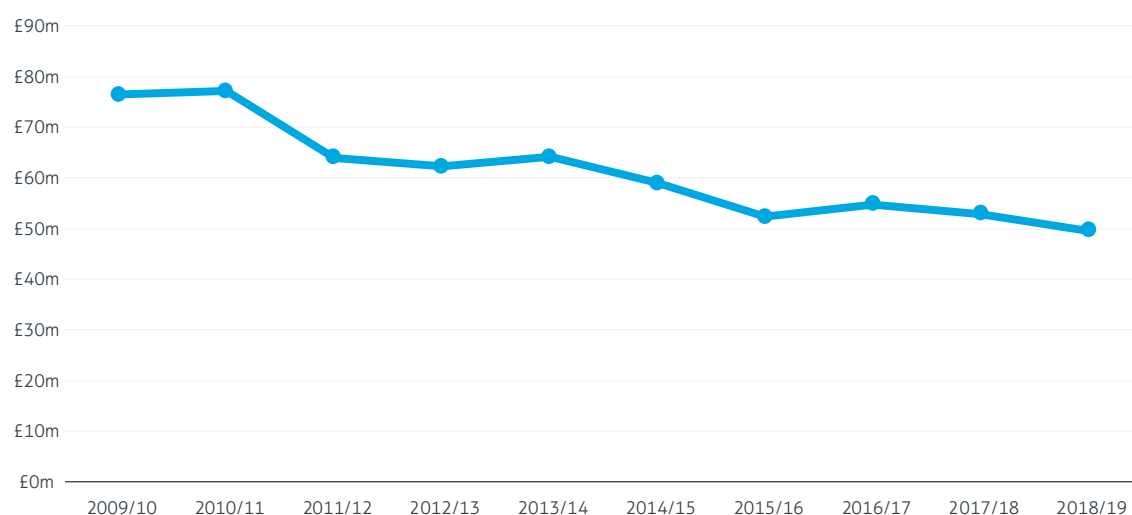
Source: Institute for Government analysis for Ministry of Housing, Communities, and Local Government, 'Local authority revenue expenditure and financing in England, individual local authority data - outturn, Revenue outturn central protective and other services (RO6)'.

Local authority planning benefited from consideration of no-deal Brexit and the collapse of Southern Cross

LRFs had planned for major disruptions arising from a potential no-deal Brexit. Interviewees told us that many already had in-depth plans to ensure that vulnerable people had access to food in the event that normal supply chains failed. These plans were quickly repurposed to support those who were advised by the government to shield from the pandemic.

Preparations for no-deal Brexit meant that LRFs had already been working to prepare for disruption to normal life. One interviewee said that the timing of the pandemic was "lucky", coming just after much of the planning for no deal (which had been taken seriously as a likely prospect) had been stood down.[4]

For adult social care, local authorities benefited from planning undertaken after the collapse of Southern Cross Healthcare. Formerly the largest care homes provider in the UK, it declared insolvency in 2012, following serious financial troubles in previous years. We were told that this event had improved the quality of local authority plans for maintaining service continuity in care homes in the event of a major disruption.[5]

National plans for adult social care were poor and did not take into account lessons from the last major planning exercise

A 2016 live government exercise to practise responding to pandemic flu, Exercise Cygnus, uncovered extensive weaknesses in adult social care's ability to handle a spike in demand during a pandemic.[6] But the government did not fully implement the lessons from this. Local authorities who took part in the exercise "raised concerns about the expectation that the social care system would be able to provide the level of support needed if the NHS implemented its proposed reverse triage plans, which would entail the movement of patients from hospitals to social care facilities".[7] The exercise found that there was a lack of joint tactical-level plans for when demand outstripped the capacity of local responders to provide social care (alongside health surge planning and excess deaths) and identified a mismatch between national plans to increase NHS capacity and local authority plans for social care.

The Cygnus report recommended that national planning should consider how and whether local flu plans would be able to deliver what was needed from the social care sector in the event that the NHS implemented reverse triage plans[8] – but the government and local authorities do not seem to have fully implemented these recommendations. The Department for Health and Social Care (DHSC) has said that the government had been 'extremely proactive' in implementing the lessons from Exercise Cygnus,[9] including having legislation ready for easements of the Care Act 2014 which was incorporated into the Coronavirus Act 2020 (discussed in more detail below) and improving data on the capacity of care homes.

DHSC has confirmed that it addressed all of the recommendations which related to the department itself[10] but local authorities and social care providers have said they were not consulted or involved in implementing recommendations. A local authority interviewee told us that the NHS had not engaged with emergency planning locally in

a meaningful way and had no familiarity with LRF structures and roles within it.[11] The Association of Directors of Adult Social Services (ADASS) has stated that social care was "a secondary consideration" during the pandemic, and that "the discharge policy was written with the NHS in mind but not sufficiently with social care in mind"[12] – suggesting that national plans for social care did not incorporate critical lessons from Exercise Cygnus.

Plans for safeguarding children did not take account of lockdown or school closures

LRFs had plans to support vulnerable children in a variety of emergencies. However, local authorities were not prepared for the exceptional circumstances arising from coronavirus, such as the requirement for social distancing.

Where possible, social workers have adapted by holding conversations in gardens or using technology to conduct 'visits' remotely. But this has not always been possible, and few formal plans existed for conducting such visits remotely, such as guidance on the use of secure online video software.[13] This made it harder for social workers to check in with vulnerable children during lockdown.

Similarly, little consideration had been given to the impact of lockdown on the ability of children's social workers to identify vulnerable children not already receiving some kind of formal support. For example, schools – which were mostly closed – provided far fewer referrals.

Well-understood local structures helped local government respond but existing communications channels between central and local government were sometimes poor

Communication within local government during the pandemic has generally been good. LRFs are activated in response to all local emergencies, creating a strong history of co-operation between the different partners. When Exercise Cygnus was carried out in 2016, six of the eight participating LRFs had conducted exercises to test their flu pandemic plans in the two years prior.[14] Even where local actors had not practised for a pandemic, they were still likely to be familiar with emergency response structures and processes thanks to the LRF model. Some local authorities in the north of England for example have used LRFs extensively over the past few years to respond to flooding.

However, communication between central and local government has been more mixed. In children's social care, interviewees told us that the Department for Education (DfE) was able to gather intelligence about the impact of the pandemic locally and understand pressures on front-line through existing weekly calls with 90 principal social workers.* The Ministry of Housing, Communities and Local Government (MHCLG) was able to use a group of nine regional chief executives, originally convened for no-deal Brexit planning, to feed information between the two layers of government.[15] And DHSC established a National Adult Social Care Covid-19 Group (NACG), based on co-ordinating committees used in previous crises, to bring together sector leaders.

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* After the crisis began, DfE also established Regional Education and Children's Teams to co-ordinate with local authorities. These cover both education and children's services, with a focus on vulnerable children.

HOW FIT WERE PUBLIC SERVICES FOR CORONAVIRUS?

However, we heard from many interviewees that the relationship between central and local government has too often been weak, particularly in the early stages of the crisis. Poor communication,[16] inadequate data-sharing,[17] and uncertainty[18] about whether, and which, of the costs of responding to the pandemic central government would reimburse, have all made it harder for local authorities to implement plans. We heard particular concern that announcements by No.10, including those in the daily press conferences, were often made without consultation with local government and with little consideration of how they would be implemented.

The number of adult social care providers made it harder to implement plans and data is poor

Local authorities are required by the Care Act to promote an adult social care market with a variety of providers.[19] In normal circumstances this diversity is desirable, improving the likelihood that people can secure support that meets their specific needs. However, interviewees told us that having thousands of care home and homecare providers, from a variety of sectors and with multiple representative bodies, had been a problem in implementing emergency response plans.[20]

Figure 7 **Care home providers by number of beds**

64% of care home beds are run by providers with 300 or fewer beds
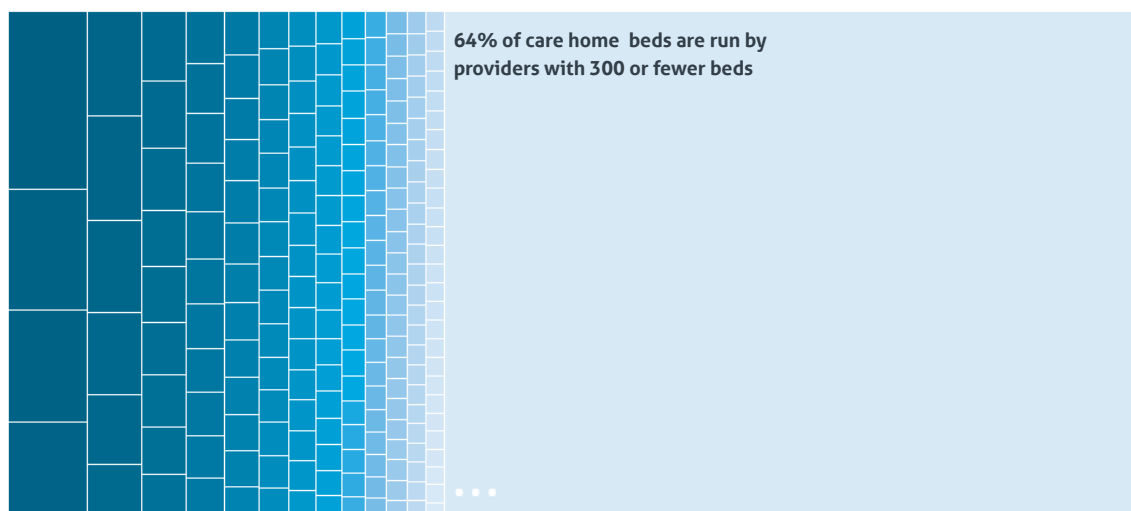
Source: Care Quality Commission, Active locations for providers registered under the Health and Social Care Act (HSCA). Lightest blue = providers with fewer than 300 beds.

The sheer number of providers made distributing information to them, and gathering intelligence from them, more difficult than in other services with better established communication channels (see Figure 7). Furthermore, many providers do not have government contracts, meaning that existing relationships with local authorities will be limited. This made it harder for councils to identify and provide support to struggling adult social care organisations. More generally, the quality of adult social care data is poor, making it difficult to understand what is going on in real time. For example, there is very little data on people who pay for their own care, rather than receiving government funded support, and on domiciliary care.

