CIPFA The Chartered Institute of Public Finance & Accountancy

INSTITUTE FOR GOVERNMENT

Performance Tracker 2020

How public services have coped with coronavirus

Nick Davies | Graham Atkins | Benoit Guerin
Sukh Sodhi | Thomas Pope

About Performance Tracker

Performance Tracker is an ongoing analysis of the performance of public services. This fifth edition brings together scores of data series with information gathered from interviews with more than 50 people to provide a picture of how five public services – general practice, hospitals, adult social care, schools and criminal courts – have coped with coronavirus.

The analysis – produced in partnership by the Institute for Government and the Chartered Institute of Public Finance and Accountancy – assesses the changes introduced to manage disruption, evaluates the success of each of these changes and makes recommendations about whether they should be kept or extended beyond the pandemic.

Find out more:
www.instituteforgovernment.org.uk/performance-tracker

Contents

Forewords 4

Summary 5

1. General practice 13

2. Hospitals 25

3. Adult social care 40

4. Schools 52

5. Criminal courts 63

Conclusion and recommendations 73

Methodology 76

List of figures and tables 79

References 81

About the authors 105

Forewords

I am delighted to introduce the 2020 edition of *Performance Tracker*, the fifth in the series. This year's report is unlike the others that we have published, reflecting the unprecedented events of recent months. Rather than focusing on the performance of public services since 2010, we have assessed how well five critical public services have coped with coronavirus. We analyse the disruptions caused by the pandemic and the changes that have been made in response, making recommendations about which should be kept or extended beyond the crisis.

As with previous editions, we have used government data to inform our analysis. However, the speed with which events have moved and the time it takes to publish official statistics has limited the effectiveness of this approach. We have therefore also drawn on a far wider range of qualitative sources than usual. This report would not have been possible without the time given by dozens of people involved in delivering public services. I would like to thank them for sharing their expertise.

Bronwen Maddox, Director, Institute for Government

CIPFA and the Institute for Government have been working together on the *Performance Tracker* now for five years, seeking to evidence the performance of public services. While quantifying government spend in relation to service performance is always a challenge, this year has been, unsurprisingly, unique.

This government came into power at the end of 2019 under a single headline policy objective – get Brexit done. However, the emergence of Covid-19 rewrote policy priorities entirely and has continued to do so at regular intervals throughout the year. In March and April, the priority was to protect the NHS. As we moved into the summer, efforts were prioritised towards jump-starting the economy. However, at the time of writing, thoughts have turned to the winter flu season, the emergence of a second wave of the virus, and whether the current uncertainties we face will be compounded by the end of the Brexit transition period.

That is why this year, we have scaled back the services we are investigating and are exploring the extent to which five key services were prepared for coronavirus, and the extent of the disruption the virus has caused. The challenges surrounding the pandemic are continually evolving, both as we learn more about the disease and develop new measures across sectors to mitigate its impacts. The question moving forward will be, where do we go from here? This report sets out our recommendations to answer just that.

Rob Whiteman, Chief Executive, CIPFA

Summary

On becoming prime minister, Boris Johnson promised to increase spending on public services. No more cuts were to be made to departmental budgets, and the NHS, schools and police would receive major funding boosts. Yet the amounts pledged, while substantial at the time, have paled in comparison to the £68.7 billion that the government has since approved to help public services cope with the disruptions caused by coronavirus.

Hospitals, GPs, adult social care, schools and criminal courts have incurred huge costs buying personal protective equipment (PPE), transforming buildings to enable social distancing and infection control, hiring additional staff and purchasing IT equipment to support virtual service delivery and remote working. Many routine services have been suspended in order to focus on coronavirus, others can only be accessed remotely. The risk of infection has resulted in fewer people using most services, leading to growing backlogs and waiting lists in hospitals, criminal courts, general practice and social care.

Nearly 1,600 working-age health and social care staff died with symptoms of Covid-19 between 9 March and 25 May,[1] with particularly high death rates among those working in adult social care. And while workforce absences, exacerbated by limited access to testing, have largely been manageable so far, the risk of burnout during a second wave is severe.

In response to coronavirus, the government provided billions of pounds of extra funding, suspended governance and regulatory requirements, services have made greater use of technology, and organisations developed new ways of working. Taken together, these changes have prevented critical public services from collapsing, and some reforms adopted since March have proved so effective that they should be maintained beyond the crisis.

With no spending plans currently set out beyond March 2021, the government should use the upcoming spending review to fund organisations to keep the most effective changes in place permanently. However, other changes have been poorly targeted, ineffective, or would be inappropriate to continue once the risk of infection has reduced.

In this year's edition of *Performance Tracker* we assess how well five critical public services – hospitals, general practice, adult social care, schools and criminal courts – have coped with coronavirus. For each we have analysed the disruptions caused by the pandemic and the changes introduced to manage these problems, including emergency funding streams, increased use of technology, easing of administrative burdens and changes to working practices. We evaluate the success of each of these changes and make recommendations about whether they should be kept or extended beyond the pandemic.

The government will need to make some extremely difficult decisions in the spending review. It must find a suitable balance between funding for public services, the level of taxation and the size of the deficit – all amid substantial uncertainty about the UK's future relationship with the European Union, the course of the pandemic, and the long-term impacts of both on the economy. In doing so, it must learn from what has worked, and what hasn't, since the crisis began. The analysis and recommendations in this report – detailed versions of which are included in each chapter – set out our view on the decisions that government should make.

How have public services been disrupted by coronavirus?

Public services incurred substantial additional costs

All five public services covered have had to spend huge additional amounts of money to respond to coronavirus. This has included buying large volumes of PPE and making physical changes to buildings to protect staff and service users, hiring additional staff to cover those who are ill or self-isolating, and purchasing new IT equipment and software to enable remote working. In some cases, these are not one-off, but recurrent costs that public services will incur as long as the pandemic continues.

Public services that raise part of their own revenue have taken large income hits. Local authorities, which are responsible for publicly funded adult social care, are projected to lose more than £6bn in 2020/21 due to falls in council tax, business rates and other sources of income. Providers of care homes have also lost income due to falling occupancy rates and schools have been unable to hire out their buildings and playing fields.

Many, though not all, of these expenses have been or will be reimbursed by central government, which has far exceeded spending plans set out in the budget on 11 March 2020 (less than two weeks before the UK entered lockdown). But the costs incurred generally surpass the additional funding provided – leaving the Johnson government further from meeting its manifesto commitments than it was at the start of the crisis.

Many services were suspended

Social distancing requirements and other measures to reduce infections led public services to pause much of their normal day-to-day work. Non-urgent elective surgeries such as routine hip replacements were cancelled, and there are now 3.86 million people waiting for elective treatments. GPs deferred new patients reviews and over-75s' health checks. The magistrates' and crown courts processed 62% fewer criminal cases between March and June 2020 than in the same period

in 2019. Jury trials were postponed entirely. Schools closed their doors to all but a handful of pupils – fewer than 3% of pupils attended school between 24 March and 1 June. Almost all (97%) care homes closed to new admissions.

Some of these services have since restarted and others have been carried out remotely. But most are still operating below pre-crisis levels. In some cases, delayed access to care has likely contributed to the number of excess deaths, though the number of these is likely to be relatively small, with most excess deaths in March, April and May caused by Covid-19, whether diagnosed or not.[2]

Fewer people using services has stored up trouble for the future

The risk of infection also meant that far fewer people used most services, particularly in the early stages of the crisis. The number of weekly GP appointments fell by 44% between the first week of March and the first week of April; 40% fewer cases were sent to magistrates' courts; and local authority admissions to care homes were down by more than a quarter (28%) compared to the same period in 2019.

Rather than accessing services as usual, people have instead sought help from friends and family – with an estimated additional 4.5m people providing unpaid care since the beginning of the pandemic – or managed, often unsuccessfully, on their own. As a result, there is now greater need for support than pre-crisis.

Children have missed out on hundreds of hours of education, medical conditions have gone untreated or been exacerbated by coronavirus, and there is a growing list of patients waiting for elective treatments in hospitals. The backlog is particularly large in the criminal courts. In the magistrates', the backlog is 27% above pre-coronavirus levels but had stabilised by the end of August. The crown court backlog is 18% higher but still growing and we calculate that the 'true' backlog – taking account of the time required to conduct jury trials – is 42% higher than it was before Covid-19. This is equivalent to around 56,000 cases, the biggest backlog in at least two decades.

Public services suffered high levels of staff absence

Throughout the pandemic, many public service staff have been off work sick or self-isolating due to coronavirus, and unable to work as normal. The number of staff days lost due to sickness absence in the NHS was 2.1 percentage points higher in April 2020 than in April 2019. In social care, the average number of days lost to sickness was approximately 8% between March and June 2020 compared to a rate of just 2.4% pre-coronavirus.

These problems have been exacerbated by limited access to timely testing – which has meant that more staff than necessary have been off work – and this had a particularly big impact in the early stages of the crisis when fewer staff were able to work from home. Ongoing problems with NHS Test and Trace could mean these problems are repeated during a second wave of infections in the coming months.

To date, public services have largely been able to cope with these absences due to the reduction in demand, and by hiring temps or redeploying staff. However, some staff, particularly those working in hospitals, may be at risk of burnout and staff will be

stretched further during the autumn and winter if trying to manage normal services while infections rates are rising. There are also fears that, following big cuts to legal aid work and payments over the last decade, the financial hit from coronavirus may put solicitors' firms out of business and lead many criminal barristers to leave the profession, compounding the problem of case backlogs.

Many frontline workers have also lost their lives. The situation has been particularly bad for adult social care workers who have died at twice the rate of health care staff.

What changes have been made to public services to manage the crisis?

Additional funding

To offset the costs of the crisis, the government has approved £68.7bn of extra funding for public services.[3] In some cases, this has been unringfenced, with spending decisions left to the discretion of frontline organisations – £3.7bn of such funding has been given to local authorities. More often, though, funding has been provided for specific purposes. The government has agreed to reimburse many coronavirus-related expenses, used a £1.1bn Infection Control Fund to control the spread of the virus in adult social care settings, provided courts with £142m to improve buildings and invest in technology, given the NHS £1.3bn to enable safe and timely discharges into care settings, and provided £1bn for extra tuition for school pupils.

These funding boosts have succeeded in preventing the collapse of critical public services and in some cases – such as funding for discharges – the government should continue to provide funding beyond the crisis. However, sometimes funding has been poorly targeted or inadequate to deliver the government's objectives.

The government has also made changes to the terms and conditions attached to funding. NHS England and NHS Improvement provided hospitals and GPs with block funding grants, rather than paying them based on activity. This successfully sped up decision making, encouraged collaboration, and enabled organisations to focus on responding to the pandemic, rather than their organisations' budget, when deciding on which services to prioritise. NHS England and NHS Improvement should learn from these changes, as well as existing pilots, to improve the effectiveness of post-crisis funding.

Greater use of technology

Coronavirus led to the rapid adoption of technologies that have been contemplated for years but had not been used widely before the crisis. This ranged from more effective use of email and social media, to the implementation of large-scale bespoke software packages enabling people to work from home. Most importantly, there has been a fundamental shift towards delivering services remotely, with school lessons, NHS appointments, social care assessments and court hearings being conducted via video, telephone and text messages. In March and April, this technology was used to deliver around 90% of criminal court hearings, education to up to 98% of pupils, and most GP appointments.

Technology enabled care home residents to speak to their families, staff could communicate quickly and easily with colleagues and those in need could access critical support, all while reducing the risk of infection. Without this, many services would have ground to a halt.

Some of these changes have enduring value and much of the technological progress made during the crisis should be retained. But government should not move to digital delivery by default. While remote working can be effective for quick check-ups with long-term patients or for administrative court hearings, our research has found that it may be less efficient and negatively affect the quality of care from the NHS, teaching from schools and of justice from criminal courts. There are particular risks for those who are disadvantaged, for whom English is a second language or who have disabilities – or who simply are without Wi-Fi, a mobile of their own or mobile data. Before continuing or expanding the use of remote working, the government should properly assess the impact on services users and staff. It should also provide additional funding for equipment and training to maximise the opportunities available.

Other technologies have been more unambiguously successful. Electronic prescriptions have saved GPs time and been more convenient for patients, while Capacity Tracker – an app monitoring the availability of beds in care homes – has helped hospitals find placements more quickly. Both initiatives predate the crisis but have been used far more during it. The government should assess how best to fund and support these innovations once the coronavirus pandemic is under control.

Changes to working practices and delivery of services

Public services – most notably schools and criminal courts – have changed the way they work to manage the disruption caused by coronavirus.

In criminal courts, the government has spread jury trials across multiple courtrooms, staggered start and finish times for hearings, restricted the number of people in public galleries, and is trialling changes to operating hours. These measures will – combined with the creation of new courtrooms – enable more cases to be heard. But they are unlikely to be enough to substantially reduce the backlog of 46,500 cases in the crown court while social distancing measures remain in place.[*] The government should set out the backlog levels and waiting times it considers acceptable and set a timetable for meeting these.

School closures meant that schools had to provide free school meals to eligible children who were at home during lockdown. The scheme was extended to cover the Easter and summer holidays (the latter following a campaign spearheaded by footballer Marcus Rashford) and more than £380m worth of vouchers had been redeemed by mid-August. The government's efforts to mitigate the impact of cancelled exams through calculated grades were far less successful and better thought through plans must be in place for 2021.

* Speaking on 22 September, the prime minister said that restrictions "will remain in place for perhaps six months".

Public services collaborated more effectively during the crisis. Local authorities have worked with adult social care providers to distribute PPE and funding, and GPs have successfully co-ordinated with others in their area to designate specific buildings as 'hot hubs' – locations that can be used to see those believed to have coronavirus. Sharing of data, particularly with councils, has often been poor during the crisis,[45] but greater sharing of patient data has facilitated collaboration in the NHS. Greater data sharing will continue to be useful beyond the pandemic but must be carefully managed to retain public trust. The government should promote this beyond the crisis but, alongside NHS England and NHS Improvement, NHS trusts and GP practices, must be more transparent about the data being collected, who has access to it and for what purposes, how it will be protected, and who is responsible for making these decisions.

Reduced administrative burdens on public services

At the start of the crisis the government removed some governance and regulatory requirements to free up the time of public service staff to focus on frontline work. In some cases – such as the eased statutory adult social care duties on local authorities – these have only been used sparingly.

In general practice and hospitals, the decisions to suspend some normal governance and regulatory requirements has allowed staff to spend more time supporting patients. However, there are concerns about the impact this will have on care quality. Given the important role that effective and proportionate governance and regulation play in care quality, the government should ensure that the results of its reviews into reducing bureaucracy in the health and care system are published by the end of 2020.

Key recommendations

The government must learn from what has and has not worked during the pandemic. Accordingly, it should use the upcoming spending review to:

1. Set out how it will deal with backlogs in services

The suspension of services during the pandemic means that there is now greater need for support than pre-crisis, and all public services face large backlogs, particularly criminal courts and the NHS.

- The government should publish policies setting out acceptable waiting lists and waiting times in the NHS and criminal courts and set a timetable for meeting these.

2. Provide additional funding to make permanent some changes made during the crisis

Some of the changes made during the crisis have helped deliver pre-crisis government objectives such as faster discharges from hospital, greater use of technology in the NHS and courts, and closing the attainment gap between disadvantaged and better off pupils. In some cases, funding is needed to enable these changes to be made permanent and in others more money is required to ensure that reforms work more effectively:

- The government should provide funding to continue faster discharges from hospital beyond the crisis. It should also give local authorities, care providers and community health services additional funding so that they have sufficient capacity to assess and then safely absorb higher numbers of patients discharged from hospital. This will require frontloading the funding for community trusts through the NHS five-year funding settlement, so that they can hire additional community nurses and other staff as quickly as possible.

- The government should invest in hardware and provide additional training for staff to ensure that remote medicine in hospitals and general practice, and remote hearings in criminal courts work more effectively.

- To prevent disadvantaged children from falling further behind during the crisis – which government has said is a priority – it should provide additional funding so that every child who needs a laptop, router or other technology to properly access remote learning can have them.

3. Review whether key crisis measures should be extended

Public services have changed the way they work to manage the disruption caused by coronavirus. In some cases, it is too early to tell whether reforms that could be beneficial beyond the crisis should be continued. The government should review:

- where, and for whom, remote general practice and hospital appointments are appropriate
- the impact of remote hearings on the quality of justice
- which digital triage and back-office IT systems for general practice are most effective and provide value for money
- the impact of free school meals in the holidays and catch up funding to help tackle the attainment gap in schools.

1. General practice

General practice has been heavily disrupted by coronavirus, with high levels of staff absence and demand for appointments falling by more than a third between the beginning of March and mid-April. In response, there has been a fundamental shift in how technology is used in general practice,* and major changes to funding and working practices.

How has general practice been disrupted by coronavirus?

GPs have incurred substantial additional costs

In the budget on 11 March, the chancellor announced an extra £6 billion of health funding over the course of the parliament. This was in addition to the £20bn real-terms funding increase the May government had committed to in 2018, which Boris Johnson recommitted to when he became prime minister a year later. The March 2020 funding was to be partly used to help the government meet its manifesto commitments for general practice: to create 50 million more GP appointments a year by recruiting, training and retaining up to 6,000 more GPs, and the same number of other primary care staff, such as pharmacists and physiotherapists (on top of the 20,000 other primary care staff previously committed to).[1]

However, the budget announcement was quickly outpaced by events. Less than a fortnight after the budget, the government introduced stringent lockdown measures as coronavirus spread throughout the country. The scale of the infection resulted in GPs incurring substantial additional costs. Large quantities of personal protective equipment (PPE) were purchased, surgeries had protective screens installed and seating removed, IT systems were upgraded to enable digital triage and remote working, and temporary staff were hired to cover those who were shielding or self-isolating.

The exact cost of this is currently unclear, but in July the government announced that it had so far approved £31.9bn of additional funding for health services. Of this, £5.5bn has been allocated to a range of health services such as keeping GP surgeries open during bank holidays, but also including using private health facilities, improving NHS discharge processes and delivering medicines to those who are vulnerable and shielding.[2]

The government has committed to reimbursing GPs for additional costs incurred, as well as protecting lost income.[3,4] However, in early July nearly 30% of practices surveyed reported that they had not been reimbursed for some of these expenses.[5] Changes to central government funding of general practice are discussed in more detail below.

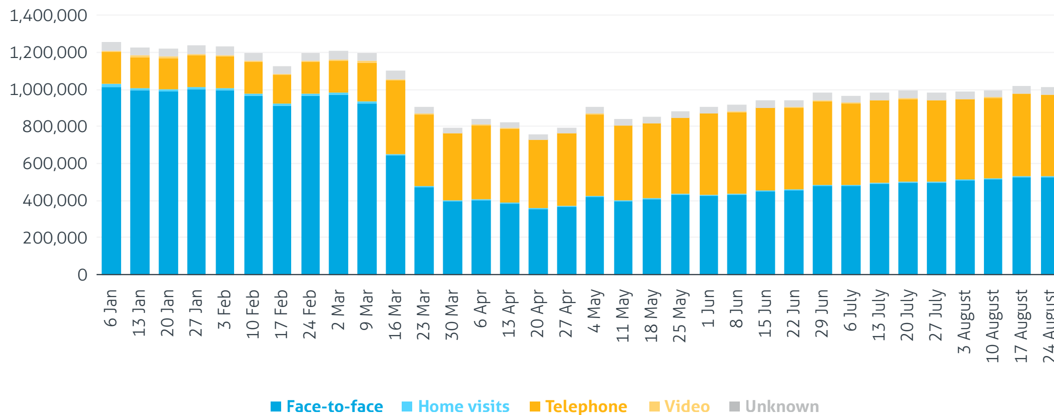
* This chapter focuses on general practice in England.

GENERAL PRACTICE

Demand for appointments fell dramatically initially – but has risen since

In the early weeks of the crisis there was a dramatic reduction in demand for GP appointments. Between the beginning of March and mid-April, the overall number of appointments per working day* fell by more than a third. Since then there has been an increase in appointments, though the total number of appointments in August 2020 was still 11% lower than in August 2019.[6]

Figure 1 **Weekly GP appointments per working day, by type, January–August 2020**



Source: Institute for Government analysis of NHS Digital, 'Appointments in General Practice'.

Part of this fall may be due to poor recording of remote consultations and a general drop in data quality during the crisis,[7] but there are good reasons to think that patients were choosing not to visit their local surgery due to concerns about coronavirus (with practices also limiting the number of in-person appointments). There was a similar fall in A&E attendances and in a survey of GPs published in June less than a fifth reported demand returning to pre-March levels.[8]

Some patients will have been diverted to other services, with the government and NHS England and NHS Improvement encouraging people to call 111 rather than contacting their GP if they had symptoms.[9] In March, the number of calls to 111 was more than double the number received in the same month in 2019. In the following months, call volumes were 14%, 12%, 6% and 4% higher than in the corresponding month the previous year.[10]

However, in many cases patients will have self-managed existing conditions, creating pent-up demand. Added to this will be demand from those suffering long-term effects of coronavirus and who need ongoing care following release from hospital, as well as those whose conditions have been exacerbated by the "isolation, financial hardship and the cessation of many face-to-face health and support networks for individuals" during lockdown.[11]

* We use this metric to account for bank holidays.

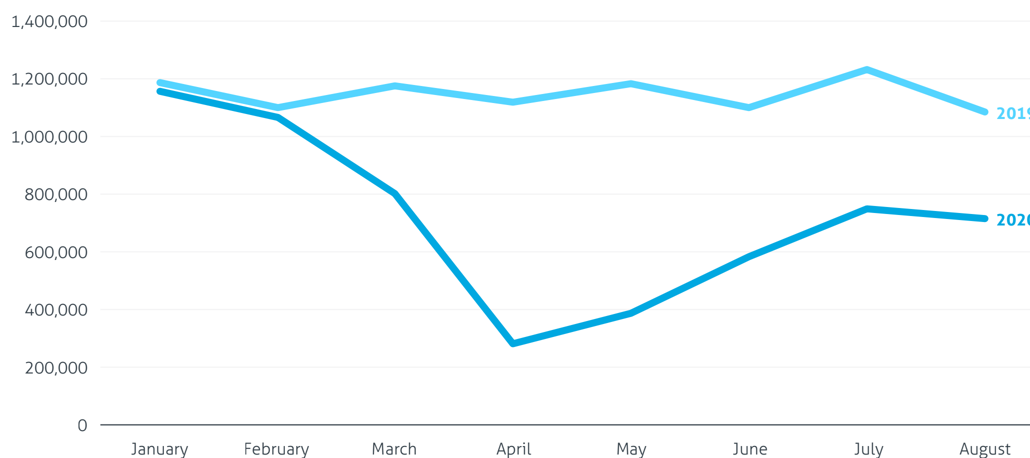
GPs are uncertain if they can handle this backlog. In August, three in five of those responding to a survey said they were 'not at all' or 'not very' confident about their ability to manage patient demand in their department or practice as normal NHS services are resumed. Nearly three quarters reported lacking confidence in the ability of their local health economy to cope.[12]

GPs stopped many normal services and largely shifted to remote appointments

In response to coronavirus and the imposition of lockdown and social distancing rules, GPs stopped or drastically reduced many services. Some of this was directed centrally. For example, on 19 March NHS England and NHS Improvement advised GPs that they could suspend or defer new patient reviews, over-75s' health checks, annual patient reviews, routine medications reviews and clinical reviews of frailty.[13] GPs were also unable to undertake cervical screenings as the centrally run programme was paused, and the suspension by hospitals of many routine diagnostic tests meant that GPs could not refer patients to these services.

The number of GP referrals to hospitals fell substantially. Between March and July 2020, there were just over 2.8m referrals from GPs for first consultant-led outpatient appointments, a 52% fall compared to the same period in 2019.[14]

Figure 2 **GP appointments made for first consultant-led outpatient appointments, January–July 2019 and 2020**



Source: NHS England and NHS Improvement, Monthly Referral Return.

During this period GPs were undertaking many activities that are not picked up in the official statistics. These included liaising with shielding patients, managing the switch to electronic prescriptions and overseeing physical changes to practices.[15]

Some services have since been restarted. On 9 July, NHS England and NHS Improvement directed GPs to resume new patient reviews, routine medication reviews, over-75s' health checks, clinical reviews of frailty, and engagement with and review of feedback from Patient Participation Groups.[16] Other activities have also ramped up again, but as of July only 19% of GPs surveyed said that medical education and training activities were at pre-March levels, and most had not restarted research

GENERAL PRACTICE

or minor surgeries.[17] In September, NHS England and NHS Improvement provided practices with a communications toolkit "to explain to patients how they can safely access general practice"[18] and a national campaign to encourage the public to seek help when necessary will be launched later this year.[19]

For appointments that did go ahead, there was a fundamental shift in how GPs consulted with patients. The official statistics show that face-to-face appointments accounted for 81% of the total in the first week of March but fell to just 48% a month later. In contrast, telephone consultations rose from 14% to 48% of the total over the same period.[20] This probably understates the scale of the change due to problems with how the data is coded. [21]

Data from askmyGP, a provider of online triage and consultation software, shows that within practices using its services face-to-face appointments accounted for 29% of consultations in the week of 2 March, but fell to just 2% three weeks later. Over the same period, online messages increased from 24% to 39%, and phone calls increased from 28% to 40%. Most arresting is the growth in video consultations – these increased by more than 600% over this period, and by more than 3,500% by 11 May (but still accounted for only 1% of appointments).[22] The reduced number of face-to-face appointments that did take place generally took longer due to the need for GPs to change their PPE, and clean consultation rooms and equipment, between each appointment, reducing the time available in each working day. [23]

Despite this, the suspension of some activities, the reduction in demand for consultations and the move to remote consultations has meant that some patients have actually been able to get appointments more quickly than before the crisis. One GP told us that most appointments in their surgery are now conducted on the same day that the patient makes contact.[24] A patient giving evidence to the Health and Social Care Committee said his local surgery was "working better during the pandemic than they were prior to it. I was absolutely amazed at how quickly I got appointments and got through on the phone."[25] However, we were told that other patients struggled to understand how to book appointments using new digital triage systems or were not able to book appointments that met their needs – for example, those requiring a face-to-face consultation.[26]

General practice suffered staff absences

General practice suffered from high levels of staff absence at the start of the crisis, with reports that up to a third of staff in some practices were self-isolating or shielding.[27] By July, 6% of GPs surveyed reported a previous confirmed case of coronavirus, and a further 16% thought they had been infected but hadn't confirmed through a test.[*] Eleven per cent were currently shielding, had previously done so or were living with someone who was.[28]

The slow rollout of testing for health care workers and symptomatic household members exacerbated the situation, with British Medical Association (BMA) council chair Dr Chaand Nagpaul writing in late March that "this failure to test is resulting in

* By comparison, around 6% of people in England had been infected by this time according to a large-scale antibody study. www.standard.co.uk/news/health/coronavirus-one-in-16-infected-study-a4524616.html

significant numbers of doctors off work, many unnecessarily, adding further pressure to an already stretched service". This was particularly problematic because at the time some doctors did not have the ability to work remotely, causing difficulties in small practices where the loss of one or two doctors substantially reduced capacity.[29]

There is evidence that this disproportionately affected services in more deprived areas. Nearly one in ten GP practices are run by a single GP and the Health Foundation estimates that nearly a third of these are run by a GP who is at high or very high risk from coronavirus.[*] These surgeries are much more likely to be in more disadvantaged areas and GPs who are at very high risk "are more than three times as likely to be working in the most deprived CCGs [Clinical Commissioning Groups] in the country than they are to be working in the most affluent CCGs".[30]

Despite these problems, there is some evidence that, to date, most practices have had enough staff to cope. For example, it appears that less use has been made of locums (temporary doctors) during the crisis. We were told by multiple interviewees that the locum market has 'tanked'[31,32] and more than half of locums responding to a BMA survey in July said that their financial position had worsened during the crisis due to circumstances beyond their control.[33]

Staff numbers were also boosted by student volunteers[34] and 'returners', though the process for bringing back retired GPs could be time-consuming: it took a month or more for GPs to have their licence restored, and then another month before they were onboarded, rostered and deployed.[35]

What changes has general practice made to manage the crisis?