This is especially unhelpful during the current crisis – where such data would be incredibly valuable for allocating support and tracing infections during the pandemic.[21]

How resilient were local government services?

A drawn-out crisis like coronavirus makes it harder for any public service to maintain standards. However, it creates bigger problems for services that are already performing badly. Unfortunately, some aspects of social care performance had been in decline before the pandemic started.

Public services with more staff and the ability to draw on extra capacity are better able to respond to shocks. Local authorities were able to redeploy and hire extra staff, but not enough to cover absences due to coronavirus, and workforce issues caused particular problems in adult social care.

Insufficient stocks of PPE and weak national distribution channels caused particular problems for adult social care, while a lack of ICT investment made it harder for some services to work remotely.

Running public services while maintaining social distancing requires flexibility in how buildings are used. While this has not yet been a major problem for children's social care, the limited amount of available space in both publicly and privately run care homes made it particularly difficult for these services to operate safely.

Declining performance in some aspects of social care services made it more difficult to respond to the crisis

The previous decade left social care services in a fragile position. Spending on adult social care fell while demand grew, resulting in fewer people receiving publicly funded care – though this was partly offset by local authorities signposting people to other types of support. As a result, those in need of care had to increasingly rely on unpaid care from friends and family.[22] Although the quality of adult social care has remained stable, or improved, in the last decade for those who receive care, the increasingly restricted scope of publicly funded care has led to a small increase in public dissatisfaction. Responding to coronavirus has created significant additional pressures, and just 4% of directors of adult social services were confident that they could meet their statutory duties within their current 2020/21 budget – down from 35% last year.[23]

There are also signs that the quality of children's social care services has fallen since 2010. Although Ofsted ratings of local authority children's services departments have improved since 2013, the inspectorate has used two different inspection frameworks in this period, with few councils being inspected twice using the same criteria. As such, these ratings are not a reliable basis for assessing how service quality has changed. There is more evidence that the quality of children's social care services declined in places. For instance, social workers were increasingly not reviewing child protection plans on time, a greater proportion of children subject to a child protection plan were doing so for a second or subsequent time, and academic evidence suggests that higher demand – which has been seen across the country – correlates with lower quality.[24]

Staffing problems left some services less able to respond to the pandemic

Local authority staff cuts resulted in the loss of experience in responding to emergencies. Exercise Cygnus found that local authorities were too reliant on a few experienced individuals to implement key aspects of emergency response, such as managing mortuaries if the number of deaths was high.[25] In the four years since, the number of staff employed in local government has fallen by 9%, potentially jeopardising the availability of this critical expertise. However, we were told that local authorities have generally not had major problems accessing corporate memory, and have been able to draw on specialist support from the Civil Contingencies Secretariat and elsewhere if needed.[26]

Figure 8 **Personal carers per 100 people aged 65 and over**
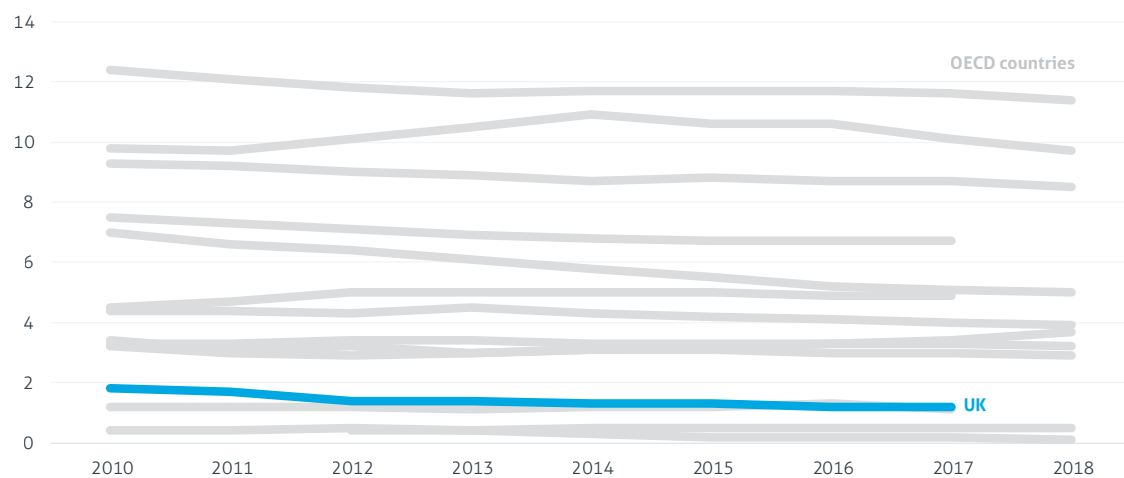
Source: OECD (2020), Long-Term Care Resources and Utilisation, 'Formal long-term care workers (headcount) per 100 population aged 65 years old and over'.

Staffing was a major problem in adult social care before the epidemic struck. Demand for social care has risen faster than social care jobs were filled, leading to a rising number of vacancies between 2012/13 and 2018/19.[27,28] Turnover in adult social care is also high (31% in 2018/19), particularly among care workers[*] (40% in 2018/19), and was rising before the crisis.[29]

Most critically, pay and working conditions in the sector are poor. Care workers' pay is one of the lowest across the economy[30] and since 2012/13 the share of the care workers employed on zero-hours contacts has consistently been around a third.[31] Public Health England (PHE) and care providers identified the lack of sick pay, low pay, and the resulting need for some care workers to work in multiple facilities, as risks to infection control.[32,33,34] The Office for National Statistics (ONS) found that care homes employing staff working in different locations were more likely to experience coronavirus infections among both staff and residents.[35,36] Although in some instances

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[*]   The social care workforce includes managers, personal care assistants, and occupational therapists, among
       other roles. Care workers are not a formally recognised profession and are not registered with Social Work
       England, although they represent a large proportion of the adult social care workforce (840,000 staff, or circa
       70% of job roles). In contrast, social workers are both recognised and registered - there are about 18,000 of
       them, representing 1% of social care job roles.

staff slept on site to minimise risks, there is some evidence that care workers with asymptomatic coronavirus contributed to the spread in care homes.[37,38,39] These problems were exacerbated by the shortage of adequate PPE and lack of testing.

In recent years, the children's social care workforce has grown more quickly than demand for the most acute services, but not as quickly as some social work activity and there is evidence that cases have become more complex.[40] Staff resilience in children's social work is also weak, with longstanding problems including low morale and high turnover – which has consistently been about 15% per year in the last decade. Interviewees told us that having experienced social care staff on the ground was hugely important for gathering the information needed to respond to the crisis. However, the children's social care workforce is now less experienced than it was due to high turnover and the growing workforce. More than half (51%) of staff had five or more years of experience in 2015/16, compared to 39% in 2019/20.

In anticipation of large staff absences due to illness, the government temporarily removed some statutory protections for vulnerable children and adults during the pandemic so that local authorities could focus on core safeguarding duties.[41,42] These flexibilities have been used. For example, 87 out of 128 local authorities spoken to by DfE during June and July had used at least one easement.[43] It may not have been necessary for local authorities to use these flexibilities as often had the social care workforce been larger or more experienced at the start of the crisis.

Local authorities have benefited from the ability to redeploy staff but have also had to recruit additional staff to cover absences

Local government was able to redeploy and hire staff, but not enough to cover the staff they lost due to coronavirus-related absences. The Local Government Association (LGA) estimated that about 6% of the local authority workforce (33,000 staff) in the councils they surveyed were unable to work in mid-June. On top of that, around 2% of staff had been furloughed. The councils surveyed by the LGA were able to partially make up for these absences by redeploying 3% of their staff to deliver services ranging from assessing welfare applications to waste management, and by recruiting more than 9,000 extra staff since March, amounting to 2% of their total workforce.[44,45,46,47,48,49,50]

To meet staffing pressures in social care, the government used the Coronavirus Act to allow Social Work England to temporarily re-register around 8,000 adult and children's social workers who had left the profession in the last two years.[51,52] Alongside this register, DfE, DHSC and the LGA set up the Social Work Together portal for individuals to sign up for opportunities. These two initiatives saw 1,000 individuals express interest in coming back to the front line, although only 2% of those (just 18 people) had actually been recruited after two months.[53,54]

Children's social care will face staffing problems as the lockdown is lifted

Lower demand has meant that children's social care services had enough staff to manage the initial lockdown, but they may struggle as restrictions are lifted.

Following the lockdown, referrals to children's social care initially fell by 50% in some areas because bodies such as the police and schools (which normally refer many children) had less contact with children than usual. This fall in demand has meant that social workers have not yet faced higher workloads.[55]

But this is unlikely to last. Children's social care leaders are concerned that the pandemic will "increase demand from families who don't meet the criteria for support from statutory services... who are wrestling with new and pressing needs created by the strains of the lockdown".[56] This currently unmet demand could place substantial pressure on children's services once lockdown restrictions are eased and referrals increase. However, we were told that local authorities have put measures in place to mitigate risks related to these 'hidden harms'.[57,58]

Social care providers did not have resilient PPE stocks or supply channels

Adult social care providers have struggled to secure PPE for their staff during this crisis. They had limited funds available to purchase PPE, especially when prices went up as demand grew. This problem could have been mitigated with larger stockpiles, but as described above these were limited at the start of the crisis. Finally, the distribution of PPE to providers was not always effective.

Social care providers were initially left to source their own PPE but this was difficult, particularly for small and medium-size providers, which make up a sizeable proportion of the market.[59] Both local authorities and care homes publicly voiced concerns about PPE shortages early on during the crisis. DHSC started issuing PPE to social care providers around 16 March.[60] Still, in late March, the LGA and ADASS wrote to the department to highlight "daily reports from colleagues that essential supplies are not getting through to the social care frontline".[61] ADASS later reiterated its public call on government to fix PPE shortages in social care in April.[62] The government now appears to have ordered enough PPE for health and social care staff for the rest of the year.[63]

In response to initial PPE shortages, DHSC arranged for new stock to be delivered directly to social care providers, to LRFs for onward distribution, and to wholesale commercial suppliers for sale to care providers.[64] Government also allowed social care providers to access PPE through the National Supply Disruption Response (NSDR) system. This increased PPE availability for care providers was still insufficient. Directors of adult social care privately labelled the national supply chain "shambolic" and added that PPE deliveries to LRFs were "haphazard".[65]

Care providers also obtained some PPE from the central stocks held by PHE, but this stockpile was only enough to deliver around 15% of the total predicted requirements[*] for PPE in care settings. In contrast, the NHS received more than 50% of most PPE items that DHSC projected it would need.

Other local services had fewer problems accessing PPE, despite limited stockpiles when the crisis began

Access to PPE was less of a problem in other local government services. Interviewees told us that local authorities broadly seemed to have enough PPE despite occasional gaps. Around 90% of the local councils surveyed by the LGA in June about the availability of PPE said that they had the right amount, while 3% had less PPE than they needed in June (down from 19% in May).[66]

Demand for PPE was lower in children's social care, as government guidance stated that children's social workers did not require PPE unless visiting or interacting with children or families displaying symptoms of coronavirus.[67,68] Despite this, there have been some reports of shortages on the ground. Children's charities have said that a lack of PPE led some managers to ration stocks or ask staff to buy their own.[69]

A lack of ICT investment across local services made it harder to respond to the crisis

Local authorities and social care providers made limited investments in ICT in recent years due to tight funding. This has made it harder to deliver services remotely during the crisis.

The care sector faces major financial pressures, and many care homes are not financially sustainable. Where care homes are mainly reliant on publicly funded residents, profit margins have only just covered day-to-day costs, excluding the additional investments needed to maintain or modernise facilities.[70] As a result, most care homes have old equipment and nearly two thirds of English care homes did not provide internet access to residents at the start of the crisis.[71,72,73] The government improved internet access in care homes during the pandemic, partly relying on devices donated by technology companies like Facebook to enable residents to speak to family members.[74] Even still, in some cases the effect of these shortcomings during lockdown was that care home residents died without being able to see the faces of loved ones.[75]

There was similar underinvestment in children's social care IT. In some instances, IT systems didn't work well before the crisis, or the IT equipment did not enable remote working.[76,77] However, we were told that councils broadly had the videoconferencing technology required to enable children's social workers to remotely attend multi-agency meetings and to organise remote visits to children, although not all set up such visits. More problematic was the lack of equipment owned by disadvantaged children. Government invested £100m to purchase computers for children, but

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[*]   DHSC calculated a 'modelled requirement' of UK demand for PPE between 20 March and 9 May, based on a 'reasonable worst-case scenario'. Although this scenario likely differs from what actually happened, it highlights some of the discrepancies in PPE provision between health and social care settings. For more information about this data, see Comptroller and Auditor General, *Readying the NHS and adult social care in England for COVID-19*, Session 2019–2021, HC 367, National Audit Office, 12 June 2002, pp. 61–2.

interviewees said local authorities were able to provide children with laptops or tablets faster than central government, notably by refurbishing them or working with local charities and companies.

Interviewees noted that some children and families appear to prefer online visits, and the charity Action for Children reported that "some young people and parents felt more comfortable opening up to support workers through digital means".[78] However, this was not seen across the board, and online visits created particular problems for those working with children with more complex needs[79] while charities also raised concerns that working remotely made it difficult to ensure confidentiality and privacy.[80]

Care homes did not have enough spare capacity to enable social distancing

It is difficult to keep social care residents isolated due to the size, facilities and high occupancy rates of homes. The average care home in the UK is relatively small, and interviewees told us that many care homes were not designed for isolation – few had en-suite rooms, and many had shared rooms. The head of the National Care Forum told parliament that many care homes built two or three decades ago were set up for shared space, and it was not possible to isolate patients without sacrificing the number of beds available.[81] With care home occupancy rates ranging from 86% to 90% in mid-April to mid-May, this was difficult to do.[82]

Some of the limitations in the care home estate already existed at the time Exercise Cygnus was conducted. After the exercise, local authorities had been advised to set up contracts with large hotel chains to obtain extra capacity, although this only appears to have happened in a few places during this crisis and one interviewee questioned the appropriateness of hotels given the care needs of some individuals.[83,84]

The UK's overall care home capacity may also decline because of the crisis, making it harder to respond to a second peak of infections. Up to a tenth of care homes face bankruptcy due to a combination of expensive bills for PPE, additional staff costs during the pandemic, and reduced occupancy due to the high number of deaths.[85,86] Around a fifth of the £3.2 billion emergency coronavirus grant funding that central government gave local authorities was spent on supporting the social care market.[87] Any fall in the number of care homes would greatly reduce the sector's capacity to take on new patients, to relocate existing patients while maintaining safe distance, and to deal with future demand. Indeed, academic analysis has found a strong correlation between the number of long-term care beds that a country has and coronavirus mortality rates.[88]

In children's social care as in other services, the ability to work remotely has meant that building capacity has not been a major problem to date. However, this may change if children's social workers are required to resume face-to-face visits.

Looking ahead

As services return to normal, some like social care may find it difficult to manage demand. Children's social care leaders are particularly concerned that the pandemic has made more children vulnerable. There is also a risk that capacity in care homes may be further reduced if providers fail as a result of the pandemic.

Local government services may find it difficult to respond to a second peak of coronavirus cases. Although PPE shortages are now less of an issue, and services have invested in infrastructure to enable online access, it may still be difficult for care homes to enable contact with relatives virtually, and for children's social care visits to be conducted online. More broadly, local authorities have raised concerns that they will be forced to make substantial service cuts to balance their books unless central government agrees to underwrite more of the lost revenue and additional costs incurred by councils due to the crisis. If such cuts are made, then local authorities will perform much less well in a second peak.

Schools

The quality of emergency plans in schools* varied substantially, and there was insufficient guidance from the Department for Education on remote learning. The schools sector is fragmented – with some coming under the jurisdiction of local authorities, some grouped together as part of multi-academy trusts and others operating as single academies. This made it harder to implement decisions consistently across the country from March, with less support available to some schools than others.

Unlike other services covered in this report, performance had remained stable or improved in schools since 2010, which left them in a better position overall to respond to the shock of coronavirus, though a lack of ICT investment hampered attempts to operate remotely. New government guidance – issued in July, relaxing social distancing requirements – means that schools should be able to accommodate all pupils when the new academic year starts in September, despite staffing weaknesses and the capacity constraints of school buildings.

How prepared were schools?

Schools have risk registers for a wide variety of disruptions, but it is unclear how much detail these included on a possible pandemic as they are not published and guidance from the Department for Education (DfE) was lacking. In addition, the fragmentation between maintained schools and academy schools made it harder to implement plans quickly and consistently.

There was insufficient guidance from DfE

The quality and content of schools' plans varied widely. Some local authorities provided templates for contingency planning to schools within their area. Similarly, some large multi-academy trusts (MATs) had made plans – although academies are less likely to have benefited from as much involvement in Local Resilience Forums (LRFs) as schools maintained by local authorities. We were told that this is partly because academies were established after the Civil Contingencies Act 2004, and are therefore not explicitly named in the Act as organisations that should be involved in LRFs.

There were also some differences in planning depending on the type of risks schools faced. Interviewees told us that schools in rural areas planned more for foot-and-mouth-disease style outbreaks, drawing on the experiences of the 2001 outbreak, while inner-city schools had prepared more for terrorism incidents.

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* This chapter examines schools in England, both mainstream academies and maintained schools. Where we refer to pupils, unless stated otherwise this means pupils aged 5–15.

Exercise Cygnus did consider the impact of a pandemic on schools. Its report recommended that DfE study the impact of school closures on society, but the department does not appear to have done this. It also recommended that schools be kept open by drafting in retired teaching staff and trainee teachers. While these were potential solutions for situations where high staff absences were the main problem, they were not appropriate for circumstances in which most schools closed as part of social distancing measures.

Indeed, mass school closures was not something the government had planned for in any of its existing emergency planning exercises and strategies. The Department of Health's 2011 *Influenza Pandemic Preparedness Strategy* stated that closing schools would have a major negative impact, and that "although school closures cannot be ruled out, it should not be the primary focus of schools' planning".[1] Moreover, there is no evidence to suggest that the government had considered the impact of weeks-long school closures nationwide on learning.
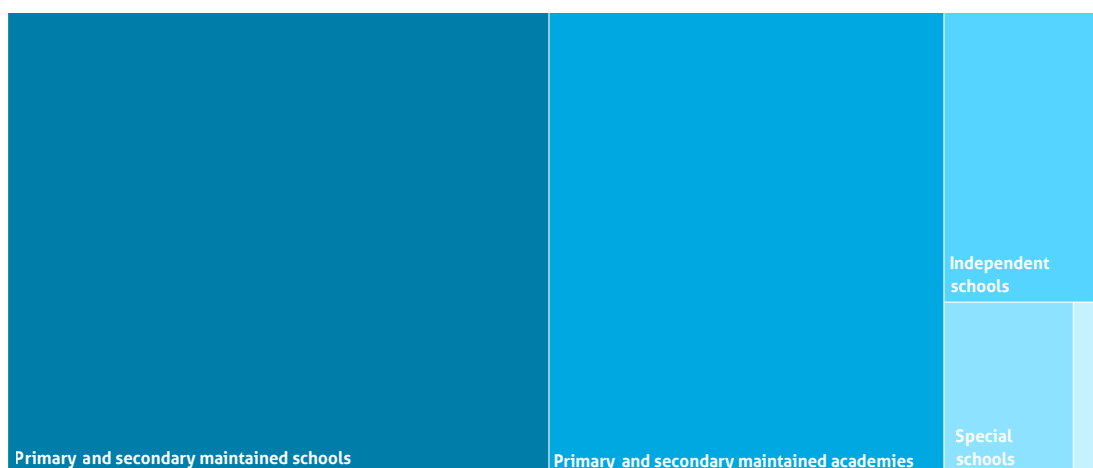
Interviewees said that DfE had done little contingency planning for remote learning, leaving schools with a "vacuum on how learning should be happening".[2] We were told that during this crisis, the government had "pushed the concept of a school-led system as far as it could go".[3] Insufficient guidance from central government meant schools were left to make decisions and tackle problems themselves, leading to considerable variability in the quality of education provided by schools during the crisis. For example, some delivered lessons through 'interactive classrooms' while most set worksheets or used video recordings.[4]

The fragmentation of schools made it harder to implement plans

The fragmentation of the school system following the introduction of widespread academisation since 2010 – with some schools under the jurisdiction of local authorities, some grouped together as part of MATs and others operating as single academies – created confusion over responsibility during this crisis.