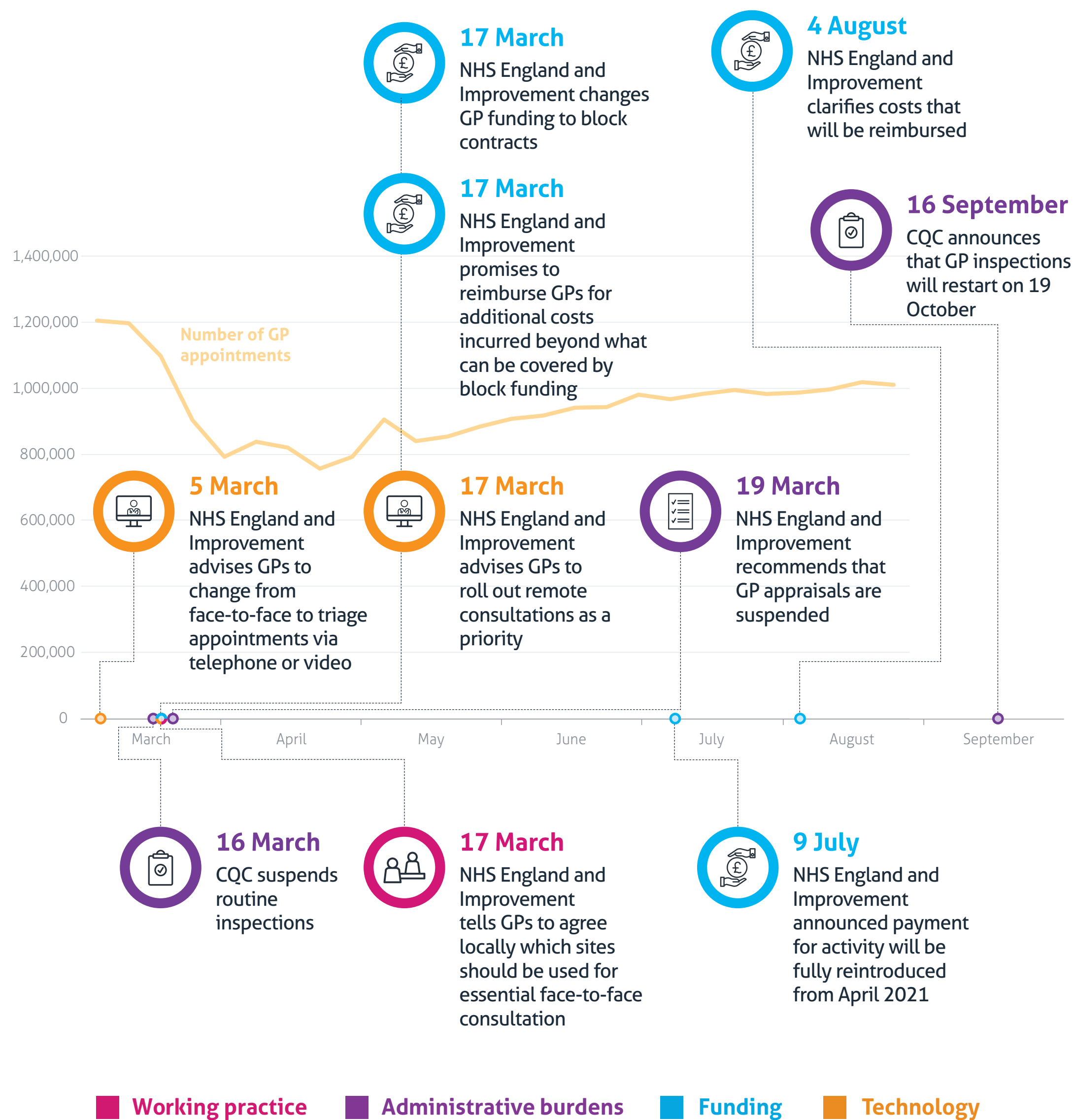
There has been a fundamental shift in how technology is used to triage, assess and manage patients

The need to reduce face-to-face contact has led to a rapid expansion in the use of technology in general practice, with changes to triage, consultations and back-office functions. Rather than patients booking an appointment online or via telephone, digital triage systems have been used to assess patients' needs first.[36] Where consultations are offered, many are now done remotely, by telephone, text or video, with far fewer taking place face-to-face. Practices have also made greater use of technology to manage patient prescriptions, tests and referrals.

These changes were made very quickly at the start of the crisis, with the support of government guidance. On 5 March, an NHS England and NHS Improvement letter advised practices to move to telephone or video appointments and to consider putting suitable patients onto electronic repeat prescriptions as soon as possible.[37] On 17 March, NHS England and NHS Improvement advised rolling out remote consultations as a priority and to consider how staff could work from home,[38] with a letter two days later advising practices to move to a 'total triage system' and remote working where possible.[39] Remote working guidance was published on 30 March,[40] with guidance on safe video consulting following on 29 May.[41]

* The risk factors were: being aged 70 years or older, ethnicity, selected underlying health conditions, and pregnancy.

Figure 3 **Timeline of changes made to general practice**



Source: Institute for Government analysis.

As noted above, the widespread adoption of technology to enable remote working largely happened in March, and by the end of May 95% of GPs responding to a survey said that they were providing remote consultations to patients, though services were patchy in some places due to hardware and software issues.[42]

The rapid expansion of remote working built on past efforts. The *NHS Long Term Plan*, published in January 2019, promised "every patient will have the right to online 'digital' GP consultations" by 2024.[43] However, the increase in remote consultations had been slow. Similarly, some practices already used digital triage systems and offered electronic prescriptions before the crisis, but this was not widespread and there was often reluctance from both GPs and patients to use these technologies.[44]

Greater use of technology has been essential during the crisis but there is currently only limited academic evidence on its impact on service quality and efficiency.[45,46] Interviewees told us they were not able to offer as high-quality care in remote

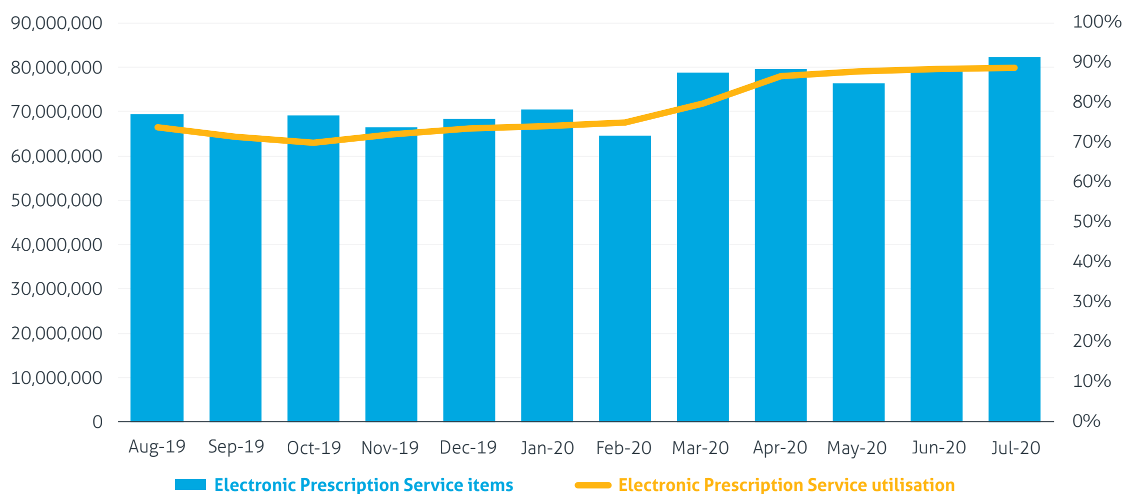
consultations. It is harder to get necessary clinical information remotely: sick patients can find it difficult to properly describe their symptoms or may feel uncomfortable sharing all relevant information when in potentially difficult home environments.

Doctors can also find it harder to build a good relationship with their patients. One GP wrote: "I feel like I am continuing [to give] decent care for patients I know well already, but I can't easily initiate a relationship with a new patient using telemedicine."[47]

A major concern is that certain groups find it harder to access remote services, including patients for whom English is a second language, and those without Wi-Fi, a mobile of their own or mobile data.[48,49] People with particular conditions – including learning disabilities, autism and some mental health problems – have also raised concerns about whether their needs can be met remotely.[50]

New technology has in some cases saved GPs time. For example, AccuRx – a system that enables GPs to send messages to patients and update digital patient records – can speed up routine exchanges of information between GPs and patients.[51] Similarly, we were told that electronic prescriptions – sent directly to the pharmacist, rather than printed out and given to patients – are far more efficient than the paper version and have been used more during the crisis.[52] The percentage of all prescriptions claimed via the Electronic Prescription Service rose more than 11 percentage points between February and April, and by June they accounted for almost 90% of the total.[53]

Figure 4 **Electronic Prescription Service use, November 2019–July 2020**



Source: NHS Digital, Electronic Prescription Service dashboard.

The evidence on the efficiency of remote consultations is more mixed. An academic analysis of evidence published before 30 September 2019 found that "digital-first access models using online, telephone, or video consultations are likely to increase general practitioner workload by 25%, 3%, and 31%, respectively".[54] Interviewees agreed, citing the additional time required to assess patients when not face-to-face and the inefficiency of contacting people remotely. We were told that patients regularly don't answer their phone first time, often requiring call backs, voicemails,

texts and replies before they are able to conduct the consultation. However, in a survey of GPs conducted in July, 67% said video or e-consultations increase efficiency, and 70% said the same of telephone consultations.[55]

The evidence on whether increased use of technology has improved patient experience of general practice is also mixed. Remote consultations are easier to attend for those who don't live near a GP surgery or otherwise find it difficult to attend in person,[56] and some patients have reported that they were listened to and had a good rapport with the doctor remotely. But others find talking through complex issues remotely and filling in lengthy online forms frustrating,[57] and one interviewee told us that patients are attending emergency departments because they are unable to access the care they need from GPs remotely.[58] Data from askmyGP showed that patient satisfaction improved between February and March but has declined in every month since April.[59,*]

Speaking in late July, Matt Hancock, the secretary of state for health and social care, said that "better tech means better health care".[60] However, while greater use of technology has enabled general practice services to continue during the crisis, there are important unanswered questions about the impact of these changes, particularly with regard to remote consultations.

The risk of infection provides justification for conducting many more consultations remotely – even if that reduces the quality of care, excludes some patients or incurs additional costs for GPs – but that calculation will change once the risk from face-to-face consultations declines.

Both remote and face-to-face consultations have an important role to play in the future of general practice. In general, it seems that the former is most helpful for routine check-ins[61] and for those who are digitally literate or might otherwise struggle to attend in person. While the latter will tend to be more appropriate for those with complex conditions and with communication difficulties.

- **GPs must retain discretion about whether to use remote consultations, but the government should provide clear, evidence-based guidance on the impact of telephone, text message and video consultations on care quality, patient satisfaction and health outcomes for different groups.**

The international evidence is currently limited, in part due to the small scale of studies and low usage of remote consultations pre-crisis.[62] The widespread use of this technology in recent months provides an excellent opportunity to learn more. The Department of Health and Social Care (DHSC) has an academic research unit, with standing academic partners for reviews such as this. It, along with NHS England and NHS Improvement, also has various stakeholder groups and other mechanisms for getting feedback from the front line. Ministers should be careful not to overplay the potential benefits of remote consultations or otherwise stray too far from what can be evidenced.

* In April the question changed.

The impact of other technology should also be assessed. New providers have entered the market but there is little understanding of the costs and benefits of different software packages for remote triage or back-office functions.

- **Before extending licences or encouraging practices to buy from particular vendors, the government should assess which digital triage and back-office IT systems for general practice are most effective and provide value for money.**

Many GPs are forced to rely on slow computers and poor internet connections, reducing their efficiency and the quality of support provided to patients. This is due to historic underinvestment in NHS ICT.[63]

- **Given the government's support for greater use of technology in the NHS, it should invest more in ICT equipment in general practice to ensure that digital medicine works more effectively.**

Successful future use of technology in general practice will also depend on the skills of the staff using it. According to the chair of the Royal College of General Practitioners (RCGP), "many of them do not have the support to set up and use the equipment, or indeed the training that is required to carry out remote consultations. It is a different style of consulting. The investment that has been made has been helpful. More investment is required."[64] Health Education England provides links through its e-Learning for Healthcare platform to resources from a variety of sources to support those working in general practice with telephone and video consulting, but more is needed.[65]

- **The government should provide additional training and support to staff to ensure that general practice can maximise the opportunities from new technology.**

Finally, the ability to work remotely will be appealing for some in general practice but for others the reduction in face-to-face interaction will be demotivating. One GP we spoke to likened telephone consultations to working in a call centre, noting that they were unable to use all their clinical skills when consulting remotely.

- **DHSC needs to better understand the impact of new technology, particularly remote consultations, on recruitment and retention of staff as well as patients.**

NHS England and NHS Improvement suspended the normal funding regime

To help GPs manage the disruption caused by coronavirus, NHS England and NHS Improvement agreed to protect their income and to cover additional costs incurred. Normally, funding for GP practices is largely determined by two factors. Most is based on the number of patients registered to that practice, with adjustments made for demographics, deprivation, and health outcomes. Practices are also paid for their performance against the Quality and Outcomes Framework (QOF), which awards practices points for delivering certain services.

GENERAL PRACTICE

On 17 March, an NHS England and NHS Improvement letter announced that the QOF would be suspended and that practices would "continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they had done previously".[66] Further details were published on 19 March.[67] In July, NHS England and NHS Improvement announced a partial reintroduction of the QOF, with most income continuing to be protected, a simplification of the quality improvement indicators and a greater focus on immunisation and screening.[68,69] These changes were made so that GPs could make decisions to cancel or reduce some routine services based on an assessment of need and risk of infection, rather than the impact that this would have on their funding. The intention was that no practice should suffer financially due to clinical decisions made in response to coronavirus.[*]

With regard to reimbursing expenses, the 17 March letter promised that practices would be repaid for additional costs incurred, where these were higher than what could be covered by the block grant for registered patients and the guaranteed funding that replaced QOF payments.[**] This would be used to cover, for example, the purchase of PPE and other goods, as well as additional staff costs. This funding was later codified as the COVID-19 Support Fund for general practice, with further detail provided on 4 August.[70]

The swift decision to suspend the normal general practice funding regime achieved its objective. Reimbursing coronavirus-related expenses was a successful temporary measure that, according to interviewees, enabled GPs to hire enough staff and purchase vital equipment to best respond to the crisis, without worrying about whether they could afford to do so. Similarly, the suspension of QOF payments and providing a block grant meant that GPs could reconfigure the services they offered based on clinical needs. But there was broad agreement from interviewees that the government is correct to reintroduce payments based on activity and performance. However, the QOF framework was last substantially reviewed in 2018.[71]

- **NHS England should review the QOF again once coronavirus is under control.**

NHS England and NHS Improvement and CQC reduced bureaucratic burdens faced by GPs

To free up GPs' time to focus on responding to coronavirus, NHS England and NHS Improvement removed governance and regulatory requirements normally placed on general practice. For example, a letter on 19 March suspended engagement with and review of feedback from Patient Participation Groups, local audit and assurance activities, and local data collections that were not directly related to the crisis response.[72,***]

* NHS England and NHS Improvement also introduced the Investment and Impact Fund, a payment model for Primary Care Networks than can be used for investment in workforce or services www.england.nhs.uk/wp-content/uploads/2020/09/IIF-Implementation-Guidance-2020-21-Final.pdf

** Decisions about whether to reimburse practices will be made by CCGs, which in turn are able to claim back money from NHS England and NHS Improvement. NHS England and NHS Improvement retain the right to verify payments and clawback those which it believes are not justified but it is expected that claims will generally be reimbursed.

*** Some of these activities were subsequently restarted following an NHS England and NHS Improvement letter on 9 July www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0569-Second-phase-of-General-Practice-response-to-COVID-19--update-to-GP-contracts-and-income-protection-a.pdf

Most notably, the Care Quality Commission (CQC) cancelled all routine inspections on 16 March[73] and two days later NHS England and NHS Improvement recommended that appraisals of GPs be suspended.[*,74] Taken together, these reforms have enabled GPs to spend more time supporting patients. According to Professor Martin Marshall, chair of the RCGP: "We have seen a dramatic reduction in administrative tasks in general practice [during the crisis], and that has freed up space that many GPs had not seen or recognised for five or ten years."[75] However, it is not possible to quantify exactly how much extra capacity this has given GPs and one interviewee raised concerns about the impact that reduced oversight may have on care quality, particularly for vulnerable groups.[76]

Before the crisis, the government had set out its intention to reduce the bureaucratic burdens on GPs. In February it announced that it would undertake a Review of Cross-Government Bureaucracy in General Practice with the BMA.[77] Given the important role that effective and proportionate governance and regulation play in care quality:

- **The government should ensure that the results of this review are published on time, by the end of 2020.**

Groups of GPs have worked together to co-ordinate local services

GPs have collaborated far more than they did previously with other practices in their area during the crisis to ensure that patients can be seen safely. This has often involved, sometimes in partnership with local authorities, designating particular practices as 'hot hubs' – locations that can used to see people believed to have coronavirus.[78] In other cases, GPs have worked together to provide services such as drive-through blood tests.[79]

These services were set up quickly during the first few weeks of the crisis. On 17 March, NHS England and NHS Improvement told GPs to "agree locally which sites should manage essential face-to-face assessments".[80] These decisions were generally made by Primary Care Networks (PCNs) – geographical networks of GPs that were established by the *NHS Long Term Plan* in 2019, typically cover 30,000–50,000 people,[81] and to which 99% of practices are now signed up.[82] Interviewees were unanimous both in agreeing that the existence of PCNs allowed them to respond more quickly to the crisis and in hoping that the crisis would accelerate the deepening of collaboration through PCNs.

While it is reasonable to include national priorities for PCNs – such as supporting early cancer diagnosis – in the GP Contract[**], there must be enough flexibility and funding to enable individual PCNs to develop their own priorities based on local needs and the workforce they have available.

- **The government and NHS England and NHS Improvement should continue to promote PCNs but must be careful not to be too prescriptive about what they should focus on.**

* A slimmed down interim appraisal form, consisting of just two sides of A4, will be used for 12 months from 1 November 2020.

** An agreement between NHS England and the BMA General Practitioners Committee in England, that is supported by the government and translates commitments in the *NHS Long Term Plan* into a five-year framework for service delivery.

Collaboration was also facilitated by greater sharing of data. In some cases, data sharing agreements were already in place. One GP told us that all the practices in their city had access to each other's digital patient records, making it easier to co-ordinate the response to coronavirus.[83] This was not the situation in most areas as pre-crisis there was a lot of nervousness about sharing data. However, the urgency of responding to coronavirus made GPs and others within the health system far less risk averse: as one interviewee put it, "who would criticise sharing data in [a] global pandemic?"[84]

Greater data sharing will continue to be useful beyond the pandemic but must be carefully managed to retain public trust and avoid further misuses of patient data.[85]According to Sir Robert Francis, chair of Healthwatch England,[*] "people understand that they are likely to get better care if their information is shared among other health and care professionals who are involved in treating them. It stops all the same questions being asked over and over again. They are willing to go along with it, but they need to be assured about data protection."[86]

- **The government, NHS Digital, NHS England and NHS Improvement and GP practices should work together to ensure more data can continue to be shared post-crisis, but must be transparent about data being collected, who has access to it and for what purposes, how it will be protected, and who is responsible for making these decisions.**[87]

Conclusion

The disruption caused to general practice by coronavirus led to years of change in a matter of weeks. The best of these reforms – improved collaboration – must be kept and expanded. To do so, the government must promote increased data sharing beyond the crisis, combining this with greater transparency about how patient data is shared and used. Most importantly, the government must rapidly assess the impact of increased use of technology, particularly remote consultations, on care quality, service efficiency, patient satisfaction and staff wellbeing.

Technology can be transformational but there is also a risk that it exacerbates existing inequalities. The government should also invest more in IT equipment and training for staff to maximise the potential benefits.

* Healthwatch England is the independent national champion for people who use health and social care services.

2. Hospitals

Hospitals were heavily disrupted by coronavirus and had to quickly and radically reconfigure themselves to provide care safely for Covid and non-Covid patients. Most importantly, there has been a big increase in the use of technology, and major temporary changes to funding and governance.

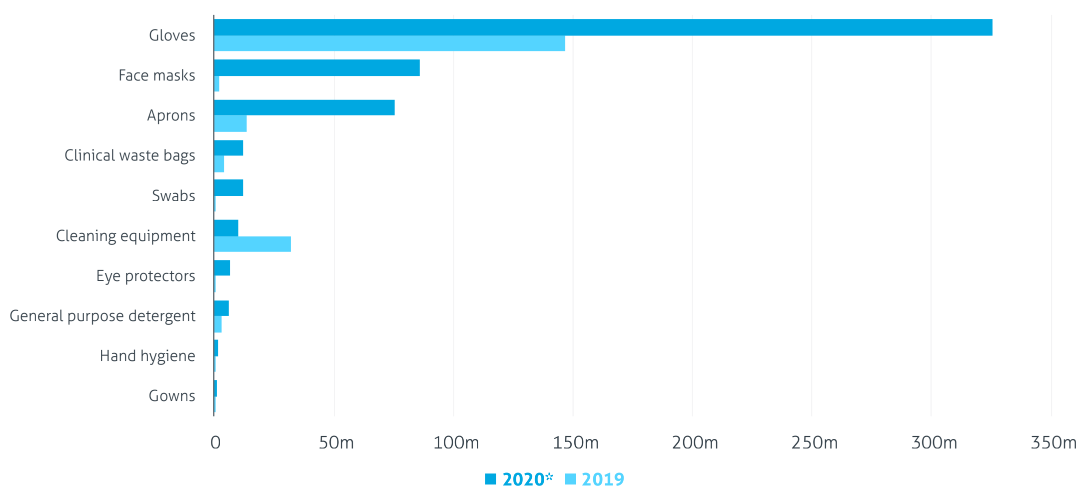
How has coronavirus disrupted hospitals?

The NHS incurred £5.6bn of additional costs between April and July 2020

NHS providers and commissioners spent an additional £5.6bn between April and July 2020, £5.1bn more than the agreed pre-Covid budget.[1] Most of this was in response to coronavirus and the need to maintain physical distance between patients and enhance infection-control measures.

Hospitals[*] have reconfigured their estate[2] by creating separate entrances[3] and wards[4] for Covid and non-Covid patients. And the need to reduce the risk of healthcare staff transferring or contracting coronavirus to and from patients has massively increased the use of personal protective equipment (PPE) such as face masks and aprons. In just over six months, between 25 February and 13 September, the Department of Health and Social Care (DHSC) distributed 3.45bn items of PPE – far more than in 2019, when it distributed 2.43bn items in the entire year.[5]

Figure 5 **Average items of PPE distributed to health and care organisations each month by DHSC**



Source: Institute for Government analysis of Department of Health and Social Care, Weekly PPE data (as of 7–13 September 2020). * = 2020 average based on data available between 25 February and 13 September 2020.

* This chapter focuses on acute foundation and non-foundation trusts in England – which govern hospitals and provide short-term treatments such as diagnostic services, emergency treatments and surgeries. These have been at the forefront of the initial response to coronavirus.

To cover these higher costs, the chancellor promised the NHS "whatever it needs" in the March 2020 budget[6] and, as of July, the government had spent an additional £31.9bn on health services in response[7] – of which £16bn was spent on ventilators and PPE partly used in hospitals.[8] The total Covid-19 additional health spending represents a 20% increase on this year's planned total DHSC budget of £148bn.[9] If this level of additional spending is maintained in the second half of 2020/21, then there will be an almost two-thirds overspend across the whole year.

Figure 6 **Additional Covid-19 spending**

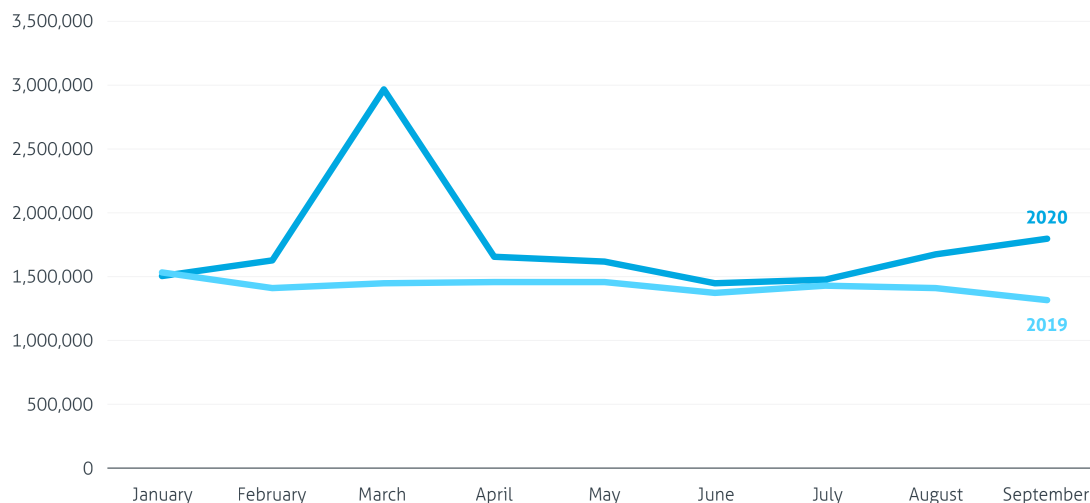
Source: Institute for Government analysis of Her Majesty's Treasury, Budget 2020 & Plan for Jobs. Lightest pink = Ventilators, £1bn. Additional spending until July 2020; spending announcements after July 2020 are not included.