It also means that schools draw on very different levels of support. Interviewees told us that schools in MATs had access to advice on HR and estate management from central teams. This helped them deal with staff absences and should aid their planning for reopening schools. Local authorities' ability to provide that support has declined over the last decade, with fewer staff to organise a coherent response across the schools in their area, due the creation of academies and cuts to education support services.[5]

Figure 9 **Breakdown of schools by type in England 2019/20**

Independent schools

Special schools

Primary and secondary maintained schools

Primary and secondary maintained academies

Source: Department for Education, 'School characteristics - Phase and type, admissions, denomination, urban-rural, gender and academy status' from 'Schools, pupils and their characteristics'. Lightest blue = Pupil Referral Units.
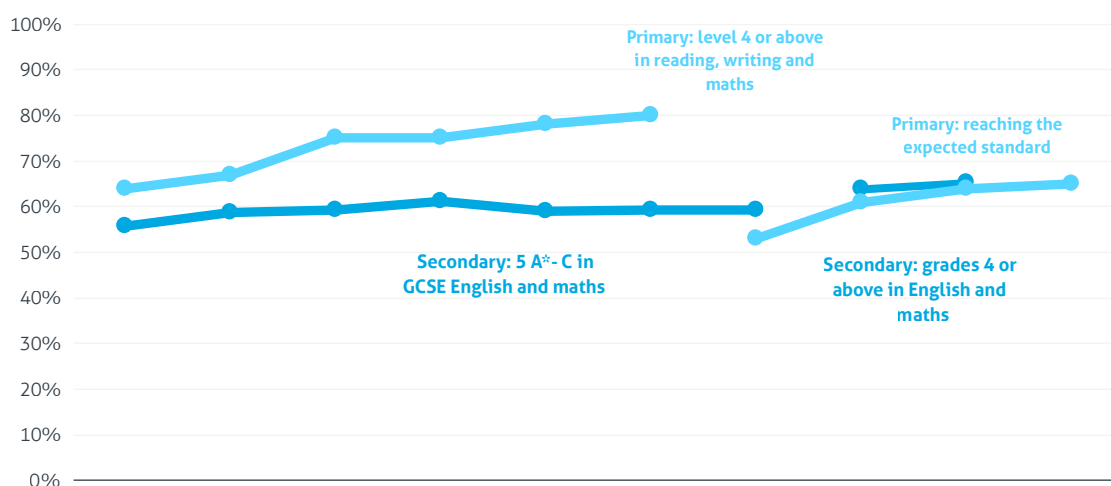
How resilient were schools?

Schools entered the crisis performing well and with enough staff to manage the crisis. The latest guidance from government means that schools should be able to return in September, when the new academic year starts, despite the difficulty of maintaining social distancing in classrooms and communal areas.[6] However, low levels of investment in equipment for remote teaching and in some cases limited availability of equipment among students made the initial response to coronavirus difficult and could create difficulties again if further lockdowns are imposed.

Schools were performing well at the start of the crisis

Schools entered the crisis in a better position than other services in terms of performance. While the disruption to pupils' learning has been damaging, this would have been worse had the quality of teaching been poor beforehand.

Figure 10 **Pupil attainment at the end of primary school (key stage 2) and secondary school (key stage 4)**

Primary: level 4 or above in reading, writing and maths

Primary: reaching the expected standard

Secondary: 5 A*- C in GCSE English and maths

Secondary: grades 4 or above in English and maths

Source: Department for Education, 'GCSE and equivalent results in England' and 'National curriculum assessments at Key Stage 2'.

The main measure of school performance is pupil attainment, although it is not as reliable a measure as pupil progress (on which there is less data).* Despite cuts to per-pupil school spending in real terms, pupil attainment has at least been maintained and may even have improved since 2010.[7,8] For instance, the percentage of children achieving expected standards in reading, writing and maths at the end of primary school (key stage 2) has grown, although this could also be due to teachers becoming more familiar with the new curriculum introduced in 2014.[9]

The performance of schools has also improved according to Oftsed inspections, with the number of schools rated Good or Outstanding rising by eight percentage points in secondary schools and 20 percentage points in primary schools between 2010 and 2018. However, changes in how Ofsted inspects schools makes comparisons over time difficult.[10]

Schools have had enough staff to manage the crisis

Fewer children attending schools due to lockdown meant that schools largely had enough staff to manage during the initial phase of the crisis. The National Foundation for Education Research found that 75% of the teacher workforce was available in May and schools did not have to draw on supply teachers or volunteers before the summer 2020 term ended in July.

Schools would have likely struggled to staff face-to-face teaching under the government's early coronavirus plans, which required smaller class sizes to allow for social distancing at two metres. Schools entered the crisis having missed their recruitment targets every year since 2012/13, and with the average number of pupils per each teacher rising since 2014/15.[11] As a result, schools would not have had enough teachers – and physical space – to reduce class sizes to 15 pupils.[12] These practical constraints almost certainly contributed to the government's U-turn over bringing children back to school in June.[13,14]

However, the government's latest guidance, issued in early July, is that schools should "prepare to welcome all children back this autumn".[15] To achieve this, DfE advised schools to widen 'bubbles' (groupings of pupils who can interact with each other but are kept separate from other pupils, also in bubbles, as a way of minimising the risk of wide-ranging transmission) to up to 30 pupils, and even whole year groups. This will make it more "workable" for all year groups to attend schools according to the headteachers' union the Association of School and College Leaders (ASCL).[16] However, if there is a second peak of coronavirus and greater social distancing is required, staffing problems will arise again.

Schools needed less PPE – but still had problems accessing it

Demand for PPE was lower in schools than in other public services. This is because schools were operating at lower capacity than usual, and government guidance stated that teachers did not require PPE unless they were interacting with children displaying symptoms of coronavirus.[17,18]

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* Pupil attainment measures the scores pupils achieve in examinations; pupil progress measures the progress pupils make between starting school and final examinations.

Regardless of need, there was no PPE available to most schools in May. The ASCL told the Education Select Committee that "we do not know what PPE is needed and none is available for schools right now anyway".[19] With only a handful of pupils attending most schools, this largely only caused problems in special schools where some children require more intimate contact. It also created "perverse situations" in these schools where medical staff in special schools could obtain PPE (which government guidance said they needed) but teachers could not because the guidance largely stipulated that they did not need it.[20]

The government's July guidance for return to school in September maintains similar PPE requirements. This means that that demand for PPE in schools will remain relatively low even when more pupils are attending again.

A lack of ICT investment in schools made it harder to respond to the crisis

Schools lacked the necessary equipment to operate remotely through online classes. This is understandable as most schools would not have anticipated conducting most of their teaching online. However, they would have likely been better placed had per-pupil spending on ICT learning resources in both local authority maintained schools and academies not fallen by 16% in real-terms between 2012/13 and 2016/17.[*,21]

To make up for the shortage in ICT equipment, DfE committed to providing £100m-worth of laptops, tablets and wireless routers to children, including those who are care leavers or who receive support from a social worker.[22,23] However, these resources began shipping only in late May, by which point many children would have gone without proper teaching for nearly two months.[24,25,26] Even by mid-June, less than 50% of the laptops had been sent out (though nearly 90% were delivered by late June).[27,28] In addition to equipment, the department also provided grant funding for the Oak National Academy, an online platform with lessons for most year groups set up by a group of teachers to support teaching during lockdown.[29,30]

Despite these initiatives, most state school children were not receiving much online tuition at the start of the lockdown (though many have used alternatives such as worksheets to teach children). Independent schools were in a better position, with the Sutton Trust, an educational charity, finding when schools closed in March, 60% of independent school teachers reported having an online platform to broadcast lessons or to receive homework, compared to 37% in state schools in affluent areas, and 23% of teachers in the most deprived schools.[31,32] In addition, children themselves did not always have the right equipment to access the internet, let alone enable video calling, which could limit their interaction with schools – and with social workers.[33] Growing concerns about educational inequality widening during lockdown led the government to announce a £1bn fund to support children to 'catch up'.[34,35]

The government's July guidance recommends that schools continue to grow their ability to teach pupils remotely. However, should a local (or a nationwide) lockdown be reinstated, the disparity in access to online teaching and resulting inequalities may persist.[36,37]

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*   This is not a perfect estimate of spending on remote learning equipment, but more detailed data is unavailable.

School buildings make social distancing difficult

Schools do not have enough classrooms or communal areas of sufficient size to allow all pupils to return while maintaining social distancing. It has been estimated schools would need twice the number of classrooms to maintain two-metre distancing.[38] Some headteachers claimed in response to government's initial plans that social distancing would be 'impossible', especially in primary schools or in communal areas.[39,40]

While it was feasible for a handful of year groups (such as Years 1 and 6, which were initially a priority for government), it would have created problems if more year groups had returned to school.[41] Even if there were enough classrooms, many could only fit 10–12 socially distanced pupils, rather than the 15 initially mooted by government. To circumvent this problem, the July guidance allows larger 30-pupil bubbles and does not explicitly mandate social distancing within classrooms for September, except for teachers.[42,43]

Communal areas are also a potential problem. Headteachers as well as some interviewees mentioned that narrow corridors in some schools would make social distancing impossible and even government's new guidance recommends avoiding crowding such areas.[44,45]

Schools may also have difficulty fully implementing other aspects of the government's updated guidance, such as cleaning hands regularly with soap and running water.[46] In a survey of 6,000 teachers conducted in March, 37% said that their school did not have hot water and soap available for pupils, likely due to poor plumbing and schools being mindful of spending.[47]

Looking ahead

The latest government guidance – published in July, and which does not feature strict guidance for social distancing or PPE – should allow schools to return as normal in September. However, if there is a second wave of infections that leads to a partial or full lockdown, or if stricter social distancing rules are brought back in, schools will face similar difficulties to the first phase of the crisis, with limited ability to conduct face-to-face lessons and the possibility of children going without much formal education once again.

However, now that most devices pledged by the department have been delivered to pupils, online learning should be less difficult to implement, despite the risk that some pupils – largely in state schools – are more likely to miss out on it than others.

The criminal justice system

The police, criminal courts and prisons* had all planned for a pandemic, though as with other services covered in this report these plans were geared towards pandemic influenza. Plans for the criminal courts were less well developed than for the other two services, though all three services had command structures in place that aided their response, and the police and prisons in particular were able to draw on extensive experience of managing emergencies.

The criminal justice system entered the crisis weakened after a decade of austerity. Performance levels had dropped and services were not as resilient as they had been in earlier years. While cuts to staff numbers have largely been manageable so far, historic underinvestment in equipment and buildings have badly impacted the response to coronavirus, making it far harder for staff to work remotely, keep workplaces hygienic and maintain social distancing, particularly in criminal courts and prisons.

How prepared was the criminal justice system?

The police, criminal courts and prisons all had a variety of pandemic plans in place at the start of the crisis. This included both strategic national plans (co-ordinated by government departments, agencies or other bodies) and operational plans (held either regionally or by individual prisons, courts or police forces). The quality, detail and relevance of these plans varied between organisations and areas but there were some common gaps across many of the plans that existed, namely on how to run services while maintaining social distancing.

The police, criminal courts and prisons have all benefited from being able to use existing command structures. These are well established and understood, and have helped speed up implementation of policy changes in response to coronavirus. The police and prisons have also been able to draw on extensive practical experience of responding to crises

The police had reasonably good plans but these lacked detail on remote working and testing for officers

The police are designated as Category 1 responders under the Civil Contingencies Act 2004, like the NHS and local authorities. We were told that pandemics have been near the top of police forces' risk registers for some time and that each force had business continuity arrangements in place that could mitigate the impact of various risks.

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* This chapter focuses on the police, criminal courts and prisons in England and Wales, which are services that the Institute for Government has been monitoring through our annual *Performance Tracker* reports. This chapter does not examine other important components of the justice landscape such as probation.

These might, for example, include plans for managing large-scale staff absences in the event of a pandemic. We were told that the plans had been tested as part of no-deal Brexit planning.[1] Further plans were in place at regional and national levels. The latter includes pandemic flu guidance produced by the National Policing Improvement Agency (NPIA),[2] though this only provides basic information and is over 10 years old, having not been updated since the functions of the NPIA were transferred to other organisations in 2012.

As a Category 1 responder, police forces are also part of Local Resilience Forums (LRFs). In some cases, police and crime commissioners (PCCs) also participate in the planning done by LRFs but this varies considerably between areas and the Association of Police and Crime Commissioners has called for PCCs to be involved more consistently.[3]

Despite all these plans, we were told that in general police forces were not as prepared as they could have been, with little consideration given to remote working or testing arrangements for officers, contributing to a sense of "organised chaos" in the first few weeks of the crisis. One officer explained that the police are better trained to deal with crises after they've begun, rather than planning for them in advance.[4]

Prisons had good plans for locking down

Interviewees spoke highly of prison plans for an emergency, despite the stringent conditions that they imposed. All public sector prisons have their own Resource Management Plans (RMPs),[5] which identify how prisons can deliver activities and services under a variety of operating conditions. As prisons regularly experience regular outbreaks of flu, norovirus and other conditions among prisoners, RMPs will include precise details of how to deploy staff to cope with staff shortages and infections among inmates. Prisons are required to develop RMPs in consultation with unions and organisations providing services within prisons, and as such they are well thought through.[6]

However, these were not sufficient for a crisis as severe or long-lasting as that posed by coronavirus. Acknowledging this, at the start of the crisis Her Majesty's Prison and Probation Service (HMPPS) asked prisons to design Exceptional Regime Management Plans by 31 March 2020, which would set out how prisons could safely deliver meals, medication, prisoner safety and welfare, and family contact in a reasonable worst-case scenario. On 27 March 2020, following the government's lockdown announcement, prisons were asked to implement these plans immediately.[7]

In addition, at the national level, the Ministry of Justice (MoJ) and HMPPS had generic pandemic plans. Prisons also benefited from the planning that had been done by MoJ and HMPPS for no-deal Brexit, with the senior civil servant who had led that work being appointed to run the department's coronavirus taskforce, as also happened in NHS England.[8]

Interviewees disagreed on whether prisons had appropriate plans in place for releasing prisoners early to reduce the risk of infection. In Northern Ireland[9] and Scotland,[10] a substantial proportion of prisoners were released quickly, whereas in England and Wales the schemes operated much more slowly, with fewer than 200 prisoners allowed out by the end of June.[11] Some interviewees argued that this was because plans in England and Wales had given little consideration to the limited political appetite for releasing prisoners early. As a result, they thought that prison management teams had wasted their time working on a unfavoured early release scheme when they could have been focusing more on restarting rehabilitation services. [12]

However, HMPPS argued that extensive prisoner release became unnecessary following the fall in prisoner numbers due to the reduction in trials taking place and the implementation of social distancing, shielding and compartmentalisation within prisons,* which Public Health England (PHE) modelled would substantially reduce the number of infections.[13,14]

Figure 11 **Proportion of prisoners released or planned for release**
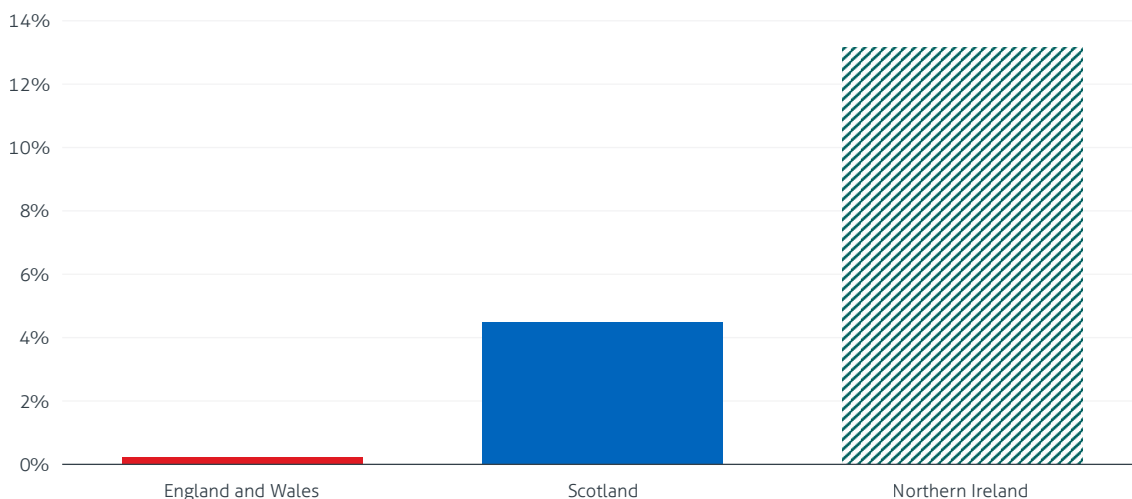
Source: Ministry of Justice, 'Population bulletin: monthly March 2020'; Ministry of Justice, 'HM Prison and Probation Service COVID-19 Official Statistics'; Scottish Prison Service, 'Prison population by custody type, sex and age group (Friday): April 2014 onwards'; Scottish Prison Service, 'ER Tranche 3 Report - Tables'; Department of Justice, 'Covid-19 – Temporary Release of Prisoners Scheme'. For England and Wales this shows prisoners released by 26 June. For Scotland this shows prisoners released by 1 June. For Northern Ireland this shows the maximum number of prisoners that the prison service anticipated would be released when announcing the scheme on 30 March. No further updates have been provided.

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*   The creation of temporary prison accommodation also helped implement these measures.

Plans for criminal courts were less well developed than those for the police or prisons

Regional business continuity plans tended to focus on how to manage if individual courthouses could not be used or if there was a spike in demand due to civil unrest (this included planning for the potential impact of a no-deal Brexit, as part of Operation Yellowhammer).[15]

Nationally, Her Majesty's Courts and Tribunals Service's (HMCTS) Business Continuity Plan included a scenario for pandemic flu, but this needed to be adjusted for coronavirus.[*] Susan Acland-Hood, the chief executive of HMCTS, acknowledged that "our plan had focused a lot more on our response to having people ill in the court system itself and in those who came to court, and less on our response to widespread lockdown and social distancing-type measures."[16] Social distancing has been particularly disruptive and the absence of a plan to manage such conditions has reduced the number of cases that criminal courts have been able to process.

More positively, criminal courts do have well developed plans for streamlining and reprioritising cases, for example, to ensure that cases are listed more quickly if defendants are in custody. While these plans have been of limited help during the first phase of the crisis, when far fewer trials have taken place, they will be used more extensively once the number of cases processed returns to normal.

The police, criminal courts and prisons have all benefited from being able to use well established and understood command structures

At the national level, the government has activated the Criminal Justice System Strategic Command (CJSSC). According to Robert Buckland, the justice secretary, this "is the meeting place for all the agencies – police, probation and other agencies – to come together to work out what the challenges are, and to make sure that all the parts are talking to each other".[17] The CJSSC involves regular meetings between gold commanders and other senior representatives from across the criminal justice system. It does not have authority over operational chains of command within individual agencies.

Rather, each service has its own command structures. The prison service was placed in "command mode" on 23 March, the day the full lockdown was enacted in the UK. Under this, governors of individual prisons act as the bronze command, reporting to regional silver commands, which in turn report to the national gold command. Privately run prisons report through their own silver arrangements. Through this system MoJ and HMPPS disseminate instructions and prisons provide daily reports on "the impact of COVID-19 on staff numbers and the prison population that morning, including an assessment against [Exceptional Regime Management Plans]".[18]

The courts have a similar system. HMCTS is gold command, silver is regional, and bronze is small clusters of courts. Daily reports are fed upwards, while decisions are passed down, though these are less directive than in the prison service as the judiciary has substantial operational independence. For example, judges decide which cases are listed. As such, major policy decisions require discussion between the MoJ, HMCTS and the judiciary.

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[*]   The HMCTS COVID Business Continuity plan was first issued on 16 March 2020.