Coronavirus increased demand for critical care

Covid-19 greatly increased demand for Intensive Care Unit (ICU) beds. In March 2020, a report from the Imperial College Covid-19 response team projected an increase in demand for intensive care which would far exceed the NHS's critical care capacity by mid-April[10] unless transmission was reduced. The NHS took drastic action – increasing the number of ICU beds by 75% to just over 7,000 between January and May[11] – to prevent this worst-case scenario. The number of confirmed Covid-19 patients in mechanical ventilation beds peaked at 3,301 on 12 April,[12] and the NHS was able to treat every coronavirus patient who needed critical care during the pandemic.[13]

But many other services also faced vastly higher levels of demand during the first peak weeks of the pandemic in March and April. Due to reduced hospital capacity, many patients who might have attended A&E were instead diverted to NHS 111 – a telephone and online service for people who need advice and information about urgent medical problems. This followed NHS England and NHS Improvement's additional funding for NHS 111[14] and guidance in February that "the public should call NHS 111 if they had been to a region affected by Covid-19, or in close contact with confirmed cases of the virus".[15] As a result, NHS 111 received twice as many calls in March 2020 compared to March 2019.

Figure 7 **Monthly calls to NHS 111**

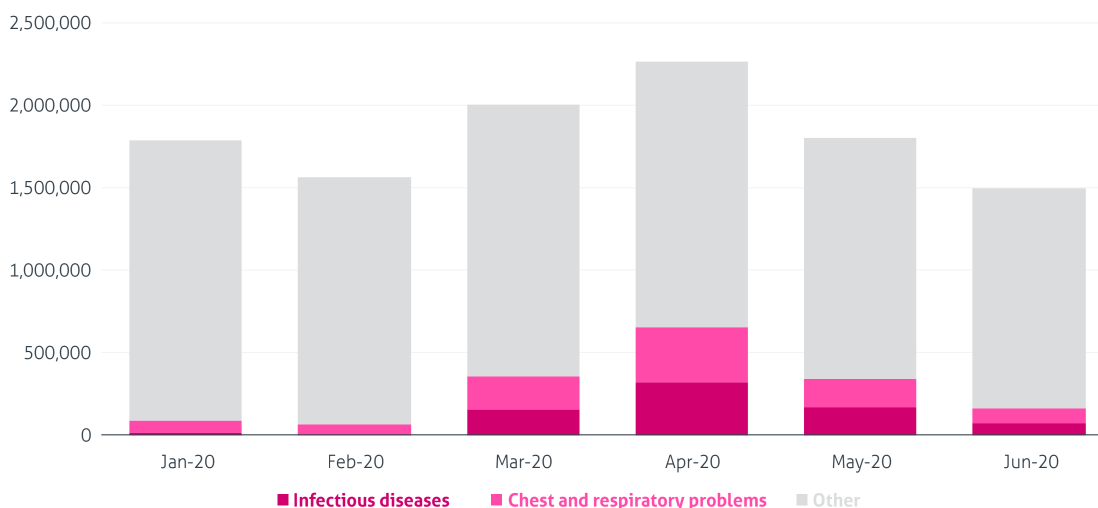


Source: Institute for Government analysis of NHS England and NHS Improvement, NHS 111 Minimum Data Set.

Infections and testing shortages reduced the number of people able to work

While demand for critical care rose, there were fewer staff available to work due to high levels of transmission in the community and within hospitals.[16] The number of NHS staff days lost due to sickness absence increased substantially in March and April 2020, and was 2.1 percentage points higher in April 2020 than in April 2019.[17] Most of the recorded rise was due to staff off sick under the categories 'suspected infectious disease' or 'chest and respiratory problems' (symptoms compatible with coronavirus).

Figure 8 **NHS staff full-time equivalent days lost due to sickness absence**



Source: Institute for Government analysis of NHS Digital, NHS sickness absence rates.

Sickness absence was highest among nurses and health visitors, clinical support staff to doctors, nurses and midwives, and hotel, property and estates staff (who work in laundry, catering and domestic services).[18] Sickness absence is likely to have been

even higher in acute roles – in early April, the *Health Service Journal* reported that 10% of nurses working in acute NHS trusts were absent during the peak weeks of the pandemic.[19]

Limited access to testing was an important factor in staff absence during the peak of the first wave. Owing to national testing shortages, NHS trusts were initially limited to using 15% of NHS labs' testing capacity for staff until 1 April.[20] There are not reliable estimates of the number of NHS staff who self-isolated because they were unable to get a test,[21] but the Academy of Medical Sciences' review of winter pressures "heard of significantly higher levels of absence in the first wave of COVID-19 infection due to staff experiencing COVID-19 symptoms, shielding or self-isolating, in addition to the usual sickness absence".[22]

The current testing shortages mean this is likely to happen again. As lab capacity reduced in late August[23] and demand for tests rose as schools went back in early September,[24] there was not enough testing capacity for everyone who requested a test to get one quickly, and there were widespread reports of NHS staff again being unable to access tests.[25] Unless demand falls or testing capacity increases, then NHS staff may again end up unnecessarily self-isolating, limiting the amount of care that hospitals can provide.[26]

Coronavirus has also had a large impact on the mental health of NHS staff. In response to a British Medical Association survey of hospital doctors in England and Wales, over a third of respondents reported that they were suffering more than normal from a mental health condition relating to or made worse by their work during the pandemic.[27]

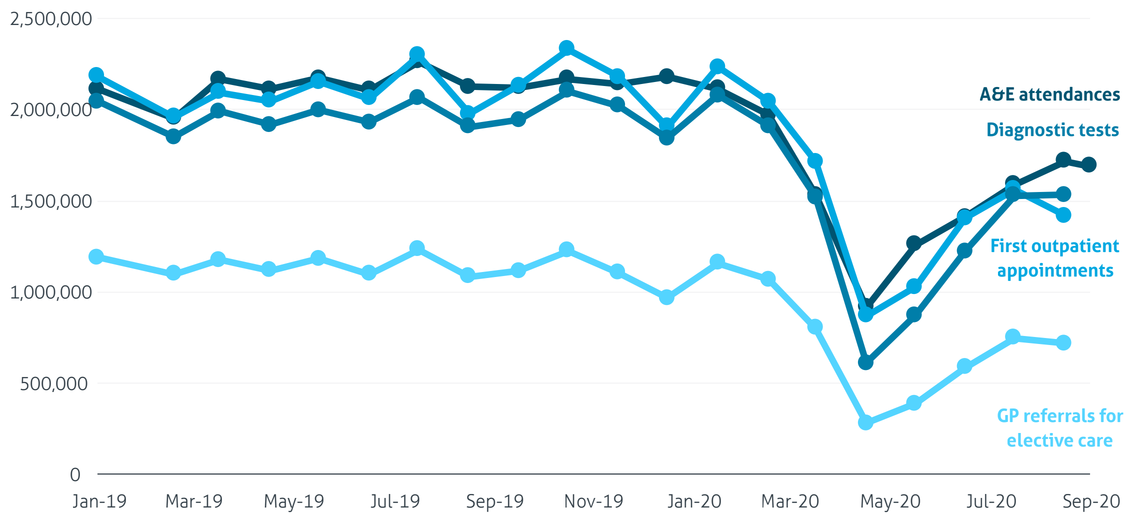
Hospitals closed routine services to free up critical care capacity

In March and April 2020, NHS England and NHS Improvement advised NHS trusts to "assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months" to free up acute care capacity and minimise transmission rates in hospitals. This advice only formally lasted between 15 April and 29 April,[28] when it was superseded by advice to "to step up non-Covid-19 urgent services as soon as possible over the next six weeks".[29]

NHS trusts redeployed limited staff to critical services such as intensive care and PPE procurement to prevent ICUs from being overwhelmed. Interviewees told us that staff in clinical commissioning groups were redeployed to procure urgent medical supplies, and that specialist surgeons had been working as assistants in ICUs,[30] for example. In the middle of May, almost one third of physicians reported working in a clinical area that was different from their normal practice.[31] This worked during the first phase of the crisis but will not be sustainable – 92% of NHS trust chief executives are concerned about staff wellbeing, stress and burnout following the pandemic.[32]

As a result of these measures, almost all kinds of hospital activity fell dramatically in March and April – partly because people were more reluctant to visit healthcare services,[33] and partly due to reduced capacity to provide care.[34]

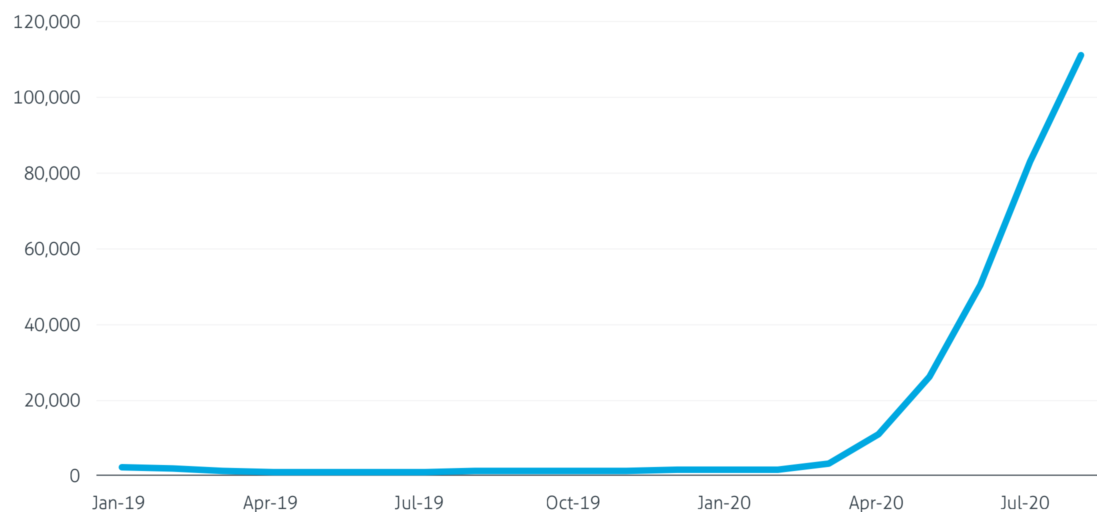
Figure 9 **Volume of hospital activity**



Source: Institute for Government analysis of NHS England and NHS Improvement, A&E Attendances and Emergency Admissions, Monthly Outpatient Referrals Data, & Monthly Diagnostics Data; NHS Digital, Provisional Monthly Hospital Episode Statistics.

Even among services that were not formally stopped during the pandemic, such as cancer operations,* hospital activity was a lot lower after March compared to the same months in 2019. This was because of a lower rate of referrals from GPs[35] and the capacity constraints created by physical distancing within hospitals[36] (hospital activity has since risen closer to 2019 levels). Consequently, patients across the country[37] already on waiting lists have waited longer to start routine treatments.

Figure 10 **Number of people waiting longer than one year for elective operations following a GP referral**



Source: Institute for Government analysis of NHS England and NHS Improvement, Consultant-led Referral to Treatment Waiting Times.

* The number of people seeing a consultant about a suspected cancer following an urgent referral from a GP was only 39% of last year's level in April, although it increased to 81% of last year's level in July. See: www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times

Lower attendance risks patients not accessing care for life-threatening diseases such as heart attacks and strokes, but for other conditions the reduction in attendances may have had no adverse consequences.[38] There were particularly stark falls in A&E attendances recorded as cardiac and myocardial ischaemia (heart diseases) in late March and early April.[39] The longer that patients wait to access care, the harder it becomes to provide curative treatment. This is a particular risk for patients with serious medical conditions such as heart disease[40] and cancer.[41] Some excess deaths are likely to have been caused by delayed access to care because the recorded causes of some of these deaths – such as diabetes, epilepsy and hypertensive diseases – can be fatal if treatment is delayed. However, the number of these is likely to be relatively small, with most excess deaths in March, April and May caused by Covid-19, whether diagnosed or not.[42]

Hospitals face a large backlog when they restart services

While patients already on waiting lists have waited longer to start treatment, the number of patients on those waiting lists fell during the pandemic, from 4.43m in February 2020 to 3.86m in June 2020.[43] This reduction reflects the fall in GP referrals to hospitals and fewer outpatient appointments to determine whether treatment is necessary, rather than a fall in demand. The waiting list is likely to increase rapidly once GP referrals to hospitals return closer to normal levels. After falling, the number of GP referrals started to increase between April and May[44] and in May the total number of referrals for elective care exceeded patients starting treatment,[45] meaning the waiting list started to grow between May and June.

The number of patients waiting for care is likely to consistently increase for at least the next few years as GPs see more patients who have stayed away during the pandemic, and whose conditions are likely to have got worse. Of people whose health treatment was reduced or cancelled during the pandemic, none thought that their health had improved, 52% thought their health had stayed the same, and 38% thought their health had got worse.[46]

In March,[47] NHS England and NHS Improvement agreed to pay all operating costs of independent hospitals in return for the right to use any of their capacity for public patients, as an insurance policy in case the number of coronavirus patients exceeded NHS capacity to treat them. But even using this additional independent sector capacity, hospitals are extremely unlikely to meet their 18-week target for elective care* given the rise in demand and restricted ability to perform operations.[48]

In light of these pressures, NHS England and NHS Improvement set trusts targets to restore near-normal levels of activity by October** – but NHS leaders and clinical bodies thought that it would be difficult to meet these targets while they still have enhanced infection control measures in place.[49] NHS Providers, the membership body for NHS trusts, surveyed its members in June and found that only 31% thought they would be ready to meet the needs of all the patients and service users that require

* That 92% of patients should start treatment or have been discharged following a GP referral for elective care.

** The targets were: for trusts to perform 90% of overnight electives and outpatient/daycase procedures, 100% of MRI/CT and endoscopy procedures, and 100% of outpatient attendances and follow-ups. Targets were all set against last year's activity levels. See: www.england.nhs.uk/wp-content/uploads/2020/08/20200820-Elective-letter.pdf, p. 1

services by October, 22% thought they would be ready by January 2021, and 12% thought they would be unable to return to previous service levels permanently.[50] The Royal College of Physicians surveyed its speciality branches, and found that just under half of physician specialities – including cardiology, gastroenterology and rheumatology – expect to be working at less than pre-Covid activity levels for at least the next year.[51]

Even if coronavirus is controlled and some enhanced infection control measures can be removed, pre-existing staff shortages in key diagnostic services such as pathology[52] will continue to limit how quickly trusts can provide care.

What changes have hospitals made to manage the crisis?

NHS England and NHS Improvement changed the NHS financial regime to better align incentives and speed up decision making

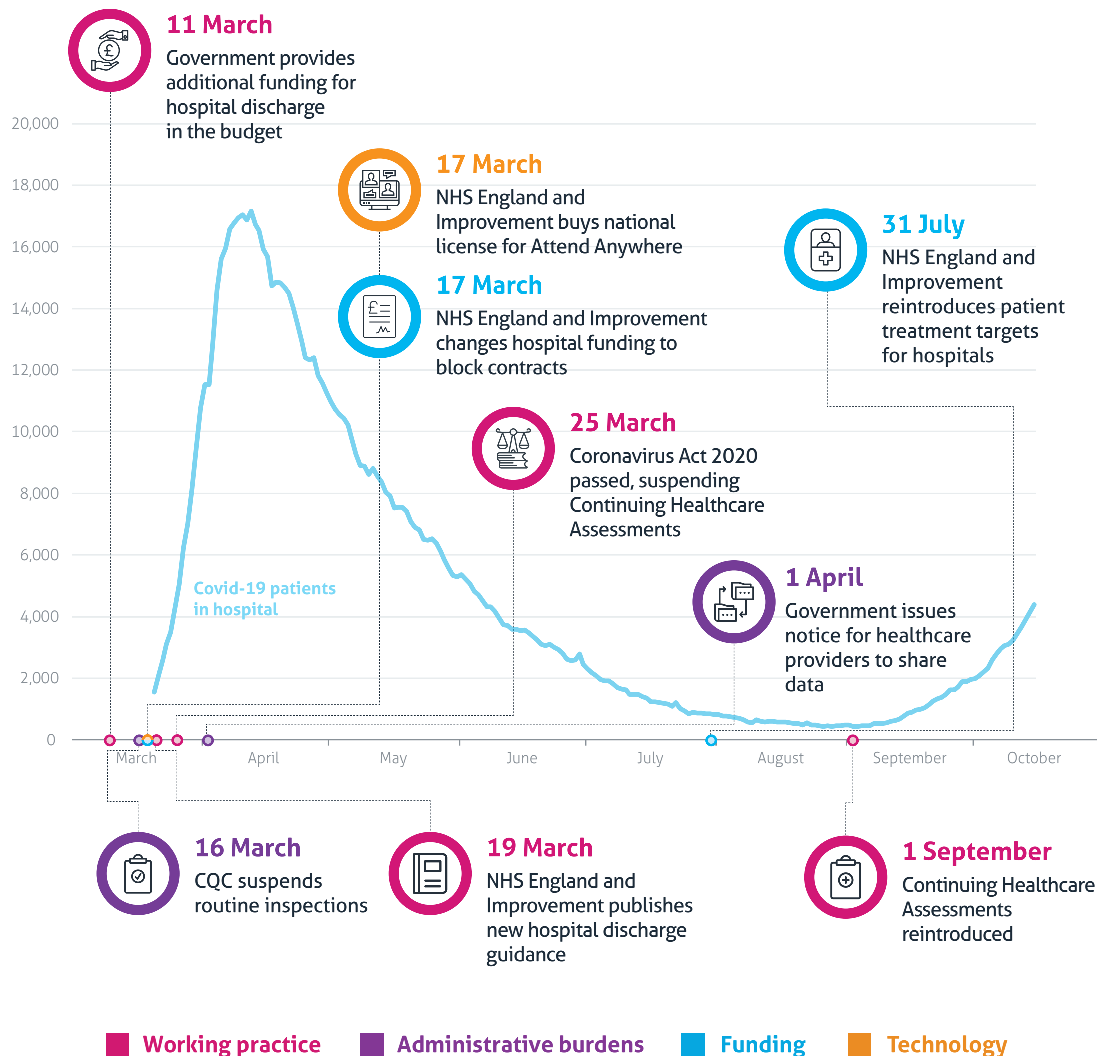
In mid-March, NHS England and NHS Improvement brought in four temporary changes to the way the NHS is funded:[53]

- Hospital funding changed from payments-for-activity for some healthcare to block payments for all healthcare – where NHS trusts were guaranteed a certain level of funding based on how much they were paid in September 2019. This lasted until October 2020, when activity targets were reintroduced.*
- A temporary scheme to allow NHS trusts to claim reimbursement for any additional costs necessary to respond to Covid-19,[54] which lasted until October 2020.
- A faster approvals process for capital projects in which NHS trusts were given permission to spend up to £250k with retrospective approval. NHS England and NHS Improvement promised to respond to all requests for projects over £250k within two days.[55] This lasted until May 2020, when NHS trusts were required to seek national pre-approval for projects less than £250k.[56]
- A temporary suspension of Continuing Healthcare assessments (which determine whether a patient in need of long-term care is eligible for NHS funding) between March and September,[57] meaning that all patients discharged from hospital were guaranteed public funding for their care needs.

NHS England and NHS Improvement brought in these changes to ensure "cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision".[58] The shift to block payments was designed to remove financial bureaucracy and contractual disputes between commissioners and providers by temporarily changing the way that NHS commissioners paid providers for healthcare. Instead of local commissioning groups agreeing expected levels of activity with NHS trusts, and some parts of the payments being contingent on the achievement of certain levels of activity and quality, NHS England told commissioners to pay local trusts a fixed amount and allowed them to claim back any extra costs associated with responding to coronavirus. This also removed the possibility of perverse 'penalties' (losing money) if acute trusts had not undertaken elective operations after NHS England and NHS Improvement had told trusts to postpone most non-urgent care from 15 April.

* The financial framework for the second half of 2020/21 will still be based on block payments, but "block payments will flex meaningfully to reflect delivery (or otherwise) against [...] patient treatment goals". See: www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

Figure 11 **Timeline of changes made to hospitals**



Source: Institute for Government analysis.

These changes have been welcomed, particularly by NHS trusts.[59] Interviewees told us that block contracts reduced the bureaucracy involved in contracting, and that the reimbursement guarantee enabled organisations to work together because there were fewer haggles over invoicing, and who would fund the costs of joint projects. For example, drafting in staff from other trusts to speed up patient transfer[60] or trusts working together to buy equipment such as PPE. One interviewee told us that changes to the financial system had eliminated arguments about out-of-area placements, or about whose money would fund what, which had prohibited joint working in the past.[61]

Trust interviewees told us that, at least during the first few months of the pandemic, capital projects had been streamlined and signed off much faster, although this had slowed down following the reintroduction of pre-approval for capital projects on 19 May.[62] The shift to block contracts also freed up staff in clinical commissioning groups – who would have otherwise been managing contracts – to work in urgent roles such as procuring PPE, running testing centres and clinical roles in intensive care.[63] Overall, interviewees told us that the removal of most payment-by-activity funding

accelerated collaborative working between different organisations and worried that the reintroduction of payments for activity would undermine the "working across systems that had developed during the crisis".[64]

Financial structures and incentives in the NHS affect how different organisations work together, but while there have been benefits to the block contracts and retrospective top-ups model, moving to this model permanently would have big disadvantages.[65] Some interviewees worried that block contracts remove incentives for hospitals to reduce costs or improve the quality of individual procedures, which NHS England and NHS Improvement is usually able to encourage under the payment-by-activity system by amending the 'tariff' – the price which determines how much NHS commissioners pay providers for each patient they treat.[66,*]

Some also worried that block contracts provided less transparency on what was being paid for and the activity undertaken. A concern was that commissioners might pay twice – once in their block payment to a provider, and again to a different provider who had taken on responsibility for that particular element of healthcare. For example, if pathology services formed part of a block payment to one trust, but that trust had subsequently contracted with another to provide the same services, commissioners might pay for those services twice.[**] Another interviewee raised concerns that even with the reimbursement guarantee it had become harder to claim Covid-19 costs back as the pandemic progressed and NHS England and NHS Improvement took a stricter view of what encompassed such costs. As one interviewee summarised: "It worked for six months but won't work for ever."[67]

Blended payment contracts[68] – which mix elements of block payments and payments for activity – can combine the flexibility of block contracts with the transparency of payments for activity and have been trialled in some areas in recent years.[69]

- **NHS England and NHS Improvement should review the lessons of pandemic experience, and evaluate the impact of existing blended payment contracts, with a view to implementing the most effective funding models more widely.**

The government put emergency funding in place to speed up hospital discharge

In addition to the changes to the financial system mentioned above, the government decided to fund the first six weeks of care for any patient discharged from hospital in 2020/21, regardless of whether they would have been eligible in normal times.[***,70] Local authorities were also told to suspend funding panels[71] – which establish whether a person entering care following hospital discharge needs to pay for part

* Block contracts also create incentives for providers to make all procedures cheaper, by setting a firm total that providers must live within. There is a risk, however, that providers respond by inappropriately rationing services or cutting the quality of care to stay within budget. See: www.nuffieldtrust.org.uk/files/2017-01/2014-nhs-payment-research-report-web-final.pdf, p. 7

** At the same time this may give providers greater flexibility to redesign care pathways and develop innovative services, and in other public policy areas, including the Work Programme, governments have argued that a payment-by-results approach is more effective than payment-by-activity.

*** The additional NHS funding was extended in July 2020, but will expire in March 2021 when NHS England has said there will be a "return to usual financial disciplines". The additional local government funding has not been extended. See: www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

of their care – during the pandemic, and the government provided some additional funding[72] to local authorities to cover the cost of this (and other services).

The government introduced these measures to reduce the amount of time it takes to discharge medically fit patients from hospital, as part of its efforts to free up hospital beds at the start of the pandemic. The move was successful in discharging patients from hospital. General and acute bed occupancy fell to 62.8% in the first quarter of 2020/21, compared to the normal occupancy level of between 88% and 92% over the last five years.[73] It was not the only factor – many hospital patients were discharged before the new national guidance came in on 19 March,[*,74] and some of the reduction will have been due to fewer elective operations, as mentioned above – but it contributed.

Notably, there was an increase in discharges of patients in hospital for longer than 11 days in March 2020 compared to March 2019,[75] suggesting that the additional funding helped hospitals discharge patients who would otherwise have stayed far longer. NHS interviewees told us that the discharge process was valuable for the time it bought them to redesign services before the first wave of Covid-19 patients[76] and ensure critical care beds were available for those who needed them most.

There were problems with faster discharge during the pandemic. Discharging patients sooner, particularly where they were discharged to care homes without testing, almost certainly resulted in asymptomatic patients entering care homes where they could spread the virus among vulnerable residents. In a survey of local authority social care directors, 23% of respondents thought that more than half of care home Covid-19 infections were attributable to rapid hospital discharge.[77]

The death rate in care homes has been horrifyingly high during the pandemic.[78] However, in the absence of testing data to provide information about the spread of the virus in February and March, it is not possible to say how much of the transmission and subsequent deaths in care homes was caused by hospital discharges,[79] as opposed to other ways, such as care home staff transmitting cases from the community.[80] One early study of care homes in Wales found that whether or not a care home accepted a patient discharged from hospital during the pandemic was not associated with a significant increase in the risk of a new outbreak.[81]

While discharges did almost certainly contribute to the spread of infections within care homes, the bigger problem during February and March was testing shortages and the absence of guidance on whether testing was necessary before discharge – not the faster discharge process itself.

Considering the discharge funding and process specifically, most NHS interviewees thought it had reduced the typical haggles over money. One interviewee told us that "this completely changed the usually antagonistic process… previously the incentives were to limit access to care, which slows down the discharge process… the discharge to assess model removed these issues".[82] In theory, faster hospital discharge also

* Hospital discharges to care homes in February were 9% higher than the historical five-year average between 2015 and 2019, for example see: www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-impact-on-social-care-users-and-staff-in-england-so-far, p. 11

provides substantial medical benefits to patients.* An evaluation of a similar recent initiative to speed up hospital discharge, the Better Care Fund, found that targeted additional funding reduced the time hospital patients waited for discharge and improved collaboration between health and social care providers.[83] However, some expressed concerns that enhanced discharge was used inappropriately for badly planned and unsafe discharges.[84]

There is a risk that maintaining faster discharge after the crisis might result in less extensive assessment of a patient's care needs,[85] and lead to more patients being discharged to inappropriate locations. This last concern is particularly strong. The Association of Directors of Adult Social Services (ADASS) found that as little as 11% of local authority social care directors believed that every individual in their local authority area was discharged to the right place for them during the pandemic.[86]

Any new scheme would have to be carefully designed to avoid this. The discharge targets in the Better Care Fund, for example, were unhelpful and created perverse incentives such as transferring hospital patients to intensive short-term care home placements where they lost some of their independence, in order to ensure patients were discharged within a certain number of days.[87] Over 80% of local authority social care directors said that the focus on reducing delayed transfers in the Better Care Fund scheme increased the number of discharges to short-term care home placements that became permanent, and over 60% said the focus had caused an increase in emergency readmissions to hospital because patients had been transferred to an inappropriate care setting.[88]

Other local government interviewees worried that having the NHS pay for the first six weeks of care following discharge may permanently increase costs, as NHS commissioners paid more for care placements than local authorities did. This, however, was probably inevitable, given evidence that councils were paying less than the cost of care-home care prior to the pandemic,[89] and NHS England and NHS Improvement discharge guidance encouraged commissioners to cover the full cost of care placements.

Despite these concerns, overall the emergency funding for hospital discharge appears to have benefited both hospitals and patients in a difficult period. Speeding up hospital discharges has been the policy of successive governments.

- **The government should therefore provide funding to continue faster discharges beyond the crisis. The amount provided and the design of the funding mechanism should be based on research, which NHS England and NHS Improvement should commission, into care pathways and key clinical outcomes, such as hospital readmission rates, for patients who were discharged under the emergency discharge process compared to similar groups in previous years.**

HOSPITALS

* This is because hospital beds are often an inappropriate place for medically-fit people with care needs as it can reduce their independence. One 2014 report estimated that a wait of more than two days negates the additional benefit of intermediate care, and a wait of seven days or more is associated with a 10% decline in muscle strength. See: www.instituteforgovernment.org.uk/sites/default/files/publications/5991%20IFG%20-%20Performance%20tracker%20Autumn%202017%20update.pdf, p. 29

Faster discharge can only be maintained if there is sufficient funding for social care and community care. Interviewees told us that the discharge-to-assess model had worked because many community services were temporarily suspended during the pandemic, freeing up staff who previously were providing community services to help discharge patients.[90]

- **The government should give local authorities, care providers and community health services additional funding so that they have sufficient capacity to assess and then safely absorb higher numbers of patients discharged from hospital.**

- **The NHS five-year funding settlement was backloaded[91] – this should be reversed, and funding frontloaded, to allow community trusts to hire additional community nurses and other staff as quickly as possible.**

Hospitals have made greater use of technology to see patients remotely

Following guidance that trusts should postpone all non-urgent elective operations in March, NHS England and NHS Improvement, along with NHS Digital, undertook a range of initiatives[92] to encourage trusts to deliver as many outpatient appointments as possible remotely. This included providing guidance,[93] rolling out remote working tools including Microsoft Teams,[94] and purchasing a national licence for Attend Anywhere,[95,96] a remote appointments software provider.

The government's goal was to provide ways for patients to continue care without attending face-to-face appointments to minimise the risk of transmission,[97] although the measures also had the benefit of accelerating trends towards greater use of remote technology, which had been set out in the 2019 *NHS Long Term Plan*.[98] Reforming outpatient appointments has long been a priority of health improvement staff – 50% of whom in a July 2019 survey said "using online/mobile technology to improve patient access and reduce demand for face-to-face consultations" was a priority.[99]

A much larger share of hospital outpatient appointments are now remote. Around 10% of outpatient appointments were classed as 'telemedicine' in March 2020, compared to just 3.5% in March 2019.[100] And 46% of outpatient appointments were completed remotely in April 2020.[101] While some of these appointments may have been better to undertake in-person and will revert back to that once it is safe to do so, the NHS has provided a lot of patients with care without them having to attend face-to-face appointments. NHS England and NHS Improvement has now set a 'national benchmark' that 25% of all clinically necessary outpatient appointments, and 60% of follow-ups, could be permanently done remotely.[102]

There has also been a rise in NHS staff using remote working technology,[103] and a rapid increase in patients accessing existing telephone and online services, including NHS 111, the Electronic Prescription Service – where a patient chooses which pharmacy they would like their prescription to be sent to – and the NHS App.[104]

The evidence on the effectiveness of new technologies deployed during the pandemic, while limited, is broadly positive.[105] Moorfields hospital found that virtual video eye consultations "showed greater than expected usefulness [and worked well] in the remote management of eye disease and supported a substantial reduction in the number of people visiting the hospital",[106,107] and the Royal National Orthopaedic Hospital found that "virtual consultations can be rapidly implemented in response to COVID-19 and that they are largely acceptable".[108]

Remote appointments will need to be carefully evaluated to analyse the effects on patients, the public, and staff, not all of which will have been apparent in the fast deployment during the pandemic. Patient charities such as National Voices and health improvement professionals are concerned, for example, that greater use of remote technology may increase 'digital exclusion'[109,110,111] among people who do not have access to, or cannot afford, reliable internet connections. NHS England and NHS Improvement has asked trusts to assess this by 31 March 2021, by gathering data on the protected characteristics of patients accessing services remotely – but it will also be important to include the perspective of non-users as well.

NHS England and NHS Improvement should also learn from the rollout of Attend Anywhere – a video appointment service – in the Scottish Highlands[112,113] and evidence from other countries about the effectiveness of video consultations,[114] which have shown that reliable internet connections and support to install technology and train staff are vital to implementing remote consultations effectively. The biggest gaps in the existing evidence are the impact on staff – recruitment, retention and the skills required to run successful remote appointments – and the types of care for which remote appointments are most appropriate. Both should be priorities for evaluation.

The way that NHS England and NHS Improvement deployed this new technology – buying a national licence with a single supplier – should not be continued. The single national licence was valuable for allowing trusts to deploy technology quickly during the pandemic but relying on a single supplier in the medium term risks a decline in the quality of service provided[*] and risks the entire NHS being affected by the problems of one supplier – as happened in early May when Attend Anywhere crashed.[115] Reliance on a single national supplier risks the government getting captured by a small set of providers and locked into legacy technologies, where the government is forced to buy expensive, second-rate equipment because it cannot join separate IT systems together.[116]

Owing to these concerns, NHS England and NHS Improvement has said that it will not renew its licence for Attend Anywhere,[117] which means that the government will have to rethink how it funds and supports trusts to make best use of remote technology next year and beyond.

* In general practice for example, interviewees told us that large incumbent providers were much slower to respond to the crisis than smaller providers who'd just entered the market.

Greater use of technology in hospitals has generally worked well during the pandemic, but there is still a lot to learn about remote consultations.

- **The government should evaluate where, and for whom remote care is appropriate. It should avoid a one-size-fits-all approach to funding, buying or encouraging remote appointments after the pandemic.**

The Department of Health and Social Care, NHS England and NHS Improvement, and the Care Quality Commission changed governance requirements and reduced administrative burdens during the pandemic

To speed up decision making during the crisis and allow staff to focus completely on the coronavirus response, NHS England and NHS Improvement reduced administrative burdens and encouraged trusts to share data. In addition to the funding changes described above, NHS England and NHS Improvement and the Care Quality Commission (CQC) temporarily suspended some bureaucracy in consultation with the medical colleges, including:

- annual reviews of competency progression for doctors in training[118]
- NHS England and NHS Improvement procurement league tables[119]
- penalties for not achieving waiting list performance targets[120]
- CQC healthcare inspections[121]
- some routine data collections,[122] such as delayed transfers of care.

NHS England and NHS Improvement told us that these were designed to improve the speed of the response to the pandemic, while maintaining minimum necessary levels of governance for safety. Interviewees told us that these changes had been beneficial because some of these "heavy-handed" regulations distracted staff from delivering care in normal times.[123] Ian Trenholm, the head of the CQC, has said that its inspections "will no longer be big, disruptive events", which NHS Providers has welcomed[124] – although patient groups have expressed concern about the suspension of CQC inspections.[125] Over the summer, the government ran a consultation on reducing bureaucracy in the health and social care system.[126]

- **Given the public concerns about changing inspection regulations, the government should publish the findings of its bureaucracy review by the end of 2020.**

DHSC also encouraged local data sharing, by putting in place regulations[127] that required NHS Digital, NHS England and NHS Improvement, health organisations, arm's-length bodies, GPs and local authorities to process and share any confidential patient information which could be used to diagnose, manage and control the spread of Covid-19.[128] Interviewees told us that this explicit statement from the government provided regulatory cover for sharing data, and really "changed the culture within the NHS" from one of risk-aversion about sharing data to one of greater collaboration,[129] although data sharing did not always extend beyond the NHS to local authorities.[130]

The more permissive atmosphere for sharing data improved the operational response to Covid-19 and also allowed academics to analyse the specific properties of the virus. Studies conducted at Oxford University, for example, analysed pseudonymised data from electronic healthcare records[131] to analyse risk factors for Covid-19,[132] improving understanding about the epidemiology of Covid-19.[133]

- **The government should promote greater data sharing beyond the crisis. It, NHS England and NHS Improvement, and NHS trusts must be transparent about data being collected, who has access to it and for what purposes, how it will be protected, and who is responsible for making these decisions.**[134]

Conclusion

The advent of Covid-19 was disruptive and transformative in the NHS. Many of the changes made in response were originally intended to be temporary, but some have had real benefits and should be kept or expanded. Faster hospital discharge had benefits but will only be maintained safely if there is sufficient funding for social care and community care. The government should give local authorities, care providers and community health services additional funding so that they have sufficient capacity to assess and then safely absorb higher numbers of patients discharged from hospital. Greater use of technology in hospitals has worked well during the pandemic, but there is still a lot to learn about remote consultations. The government should evaluate where and for whom remote care is appropriate.

3. Adult social care

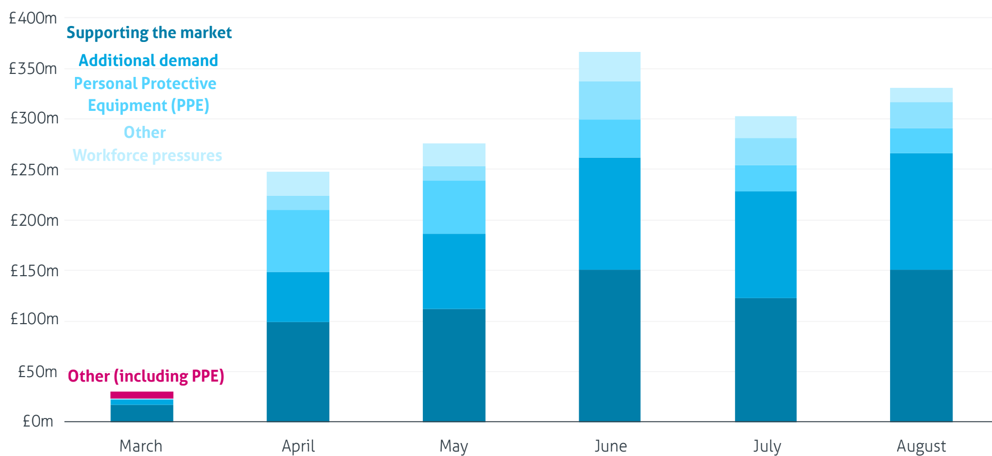
Local authorities and care providers faced immense disruption during the crisis and had to take drastic steps to manage the pandemic. While many changes were only appropriate as temporary measures, greater use of technology, in particular the capacity tracker app, could have longer-term benefits if continued.

How has adult social care been disrupted by coronavirus?

Local authorities in England spent an additional £1.6bn on adult social care between March and August 2020

Between March and August local authorities have spent almost an additional £1.6bn on adult social care, mostly to help providers avoid collapse, and to provide social care to meet additional demand.

Figure 12 **Additional local authority spending on social care, 2020/21 (£m)**



Source: Institute for Government analysis of Ministry of Housing, Communities and Local Government, Local authority Covid-19 financial impact monitoring information, Round 5.

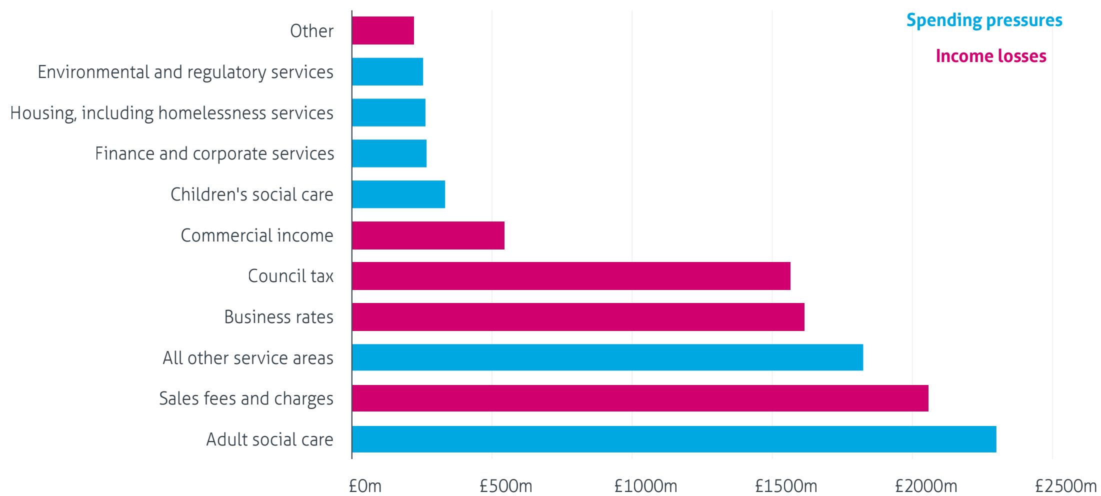
Local authorities forecast that they will need to spend an additional £2.3bn on adult social care in 2020/21 due to coronavirus, consisting of:

- £900m to support providers
- £840m for additional adult social care demand
- £260m for personal protective equipment (PPE)
- £150m for additional workforce pressures
- £150m of other adult social care related spending.[1]

As spending pressures have grown, local authorities' income from social care has also fallen. This includes income that councils receive from charging people for care – known as client contributions. Adult social care directors surveyed by the Association of Directors of Adult Social Services (ADASS) forecast that the loss of client contributions would cost local authorities £190m this year alone.[2]

The bigger problem facing local government, however, is the loss of revenue from council tax, business rates, sales fees and other charges. These losses have only been partly covered by central government,[3] and will limit their ability to spend more on adult social care while balancing their books over the next three years.

Figure 13 **Local authorities in England, spending pressures and income losses, 2020/21 (£m)**



Source: Institute for Government analysis of Ministry of Housing, Communities, and Local Government, Local authority COVID-19 financial impact monitoring information, Round 5, Tables 31 and 32, 2020/21.

The combination of pressures to spend more and loss of income have increased the size of the gap between the money councils have and what they need to spend on public services.[4]

Social care providers are also facing financial difficulties. Responding to a survey in May, 82% of local authority directors of adult social care said they had concerns about the financial sustainability of their residential and nursing care homes, and 75% were concerned about the financial sustainability of their homecare providers.[5] In a survey of care providers conducted in late May, 64% of respondents were concerned their service was financially unsustainable.[6]

Providers who survived the acute phase of the pandemic have faced continued threats to their financial stability. Laing Buisson, a healthcare consultancy, estimates that care providers will face costs of £6.6bn between April and September 2020 for PPE, regular deep cleans of care homes, and paying for additional cover for staff who are sick or self-isolating.[7] These spending pressures have meant that local authorities have had to provide immediate and widespread financial support to maintain existing services.

Coronavirus led to a reduction in use of care homes and homecare

Care home occupancy fell during the pandemic. A survey of care providers found that the average care home occupancy rate was 81% in June 2020, 11% lower than June last year.[8]

The fall in care home occupancy rates has been driven by a large number of deaths and fewer new admissions. The Care Quality Commission (CQC) found that in early June the number of new publicly funded clients admitted to care homes was on average 72% of the level of the same time last year;[9] more arrestingly, new admissions from people who fund their own care were just 35% of 2019 levels in early June.[10] The health consultancy Carterwood estimates that, depending on the path of coronavirus, care home occupancy rates might not recover to pre-pandemic levels until October 2022.[11]

The use of homecare also fell as people were reluctant for carers to enter their homes.[12] While homecare providers reported that they were paid for 94% of the hours they were providing pre-pandemic, the actual reduction is probably larger because some local authorities have paid providers for planned hours, regardless of whether they have been delivered.[13]

Reductions in formal care – from, for example, local authorities closing day and respite centres due to infection risks – is likely to have increased under-met and unmet need, meaning those who should be receiving care are not receiving enough, or any at all. The picture, however, is mixed: 55% of adult social care directors say there hasn't been an increase in unmet need since March 2020; 25% say unmet need has increased between 1 and 5%; and more than 10% have said unmet needs have increased between 6 and 10%.[14]

Any new burden is likely to have fallen on unpaid carers. The charity Carers UK estimated that 9% more of the adult population – an additional 4.5m people – have provided unpaid care since the pandemic started[15], and that people providing unpaid care before the pandemic are doing so even more. In April it estimated that unpaid carers were providing, on average, 10 additional hours of care each week, and a majority of carers reported that they will "burnout in the coming weeks".[16] This could also have a big impact on the labour market if large numbers of mainly female unpaid carers remove themselves from the labour market to provide care.[17]

The adult social care workforce has been affected badly by coronavirus

The adult social care workforce began the pandemic with a large number of vacancies,[18] high staff turnover and some of the lowest pay in the economy.[19] Despite remarkable staff resilience, these problems left the workforce in a weak position to weather the absences and social distancing requirements caused by coronavirus.

These problems were exacerbated by difficulty accessing timely tests. On 3 July, the government pledged to test care home workers each week, beginning on 6 July.[20] This did not happen: in August, the timeline for this was revised to the second week of September at the earliest due to "unexpected delays"[21] such as having to recall testing kits that did not meet required safety standards.[22]

Between March and June 2020, the average number of days lost to sickness across the sector was approximately 8% compared to a rate of 2.4% pre-coronavirus.[23] In care homes with at least one coronavirus case[*], the Office for National Statistics (ONS) estimated 7% of staff also tested positive. This means that every home where coronavirus was found lost close to one in 14 of its workforce (and in some, many more).

Tragically, the number of social care workers who have died from Covid-19 has also been very high. For those working in social care (including care workers and home carers) the death rates were 56.8 deaths per 100,000 males and 22.6 deaths per 100,000 females, compared to 34.2 and 13.1 for men and women working in health care.[24]

Adult social care staff were exposed to coronavirus in several different ways. First, the discharging of hospital patients into adult social care settings without being tested for coronavirus (see chapter on Hospitals)[25] has been widely acknowledged as a major error in retrospect. By the time testing of discharged patients became policy on 15 April, no fewer than 25,000 people had been discharged from hospital into care homes. It is, of course, not known how many were infected with coronavirus.[26]

Second, the use of agency and 'bank' workers in the sector – who typically work and travel between several different sites – meant there were greater opportunities for staff to contract the virus and then spread it to multiple settings (including other care homes). While it is estimated that in March 2020 just 6% of adult social care jobs were not directly employed workers (i.e. bank and pool workers, agency staff, volunteers and students), this still equates to around 140,000 people. The ONS found that care homes using bank or agency staff most days or every day were more likely to have more virus cases among residents, estimating that 12% of care homes had staff who work at more than one location and more than half employed bank or agency staff.

The demography of the care workforce also increased the risk for care staff. The adult social care workforce in England before the pandemic was, on average, slightly older than the economically active population, and a quarter of the sector's workforce were aged 55 and over.[27] The workforce in England was also more diverse: 21% are categorised as Black, Asian or Minority Ethnic (BAME) compared to 14% of the country's population.[28] Given that the risk of dying from coronavirus increased with age,[29] and that BAME people have a higher risk of death compared to those categorised as White British[30], the UK's care workforce was already at higher than average risk, even before taking care working conditions into account.

* The ONS estimates that 56% of care homes had at least one coronavirus case. See: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/impactofcoronavirusincarehomesinenglandvivaldi/26mayto19june2020#strengths-and-limitations

What changes has adult social care made to manage the crisis?

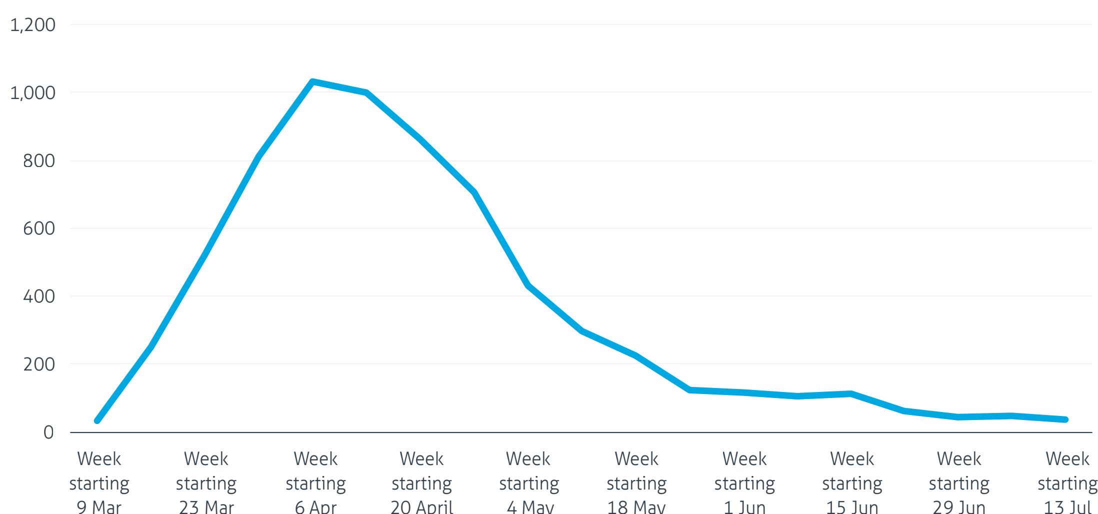
The government provided short-term funding to ensure local authority financial sustainability and reduce transmission in social care

The government provided local authorities with several tranches of funding during the pandemic:

- On 19 March, it provided £1.6bn to local authorities
- On 16 April, the government paid £850m worth of adult and children's social care grants for April, May and June upfront to relieve immediate cashflow pressures[31]
- On 28 April, it allocated a further £1.6bn for local authorities[32]
- On 15 May, the government announced a £600m Adult Social Care Infection Control Fund to reduce coronavirus transmission in and between care homes and support wider workforce resilience,[33] of which 75% was for care homes, with the remaining 25% available for other care providers at the discretion of local authorities[*]
- On 2 July, the government announced an un-ringfenced £500m for local authorities[34]
- On 17 September, the government provided £546m to extend the Infection Control Fund until March 2021.[35]

This emergency funding had two primary goals: to ensure local authorities remained financially solvent, and to reduce coronavirus transmission in social care settings. The funding ensured that no English local authority issued a Section 114 notice (declared bankruptcy) during the pandemic, although it will not be sufficient to provide support over the rest of the financial year. In an ADASS survey of adult social care directors only 4% were confident their budget would be sufficient for statutory needs in 2020/21, down from 35% in 2019/20.[36]

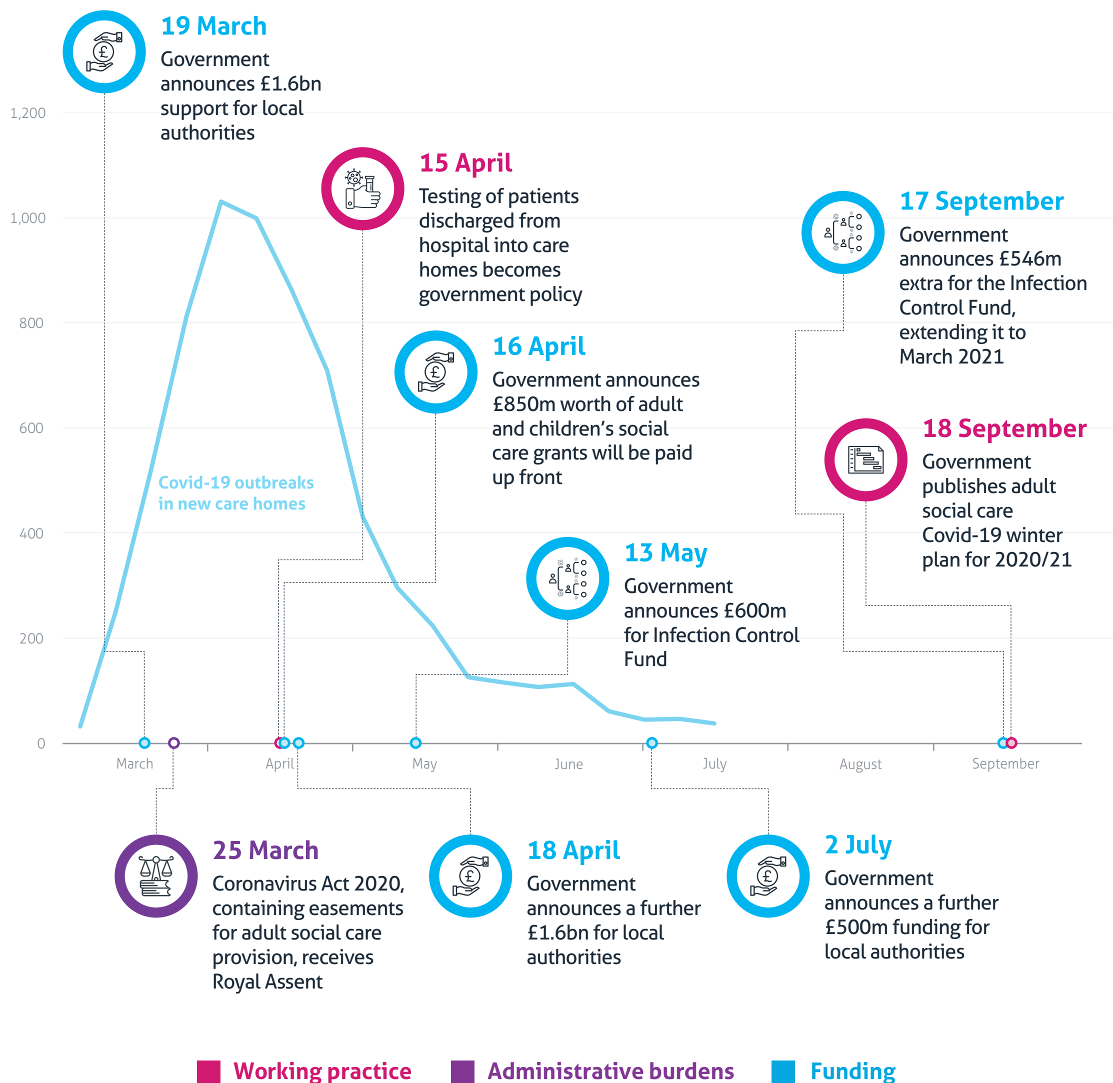
Figure 14 **Suspected or confirmed Covid-19 outbreaks in new care homes**



Source: Institute for Government analysis of Public Health England, 'COVID-19: number of outbreaks in care homes – management information'. Individual care homes are only included once. If a care home had more than one outbreak, only the first outbreak was counted.