A similar process takes place in the police. The Home Office works closely with the National Police Coordination Centre (NPoCC, which co-ordinates the deployment of officers for large events and during national crises) and the National Police Chiefs' Council (NPCC, which issues guidance). The 43 territorial police forces in England and Wales, which operate their own gold/silver/bronze command structures, are completely independent and can interpret, amend or discard this guidance, taking into account local circumstances. This has resulted in variation in how the crisis has been policed in different parts of the country. For example, between 27 March and 6 July North Yorkshire Police issued 1,141 fines for breaches of the lockdown rules, whereas Warwickshire Police issued only 61.[19] However, one interviewee told us that media criticism of such variation, plus the national nature of the crisis, had encouraged closer and more regular co-ordination between the Home Secretary and senior police leadership.[20]

Figure 12 **Number of fixed penalty notices issued under Covid-19 emergency health regulations per 10,000 adults aged 16 and over by police forces in England and Wales**
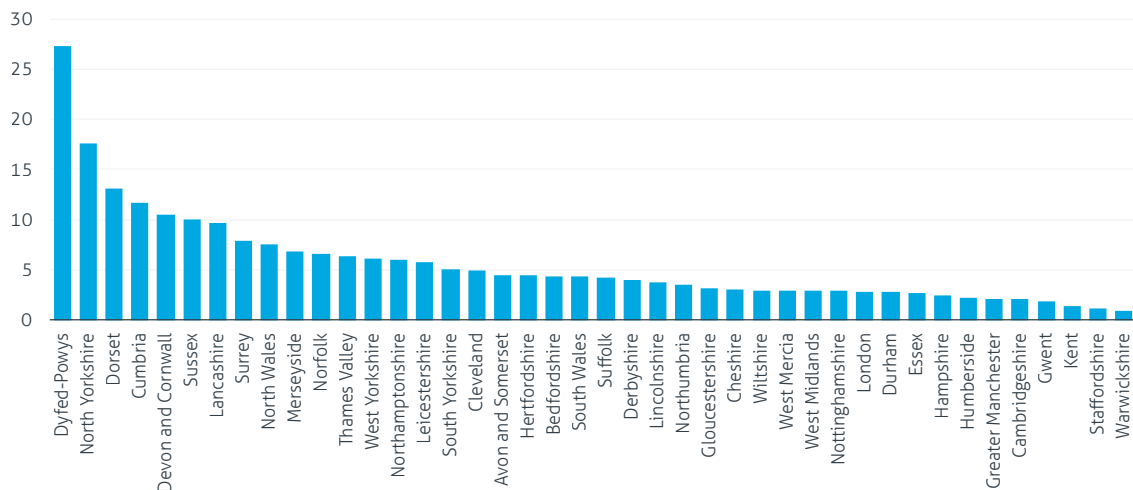
Source: ONS, 'Crime in England and Wales: Police Force Area data tables'; National Police Chiefs' Council, 'Statistical update on number of lockdown fines given by police'. London includes Metropolitan Police and City of London Police.

There are pros and cons to different command and control structures

Although all three services are relatively hierarchical, the differences between them neatly illustrate the strengths and weaknesses of centralised and delegated decision making structures. In prisons, the direct line of management from Whitehall to individual public sector prisons enabled quick and relatively consistent implementation of the initial lockdown. In contrast, the independence of police forces and the resulting lack of consistency in how they have policed the lockdown has made the work of front-line officers more difficult.[21]

However, delegated decision making may prove more helpful in the second phase of the crisis, enabling greater local variation and flexibility as restrictions are eased or reimposed in response to infection levels. An early illustration of this can be seen in prisons. The central negotiation of staffing across all public sector prisons by HMPPS

has been much slower than the negotiations by the small number of private sector prisons, which have been able to increase the time spent by prisoners out of their cells and restart rehabilitation programmes more quickly[22] (though other factors such as the size, layout and resourcing requirements of individual prisons have also influenced this).

The police and prisons have been able to draw on extensive practical experience of responding to crises

The police, as Category 1 responders, are required to train staff and run emergency planning exercises – either paper, tabletop or live.[23] In evidence to the Home Affairs Committee, Chief Constable Lisa Winward from North Yorkshire Police, said:

> "We have very experienced local resilience forums and critical incident structures already in place and well practised for these sorts of incidents, and we found it was very helpful to come together with partners we already work with in the longer term – we run tabletop exercises and we have practised for pandemic-type situations. We have found that, due to those existing relationships, those teams of people have been brought together very quickly".[24]

Interviewees agreed with this analysis, noting that police training and culture, which puts great emphasis on responding to emergency situations, has helped forces to manage coronavirus. The police's ability to supervise the lockdown – when normal activities had temporarily become illegal – was further aided by the principle of policing by consent,* which underpins the approach taken by British forces, compared to the more militarised culture in other countries.

Prisons also undertake regular exercises. One former governor told us that they conducted around six exercises a year – four tabletop exercises and two live exercises.[25] Furthermore, as noted above, prisons have experience of managing infectious diseases.

In contrast, while HMCTS has established business continuity processes for dealing with various scenarios, criminal courts had not conducted exercises to practise responding to a pandemic.** One interviewee noted that criminal courts are "struggling to keep up with the real world, never mind the future world".[26]

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* Policing by consent is the "long standing philosophy of British policing". This states that the power of the police is dependent on public co-operation, and that police officers should maintain public respect through courteous and friendly behaviour, rather than extensive use of force. https://www.gov.uk/government/publications/policing-by-consent/definition-of-policing-by-consent

** Courts did conduct exercises to prepare for a no-deal Brexit.

How resilient was the criminal justice system?

The three criminal justice services, particularly prisons, started the crisis with worse performance than in previous years, following substantial cuts. Despite the loss of staff over the past decade, staffing across the criminal justice sector has proved sufficiently resilient to manage the first stage of the crisis, due to reduced demand and the ability of services to redeploy staff. However, like other public services, the criminal justice system has been severely hamstrung by historic underinvestment in ICT equipment, which has made it far harder to operate remotely, and the poor state of physical infrastructure.

All three services entered the crisis with performance problems

A disruption as wide-ranging and long-lasting as coronavirus will inevitably have a detrimental impact on the quality of public services. A better performing service is more likely to be able to maintain acceptable standards during a crisis than a poorly performing service. Unfortunately, all three criminal justice services were performing worse at the start of the crisis than they had been in previous years.

Prison spending in 2018/19 was 10% lower in real terms than in 2009/10, having fallen to 19% lower in 2015/16. As a result of this funding cut, performance declined substantially on virtually every meaningful metric from 2012/13 onwards, with a major increase in the volume of violence, self-harm, and poor prisoner behaviour, and reduced provision of rehabilitative activities.[27]

Police spending fell 16% in real terms between 2009/10 and 2018/19, with PCCs using reserves and selling police stations and other assets to meet the funding gap.[28] While inspections suggest that the quality of policing has been maintained, there's evidence police have had to prioritise easier-to-solve, or the most serious cases, to manage with fewer resources, and public confidence in the police and victim satisfaction have both fallen.[29]

Spending by HMCTS fell 18% in real terms between 2010/11, when it was created, and 2018/19. The lord chief justice, Lord Burnett of Maldon, said in evidence to the Justice Committee that the justice system "has been underfunded for years and years. The consequences of that underfunding are coming home to roost."[30] Despite this, criminal courts entered the crisis with relatively low backlogs by historic standards, though interviewees argued that these would have been smaller had criminal courts been provided with more funding. Concerns have also been raised that funding pressures have diminished the quality of justice, but the available data does not allow us to evaluate these claims conclusively.[31]

Figure 13 **Change in spending on the police, criminal courts and prisons since 2010/11 in real terms**
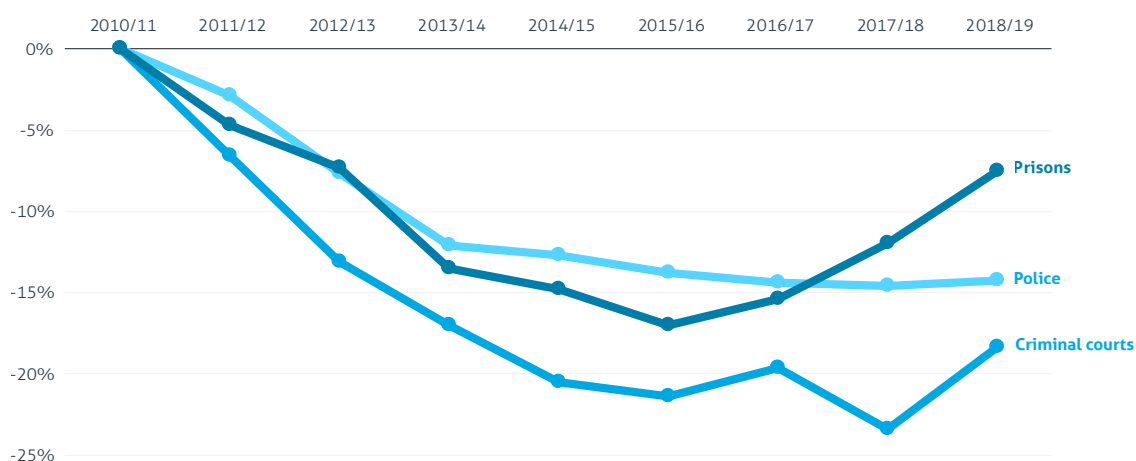
Source: Ministry of Housing, Communities, and Local Government, 'Local Authority Revenue Expenditure and Financing in England, individual local authority area - outturn: Revenue outturn central, protective and other services (RO6); StatsWales, 'Revenue outturn expenditure summary'; Her Majesty's Courts and Tribunals Service, 'Annual Reports and Accounts', total operating expenditure; Ministry of Justice, 'Cost per place and per prisoner per individual prison establishment' (overall resource expenditure).

All three services have fewer staff than they did 10 years ago

The number of police officers has fallen by more than 20,000 – or 14% – since 2009/10 and in 2016, the last year for which comparable figures are available, the UK had one of the lowest ratios of officers per 100,000 inhabitants in the EU.[32*] There are far more crimes than the police have capacity to investigate: in 2018/19 the charging rate was just 8%.[33]

In the criminal courts, the number of judges has fallen by 10% and the number of magistrates has halved since 2010. There has been a nearly 30% reduction in the number of HMCTS staff since 2011, with the Justice Committee reporting "powerful evidence of a court system in administrative chaos, with serious staff shortages threatening to compromise the fairness of proceedings".[34]

The criminal legal profession also entered the crisis in a perilous state. Substantial cuts to criminal legal aid spending, resulting in squeezed fees, have seen the criminal bar "pared down to the bone" and the number of duty solicitors fall by 29% between 2016 and 2019.[35] The justice secretary recently said, "Prior to this crisis, I had already asked for work to be done to map the provision of criminal legal aid across the jurisdiction. There is definitely an issue. The sustainability of practice in this area is a real question in many respects."[36]

In prisons, staff numbers fell dramatically between 2009/10 and 2013/14. Despite recovering in recent years, there are still 11% fewer prison officers than a decade ago, and recruitment and retention have become increasingly difficult.[37] England and Wales had one of the highest ratios of prisoners to staff in the EU. In 2016, the last year for which there were comparable figures, only Portugal, Bulgaria and Poland had a higher ratio.