* Local authorities split the first portion of the ringfenced Infection Control Fund fairly evenly between measures to isolate residents within care homes (21.4%), restricting staff movement within care homes such as a particular floor or wing (24.7%), paying staff full wages while isolating after a positive test (18.7%), and other measures (34%), MHCLG, Local authority spending of the first tranche of the Infection Control Fund. See: www.gov.uk/government/publications/adult-social-care-infection-control-fund

Figure 15 **Timeline of changes made to adult social care**



Source: Institute for Government analysis.

Social care providers also benefited from the economy-wide measures to incentivise self-isolation when necessary such as the change to statutory sick pay, which was made available from the first (rather than the usual fourth) day of absence, and changes to allow part-time workers (or any workers receiving less than £118 per week) to claim employment and support allowance from the first – rather than the eighth – day of illness.[37,*] Together with the Infection Control Fund, these measures ensured some staff who would have otherwise worked did self-isolate, but the Infection Control Fund was "overly bureaucratic"[38] and the funding available was not enough to enable all care workers to self-isolate without losing money.

* For some workers the official guidance was unclear, for example: initial guidance and following updates from the government provided no assurances that those workers on zero-hours contracts would be entitled to statutory sick pay if they were earning over £118 per week. https://media.www.kent.ac.uk/se/11148/CareworkersHealthandSafetyreport15042.pdf, p. 12.

After the Infection Control Fund was introduced, a survey of 433 Unison member care workers in June found that 31% of those who needed to shield were fully paid, and 10% of respondents said they were aware of colleagues who continued working despite having Covid-19 symptoms.[39] Such continued working when ill risks other staff and patients contracting coronavirus.

- **The government should provide more generous funding if it wants a greater proportion of care workers who might be infected to self-isolate when required.**

The funding for local authorities and for social care helped prop up local authorities and reduce coronavirus transmission in the short term, but continued the unhelpful trend of repeated short-term funding announcements for adult social care.[40]

The pandemic was a rare occasion when short-term additional funding was justified by the severity of an unexpected shock. But funding in this way in normal times should be unnecessary given that the key drivers of adult social care expenditure are easily predicted and slow-moving demographic changes. These short-term settlements and a failure to properly address the thorny issue of adult social care funding reform (nearly a decade after the Dilnot Commission[*]) prevented local authorities and care providers from undertaking long-term financial planning and left the sector in a weak state going into the pandemic.[41]

In his first speech as prime minister in July 2019, Boris Johnson committed to reform adult social care.[42] If the government is serious about this, then local authorities and providers will require certainty while reform is negotiated and enacted, which the government has said is unlikely to be until 2021 at the earliest. ADASS has recommended a two-year ringfenced funding settlement as a bridge during adult social care reform.[43]

- **The government should outline what local authority income they will replace and costs they will cover over the next two years so that local authorities can provide greater certainty to adult social care providers.**

The government provided specific funding to enable more rapid discharge of patients from hospitals into social care

In addition to general funding increases to local authorities and the Infection Control Fund, the government provided the NHS with £1.3bn to enable safe and timely hospital discharge to care.

The NHS discharge funding successfully removed barriers to discharging patients from hospital, but did not fully consider the implications for adult social care. We were told that the extra discharge funding enabled some Clinical Commissioning Groups (CCGs) to pay as much as 20% above local authority rates for care. This inflated prices in the short term and some local government interviewees were concerned that it may have a longer impact on the prices they pay for care in the future.

* An independent inquiry which made recommendations for changes to the funding of care and support in England.

NHS discharge funding also resulted in a large number of patients with asymptomatic coronavirus being discharged into care homes and other settings, though this was largely due to the lack of testing capacity rather than the discharge process.

Despite these problems, and concerns about extending the process in normal times, the changes appear to have benefited both hospitals and patients. We discuss these issues in more detail in the hospitals chapter and our recommendations for how adult social care should approach patient discharge are the same as given in that:

- **The government should provide funding to continue faster discharges beyond the crisis. The amount provided and the design of the funding mechanism should be based on research, which NHS England and NHS Improvement should commission, into care pathways and key clinical outcomes, such as hospital readmission rates, for patients who were discharged under the emergency discharge process compared to similar groups in previous years.**

- **The government should give local authorities, care providers and community health services additional funding so that they have sufficient capacity to assess and then safely absorb higher numbers of patients discharged from hospital.**

- **The NHS five-year funding settlement was backloaded – this should be reversed, and funding frontloaded, to allow community trusts to hire additional community nurses and other staff as quickly as possible.**

The government required care homes to provide capacity information via the 'Capacity Tracker' app

A strict condition of the Infection Control Fund was that residential care providers could only receive the funding if they provided information to Capacity Tracker – an app tracking the availability of beds in care homes – at least once and committed to doing so consistently.[44] Capacity Tracker launched before the pandemic in April 2019 (after a pilot) to help hospitals find care home places when discharging patients[45] by providing information about vacancies, removing the need to contact individual providers to discover whether they had places.

The requirement to use Capacity Tracker (at least once) led to a huge increase in the number of care homes using it, and in the data available to central government and NHS trusts as a result. This included information about bed capacity, staff absences, PPE availability, and overall risk levels.[46] Almost all (99%) of care homes in England are now registered on the app[47] and, as of June, 60% updated details every 48 hours.[48]

This data has been used by central government to get an overall picture of capacity and conditions, and by local authorities and Local Resilience Forums (LRFs) to target their responses to care providers. One local authority leader told us Capacity Tracker had provided them with information they hadn't previously realised that they needed to know – such as people in their area who self-fund their care – which the local authority could then use to target resources to potentially vulnerable people such as the partners of those in care homes.[49]

The effectiveness of the tracker to date is because it was explicitly linked to accessing additional funding.[50] Fewer care homes are likely to submit data once the Infection Control Fund ends. Although providers should benefit from being able to fill vacancies quickly, many are sceptical about the benefits of taking the time to input data. In interviews with the Institute of Public Care not a single provider said the app had led to *any* of the seven suggested benefits – from easier admission of people into care to reducing time spent on administrative tasks.[51]

The tracker should provide useful data for central government, CCGs, care providers and local authorities. If its current rate of usage can be sustained beyond the pandemic, it has the potential to reduce the time and cost of hospital discharge.

- **The government should work with providers and their representatives to identify how Capacity Tracker can be most beneficial, and ensure that providers have the necessary hardware and training to make best use of the app. The government should also explore whether a capacity tracker to track demand and capacity in homecare providers would be useful.**

Providers and service users have made much greater use of technology to communicate

The pandemic has sparked considerable innovation in the sector's use of digital technology. This has aided communication between different organisations and staff, with service users, and between service users and their families.[52] The best of these initiatives should be widely adopted after the pandemic.

A variety of secure email and videoconferencing initiatives were launched between local authorities and care providers within their jurisdiction, and between different local authorities. Some of these were extremely simple. For example, one local authority set up a single WhatsApp group with all the providers in its area to streamline communication. In another instance, a council created a shared email inbox which provided a single point of contact for social care providers to the local authority. This streamlined communication between the two and saved time for providers, who do not need to spend time establishing and maintaining contact with individual people in local authorities.

A more complex innovation has been an initiative in the east of England where 11 local authorities collaborated to use the same platform to collect and share adult social care data for a comprehensive overview of adult social care across the region.[53] Using a single platform has made data sharing much easier and allowed the local authorities to 'broadcast' the same questions to providers, making it easier to compare feedback between different local authorities.[54] These local innovations have been supported by national programmes such as the NHS Digital Social Care Programme and the Social Care Data and Cyber Security Programme, which match the funding from individual councils.[55]

There have also been national efforts to improve communication, through the fast-tracked rollout of NHSmail – which enables secure communication between health and social care services – and waiving certain requirements, allowing care providers free access to Microsoft Teams videoconferencing technology.[56]

Most providers said that secure email and videoconferencing led to better infection control by replacing what would normally have been in-person contact between professionals with online communication instead. This should have wider benefits in normal times by speeding up communication between local authorities and providers.[57]

Technology has also delivered benefits for staff interacting with service users, enabling flexible and efficient remote assessments. In some areas, social workers and occupational therapists have been able to spend more time online with patients and less time travelling.[58] The government-sponsored TechForce19 challenge – which encouraged technological innovation to support vulnerable people – attracted more than 1,600 bids and included app ideas to support isolating people, checking on the elderly and supporting carers. Eighteen bids – including one to identify health risks and deterioration in the elderly population – received funding of up to £25,000 each.[59]

Lockdown and social distancing requirements, including closing care homes to visitors, led to an increase in the use of technology such as iPads and videoconferencing to keep service users in touch with their friends and family. This has been facilitated by the provision of hardware which, in many local cases, was funded charitably, such as an appeal for second-hand tablets by a care home in Aylesbury[60] and the donation of more than 100 iPads to care homes from Wigan Council.[61] This accelerated existing efforts to introduce more technology in care homes. There had, for example, already been several initiatives trialling iPads for dementia patients.[62] There have also been innovations in the use of technology for entertainment, ranging from online yoga to 'Coronavirusfest' (a live music festival on Facebook),[63] which provided a partial replacement for otherwise cancelled services.

Greater use of technology in adult social care has been a success during the crisis and could improve care in normal times. But this depends on whether the government, local authorities and providers invest to embed technology into everyday life. But it is not just about buying tablets: staff and service users will need adequate training to ensure the most vulnerable individuals can access and use technology safely.

- **The government should commission an independent review – like the Topol Review for technology in healthcare[64] – to assess how to prepare social care to make greater use of digital technology safely and effectively. If the government wants to maximise the potential of technology, it will also need to provide sufficient funding for local authorities and care providers to purchase appropriate hardware.**

Central government eased statutory social care duties on local authorities

At the beginning of the pandemic, the government passed emergency legislation – the Coronavirus Act 2020 – containing a range of measures to support public bodies to respond to the crisis.[65] For adult social care, the Act gave local authorities the option, where absolutely necessary, to streamline and prioritise care in four ways:

1. Suspending the need to carry out detailed assessments of people's care and support needs in compliance with the pre-amended Care Act 2014

2. Suspending the need to carry out financial assessments in compliance with the pre-amended Care Act 2014

3. Suspending the need to prepare and review care and support plans in compliance with the pre-amended Care Act 2014

4. In the event local authorities cannot meet all eligible needs, they have the powers to enable them to prioritise the most pressing needs and to temporarily delay/reduce other care provision.[66]

Before ceasing any care assessments or temporarily delaying or reducing other care provision using easements in the Coronavirus Act, local authorities had to notify the Department of Health and Social Care (DHSC). While local authorities welcomed the flexibility the Act created during the pandemic, disability charities and campaigners were concerned that the easements would result in restricting care to some of the most vulnerable adults.[67] The quick passage of the Act, which provided limited scrutiny of wide-ranging measures, intensified these concerns.

In practice, however, local authorities have used the emergency easements sparingly – only 12 local authorities have done so.[68] Even at the height of the pandemic in April just eight local authorities were using easements; by the end of July none was.[69,70] They were widely seen as a last resort when either staff shortages or demand placed an immediate, unmanageable burden on local authorities.[71] Instead, local authorities found other ways to manage demand by using volunteers, retraining local authority staff or moving staff from other areas.[72]

- **The government should evaluate whether the Care Act 2014 has sufficient provisions for easements in an emergency, and if not, subject any proposed amendments to proper scrutiny by parliamentarians, local authorities and service users.**

It should not rely on fast-tracked legislation. Proper scrutiny would ensure that those who would use or be affected by easements were familiar with the worst-case scenario before a crisis and give confidence to service users that easements would be enacted fairly based on established procedures rather than non-legally binding guidance.[73]

Some local authorities and providers have worked together more collaboratively

The pandemic has seen an increase in communication and collaboration between some local authorities and care providers, from directly providing PPE,* to facilitating training, guidance and engagement between providers, primary care and other community services.[74] Collaborative working was encouraged by the Infection Control Fund, which explicitly stated that local authorities could not exclude providers whom they did not have contracts with.[75] This required councils to build relationships with providers that they did not normally deal with, and is likely to improve future planning because, as one council chief executive told us: "Before the pandemic there was no reason why we [the council] would know about a provider if it only served self-funders."[76]

The experiences during the pandemic provide an opportunity for longer-lasting co-operation in the future, even for those council–provider relationships which have been historically less co-operative. We heard from one local authority chief executive who said that they had had more 'thank you' letters from care providers during the pandemic than in the previous 10 years.[77]

- **Local authorities and providers should review the barriers to closer co-operation both before and during the pandemic and consider how they can work together more effectively during a second wave this winter and beyond. These discussions should inform contingency planning through LRFs.**

Conclusion

Adult social care has suffered from immense disruption during the pandemic. All organisations involved in regulating, funding and delivering social care have made major changes at speed to respond to coronavirus. Some changes have been so beneficial that they should be kept in normal times. Widespread use of the Capacity Tracker app has provided central government, local authorities, NHS trusts and providers with useful data on capacity and the government should explore whether it is possible to create a capacity tracker to track demand and capacity in homecare as well.

Greater use of technology has also improved communication between local authorities, providers and the families and friends of service users – and provided real comfort to the service users themselves at an unimaginably difficult time. The government should commission an independent review – like the Topol Review for technology in healthcare[78] – to assess how to prepare social care to make greater use of digital technology safely and effectively in the future.

* Which more than 90% of local authorities have done for residential and domiciliary care providers.

4. Schools

Coronavirus created unprecedented disruptions for schools in England. Most importantly, face-to-face teaching ceased for all but children of key workers and those deemed vulnerable. In response, schools turned to remote learning and the government has provided additional funding to help them manage the impact of the pandemic.

How have schools been disrupted by coronavirus?

Schools have incurred extra costs and lost income

Schools[*] have had to absorb additional costs during the pandemic. They recruited extra supply teachers to manage staffing pressures before the national lockdown, delivered free school meals to eligible students not in school and bought additional cleaning services to reduce transmission of the virus in the summer and autumn terms.[1] According to a National Foundation for Educational Research (NFER) study conducted in July, the worst-hit primary and secondary schools in England faced average costs of £280,000 and £720,000 respectively to cover spending on staff and cleaning costs to reopen in September.[2]

Schools have also lost most of the income they had from catering or hiring out space. In 2018/19, this income represented around 5% of local authority-maintained and academy schools' total funding.[**] This, though, is balanced out at least in part by schools making some savings on regular costs such as paying utility bills or supply teachers during lockdown.

The Department for Education (DfE) set out financial support measures in early April to enable schools to claim back legitimate Covid-19-related spending incurred between March and July.[3] This included spending on building costs (for example, if schools stayed open for vulnerable children during the holidays); free school meals (where costs were incurred before the government introduced its voucher scheme or where the scheme did not apply); and extra cleaning to support infection control.[4] Depending on their size, schools could claim between £25,000 and £75,000. The window for sending a claim for these costs closed on 21 July, by which point nearly 60% of schools – 14,075 – had submitted one.[5,6] The Education and Skills Funding Agency reimbursed maintained schools (through local authorities) and academies between late August and early September 2020.[7]

SCHOOLS

* This chapter focuses on primary and secondary school pupils aged 5–15 in schools managed by local authorities or in academies (which have greater control over admissions, budgets and curriculum) in England. This excludes special schools, pupil referral units, independent schools, or 16–18 education such as sixth form.

** To estimate these percentages, we added the total revenue for local authority-maintained schools and for academies (including government grants and some types of income, but excluding donations), and calculated what proportion of total income is derived from contracts, rental, catering or other activities to generate income. We have excluded income from insurance claims for locally maintained schools and from capital and revenue donations in academies.

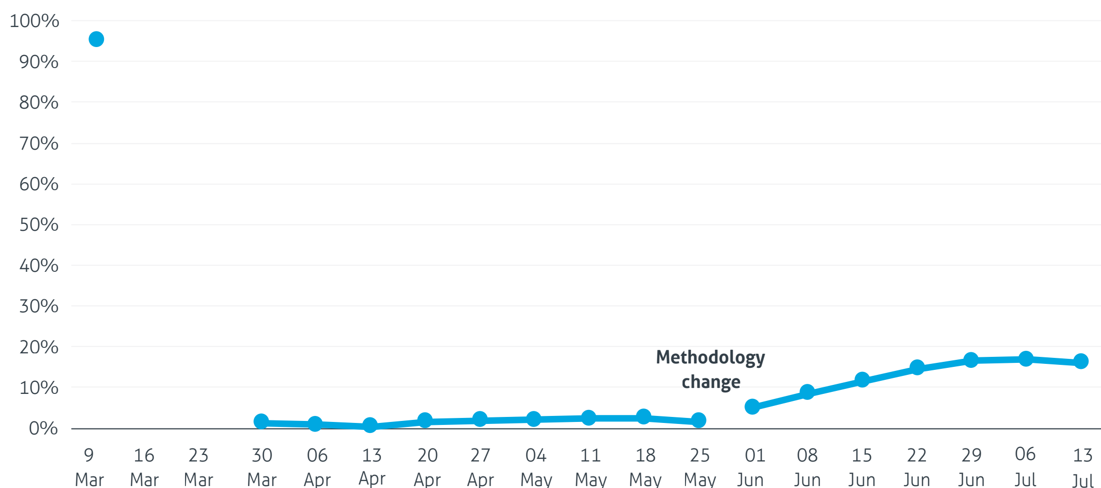
The financial support provided by the government does not cover all costs incurred by schools, and some will be left out of pocket. There are particular risks for some schools that earn additional income from venue hires and other sources as the government has said that it will not replace this.[8] Furthermore, the government has not yet provided details on which costs associated with reopening schools in September can be reclaimed.[9]

The number of children in school fell sharply

On 18 March 2020 the government announced that schools and colleges would close two days later for all but children of key workers and vulnerable children (children with a social worker or with an education, health and care plan).[10,11] On the same day, government cancelled national exams including GCSEs, AS and A levels.[12,13]

DfE expected that around 20% of all pupils would continue to attend school.[14] Yet in April and May as little as 2% of all pupils were still attending, although this figure increased after June (though never to the 20% level expected). Few vulnerable children attended, but again the proportion gradually increased, from 2% to 10% – although the department notes this could be an underestimate.[*,15,16]

Figure 16 **Percentage of pupils attending schools in England between March and July 2020**



Source: Institute for Government analysis of Department for Education, Attendance in education and early years settings during the coronavirus (Covid-19) outbreak & Pupil absence in schools in England: 2018 to 2019.

SCHOOLS

The sharp decline in physical attendance also led to a decline in how much time children spend learning. Primary and secondary school pupils spent an average of five and six hours respectively per day at school – including breaks – before the pandemic. By late April and early May, estimates put the time spent on learning activities at

* Some schools recorded the number of children of critical workers who either have an education, health and care plan (EHC) or a social worker, but they did not include these children when counting the number of vulnerable children. The DfE therefore warns that it likely underestimated the number of vulnerable children in school, but that the actual figure is within 5% of this estimate.

between just one and five.* This appeared to improve throughout the summer[17,18] but varied depending on pupils' backgrounds, with children from lower-income families less likely to spend time on home learning.[19]

School care services were stopped or severely reduced

The pandemic also caused disruptions to other school services such as breakfast and after school clubs. Partly because they rely on fees paid by parents rather than government funding, many clubs closed on 20 March. Although government-funded breakfast clubs kept running in some areas,[20] only around 11% of all breakfast clubs remained open during lockdown, mainly to cater for vulnerable children or children of key workers. Around 80% of clubs used the government's furlough scheme for their staff.[21] To balance safety with the financial sustainability of running the clubs, government guidance asked providers to stick to groups of 15 or fewer children in the autumn term, although several groups of 15 could meet in a single venue while distanced.[22] Many clubs were concerned about the financial sustainability of reopening, and around 60% told the Out of School Alliance they might need to close down permanently in the next three to six months if attendance was slow to return to pre-coronavirus levels.[23] This in turn will likely have an impact on parents' ability to return to work full-time.

Other care services were also affected. In 2018/19 schools made around 20% of referrals to children's social care services.[24] Fewer pupils attending school in person almost certainly resulted in schools making fewer referrals. Partly because of this, many local authorities reported a fall in referrals of up to 50% in the early stages of the lockdown.

Schools had enough staff to teach face-to-face during lockdown but may struggle now pupils have returned

Schools faced workforce problems in early March when many teachers were ill or self-isolating.[25] However, staffing pressures diminished once schools closed during lockdown, and over 50% of teachers reported working less or much less than usual in March and April.[26] By May, schools had around 75% of their normal full-time equivalent teaching capacity according to the NFER – although around 30% of teachers could only work from home.[27]

However, schools could struggle to meet demand now that pupils have returned. In the first week of September, 92% of school heads reported attendance of 81% or higher.[28] Many children in England have missed between a third and half of an academic year's worth of in-person education. Providing continued support to pupils who have fallen behind during the lockdown is likely to place additional burdens on teachers.[29]

SCHOOLS

* The five hours estimate from the Institute for Fiscal Studies may overestimate actual time spent doing work which is comparable to what children would have done at school because it includes learning activities which are separate from schoolwork, such as primary school children reading. Also, this estimate is based on parents reporting that their child did 'at least some' of these activities for an hour, but does not mean that the child spent an entire hour on them. See Green F, 'Schoolwork in lockdown: new evidence on the epidemic of educational poverty', LLAKES Research Paper 67, UCL Centre for Learning and Life Chances in Knowledge Economies and Societies, 2020.

Teachers and pupils are required to self-isolate if they have been in close contact with people who have tested positive.[30] Even if schools can use supply teachers to cover staff absences, their capacity will be stretched if a sizeable proportion of classes are both at home and in schools, rather than the majority being one or the other. Back in May, more than half of the senior leaders in primary and secondary schools felt unprepared to deal with both face-to-face *and* online teaching if not all pupils are in school at the same time.[31] Some schools are planning to teach classes of up to 60 to make up for potential staff shortages.[32]

What changes have schools made to manage the crisis?

Schools largely shifted towards remote learning

Schools had to find ways to teach remotely after closing buildings. Many set up live, online lessons but the majority prepared 'offline' teaching materials such as worksheets or recorded videos.[33] DfE provided some support to make this possible. From 17 April, it published guidance on teaching during the pandemic including examples of best practice.[34,35] The department also gave funding to Oak National Academy – an online school developed by a group of teachers which launched on 20 April[36] – and partnered with the BBC to launch the corporation's largest ever education package (comprising 14 weeks of online and TV material).[37,38]

The academic evidence on the effectiveness of remote learning is quite limited. A review of international academic evidence by the Education Endowment Foundation found that the quality of teaching is more important than how lessons are provided, with both live lessons and pre-recorded videos working well if properly structured. It also found that pupils, particularly disadvantaged ones, benefit from support to work independently at home, and that different approaches to remote learning are necessary depending on the content taught and the task pupils need to complete.[39]

Interviewees told us that the quality of online teaching varied substantially between schools but there have been no systematic evaluations of performance during the period when most pupils were learning from home.

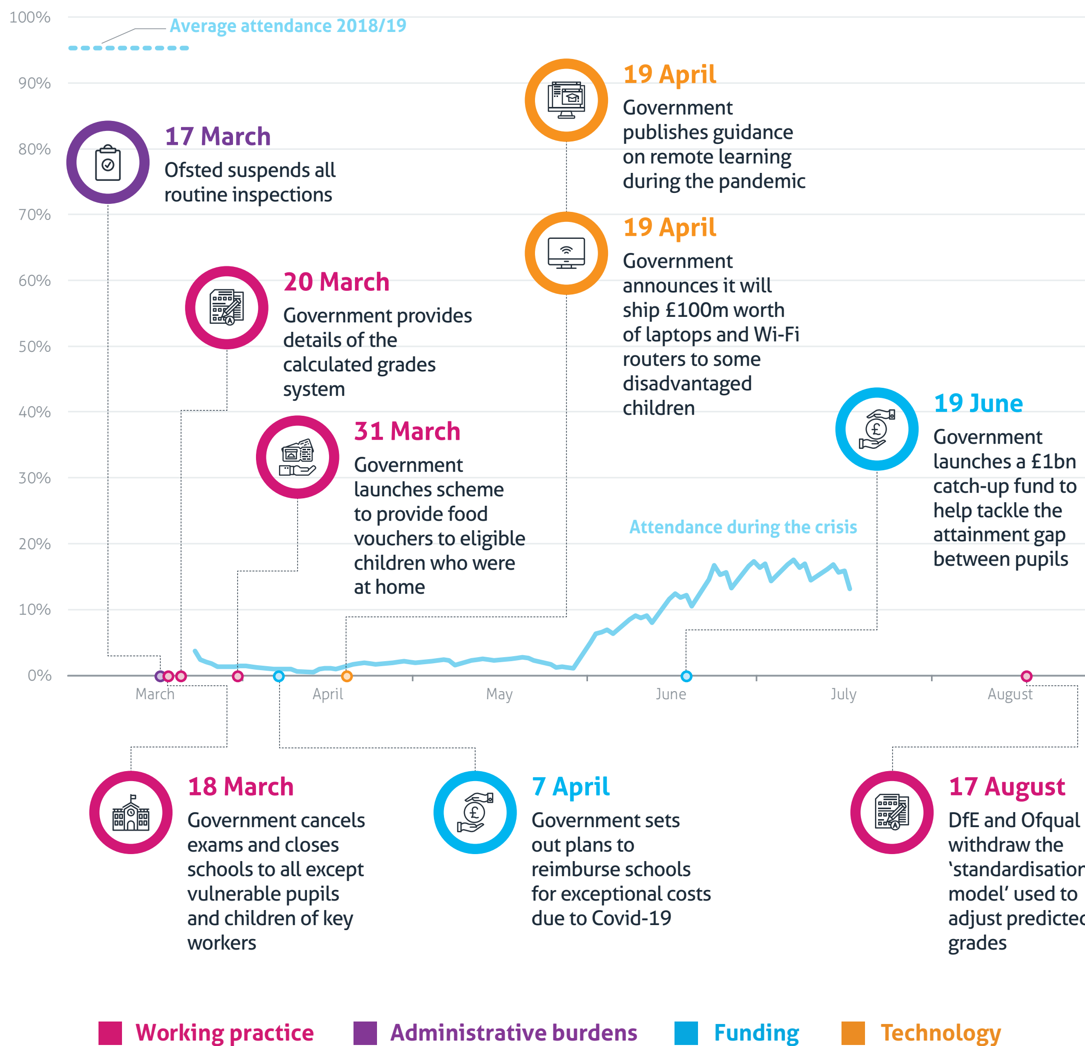
Children have now largely returned to school but the government expects schools to be able to offer immediate remote education if pupils have to remain at home.[40] With infections rising, pupils forced to self-isolate if they are in close contact with someone with a confirmed infection, and the likely prospect of further local or national lockdowns, remote teaching will continue to be important while the crisis persists.

- **The Department for Education, in partnership with Ofsted, should assess the quality of remote learning to date. It should also continue identifying and sharing best practice as new evidence becomes available, and work with multi-academy trusts, unions and others to ensure that teachers are able to best support those learning from home during the crisis.**

Remote learning requires that all pupils have access to technology.[41] Unfortunately, to date, government efforts have generally been a case of too little, too late. DfE announced on 19 April that it would ship £100m worth of laptops and Wi-Fi routers to disadvantaged Year 10 pupils, children and young people with a social worker,

and care leavers.[42,43,44] Yet, this was a month after schools were closed to the majority of pupils[45] and most of the equipment only began shipping in late May, nearly two months after most children had their last face-to-face lesson.

Figure 17 **Timeline of changes made to schools**



Source: Institute for Government analysis.

By mid-June less than 50% of the equipment had been shipped, with 90% delivered only by the end of that month.[46,47] Even then, equipment has largely only been provided to Year 10 pupils, "a tiny proportion of the children who don't have access to technology".[48] School leaders surveyed by the NFER in June and July estimated that more than a quarter of pupils had limited access to technology at home. The lack of equipment was a particular problem in deprived areas.[49,50]

It wasn't until early August that the government widened the scheme to disadvantaged pupils in Years 3–11 and published guidance on when laptops can and cannot be ordered.[51] For instance, schools can't order laptops for disadvantaged children who are self-isolating due to coronavirus in secondary schools where there are fewer than 15 pupils self-isolating and no broader recommendations have been issued to the bubble or year group these children belong to.[52]

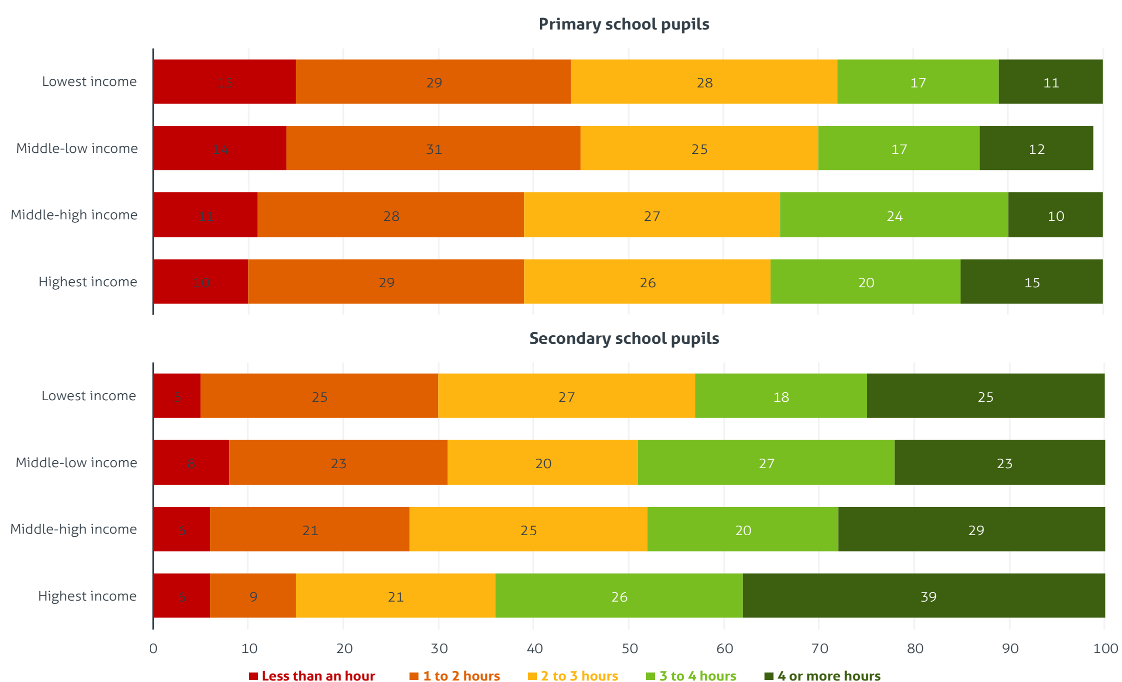
In early September, DfE awarded a contract to provide another £27m worth of laptops and devices to children up to March 2021.[53] Yet, at the end of October some schools reported that their allocation of laptops for disadvantaged students had been cut by 80%.[54]

Interviewees told us that local authorities, who have more knowledge of schools in their community, could have delivered laptops more rapidly if government had sent them money directly to procure laptops locally.[55] Some partnered with local companies and charities to provide refurbished laptops to pupils.[56]

Differences in access to technology and lower engagement with online learning among disadvantaged pupils compared to better off pupils could result in a widening attainment gap.[57,58] There was no difference in how much time richer and poorer primary school pupils spent on educational activities before the pandemic. During lockdown, however, wealthier students spent around 75 more minutes a day – 31% longer – on educational activities than the least well-off pupils.[59] Evidence from the literature on the impact of closures suggests that the attainment gap may have widened to as much as 75% between March and September.[60] However, these estimates are uncertain (the lower end of the above range was 11%) and vary widely across studies, which examined disruptions to schooling in very different contexts from Covid-19.[61,62]

- **Given the government's goal to prevent disadvantaged children from falling further behind during the crisis, it should provide additional funding so that every child who needs a laptop, router or other technology to properly access remote learning can have them.**

Figure 18 **Daily time spent on schoolwork by pupils' background, April 2020**



Source: Institute for Government analysis of National Foundation for Education Research, Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study.

Government plans to tackle the attainment gap through extra tuition

On 19 June the government announced a £1 billion 'catch up' fund to help tackle the attainment gap between pupils, which had likely grown during lockdown. This is in addition to the existing £2.4bn annual pupil premium funding which continued to be paid to schools.[63] The government pledged a £650m one-off universal catch-up premium grant to schools for the 2020/21 academic year. It also set up a £350m National Tutoring Programme for disadvantaged and vulnerable pupils. This will offer tuition partners to children aged 5–16 and academic mentors trained by Teach First to disadvantaged 16–19 pupils.[64]

Funding to enable pupils to catch up on missed education is a sensible long-term investment. The short-term effects of disruptions to schooling can be minimal.[65] However, others have suggested that missing out on schooling could result in children earning 2–2.5% less later in life and having a higher probability of being unemployed and in poverty.[66,67]

The funding should provide a welcome boost to schools' efforts to support pupils. Some of the approaches schools can spend this funding on, like one-to-one tuition and tuition in small groups, can enable pupils to make substantial academic progress.[68,69] However, the catch-up premium grant does not take levels of local deprivation into account, with all schools receiving the same amount per pupil.[70] The total funding is equivalent to just £80 per pupil and would cover little more than 10% of a teaching assistant's salary for a class of 30.[71]

The National Tutoring Programme has also faced criticism. It should reach 1m pupils, but this is far less than the 4m children in England who live in poverty and could need additional support.[72,73] And because tutoring organisations need to recruit and train staff, the programme won't be available to schools until November.[74] Finally, some academic mentors for disadvantaged schools will have only had one to two weeks' training.[75] It may have been more effective to give money directly to schools or to double the pupil premium – designed to help schools improve disadvantaged children's attainment – so they can arrange their own catch-up programmes.[76]

- **The government should evaluate how effective these measures to help pupils catch up on lost learning are, and whether they could be delivered more effectively. It should also consider whether to extend them beyond the coronavirus crisis.**

Every summer many pupils experience 'summer learning loss', which some evidence shows can lower their test scores and causes less-advantaged pupils to fall behind by several weeks in particular subjects compared to their better-off peers.[77,78] Coronavirus threatens to be a longer-drawn-out version of this, and the government may need to act to avoid this generation seeing the attainment gap widen substantially.

Government funded free school meals for eligible children at home

To prevent vulnerable children from going hungry during lockdown, some schools prepared meals or food parcels for their pupils for delivery or collection.[79] Not all schools were able to do so, and on 31 March the government announced the details of a scheme to provide food vouchers to eligible children* who were at home.[80] It provided every eligible child with a £15 weekly shopping voucher to spend in supermarkets during school closures. By late April, about 45% of schools – 11,000 – had signed up, and interviewees told us that by July nearly all schools had registered for the scheme.[81] Over £380m worth of vouchers had been redeemed by mid-August.[82]

The government extended the programme to provide vouchers during the Easter holidays and – following a campaign from charities, MPs and footballer Marcus Rashford – the summer holidays.[83,84] To avoid the risk of legal action, the government also expanded the scheme to those with no access to public funds such as refused asylum seekers who are destitute.[85,86]

Providing food to children can be effective in tackling the attainment gap. Children who experience food insecurity (i.e. going hungry or missing nutrition) have lower cognitive test scores and learn more slowly than those who do not.[87] However, children who benefit from extra money for food or free meals are in better health, score higher on tests, and make more academic progress than those who do not.[88,89]

In practice, government and its supplier initially struggled to deliver the scheme. Government launched the scheme 13 days after it announced school closures, by which point some schools had already set up their own system.[90,91] It was the first time that government set up a scheme at this scale at such short notice. The supplier, Edenred, had some experience of delivering vouchers, but not at this scale, and was not prepared to deal with initial demand. This resulted in delays in getting vouchers to families. Witnesses to parliament and interviewees said that it had created a "nightmare for schools" whose staff had spent "inordinate amounts of time" accessing the system.[92,93] There is also evidence that families who are struggling because of the pandemic but not eligible for free school meals also missed out on food during lockdown.[94]

A key weakness in England appears to be the government's decision to push for a centralised voucher scheme. The Welsh and Scottish governments instead opted for more flexible approaches. They gave money directly to local councils, who were familiar with their communities' needs.[95,96] This enabled local councils to either use vouchers, partner with local charities and community groups to deliver meals, or to set up direct transfers to families' bank accounts.[97] This appears to have worked more effectively than the national voucher scheme in England, though the evidence on these schemes is relatively limited.[98,99]

* The scheme was only for pupils who receive free school meals based on their family's income (means-tested), and did not replace the universal free school meal programme for children in Reception and Years 1 and 2.

'Holiday hunger' was an issue for many children long before the pandemic.[100] At around £300m,[*] the cost of providing free school meals during the holidays in the school year represents only a fraction of the £45bn annual budget for schools.[101] Although the government has, at the time of publication, rejected calls to extend free school meals, it may change its mind again.

- **The government should examine the case for providing additional funding for free school meals during holidays on a permanent basis to combat holiday hunger and to improve pupils' performance. It should also consider whether there are more effective alternatives to a national voucher scheme for distributing money for food to families during future lockdowns.**

The government gave pupils calculated grades after cancelling exams

The secretary of state for education, Gavin Williamson, announced on 18 March that all exams for 2019/20 academic year would be cancelled.[102] Two days later DfE confirmed that students would instead be provided with calculated grades based on teacher assessments and a range of other factors.[103] In early April Ofqual, the exams regulator for England, announced that teachers would grade and rank their students, with these then going through a 'standardisation model' which would moderate grades based on historical data.[104]

The government's goal in providing calculated grades was to enable students to move to the next stages of their lives, including going to sixth form and university, despite the disruption caused by coronavirus.[105] It wanted Ofqual's approach to maintain a similar grade distribution as in previous years, so as to avoid grade inflation and be fair to previous and future cohorts of students.[106]

This approach was widely contested. Education experts and others expressed many concerns about Ofqual's model, which the regulator acknowledged.[107] Most problematic was the 25–50% chance that grades would not be accurate depending on the subject, with high-performing students in schools that traditionally did not perform well being penalised particularly harshly.[108,109]

On 17 August following weeks of intense public pressure that included pupils of all ages carrying out (socially distanced) protests in Westminster, the secretary of state announced that DfE would abandon the model and that pupils could retain whichever grade was higher between their teacher predicted grades or their previous, standardised, grades.[110]

But predicted grades are not a perfect solution, and can result in the grades of able students being under-predicted, those of less able students being over-predicted. They are also open to bias, particularly against pupils from minority-ethnic or low-income backgrounds, or who have special educational needs or disabilities.[111]

* This figure is calculated by multiplying the weekly cost of the vouchers (£15) by the number of children eligible for free school meals (1.4 million), multiplied by the 13 weeks of school holidays and the 5 days of teacher training run by schools (a total of 14 weeks). It assumes that all children who are eligible receive meals, although not all children who are eligible do normally receive them.

However, initial evidence suggests that using predicted grades did not increase the attainment gap between disadvantaged and non-disadvantaged pupils in achieving grade 4 or higher in English and maths GCSEs, and may even have reduced it a little.[112]

DfE and Ofqual have announced that exams will take place in 2021 three weeks later than usual to give students more time to prepare.[113] But the government must learn from this year's mistakes. In the absence of exams, there simply isn't enough information, either from teacher predictions or the past performance of schools, to fairly judge the performance of individual pupils.

- **If it is not possible to conduct exams, the government and Ofqual should work with the sector to consider other ways to assess pupils' performance. It should also evaluate the likely impact of these solutions on higher education admissions.**[114]

Ofsted temporarily stopped routinely inspecting schools

On 17 March, Ofsted received permission to suspend all routine inspections except where individuals had raised specific concerns.[115] This involved suspending its inspection powers under Section 5 of the Education Act 2005, which mandates it to inspect each school every five years.

The government intends for inspections to start again in January 2021, although it will keep the date under review. Meanwhile, Ofsted will conduct some visits – not inspections – in the autumn without awarding grades.[116,117] During these visits, Ofsted expects that inspectors will have "collaborative discussions" with staff on welcoming pupils back to school, how remote learning fits with their curriculum and how they are planning to spend the government's 'catch up' funding.[118] Ofsted will then write a brief outcome letter setting out findings from the visit, to help parents understand what is happening in their child's school.

It is too early to properly assess the impact of the temporary regime. Some headteachers reported having a positive experience of these inspections, though some unions have warned that the outcome letters would "feel like an inspection report" and could create pressure for schools during a busier than usual period.[119,120]

- **Ofsted should keep its temporary visits framework under review to ensure that it is working as intended.**

Once Ofsted inspections resume, they will assess the quality of education and examine how school leaders are using their new funding to ensure that all pupils are benefiting.[121] This inspection framework was introduced in 2019, following two years of consultation, and was only in operation for a term and a half before inspections were suspended.[122]

The framework aims to minimise the amount of data schools need to prepare in advance of inspections. It also looks "beyond data and test results" in favour of a focus on the curriculum, using more qualitative discussions.[123]

- **When inspections resume, Ofsted should keep collecting data on how well the new framework is working and assess its performance in consultation with the sector, taking into account any lessons from the operation of the temporary visits framework.**

Conclusion

The pandemic led to a seismic change in how pupils are educated. Most importantly, during the national lockdown, the vast majority of schooling took place remotely. While most children are now back in their classrooms, rising infections, requirements to self-isolate and the prospect of further lockdowns mean that remote teaching will continue to be key. The government must assess the quality of remote learning to date, provide further support to schools and ensure that children learning from home during the crisis have the necessary equipment to access lessons and teaching materials. It should also review the impact of free school meals in the holidays and catch up funding to help tackle the attainment gap in schools.

5. Criminal courts

Criminal courts have been affected as badly as any public service during the coronavirus pandemic due to the difficulty of delivering a courtroom-based service while maintaining social distancing. Despite the greatly increased use of remote hearings and other changes to working practices, the backlog of cases has grown dramatically, reaching record levels in the crown court.

How has coronavirus disrupted the criminal courts?

Demand for criminal courts fell

Criminal court* demand is determined by activity 'upstream' in the criminal justice system – namely, the number of crimes committed but, even more importantly, police activity to charge those crimes.** Coronavirus has affected both.

First, the lockdown and dramatic changes to our way of life have affected the volume and nature of crimes committed. Overall, crime numbers have been substantially down. In April and May, reported crime was almost a third (32%) lower than the pre-lockdown average, with especially large falls in theft offences.[1] At the same time, some other crimes have increased: drug offences[2] and reports of domestic violence have both risen.[3]

Second, police activity has changed. The police, along with the Crown Prosecution Service (CPS), have made greater use of out-of-court options (such as cautions) for less serious offences to reduce the number of cases entering the court system that would be subject to long delays.[4] Chris Philp, the minister for immigration compliance and the courts, was keen to emphasise that cases were not being "dropped for administrative convenience",[5] but alternative options have nonetheless been considered. The overall result has been a reduction in the number of cases entering the court system. Between the end of March and the end of August, the average number of new cases per week received in the magistrates' courts – the entry point to the criminal courts system – has been 40% down on the pre-coronavirus baseline.[6] Cumulatively, that amounts to over 300,000 fewer cases than the magistrates' courts would otherwise have expected to receive.

An even bigger fall in criminal court capacity

While a fall in demand has eased pressure on the courts system, its capacity has fallen even further. Social distancing requirements have made courthouses very difficult to operate in. At first, very few physical hearings took place at all. Physical hearings require judges, court staff, lawyers, witnesses and defendants to gather in person. In April, there were only around 350 hearings in person per day in the entire courts and tribunals system (criminal and non-criminal), compared with thousands in normal

CRIMINAL COURTS

* This chapter assesses the impact of coronavirus on the criminal courts in England and Wales.
** Police activity is more important than the number of crimes committed in determining criminal court demand because the police charge less than 10% of all reported crimes.

times.[7] As we outline below, virtual (video and telephone) hearings made up for part of the shortfall, but the number of hearings processed was much lower than the pre-coronavirus normal. In the crown court, the number of cases processed averaged 58% of pre-coronavirus levels between the end of March and the end of August; in the magistrates' the figure was just 41%.[8]

Most problematically, jury trials, which require 12 jurors on top of the aforementioned attendees, were initially stopped entirely. Jury trials account for less than 20% of cases processed in the crown court, which deals with the most serious cases, but over 75% of total crown court hearing time.[9] Jury trials have returned, slowly, but even in August they were running at 25% of their pre-coronavirus case numbers.[10]

This problem is not unique to England and Wales. Most court systems around the world have reduced court usage and paused jury trials.[11] However, the criminal courts system in England and Wales is in an especially vulnerable position because it tries a greater proportion of people by jury than most other jurisdictions. This is because any case where a sentence of greater than six months could be imposed can elect for jury trial – by comparison, in New Zealand trials are only held in cases with a maximum sentence of at least 48 months.[12]

Substantial growth in court case backlogs which are worse than the headline figures suggest

In the magistrates' courts, the backlog – the number of cases outstanding – at the end of August was 27% higher than before coronavirus, having fallen slightly through that month as capacity in magistrates' courts exceeded the lower-than-normal number of cases received. Aside from the levels reached in the previous six weeks, this is the highest it has been since at least 2012.

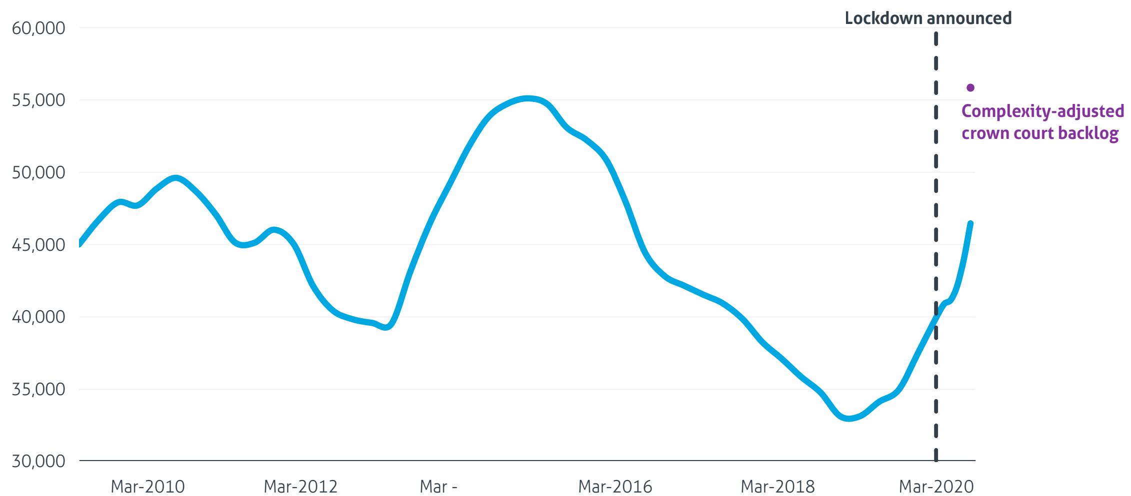
On the face of it, the numbers in the crown court do not look as bad. Initially during the crisis, the backlog fell slightly because the number of cases being passed through from the magistrates' courts fell and the crown court was still able to process simple hearings and cases. As cases entering the crown court have picked up, and with jury trials still running far lower than pre-Covid levels, the backlog has begun to increase rapidly. At the end of August, the official crown court backlog stood at 46,500[13] – 18% higher than before coronavirus, but less than the peak of 55,000 at the end of 2014.[14]

However, the raw number of cases in the backlog understates the scale of the problem. Jury trials are by far the most time-consuming cases to hear, and as Justice Secretary Robert Buckland acknowledged: "I accept that quite a significant number of the… cases that we now have will be resolved only by way of trial."[15] When accounting for the additional complexity, we calculate that the backlog at the end of August is equivalent to a backlog of around 56,000 cases* – far higher than the 44,000 average recorded since 2010,[16] and the highest backlog since at least 2000.[17] If this backlog were left unaddressed it would lead to waiting times** of 22.5 weeks for trial cases, also the highest on record.[18]

CRIMINAL COURTS

* See the methodology for details on how this was calculated.
** The time between when a case is first received in the Crown Court from the magistrates' to when the case reaches its conclusion.

Figure 19 **Crown court case backlog**



Source: Institute for Government calculations using Ministry of Justice, 'Criminal court statistics: January to March 2020' and HM Courts and Tribunals Service, 'Weekly management information: September 2020'.

And this backlog is still growing. It increased by 2,500 in less than a month, between 26 July and 23 August.[19] The HM Courts and Tribunals Service (HMCTS) recovery plan[20] intends for jury trials to reach pre-Covid levels in November, but that suggests that we can expect the backlog to continue to grow until then. Even that plan may prove infeasible if lockdown restrictions are reimposed, for example if the government returned to blanket two-metre social distancing (as opposed to the current 'one metre plus' used in places of work and business), or again closed courthouses.

HMCTS has incurred substantial additional costs

To deal with the disruption caused in the criminal courts, HMCTS has been provided additional funds. While courtrooms have been closed, staff have still been required and additional capital spending has been needed to implement physical changes to existing courthouses and create new space in which to hold trials. In June, the Ministry of Justice (MoJ) committed £142m to the HMCTS capital budget, of which £105m was invested in the court and tribunal estate, to make physical changes to the court estate in light of coronavirus and to support the implementation of technology.[21]

On top of this funding, the government has announced an extra £80m of resource spending as part of its recovery plan for the criminal courts announced in September to reflect increased running costs, the need to hire additional staff and adaptations to courtrooms.[22]

Legal aid lawyers have seen a sharp drop in income

One saving for the MoJ related to the criminal courts has been on legal aid (means-tested support for those who cannot pay for their own defence). The amount of legal work for solicitors and barristers has fallen substantially, and so legal aid payments have also fallen. This saving is likely to be temporary as the cases will be processed eventually, but in the short term it has created a cashflow crisis for legal aid solicitors and barristers.

Even before the crisis, lower activity in the criminal courts and lower fees announced in 2012 meant legal aid solicitors and barristers had been struggling. Criminal legal aid spending fell by 35% between 2011 and 2019, and the number of duty solicitors fell by 29% between 2016 and 2019.[*,23]

From this low base, there was a 75% fall in criminal legal work at the height of the pandemic and some solicitor firms have announced cuts or suspensions to partner pay.[**,24] Barristers are also facing difficulties: 69% of publicly funded barristers reported in April that they could not survive financially beyond October.[25]

The major concern is that this short-term disruption will become a long-term problem if firms go bust and barristers leave criminal work and move to other areas of law. It would then be much more difficult to ramp up court activity again because the legal profession's capacity is crucial for such an increase to be possible, and long training times for solicitors and barristers mean that it would be difficult to train new criminal lawyers quickly.

What changes have been made to criminal courts to manage the crisis?

The government has rapidly increased the use of remote hearings

Lockdown and ongoing social distancing requirements drastically reduced the number of hearings that could take place in person. In response, the government substantially increased the use of remote hearings in criminal courts.