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*   The government has committed to increasing police officer numbers by 20,000 by 2023.

Even with the increase in staff numbers in the last few years, the ratio is still likely to be worse than most northern European countries, and substantially worse than Scotland and Northern Ireland.[38]

Figure 14 **Change in the number of police officers, judges, courts staff and prison officers since 2010/11 (full-time equivalent)**
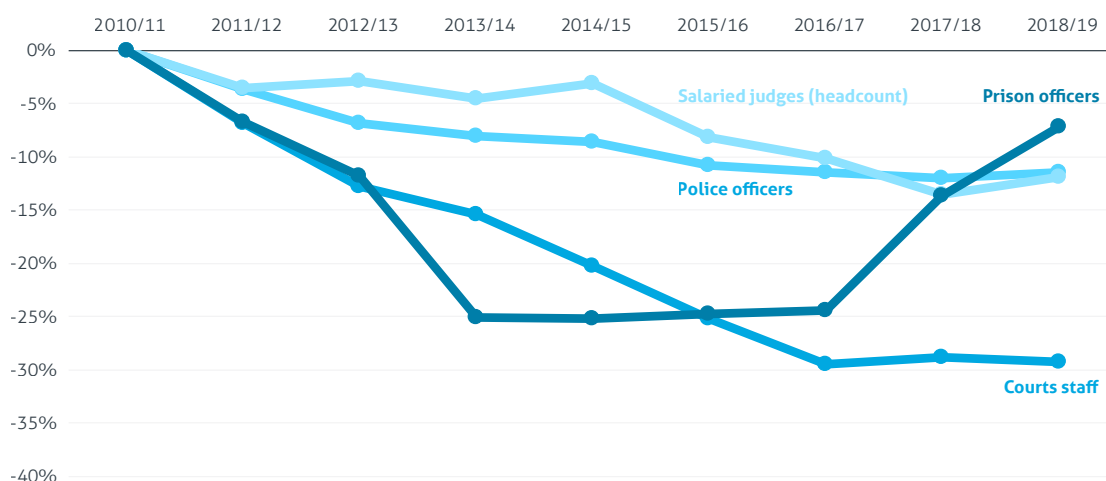
Source: Home Office, 'Police Workforce England and Wales Statistics', Table H3; Office for National Statistics, 'Public Sector Employment data', Table 9 (all figures are Q1, except 2010/11 which is Q2); Her Majesty's Courts and Tribunals Service, 'Annual reports' (refers to the average number of judges in post during the financial year); Her Majesty's Prison and Probation Service, 'Workforce Statistics Bulletin', Table 3.

All three services have largely been able to manage staffing pressures in the initial months of the coronavirus crisis due to reduced demand and flexible staffing arrangements

The police have a generalist workforce – all officers receive basic training and have warranted powers – making it easy for forces to redeploy them from specialist roles to the front line if needed. At the national level, the NPoCC can move officers around the country from forces with spare capacity to those in need (as happened during the 2019 Extinction Rebellion protests, for example). Forces have been able to use these flexibilities to manage staffing during the crisis – particularly in the initial phase when staff absences were higher due to officers being off sick or isolating.[*] This has been made easier by the substantial fall in recorded crime[**] in and around the lockdown compared to the same period last year – by 28% in the four weeks to 12 April, by 25% in the four weeks to 10 May and by 18% in the four weeks to 7 June.[39]

Similarly, prisons have been able to successfully operate with fewer staff in recent months in part due to the stringent restrictions imposed on prisoners. Prison staffing is also reasonably flexible and HMPPS was able to quickly introduce overtime arrangements – the COVID19 Special Payment Schemes[***] – building on existing mechanisms for overtime payments.[40] This has likely reduced staff absences.

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[*]   We were told by the Home Office that absence levels quickly dropped and remained low, partly due to testing of symptomatic police officers and their families.
[**]   Police recorded crime from 43 police forces in England and Wales, excluding fraud.
[***] This gave prison officers the opportunity to work nine additional hours a week at the normal payment plus rate, with an additional £500 payment on top for four weeks of work at extra hours www.prisonreformtrust.org.uk/PressPolicy/News/vw/1/ItemID/855

Criminal courts also largely had enough staff in the early stages of the crisis due mainly to the dramatic drop in case volumes – with the number of cases received falling over half in the magistrates and by two thirds in the crown court.[41] We were also told that the courts reform programme[42] – launched in 2016 – had made HMCTS more flexible during the crisis, with staff able to work remotely much more easily.[43] However, one interviewee told us that cuts to HMCTS staff – numbers fell by 30% between 2011 and 2017, and have been flat since[44] – had contributed to technical problems with remote hearings as judges no longer have the support they once did.[45] Criminal courts can draw on temporary agency staff if required but HMCTS has previously faced complaints that an overreliance on agency staff has resulted in delays, lost files, unanswered telephones and other problems.[46]

The resilience of staffing in all three services will be tested more as lockdown restrictions are eased

The police are likely to find the easing of lockdown easiest. In addition to the flexibilities mentioned above, they can also draw on additional personnel – special constables, retired officers and volunteers, or even the military as a last resort – although there are limitations to this as those who are not warranted officers are unable to perform certain police roles. To date, police forces have not had to make much use of these resources[47] but will be able to if demand increases substantially.

In the criminal courts, staffing is less of a constraint to managing higher case volumes than inadequate buildings and equipment. There is, for example, substantial spare capacity in the judiciary if needed, with one interviewee describing judges as "underemployed".[48] Far more problematic is the position of the criminal bar. Some criminal barristers are excluded from the Self-Employment Income Support Scheme and other government measures to support businesses and individuals during the crisis.[49] There is a risk that there will not be enough criminal barristers left by the time that case volumes return to normal. The Criminal Bar Association has said that "the financial pressures caused by Covid–19, together with the cumulative effect of deleterious policies is without exaggeration, the greatest threat the Criminal Bar has ever faced."[50]

The government has set out how it will make decisions about easing restrictions in prisons[51] but interviewees raised concerns that staffing numbers will make it difficult to fully resume activities while social distancing rules are in place. Prisoners have largely accepted the stringent restrictions to date without the spike in poor behaviour that might have been expected. We were told that they have been more willing to live with these conditions as the whole country has been locked down. But with restrictions easing elsewhere, there will be greater demand to spend more time out of cells, visit the gym, undertake work and access education. If this is not possible, then tensions could flare. This will be a test of staff–prisoner relations – something that will not be helped by the fact that prison officers are now on average substantially less experienced that they were 10 years ago.[52]

The criminal justice system required less PPE than other sectors and has therefore had fewer problems accessing it, despite limited stockpiles when the crisis began

All three services had limited PPE stocks at the start of the crisis and experienced some shortages. For example, on 24 March Buckland said about prisons: "I need more PPE. I have raised the issue at the highest levels."[53] However, these problems tended to be resolved quickly, with recent inspections finding that PPE is generally available in prisons.[54] As such, the absence of a generous stockpile has not caused long-term problems.

Similarly, Sir Robert Neill, the chair of the Justice Committee, highlighted early concerns in courts, citing the "difficulties for lawyers, especially duty solicitors, of getting safe access to take instructions when there was no PPE".[55] However, HMCTS had largely fixed these problems by early May.

Police forces have also largely had access to PPE, following some initial difficulties with distribution. In early April, four chief constables giving evidence to the Home Affairs Select Committee said that PPE had been issued to all their patrol cars. However, they had concerns about the sustainability of supply chains[56] and the Police Federation – which represents front-line officers – has complained about conflicting advice on PPE from the NPCC and by the different approach taken by different police forces.[57] We were also told that whereas police in Italy initially wore PPE at all times, the same approach was not adopted in England and Wales, partly due to worries about insufficient stock.[58]

All three services have suffered from historic underinvestment in ICT

Police IT and communications equipment have proved most resilient. While there have been some problems – such as forces struggling to support home working or staff being unable to access internal systems remotely[59] – these have been far less disruptive than in criminal courts and prisons.

Digital infrastructure in the criminal courts – including Wi-Fi, video calling and file sharing technology – is often defective and courts would have been able to process more cases both during lockdown and as restrictions are eased had the modernisation programme[60] been more advanced at the start of the crisis. In October 2019, the Justice Committee said that "the interests of justice are not served by unreliable video equipment and Wi-Fi facilities throughout the criminal courts estate; HMCTS must expedite planned investment upgrading these".[61]

Furthermore, the court system is lacking basic data. For example, at the end of May 2020 the lord chief justice was unable to say "how many trials we have, how many are trials with defendants awaiting trial in custody, and how many are defendants awaiting trial on bail."[62] Yet, he acknowledged how important this data would be for decision making. Interviewees told us that scheduling and listing of cases was often still done on paper due to a delay to this strand of the HMCTS reform programme.[63]

However, while investment should have happened sooner, recent reforms to introduce new technology and alternative ways of working have left courts far better placed than they would have been just a few years ago. Interviewees agreed with Susan Acland-Hood, chief executive of HMCTS, that despite the system remaining "very paper-based and very physically-based", recent reforms have made it "much easier for judges and others to work remotely".[64] We were told that England and Wales are further ahead than other countries – including Scotland and Northern Ireland – and have been able to conduct more hearings throughout the crisis than other jurisdictions.[65] And criminal courts will be better placed to manage future lockdown thanks to the accelerated rollout of planned technology upgrades during the crisis, including the Cloud Video Platform – a video conferencing system for conducting hearings.[66]

Underinvestment in ICT has been most problematic in prisons. Widespread availability of in-cell video-calling facilities would have enabled prisoners to continue with important activities – keeping in touch with families, pursuing education, and arranging benefits, jobs and housing in advance of release, among others – despite being restricted to their cells. As such, the stringent lockdown conditions would have been more sustainable. However, video-calling facilities were extremely limited[67] and recently inspected prisons have been slow to implement video calls with families.[68]

As part of the Prison Estate Transformation Programme, HMPPS had planned to introduce video conference centres into 22 prisons in order to reduce "the time and cost of taking prisoners to court, the risk of escape, and prisoners' time away from work and training opportunities." However, by November 2019, video conference centres had only been installed in seven prisons, following cuts to the programme's budget in 2016.[69] In mid-May, the government announced that it would introduce video calls to 10 prisons, with a wider rollout to follow.[70]

Even telephone facilities are limited. Around 60% of prisons have in-cell telephones[71] but they only allow outward going calls.[72] Where prisons do not have phones in cells, they largely rely instead on communal wing phones. This makes it "difficult for prisoners to speak to family or friends at length given the brief" time they have out of their cells during the lockdown – time that might otherwise be used for showering, exercise or other activities. This is exacerbated in some prisons by the fact that communal phones may be broken.[73] However, these problems have been mitigated by the introduction of 900 secure phone handsets into prisons in March.[74]

All three services have lost buildings in recent years

Between 2010 and 2018, up to 600 police stations were closed.[75] We were told that this has left little spare space over which to spread staff. While those doing desk-based work may be able to operate from home, others need to be able to respond to emergencies. One interviewee gave the example of firearms teams, which tend to operate from one or two sites in each force area. If they are unable to socially distance, then a single infection could require all of a force's firearms officers to self-isolate.