Although the courts already had powers to make use of technology, the Coronavirus Act 2020 extended these, amending existing legislation to allow partial or full video and audio hearings in criminal proceedings, and allowing the live streaming of remote hearings so that the public can see and hear them.[26]

Criminal courts have made use of both off-the-shelf software packages and bespoke technology.[***] Increasingly, hearings are taking place using the new cloud video platform (CVP). CVP enables users to securely access the existing justice video system connecting courts to police stations and prisons from any internet-enabled device with a microphone and camera. The first cases were heard using CVP in April and the system was initially rolled out to 60 magistrates' courts and 48 crown courts.[27] As of 1 September, CVP had been implemented in 147 magistrates' courts and 73 crown courts.[28]

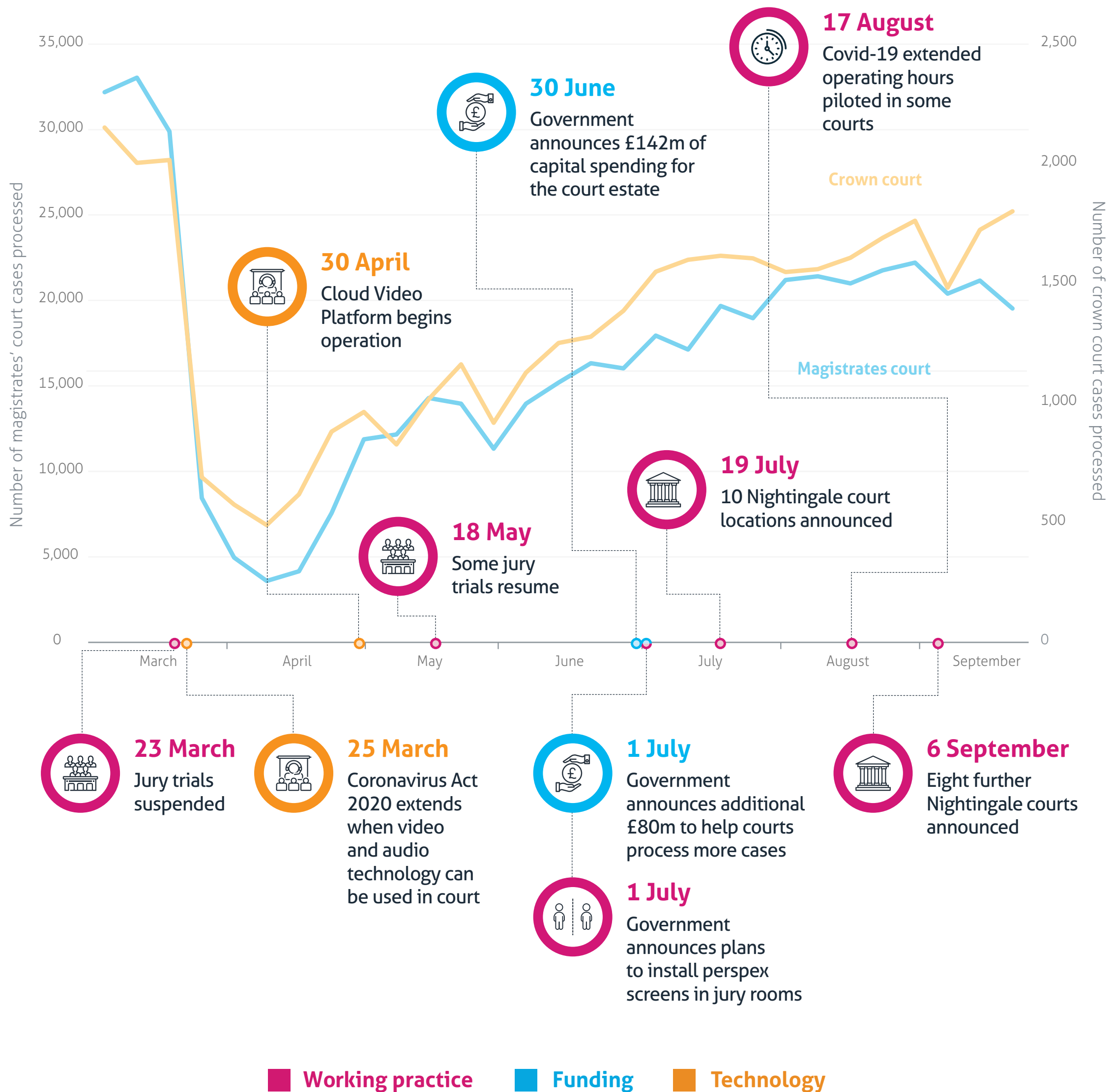
CRIMINAL COURTS

* This reflects the lower number of cases being processed in the courts as well as lower payments for work completed.

** The Coronavirus Job Retention Scheme was available to solicitor firms for employees earning less than £50,000, but not for partners who are taxed as self-employed.

*** HMCTS has approved the use of BTMeetMe for teleconferences and Skype for Business for video conferences, though interviewees told us that other systems such as Microsoft Teams are also being used in different parts of the country.

Figure 20 **Timeline of changes made to criminal courts**



Source: Institute for Government analysis.

These changes represent an acceleration of existing reforms.* Section 28 of the Youth Justice and Criminal Evidence Act 1999 allowed pre-recorded cross-examinations for vulnerable victims. However, at the start of the crisis, this system was operating in just 18 crown courts. In August it was implemented in a further 16 crown courts and it is due to be rolled out to all remaining crown courts by the end of 2020.[29]

Since 2016, HMCTS has been implementing a major – but delayed – reform programme in courts, with the intention of using new technology to modernise and streamline processes.[30] But while this included trialling the use of video remand hearings, widespread concerns in the judiciary and legal profession about the impact of remote technology on the quality and openness of justice meant that

* While the use of remote hearings has been accelerated by coronavirus, other important reforms have been delayed. The Common Platform – a digital case management system that allows all those involved in criminal cases to access relevant information – was meant to go live in March. While it would have provided very useful information for the government during the crisis, implementation had to be pushed back as those working on it were redeployed to quickly roll out other technology, including CVP, which was needed immediately to deal with the crisis.

final decisions had not been made about the circumstances under which it would be appropriate to use it. While these worries remain, the crisis, and the delays to justice that have resulted, meant concerns became less pressing in the short term, allowing more rapid agreement between the government, judiciary and legal profession about the use of remote hearings.

In terms of the number of cases processed, greater use of remote hearings has been a success.[*] On 23 March, 550 court or tribunal hearings used video or audio technology. Two weeks later, the figure stood at more than 3,000, accounting for around 90% of the total cases processed.[31] While the backlog of cases has grown substantially in both the magistrates' and crown court, the situation would have been much worse without remote hearings.

Interviewees unanimously agreed that video and telephone technology work best for routine administrative hearings. The change has been particularly beneficial for less senior barristers, who might otherwise be required to travel for an hour or more each way for hearings that last less than 10 minutes, and for barristers with caring responsibilities.[32] In a Bar Council survey, 68% of barristers stated that they would welcome targeted use of remote hearings in future.[33]

However, poor internet connections, unreliable technology and a lack of user familiarity with the new systems have meant that remote hearings have not always proceeded smoothly,[34] particularly in less well-resourced lower courts. We were told that hearings tend to take longer when conducted remotely, and that this can be particularly frustrating for judges, some of whom feel that face-to-face hearings are much more efficient. Part of this reflects a 'bedding in' process as people adjust to using the technology, and it may be that remote hearings will be more efficient in the long run.

One important unresolved question is over whether and to what extent remote hearings affect the quality of justice. Here interviewees raised two main concerns.

First, lawyers we spoke to felt that remote hearings work particularly badly for vulnerable defendants. We were told that many do not grasp the importance of proceedings without physically having 'their day in court' and that much of what happens 'may go over their heads'.[35] These issues are exacerbated by the second problem: that remote trials make it harder for lawyers to brief their clients and to explain what is happening during proceedings. Partly this is due to limitations with the software used, which currently does not allow communication as easily as in-person hearings. We also heard that, at the start of the pandemic, lawyers were struggling to communicate with clients before and after trials, largely due to limited access to video facilities in prisons, but that this has improved since.

* Decisions and when and how to use remote hearings are made by judges, or magistrates and legal advisers. Interviewees said there was substantial variation across the country in how they were being used, with one calling it "incredibly inconsistent".

There remains a paucity of evidence on these issues, which means that we cannot assess how widespread these problems are, or whether they can and have been mitigated.[*,36] Since the crisis began, there have been rapid evaluations of technology in civil[37] and family[38] courts but not criminal courts. The burden of proof, when introducing new technology, should be on those promoting the technology to show that any negative effects on the quality of justice can be mitigated or are outweighed by other benefits. This has not yet happened.

Some of these problems can be resolved with greater investment. The government has already committed £142m to improve more than 100 courts, which will include enabling 750 more courtrooms to conduct remote hearings.[39] A further £20m has also been announced for improving videoconferencing facilities in prisons.[40] This will help, but may not be sufficient given historic underinvestment in the criminal justice system. Indeed, in October the National Police Chiefs' Council announced that police forces would no longer use virtual remand hearings due to a lack of funding.[41]

- **The government should thoroughly evaluate the impact of remote hearings on the quality of justice.**

While the rapid expansion of video and telephone technology was justified by the difficulties caused by coronavirus, that does not mean that they should be used as extensively once more cases can be heard in-person. They should proceed with evaluation as they would have in the courts reform programme.

- **Any decisions about the future role of technology should be made in partnership with the legal profession. Victims and defendants should also be consulted.**

Interviewees both in government and the legal profession told us that there had been far more collaborative working between the two during the crisis.[42] It is essential that these relationships are maintained. Victims and defendants should also be consulted, and the lord chief justice has already said that "when we are back into normal times, nobody will be forced to use digital engagement with the courts if they are not able to do so".[43]

HMCTS made changes to the court estate

During May, HMCTS moved from emergency response to recovery and by September had reopened most court buildings.[44] However, ongoing social distancing requirements dramatically reduced the volume of cases, particularly jury trials, that could be heard. To mitigate this problem, HMCTS made physical changes to existing courthouses and created new space in which to hold trials.

[*] A pre-coronavirus evaluation of the Video Enabled Justice programme, which trialled the use of video technology in criminal courts, found that defendants were less likely to have legal representation and more likely to receive custodial sentences, as well as problems with lawyer-client confidentiality, but the methodology underlying that study has been contested by the government, among others.

On 1 July, HMCTS set out plans to install screens and make other modifications to existing courts,[45] for example using signs and floor marking to create one-way systems in courthouses.[46] The government is also adding portable or modular buildings to existing courthouses so that these can be used as public waiting rooms or jury rooms.[47]

Most substantially, the government announced that it would use alternative venues as courts – so called 'Nightingale courts'. On 19 July, the government announced the locations of 10 Nightingale courts and confirmed that the first hearings would take place in these the following week.[48] On 6 September, HMCTS announced that it would open eight further Nightingale courts in September and October. Together these 18 courts should provide 30 courtrooms.[49] These are being used primarily for civil and family work, but also for non-custodial criminal cases, due to the expense of providing secure docks and cells in these temporary facilities. However, the Nightingale courts will free up additional space in the existing estate for crown court trials,[50] though more may be created as the justice secretary, Robert Buckland, stated in late July that "quite a few dozen of these courtrooms will be necessary".[51]

The decision to open new courts (temporarily) reverses the trend since 2010, during which time 162 of 323 magistrates' and eight of 92 crown courts closed.[52] The decision to close courts was driven by funding cuts and justified on the basis that more work could be completed outside court and that the number of cases received by courts had fallen.[*] These closures have long been criticised by the legal profession and interviewees pointed out that far more socially distanced trials could have taken place had more courts remained open. However, this would have entailed additional costs and before the crisis the low number of cases being heard meant that even the reduced court estate was not being fully utilised.

HMCTS has made changes to court operating practices

In addition to physical changes to courts, the government has altered working practices to enable cases to be tried safely.[**] This has included staggering start and finish times for hearings, requiring people to wear face coverings, restricting the number of people in public galleries and co-ordinating when people can enter and leave courtrooms so as to avoid overcrowding in communal areas. Jury trials are also now being conducted using multiple courtrooms so that there is sufficient space for court staff, juries, the public and media to remain socially distanced.

More controversially, the government is testing a new COVID Operating Hours model. In the magistrates', this involves the use of three sessions per day, leading to an extra 15 hours of sitting time per week, while many magistrates' courts are also sitting on Saturdays. In the crown court, two four-hour sessions are used instead of the normal single six-hour session. This is being trialled alongside a court with standard operating hours, so that cases can be listed in the usual way if the amended operating hours

* Since then, the number of cases received by the courts has fallen, and the Single Justice Procedure has meant that many of the least serious cases no longer take up court time.

** By law, HMCTS must adhere to Public Health England and Public Health Wales guidance.

model is not suitable for participants.[53] The government has stressed that this will be a "time-limited measure" and that while courts will be open for longer, no individual will need to spend more time in court.[54] However, the government should make several important assessments before it is rolled out more widely.

- **the government should assess whether extended hours improve court efficiency and any negative effects on court staff, lawyers, judiciary, victims, witnesses and defendants.**

HMCTS has introduced a 'recovery plan' to get the backlog under control

The government hopes that the combination of these measures will enable them to increase the number of jury trials processed a week from 133 in August to 333 in November, close to pre-crisis levels.[55] Whether it is able to achieve this objective will depend on whether social distancing requirements are changed, the speed with which additional court space is created and the success of new working practices. Interviewees were particularly sceptical about whether the new operating hours model would work, arguing that the decision to split the day into multiple sessions will actually be less efficient. They noted that the reduction of session length from six hours to four hours will likely mean more hearings are forced to finish before they are complete and will have to return on a subsequent day.[56]

Even if the volume of cases processed returns to pre-crisis levels by the end of the year, the backlog of cases will be substantial. We calculate that, if the government's recovery plan for jury trials is met, the backlog in the crown court could reach 48,000 cases by November 2020. When adjusted for complexity, this amounts to a backlog of 61,000 cases.

In practice, it will be difficult to substantially reduce the crown court backlog while social distancing remains in place. To get the backlog to pre-crisis levels would require a year in which crown court sitting days – the number of court days that the government funds – reached 111,000, a 33% increase on 2019/20 levels and similar to the 109,000 sitting days in 2015/16.[57] Running courts at this level would require a similar increase in crown court funding. But more money may not be sufficient. While social distancing remains in place, it is unlikely to be possible to run existing courts at this capacity, and it is unlikely that additional Nightingale courts could be sufficient given most would not, as noted above, have the facilities to hold crown court trials.

In magistrates' courts, jury trials are not required and it is therefore easier to work at pre-coronavirus capacity levels. If the backlog does not increase any further (it did not do so in August), it could be returned to pre-coronavirus levels by running the magistrates' courts at 5% above pre-Covid capacity for 12 months. Under the current recovery plan, the government expects to be running magistrates' courts at 2% above pre-coronavirus capacity from December. At that rate, it would take just over two years for the backlog to return to pre-crisis levels.[58]

- **The government should publish its views on acceptable backlog levels and waiting times, and set a timetable for meeting these.**

Conclusion

Criminal courts have struggled during the pandemic, entering autumn with record-level backlogs. While remote hearings have been critical for keeping the wheels of the criminal courts turning, the government should thoroughly evaluate the impact of remote hearings on the quality of justice before they are used more widely in normal times. Any decision over the future use of technology should be in partnership and consultation with the legal profession, victims and defendants.

In the meantime, the government needs to clarify its views on acceptable backlog levels and waiting times and set out a plan to get there. This should only include use of extended court hours if an evaluation finds that this leads to more cases heard without undue negative impacts on court staff, the judiciary, lawyers, victims, witnesses and defendants.

Conclusion and recommendations

Boris Johnson and the Conservative Party won a sizeable parliamentary majority less than a year ago on a manifesto promising substantial investment in public services. While ambitious at the time, the sums involved – nearly £40 billion a year extra for the NHS and schools alone by 2023/24 – have been dwarfed by the £68.7bn that has since been required to enable public services to respond to coronavirus.

Some of this money has been needed to provide extra capacity and to keep staff and service users safe. But in other cases, it has been used to implement major changes to working practices. Many of these – such as greater collaboration and use of technology – are not new but had been rolled out slowly before the crisis began. The urgency of the pandemic has swept away some of the usual barriers to change, enabling years of reform to take place in a matter of weeks.

Given the speed of transformation and the unprecedented circumstances, it is inevitable that some changes have not succeeded. We should not judge the government too harshly for decisions made in haste with only limited information about the course that the virus would take. In other cases, trade-offs in service quality, access or oversight that have been necessary during the crisis would not be acceptable once the risk of infection has reduced. Equally, stretched staffing, unusual levels of demand and old IT equipment have hampered performance in some cases, but could be improved with time and investment.

Other changes have not only succeeded in enabling public services to respond to coronavirus but also show that they can be run more effectively beyond the crisis, if given the necessary political and financial support. However, the latter will be in particularly short supply in the coming years and the government will be faced with some unenviable choices. In making these, it must learn from what has and has not worked during the pandemic. The analysis and recommendations in this report set out our view on the decisions that government should make.

Key recommendations

The government should use the upcoming spending review to:

1. Set out how it will deal with backlogs in services

The suspension of services during the pandemic means that there is now greater need for support than pre-crisis, and all public services face large backlogs, particularly criminal courts and the NHS.

- The government should publish policies setting out acceptable waiting lists and waiting times in the NHS and criminal courts and set a timetable for meeting these.

2. Provide additional funding to make permanent some changes made during the crisis

Some of the changes made during the crisis have helped deliver pre-crisis government objectives such as faster discharges from hospital, greater use of technology in the NHS and courts, and closing the attainment gap between disadvantaged and better-off pupils. In some cases, funding is needed to enable these changes to be made permanent and in others more money is required to ensure that reforms work more effectively:

- The government should provide funding to continue faster discharges from hospital beyond the crisis. It should also give local authorities, care providers and community health services additional funding so that they have sufficient capacity to assess and then safely absorb higher numbers of patients discharged from hospital. This will require frontloading the funding for community trusts through the NHS five-year funding settlement, so that they can hire additional community nurses and other staff as quickly as possible.

- The government should invest in hardware and provide additional training for staff to ensure that remote medicine in hospitals and general practice, and remote hearings in criminal courts work more effectively.

- To prevent disadvantaged children from falling further behind during the crisis – which government has said is a priority – it should provide additional funding so that every child who needs a laptop, router or other technology to properly access remote learning can have them.

3. Review whether key crisis measures should be extended

Public services have changed the way they work to manage the disruption caused by coronavirus. In some cases, it is too early to tell whether reforms that could be beneficial beyond the crisis should be continued. The government should review:

- where, and for whom, remote general practice and hospital appointments are appropriate
- which digital triage and back-office IT systems for general practice are most effective and provide value for money
- the impact of free school meals in the holidays and 'catch up' funding to help tackle the attainment gap in schools.

Methodology

General methodology

The analysis in this report is based on evidence collected in three main ways. First, we examined key datasets across the five public services assessed, building on work undertaken for previous editions of *Performance Tracker*.[1] Second, we conducted interviews with more than 50 people, including civil servants, local authority leaders, frontline staff, researchers and representatives of unions and membership bodies. Third, we undertook desk research, building on our rolling literature review of the latest developments in public services.[2] Early drafts of the chapters were reviewed by the relevant government departments and other experts to ensure accuracy.

Crown court backlogs methodology

Backlog at the end of August

We take as a starting point the reported cases outstanding at the end of August in the HMCTS weekly management information.

Complexity-weighted backlog

We want to account for the fact that jury trials have reduced much more than other case disposals, and therefore the backlog will take longer to clear. In 2019, jury trials accounted for 18%[3] of all cases disposed of but 73%[4] of total hearing time. The management information allows us to break down the change in disposals (although not the change in receipts) between jury trials and other crown court cases (see table). We assume the change in receipts is proportionally the same for all case types.

Table 1 **Crown court August backlog calculations (changes and increases from pre-coronavirus baseline)**

	Jury trials	Other crown court cases	Total
Share of cases	18%	82%	100%
Share of usual court time	73%	27%	100%
Change in receipts	-33%	-33%	-40%
Change in disposals	-92%	-30%	-42%
Change in backlog	+5,500 cases	+1700 cases	+7,100 cases
Increase in backlog weighted by hearing times of cases disposed	+22,200 cases	+500 cases	+22,700 cases
Increase in backlog weighted by hearing times of cases in previous backlog	+17,000 cases	+300 cases	+17,300 cases

Source: Institute for Government calculations using criminal court statistics and HMCTS September management information.

The weighted increase in the backlog is calculated by multiplying new outstanding jury trials by [share of usual court time]/[share of cases] and doing the same for other cases.

This implies that getting the backlog down will require disposing of the equivalent of an additional 22,700 cases based on average complexity. However, this is not a fair comparison to the previous backlog because the backlog tends to include more trial cases, which are more complex.* We therefore need to account for the complexity of the previous backlog. To do this, we split cases in the backlog between trial cases, sentencing cases and appeal cases and assume that, within each case type, the hearing time will be the same as the 2019 average for cases disposed. We then scale the increase in the backlog by the ratio between the average backlog complexity and the average normal case complexity.

This implies that, on a comparable basis, the complexity-weighted increase in the backlog is 17,300 cases, implying a 'true' backlog of 56,000 cases.

Increase in sitting days required

To get the backlog back to pre-coronavirus levels would require processing the equivalent of 23,000 additional cases at average case complexity.** This would require the equivalent of an extra 2,000 cases per month to be processed.[5]

Throughout we assume that case disposals increase in direct proportion to sitting days.

Sitting days in 2019/20 were 83,000,[6] but this was not sufficient to stop the backlog increasing. For receipts to have equalled disposals would have required 89,000 sitting days.

Reducing the backlog would require an additional 18% increase in activity, implying that 106,000 sitting days would be necessary to return the end of August backlog to pre-coronavirus levels.

Waiting times

We calculate the steady state change in waiting times by scaling the December 2019 waiting time (17.7 weeks) by the change in [(Receipts + (weighted) Backlog)/Disposals]. This is because waiting times increase when there are more cases to process (numerator) and decrease when more cases are processed (denominator). We calculate this measure using 2019 Q4 disposals.

Backlog at the end of October

The backlog is still increasing, and this is expected to continue until at least November. We project where the backlog is likely to end up by assuming that the HMCTS recovery plan is accurate regarding the number of jury trials that will be processed in September and October. Accordingly, we assume that jury trials will be 50% of their usual volume in September and 75% of their usual volume in October. We assume that non-jury trial cases are processed in a timely manner and the backlog for those cases neither increases nor decreases. We assume that receipts recover to normal levels.

* These are cases which are potentially trial cases – the defendant could still plead guilty and not require a jury trial.

** The relevant increase in the weighted backlog is 23,000 here because we are looking at the increase in the cases that need to be disposed of rather than the increase in the official backlog.

This implies a further 1,400 trials added to the backlog.

We calculate the weighted increase in the backlog, changes in waiting times and required change in sitting days in the same way for this new, higher backlog as we do for the end-August backlog.

Table 2 **Projected change in crown court backlog between August and October 2020**

	Jury trials	Other crown court cases	Total
Change in receipts (compared to pre-coronavirus baseline)	0%	0%	0%
Change in disposals (compared to pre-coronavirus baseline)	-38%	0%	-7%
Change in backlog	+1,400 cases	+0 cases	+1,400 cases
Increase in backlog weighted by hearing times of cases disposed	+5,700 cases	+0 cases	+5,700 cases
Increase in backlog weighted by hearing times of cases in previous backlog	+4,400 cases	+0 cases	+4,400 cases

Source: Institute for Government calculations using criminal court statistics and HMCTS September management information

Based on these assumptions, on a comparable basis, the complexity-weighted increase in the backlog from the start of the pandemic to the end of October would be 21,800 cases, implying a 'true' backlog of 61,000 cases.

List of figures and tables

Figure 1 Weekly GP appointments per working day, by type, January–August 2020 14

Figure 2 GP appointments made for first consultant-led outpatient appointments, January–July 2019 and 2020 15

Figure 3 Timeline of changes made to general practice 18

Figure 4 Electronic Prescription Service use, November 2019–July 2020 19

Figure 5 Average items of PPE distributed to health and care organisations each month by DHSC 25

Figure 6 Additional Covid-19 spending 26

Figure 7 Monthly calls to NHS 111 27

Figure 8 NHS staff full-time equivalent days lost due to sickness absence 27

Figure 9 Volume of hospital activity 29

Figure 10 Number of people waiting longer than one year for elective operations following a GP referral 29

Figure 11 Timeline of changes made to hospitals 32

Figure 12 Additional local authority spending on social care, 2020/21 (£m) 40

Figure 13 Local authorities in England, spending pressures and income losses, 2020/21 (£m) 41

Figure 14 Suspected or confirmed Covid-19 outbreaks in new care homes 44

Figure 15 Timeline of changes made to adult social care 45

Figure 16 Percentage of pupils attending schools in England between March and July 2020 53

Figure 17 Timeline of changes made to schools 56

Figure 18 Daily time spent on schoolwork by pupils' background, April 2020 57

Figure 19 Crown Court case backlog 65

Figure 20 Timeline of changes made to criminal courts 67

Table 1 Crown court August backlog calculations (changes and increases from pre-coronavirus baseline) 76

Table 2 Projected change in crown court backlog between August and October 2020 78

References

Summary

1 Office for National Statistics, 'Coronavirus (COVID-19) related deaths by occupation, England and Wales', Table 7, 26 June 2020, www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/coronaviruscovid19relateddeathsbyoccupationenglandandwales

2 Office for National Statistics, ' Analysis of death registrations not involving coronavirus (COVID-19), England and Wales: 28 December 2019 to 10 July 2020', retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/analysisofdeathregistrationsnotinvolvingcoronaviruscovid19englandandwales28december2019to1may2020/28december2019to10july2020#causes-of-non-covid-19-deaths

3 HM Treasury, *Winter Economic Plan*, CP 297, The Stationery Office, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921059/CCS207_CCS0920237970-001_Winter_Economy_Plan_Web_Accessible.pdf

4 de Castella T, ' Public health directors' plea for 111 data to track coronavirus', *Health Service Journal*, 30 March 2020, retrieved 15 October 2020, https://bit.ly/37GnZ1A

5 Golding N, 'UPDATED: NHS data sharing failure 'exasperating and could cause error'', *Local Government Chronicle*, 21 April 2020, retrieved 15 October 2020, www.lgcplus.com/services/health-and-care/nhs-data-sharing-failure-exasperating-and-could-cause-error-21-04-2020

General practice

1 HM Treasury, *Budget 2020*, HC121, The Stationery Office, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/871799/Budget_2020_Web_Accessible_Complete.pdf

2 HM Treasury, *Plan for Jobs*, CP261, The Stationery Office, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/898422/A_Plan_for_Jobs__Print_.pdf

3 Stevens S and Pritchard A, 'Important and urgent – Next steps on NHS response to Covid-19', NHS England and NHS Improvement, 17 March 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf

4 Kanani N and Waller E, 'Next steps on general practice response to Covid-19', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.worcslmc.co.uk/cache/downloads/Preparedness-letter_primary-care-_19_March_2020.pdf

5 British Medical Association, *COVID-19 tracker survey*, GPs only, 13 July 2020, www.bma.org.uk/media/2847/bma-covid-19-survey-results-for-gps-july-2020.pdf

6 NHS Digital, 'Appointments in General Practice', August 2020, https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/august-2020, Table 2C.