The capacity of prisons has also shrunk in recent years, with 1,730 prison cells lost between 2009/10 and 2019/20.[76] The Cameron government had pledged in 2015 to build 10,000 new prison places by 2020, but due to financial pressures only delivered 206. When the coronavirus crisis began, prisons were effectively full, running at 97% of operational capacity.[77] Around 60% of prisons were crowded, with the 10 most crowded all "running at or above 147% of their uncrowded capacity, meaning that prisoners are sharing cells designed for fewer people".[78]

It is necessary to move people within and between prisons as people are sentenced, remanded or released. More spare capacity would have made it easier for prisons to implement social distancing, shielding and compartmentalisation in order to reduce transmission of the virus. As it was, by 21 April – a month after the lockdown strategy was launched – only a quarter of prisons had been able to fully implement compartmentalisation.[79,*] In addition, Her Majesty's Inspectorate of Prisons (HMIP) has found that prison staff are working in offices that are too small to enable social distancing.[80]

Since 2010, 164 out of 320 magistrates courts[81] and eight out of 92 crown courts have been closed.[82] Last year the Justice Committee raised concerns that the court closure programme has reduced access to justice, with some people forced to travel much further to attend court. This problem has now been exacerbated by coronavirus, with many courthouses closed temporarily during lockdown.

However, despite the closures, criminal courts did still have spare capacity when the crisis began. And fewer cases now need to be tried inside courthouses thanks to the introduction of the single justice procedure in 2015. This allows less serious summary cases to be tried outside of a courtroom and without the defendant by one magistrate assisted by a legal adviser. As a result, magistrates have been able to process a large number of cases despite the lockdown. More than half of all magistrates' cases are processed in this way.

Even with spare capacity and fewer cases, it is difficult to make use of the available space while maintaining social distancing. We were told that a courthouse with five courtrooms might only be able to use one at a time due to limited space in corridors and other communal areas.[83] Jury trials have restarted but now require between two and three courtrooms each.[84]

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*   The reduction in prisoner numbers due to the fall in court hearings and the acquisition of 1,049 temporary single-cells for installation at 29 prisons sites enabled 98% of prisons to fully implement compartmentalisation by 19 June 2020, according to the Ministry of Justice.

Criminal courts and prisons have also found it harder to respond to coronavirus due to the poor state of repair that their buildings are in

Criminal courts and prisons both entered the crisis with a large maintenance backlog. This is a direct result of capital investment being diverted to day-to-day spending. Over the past four years, £0.6bn of the £1.6bn planned capital investment has been reallocated.[85]

In recent years the lord chief justice has made a point of highlighting the poor state of court buildings in his annual report, writing in 2019 that: "It is a matter of regret that resources have not been made available by government to begin to tackle the backlog of repairs and maintenance needed in the court estate."[86]

Interviewees told us that basic hygiene issues had made it harder to operate courthouses safely during the crisis, citing the difficulty of cleaning decrepit buildings with broken sinks and toilets. Initially courts also struggled to provide basic sanitary equipment such as soap, sanitiser and paper towels,[87,88] though these materials have now been provided. The dilapidated state of criminal courts will likely hinder efforts to safely increase the number of cases processed now that lockdown restrictions have been eased, though HMCTS has hired 150 additional cleaners to wipe down frequently touched surfaces in courts[89] and in June the government pledged £142m this year for court maintenance and digital upgrades.[90]

The situation in prisons was even worse. As of April 2019, there was a £900m maintenance backlog, with 63,200 jobs outstanding. According to the National Audit Office, 41% of prisons needed "major repair or replacement in the next three years to remain operational... with 2% of prisons running a serious risk of 'imminent breakdown.'"[91] On 30 June the prime minister announced £83m for maintenance of prisons and youth offender facilities, though these improvements will take time to implement.[92]

Some prison cells lack basic facilities such as showers and toilets. This has meant many prisoners have been forced to choose between showering or exercise in the limited time they have out of their cells during lockdown[93] and some shower rooms have been found to be "too dilapidated to be cleaned to a safe standard."[94]

Those prisons without in-cells toilets are using the night sanitation system during the crisis, which can mean waiting for hours to go to the toilet throughout the day,[95] with prisoners urinating or defecating "in buckets or bags in their cells instead".[96]

As noted above, prisoners have largely accepted stringent restrictions to date. But these horrendous conditions mean that the lockdown is far less sustainable than it otherwise might have been. Prisons may be left with a difficult choice between stricter lockdown with greater risk of violence and self-harm, or easing restrictions but risking increased infections.

Looking ahead

If England and Wales experience a second peak of infections, then criminal justice services will be better prepared than they were at the start of the crisis, with specific coronavirus plans and recent experience of managing lockdown conditions. Investment in ICT during the crisis will make it easier for police officers to work remotely, prisoners to speak to family members and courts to conduct remote trials. There should also be fewer initial problems with PPE.

However, it may be hard to maintain good order in prisons if there is a second peak of infections. Despite greater provision of telephones and some new funding for prison maintenance, many prisoners would still find themselves in extremely unpleasant conditions, locked in cells for more than 23 hours a day, often without easy access to toilet and shower facilities.

Even without a second peak, the continuation of social distancing requirements will make it difficult for criminal court case volumes to return to normal due to the space required to safely conduct jury trials, and to prevent jurors, witnesses and staff from getting too close together in communal areas. This will heap further financial pressure on the criminal bar.

Social distancing will also make it difficult for prisons to reimplement regular operating regimes, particularly if courts begin to process more cases again and the number of prisoners returns to pre-crisis levels. In both courts and prisons, these problems will be exacerbated by the poor state of repair of buildings.

Conclusion and recommendations

From treating patients in hospitals, to providing vital social care, policing the lockdown and protecting vulnerable children – public services have been at front line of the response to coronavirus. Staff have coped admirably, showing incredible dedication in the face of adversity. But critical public services have faltered, and serious questions must be answered about whether these services could and should have been better prepared and more resilient.

This report has found that public services benefited from the existence of emergency plans and command structures but that these varied greatly in detail, focus and adaptability. Plans were too focused on pandemic influenza, which proved an imperfect basis for a coronavirus pandemic, and the government failed to learn key lessons from Exercise Cygnus, conducted in 2016. Public services were also let down by poor ministerial communications and most were also far less resilient after a decade of austerity, entering the crisis with ailing performance levels, severe staffing pressures and having underinvested in buildings and equipment.

There's no doubt public services could have been better prepared. However, coronavirus has been of unprecedented scale and duration, and public services around the world have struggled in response. No plan will be perfect and it is unreasonable to expect staff to be well prepared for every possible emergency. Government must also be wary of tailoring plans to the most recent crisis, rather than considering what is needed to respond to future threats.

Public services could also have been more resilient, but resilience comes at a price. Ensuring spare capacity means spending more money or diverting resources from current priorities to future possibilities, some of which may not materialise. Decisions about the prioritisation of public spending are necessarily political: there is no objective answer to the appropriate balance between efficiency and resilience, or to the right level of public spending to pay for it.

It is easy in hindsight to judge whether services are sufficiently resilient, but governments can just as easily be criticised for being overly cautious, as they can be for not leaving enough slack in the system. The Labour government was heavily criticised a decade ago for overreacting to swine flu,[1] and the subsequent Hine review into the government's response recommended that ministers determine "how they will ensure that [government's] response is proportionate to the perceived level of risk".[2] This is particularly difficult to do with low-probability, high-risk events, such as a novel coronavirus pandemic.

Given these uncertainties, our recommendations focus on practical steps to improve preparedness and resilience that would help public services respond to a range of emergencies at relatively little financial cost.

To improve preparedness in public services, we offer the following recommendations:

- **Government departments, agencies, local authorities, police forces, NHS bodies and other providers of public services ought to publish their plans for dealing with emergencies – currently only released in summary form, if at all.** They should also publish the key findings from planning exercises and implement them. They should report annually on progress implementing the key findings from these. In some cases, it may be necessary to redact or withhold information if publication would compromise national security, but overall better transparency would be beneficial.

- **Government ought to conduct more regular emergency planning exercises to assess the interdependencies between services and the extent to which plans take these into account.** Key ministers such as the prime minister and health secretary should take part in such an exercise within six months of taking office. Government must make efforts to improve planning and co-ordination between different levels of government, and with private and voluntary sector providers of public services.

- **Select committees ought to scrutinise departmental plans for emergencies and hold government to account for resolving shortcomings identified in major exercises.** Departments should provide annual updates to the relevant select committee on progress towards implementing key findings from major exercises.

- **The government ought to update the Civil Contingencies Act 2004 so that police and crime commissioners and multi-academy trusts are involved as standard in LRFs.** These organisations were created after the Act was passed, and are currently not consistently involved in LFRs despite the important role they play during emergencies.

To improve public services' resilience:

- **The government ought to analyse the resilience of public services when making spending decisions in the 2020 spending review.** This should include an assessment of the ability of staffing, equipment and buildings to cope with scenarios identified in emergency plans. If the government wants public services to be more resilient, then it needs to spend more.

- **Government departments ought to maintain an updated list of trained reserves, recent leavers and volunteers who are appropriately certified and can be deployed to key services in an emergency.** This would be a quicker and more effective than ad-hoc schemes at allocating appropriately skilled people to services in need of additional staff capacity.

- **Government departments ought to identify and fill data gaps that prevent them from making real-time assessments of demand and capacity in critical public services.** This is a particular problem in criminal courts – which lack data on the number of trials and defendants – and adult social care – where there is limited data on self-funders and domiciliary care.

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