7 Kendall G, 'We cannot trust the official figures showing a boom in online consultations', *Health Service Journal*, 22 May 2020, retrieved 15 October 2020, https://bit.ly/2HFwdvV

8 British Medical Association, *COVID-19 tracker survey*, GPs only, 1 June 2020 www.bma.org.uk/media/2557/bma-covid-19-survey-results-for-gps-4-june-2020.pdf

9 Kanani N and Waller E, NHS England and NHS Improvement, 27 March 2020, retrieved 15 October 2020, https://madeinheene.hee.nhs.uk/Portals/0/GP%20preparedness%20update%20letter%2027%20March.pdf

10 NHS England and NHS Improvement, 'NHS 111 Minimum Data Set', August 2020, www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2020-21/, Geography

11 Aziz Z, 'This pandemic has strengthened bonds between doctors and patients', *The Guardian*, 14 July 2020, retrieved 15 October 2020, www.theguardian.com/society/2020/jul/14/this-pandemic-has-strengthened-bonds-between-doctors-and-patients-gps-covid-19

12 British Medical Association, *COVID-19 tracker survey*, GPs only, 13 August 2020, www.bma.org.uk/media/3071/bma-covid-19-survey-results-for-gps-aug-2020.pdf

13 Kanani K and Waller E, 'Next steps on general practice response to Covid-19', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.worcslmc.co.uk/cache/downloads/Preparedness-letter_primary-care-_19_March_2020.pdf

14 NHS England and NHS Improvement, 'Monthly Referral Return', August 2020, www.england.nhs.uk/statistics/statistical-work-areas/outpatient-referrals/mrr-data

15 Institute for Government interview.

16 Kanani K and Waller E, NHS England and NHS Improvement, 9 July 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0569-Second-phase-of-General-Practice-response-to-COVID-19--update-to-GP-contracts-and-income-protection-a.pdf

17 British Medical Association, *COVID-19 tracker survey*, GPs only, 13 July 2020, www.bma.org.uk/media/2847/bma-covid-19-survey-results-for-gps-july-2020.pdf

18 NHS England and NHS Improvement, 'NHS Volunteer Responders: communications toolkit', September 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/access-to-general-practice-comms-toolkit-sept-2020-v6.pdf

19 Institute for Government interview.

20 NHS Digital, 'Appointments in General Practice', August 2020, https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/august-2020, Table 2C.

21 Spencer J and Oung C, 'How has lockdown affected general practice and where do we go from here?', Nuffield Trust, 8 July 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/news-item/how-has-lockdown-affected-general-practice-and-where-do-we-go-from-here

22 askmyGP, 'Live analytics', Consult mode preference and actual, retrieved 15 October 2020, https://askmygp.uk/live

23 Aziz Z, 'This pandemic has strengthened bonds between doctors and patients', *The Guardian*, 14 July 2020, retrieved 15 October 2020, www.theguardian.com/society/2020/jul/14/this-pandemic-has-strengthened-bonds-between-doctors-and-patients-gps-covid-19

24 Institute for Government interview.

25 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond, HC 320', The Stationery Office 2020, https://committees.parliament.uk/oralevidence/513/pdf

26 Institute for Government interview.

27 Trueland J, Blackburn P, Tonkin T and Cooper K, 'United front: BMA members respond to the COVID-19 pandemic', British Medical Association, 9 April 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/united-front

28 British Medical Association, *COVID-19 tracker survey*, GPs only, 13 July 2020, www.bma.org.uk/media/2847/bma-covid-19-survey-results-for-gps-july-2020.pdf

29 Blackburn P, 'Doctors kept away from front line', British Medical Association, 27 March 2020, retrieved 15 October 2020, https://www.bma.org.uk/news-and-opinion/doctors-kept-away-from-front-line

30 Fisher R and Asaria M, 'How might COVID-19 affect the number of GPs available to see patients in England?', The Health Foundation, 6 August 2020, retrieved 15 October 2020, www.health.org.uk/publications/long-reads/how-might-covid-19-affect-the-number-of-gps-available-to-see-patients-in-england

31 Institute for Government interview.

32 Institute for Government interview.

33 British Medical Association, *COVID-19 tracker survey*, GPs only, 13 July 2020, www.bma.org.uk/media/2847/bma-covid-19-survey-results-for-gps-july-2020.pdf

34 Trueland J, Blackburn P, Tonkin T and Cooper K, 'United front: BMA members respond to the COVID-19 pandemic', British Medical Association, 9 April 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/united-front

35 Martin P, 'GPs are returning to practice – but held up by red tape', British Medical Association, 27 April 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/gps-are-returning-to-practice-but-held-up-by-red-tape

36 Tonkin T, 'A wholesale transformation', British Medical Association, 11 May 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/a-wholesale-transformation

37 Kanani N, NHS England and NHS Improvement, 5 March 2020, retrieved 15 October 2020, https://web.archive.org/web/20200527044149/https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Preparedness-letter_primary-care_NK_5-March2020.pdf

38 Stevens S and Pritchard A, 'Important and urgent – Next steps on NHS response to Covid-19', NHS England and NHS Improvement, 17 March 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf

39 Kanani N and Waller E, 'Next steps on general practice response to Covid019', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.worcslmc.co.uk/cache/downloads/Preparedness-letter_primary-care-_19_March_2020.pdf

40 NHS X, 'Remote Working in Primary Care Guidance for GP Practices during COVID-19 Emergency Response', 30 March 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0165-remote-working-in-primary-care-gp-practices-during-covid-19-v1.2.pdf

41 NHS England and NHS Improvement, and Royal College of General Practitioners, 'Principles for supporting high quality consultations by video in general practice during COVID-19', 29 May 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf

42 Kasaraneni K, 'Can general practice learn from the COVID-19 global pandemic?', British Medical Association, 4 June 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/can-general-practice-learn-from-the-covid-19-global-pandemic

43 NHS England, 'The NHS Long Term Plan', 2019, www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

44 Institute for Government interview.

45 Mold F, Hendy J, Lai Y, de Lusignan, 'Electronic Consultation in Primary Care Between Providers and Patients: Systematic Review', *JMIR Med Inform*, 2019, vol. 7, no.4, https://medinform.jmir.org/2019/4/e13042

46 Ignatowicz A, Atherton H, Bernstein C, 'Internet videoconferencing for patient–clinician consultations in long-term conditions: A review of reviews and applications in line with guidelines and recommendations', *Digital Health*, 2019, vol. 5, pp 1-27, https://journals.sagepub.com/doi/pdf/10.1177/2055207619845831

47 Tonkin T, 'A wholesale transformation', British Medical Association, 11 May 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/a-wholesale-transformation

48 Institute for Government interview.

49 House of Commons Health and Social Care Committee, 'Delivering core NHS and care services during the pandemic and beyond', HC 320, 1 October 2020, https://committees.parliament.uk/publications/2793/documents/27577/default, pp. 56–7

50 Healthwatch England, National Voices and Traverse, 'The Doctor Will Zoom You Now', 18 August 2020, retrieved 15 October 2020, www.nationalvoices.org.uk/sites/default/files/public/publications/the_dr_will_zoom_you_now_-_insights_report.pdf

51 Institute for Government interview.

52 Institute for Government interview.

53 NHS Digital, 'Electronic Prescription Service dashboard', Page 2: EPZ National Statistics, https://digital.nhs.uk/data-and-information/data-tools-and-services/tools-for-accessing-data/deployment-and-utilisation-hub/electronic-prescription-service-deployment-and-utilisation-data

54 Salisbury C, Murphy M, Duncan P, 'The Impact of Digital-First Consultations on Workload in General Practice: Modeling Study', *Journal of Medical Internet Research*, 2020, vol. 20, no. 6, https://pubmed.ncbi.nlm.nih.gov/32543441

55 Royal College of General Practitioners, 'RCGP survey provides snapshot of how GP care is accessed in latest stages of pandemic', 30 July 2020, retrieved 15 October 2020, www.rcgp.org.uk/about-us/news/2020/july/rcgp-survey-provides-snapshot-of-how-gp-care-is-accessed-in-latest-stages-of-pandemic.aspx

56 Healthwatch England, 'What people want from the next ten years of the NHS', 29 January 2020, www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20200128%20-%20What%20people%20want%20from%20the%20next%20ten%20years%20of%20the%20NHS.pdf

57 Healthwatch England, National Voices and Traverse, 'The Doctor Will Zoom You Now', 18 August 2020, retrieved 15 October 2020, www.nationalvoices.org.uk/sites/default/files/public/publications/the_dr_will_zoom_you_now_-_insights_report.pdf

58 Institute for Government interview.

59 askmyGP, 'Live analytics', Patient feedback, retrieved 15 October 2020, https://askmygp.uk/live

60 www.gov.uk/government/speeches/the-future-of-healthcare

61 Institute for Government interview.

62 Mold F, Hendy J, Lai Y, de Lusignan, 'Electronic Consultation in Primary Care Between Providers and Patients: Systematic Review', *JMIR Med Inform*, 2019, vol. 7, no.4, https://medinform.jmir.org/2019/4/e13042

63 Davies N, Atkins G, Guerin B, Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf

64 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond, HC 320', The Stationery Office, 2020, https://committees.parliament.uk/oralevidence/331/pdf/

65 Health Education England, 'e-Learning for Healthcare', retrieved 15 October 2020, https://portal.e-lfh.org.uk/catalogue/Index?HierarchyId=0_45016_45125&programmeId=45016#

66 Stevens S and Pritchard A, 'Important and urgent – Next steps on NHS response to Covid-19', NHS England and NHS Improvement, 17 March 2020, retrieved 15 October 2020 www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf

67 Nikita Kanani and Ed Waller, 'Next steps on general practice response to covid 19', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.worcslmc.co.uk/cache/downloads/Preparedness-letter_primary-care-_19_March_2020.pdf

68 Kanani N and Waller E, NHS England and NHS Improvement, 9 July 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0569-Second-phase-of-General-Practice-response-to-COVID-19--update-to-GP-contracts-and-income-protection-a.pdf

69 British Medical Association, 'QOF (quality and outcomes framework)', 22 September 2020, retrieved 15 October 2020, www.bma.org.uk/advice-and-support/covid-19/gp-practices/covid-19-toolkit-for-gps-and-gp-practices/qof-quality-and-outcomes-framework

70 Kanani N and Waller E, NHS England and NHS Improvement, 4 August 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0651-covid-support-fund-letter-aug-2020.pdf

71 NHS England, 'Report of the Review of the Quality and Outcomes Framework in England', 2018, www.england.nhs.uk/publication/report-of-the-review-of-the-quality-and-outcomes-framework-in-england

72 Nikita Kanani and Ed Waller, 'Next steps on general practice response to covid 19', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.worcslmc.co.uk/cache/downloads/Preparedness-letter_primary-care-_19_March_2020.pdf

73 Trenholm I, Baker T, Benneyworth R, 'Routine inspections suspended in response to coronavirus outbreak', Care Quality Commission, 16 March 2020, retrieved 15 October 2020, www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak

74 Powis S, 'Covid-19 and professional standards activities (including appraisal and revalidation)', NHS England and NHS Improvement, 19 March 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/letter-from-prof-powis-to-ros-and-mds-19-march-2020.pdf

75 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond, HC 320', The Stationery Office, 2020, https://committees.parliament.uk/oralevidence/331/pdf/

76 Institute for Government interview.

77 NHS England and NHS Improvement and British Medical Association, 'Update to the GP contract agreement 2020/21 – 2023/24', 2020, www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf, p. 26

78 Baird B, 'How has general practice responded to the Covid-19 (coronavirus) outbreak?', The King's Fund, 8 April 2020, retrieved 15 October 2020, www.kingsfund.org.uk/blog/2020/04/covid-19-general-practice

79 Kemp N, 'Moving on together: sessional GPs' role in the future of general practice', British Medical Association, 2 July 2020, retrieved 15 October 2020, www.bma.org.uk/news-and-opinion/moving-on-together-sessional-gps-role-in-the-future-of-general-practice

80 Stevens S and Pritchard A, 'Important and urgent – Next steps on NHS response to Covid-19', NHS England and NHS Improvement, 17 March 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/20200317-NHS-COVID-letter-FINAL.pdf

81 NHS England, 'The NHS Long Term Plan', 2019, www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

82 Institute for Government interview.

83 Institute for Government interview.

84 Institute for Government interview.

85 BBC, 'NHS data breach affects 150,000 patients in England', 2 July 2018, retrieved 15 October 2020, www.bbc.co.uk/news/technology-44682369

86 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond, HC 320', The Stationery Office 2020, https://committees.parliament.uk/oralevidence/513/pdf

87 Understanding Patient Data, 'Health data and Covid-19: taking action while maintaining trust', 17 April 2020, retrieved 28 October 2020, https://understandingpatientdata.org.uk/news/health-data-and-covid-19-taking-action-while-maintaining-trust

Hospitals

1 NHS England, 'Financial position month 4 2020/21', NHS England, 1 October 2020, www.england.nhs.uk/wp-content/uploads/2020/10/BM2022Pu-item-3-month-4-financial-position.pdf

2 Davies N, Atkins G, Guerin B and Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf, p. 27.

3 Warrington and Halton Teaching Hospitals, 'Covid-19 (coronavirus) Temporary reconfiguration of Halton Hospital', Warrington and Halton Teaching Hospitals, (no date) retrieved 15 October 2020, https://whh.nhs.uk/about-us/news-events-and-features/latest-news/covid-19-coronavirus-temporary-reconfiguration-halton-hospital

4 NHS Providers, 'Confronting coronavirus in the NHS: The story so far', NHS Providers, 15 April 2020, https://nhsproviders.org/media/689450/confronting-coronavirus-in-the-nhs.pdf, p. 4.

5 Department of Health and Social Care, 'Experimental statistics – personal protective equipment distributed for use by health and social care services in England: 17 August to 23 August 2020', Department of Health and Social Care, 25 August 2020, retrieved 15 October 2020, www.gov.uk/government/publications/ppe-deliveries-england-17-august-to-23-august-2020/experimental-statistics-personal-protective-equipment-distributed-for-use-by-health-and-social-care-services-in-england-17-august-to-23-august-202

6 Sunak R, 'Budget Speech 2020', HM Treasury, 11 March 2020, retrieved 15 October 2020, www.gov.uk/government/speeches/budget-speech-2020

7 HM Treasury, 'A Plan for Jobs 2020', HM Treasury, 8 July 2020, retrieved 15 October 2020, www.gov.uk/government/publications/a-plan-for-jobs-documents/a-plan-for-jobs-2020

8 National Audit Office, 'COVID-19 Cost Tracker', National Audit Office, September 2020, www.nao.org.uk/wp-content/uploads/2020/09/COVID-19-cost-tracker-2020-09-08.pdf, pp. 4-5.

9 Appleby J and Palmer B, 'Chart of the week: How much additional money has the pandemic response cost the NHS so far?', Nuffield Trust, 22 July 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/resource/chart-of-the-week-the-direct-health-and-care-costs-of-covid-19-so-far

10 Ferguson N, Laydon D, Nedjati-Gilani G and others, 'Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand', Imperial College COVID-19 Response Team, Imperial College London, 16 March 2020, www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf, p. 8.

11 Cabinet Office, 'Our plan to rebuild: The UK Government's COVID-19 recovery strategy', CP 239, The Stationery Office, 11 May 2020, retrieved 15 October 2020, www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy

12 Public Health England and NHSX, 'Healthcare in United Kingdom', Coronavirus Tracker, GOV.UK, 14 October 2020, retrieved 15 October 2020, https://coronavirus.data.gov.uk/healthcare

13 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, providers of community health services and NHS 111 providers, NHS England, 31 July 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf, p. 1.

14 NHS England, 'NHS 111 online to help people with coronavirus', NHS England, 2 March 2020, retrieved 15 October 2020, www.england.nhs.uk/2020/03/nhs-111-online-to-help-people-with-coronavirus

15 NHS England and NHS NHS Improvement, 'Briefing: Primary care providers and the coronavirus (COVID-19)', NHS England, 18 February 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/coronavirus-primary-care-briefing.pdf

16 Davies N, Atkins G, Guerin B and Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf, p. 24.

17 Rolewicz L, 'Chart of the week: Sickness absence rates in the NHS in April were at their highest since records began', Nuffield Trust, 28 August 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/resource/chart-of-the-week-sickness-absence-rates-in-the-nhs-in-april-were-at-their-highest-since-records-began

18 NHS Digital, 'NHS Sickness Absence Rates April 2020, Provisional Statistics', NHS Sickness Absence Rates, NHS Digital, 20 August 2020, retrieved 15 October 2020, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/april-2020-provisional-statistics

19 West D, 'One in 10 hospital nurses absent due to coronavirus', *HSJ*, 13 April 2020, retrieved 15 October 2020, www.hsj.co.uk/workforce/one-in-10-hospital-nurses-absent-due-to-coronavirus/7027394.article

20 Iacobucci G, 'Covid-19: Hospitals can remove 15% cap on testing of NHS staff', *BMJ*, 1 April 2020, retrieved 15 October 2020, www.bmj.com/content/369/bmj.m1339

21 Woodcock A, 'Coronavirus: Fewer than one in 50 NHS frontline staff forced to stay at home have been tested', *The Independent*, 1 April 2020, retrieved 15 October 2020, www.independent.co.uk/news/uk/politics/coronavirus-nhs-staff-tests-stay-home-how-many-a9441251.html

22 The Academy of Medical Sciences, 'Preparing for a challenging winter 2020/21', The Academy of Medical Sciences, 14 July 2020, retrieved 15 October 2020, https://acmedsci.ac.uk/file-download/51353957, p. 19.

23 Lintern S, 'Analysis: Why is there a coronavirus testing shortage?', *The Independent*, (no date) retrieved 15 October 2020, www.independent.co.uk/news/health/coronavirus-testing-shortage-matt-hancock-lighthouse-labs-b448161.html

24 Conway E, 'Coronavirus: Why has the UK run out of testing capacity? The three fateful decisions behind our stumbling system', Sky News, 18 September 2020, retrieved 15 October 2020, https://news.sky.com/story/coronavirus-why-has-the-uk-run-out-of-testing-capacity-the-three-fateful-decisions-behind-our-stumbling-system-12073592

25 Collins A, 'The Ward Round: Tell staff the truth about testing', *HSJ*, 17 September 2020, retrieved 15 October 2020, www.hsj.co.uk/workforce/the-ward-round-tell-staff-the-truth-about-testing/7028460.article

26 NHS Providers, 'NHS service recovery and winter preparation at risk from current testing shortages', NHS Providers, 15 September 2020, retrieved 15 October 2020, https://nhsproviders.org/news-blogs/news/nhs-service-recovery-and-winter-preparation-at-risk-from-current-testing-shortages

27 British Medical Association, 'BMA COVID-19 tracker survey', British Medical Association, 13 August 2020, www.bma.org.uk/media/3072/bma-covid-19-survey-results-for-hospital-doctors-aug-2020.pdf, p. 1.

28 Hopson C, 'Calling the NHS a 'COVID only service' is untrue, unfair and potentially dangerous', NHS Providers, 12 August 2020, retrieved 15 October 2020, https://nhsproviders.org/news-blogs/blogs/calling-the-nhs-a-covid-only-service-is-untrue-unfair-and-potentially-dangerous

29 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, providers of community health services and NHS 111 providers, NHS England, 29 April 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/second-phase-of-nhs-response-to-covid-19-letter-to-chief-execs-29-april-2020.pdf, p. 5.

30 Davies N, Atkins G, Guerin B and Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf, p. 22.

31 Royal College of Physicians, 'COVID-19 and the workforce – what we've learned', Royal College of Physicians, 8 June 2020, retrieved 15 October 2020, www.rcplondon.ac.uk/news/covid-19-and-workforce-what-we-ve-learned

32 NHS Providers, 'The impact of the pandemic on the workforce', NHS Providers, June 2020, retrieved 15 October 2020, https://nhsproviders.org/recovery-position-what-next-for-the-nhs/the-impact-of-the-pandemic-on-the-workforce

33 Ipsos MORI, 'The Health Foundation COVID-19 Survey', The Health Foundation, June 2020, www.health.org.uk/sites/default/files/2020-06/Health-Foundation-2020-COVID-19-Polling-v2.pdf, p. 16.

34 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond', Questions 179-257, HC 320, 30 June 2020, https://committees.parliament.uk/oralevidence/607/pdf, p. 2.

35 Morris J, 'Chart of the week: The alarming drop in referrals from GPs to hospital services since the Covid-19 outbreak', Nuffield Trust, 18 June 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/resource/new-chart-of-the-week-the-alarming-drop-in-referrals-from-gps-to-hospital-services-since-the-covid-19-outbreak

36 Neville S, 'NHS patient backlog threatens to undermine return to pre-pandemic service', *Financial Times*, 2 September 2020, retrieved 22 October 2020, www.ft.com/content/21250aa2-1985-4463-80f4-74d59d75649b

37 Reed S and Scobie S, 'Chart of the week: The proportion of people waiting more than 18 weeks for planned treatment has rocketed since Covid-19', Nuffield Trust, 19 August 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/resource/chart-of-the-week-the-proportion-of-people-waiting-more-than-18-weeks-for-planned-treatment-has-rocketed-since-covid-19

38 Vaughan L, 'Where are the patients? The factors affecting the use of emergency care during Covid-19', Nuffield Trust, 16 June 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/news-item/where-are-the-patients-the-factors-affecting-the-use-of-emergency-care-during-covid-19#system-level-factors

39 Public Health England, 'Emergency Department Syndromic Surveillance System', GOV.UK, 8 September 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/916481/EDSSSBulletin2020wk36.pdf, p. 9.

40 Bottle A, Kim D, Aylin P and others, 'Routes to diagnosis of heart failure: observational study using linked data in England', *Heart*, 2018, vol. 104, no. 7, pp. 600–5, https://heart.bmj.com/content/104/7/600

41 Richards M, Thorlby R, Fisher R and Turton C, *Unfinished business: An assessment of the national approach to improving cancer services in England 1995–2015*, The Health Foundation, November 2018, retrieved 15 October 2020, www.health.org.uk/publications/unfinished-business

42 Office for National Statistics, 'Analysis of death registrations not involving coronavirus (COVID-19), England and Wales: 28 December 2019 to 10 July 2020', Office for National Statistics, 2 September 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/analysisofdeathregistrationsnotinvolvingcoronaviruscovid19englandandwales28december2019to1may2020/28december2019to10july2020#causes-of-non-covid-19-deaths

43 NHS England, 'Consultant-led Referral to Treatment Waiting Times', NHS England, (no date) retrieved 15 October 2020, www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times

44 NHS England, 'Monthly Hospital Activity Data', NHS England, (no date) retrieved 15 October 2020, www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data

45 Morris J, 'The number of new referrals for #electivecare is now exceeding the number starting consultant-led treatment. We are at the point where the waiting list may start to increase dramatically', Twitter, 13 August 2020, retrieved 15 October 2020, https://twitter.com/JessieSMorris/status/1293886431807655936

46 Office for National Statistics, 'Coronavirus and the social impacts on Great Britain', Office for National Statistics, 9 April 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritaindata/current

47 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, and providers of community health services, NHS England, 17 March 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf, p. 2.

48 Charlesworth A, Watt T and Gardner T, 'Returning NHS waiting times to 18 weeks for routine treatment: The scale of the challenge pre-COVID-19', The Health Foundation, 22 May 2020, retrieved 15 October 2020, www.health.org.uk/publications/long-reads/returning-nhs-waiting-times-to-18-weeks#lf-section-81096-anchor

49 Buckingham H, 'The people's plans?', Nuffield Trust, 12 August 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/news-item/the-people-s-plans#throwing-down-the-gauntlet

50 NHS Providers, *Recovery position: What next for the NHS?*, NHS Providers, June 2020, https://nhsproviders.org/media/689775/recovery-position-what-next-for-the-nhs.pdf, p. 18.

51 Royal College of Physicians, 'Returning the NHS to an even keel', Royal College of Physicians, 29 June 2020, retrieved 15 October 2020, www.rcplondon.ac.uk/guidelines-policy/returning-nhs-even-keel

52 Lintern S, 'NHS on life support: Patients face diagnosis delays as hospitals struggle with surge in screenings', *The Independent*, 26 August 2020, retrieved 15 October 2020, www.independent.co.uk/news/health/coronavirus-nhs-delays-cancer-pathology-screening-radiologists-a9554871.html

53 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, and providers of community health services, NHS England, 17 March 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf

54 *Ibid.*, p. 10.

55 NHS England and NHS Improvement, 'Submission and approval process for capital expenditure related to COVID-19', NHS England, 27 March 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/COVID-19-capital-reimbursement-process-27-04-20.pdf

56 NHS England and NHS NHS Improvement, 'Changes to COVID-19 finance reporting and approval processes as we move into the second phase of the NHS response', NHS England, 19 May 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/publication/changes-to-covid-19-finance-reporting-and-approval-processes

57 Department of Health and Social Care, 'Reintroduction of NHS continuing healthcare (NHS CHC): guidance', GOV.UK, 21 August 2020, retrieved 15 October 2020, www.gov.uk/government/publications/reintroduction-of-nhs-continuing-healthcare/reintroduction-of-nhs-continuing-healthcare-nhs-chc-guidance

58 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, and providers of community health services, NHS England, 17 March 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf, p. 11.

59 Lewis R, Pereira P, Thorlby R and Warburton W, *Understanding and sustaining the health care service shifts accelerated by COVID-19*, The Health Foundation, 15 September 2020, www.health.org.uk/sites/default/files/2020-09/Understanding%20and%20sustaining%20the%20health%20care%20service%20shifts%20accelerated%20by%20COVID-19.pdf, p. 8.

60 Leung H, Taylor E and Pett E, 'The ITU Transfer Project - A contribution from North West London Critical Care Network', Patchwork, (no date) retrieved 15 October 2020, www.patchwork.health/blog/the-itu-transfer-project-written-by-north-west-london-critical-care-network

61 Institute for Government interview.

62 NHS England, 'Changes to COVID-19 finance reporting and approval processes as we move into the second phase of the NHS response', NHS England, 19 May 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/05/C0518-changes-to-finance-reporting-and-approval-processes.pdf, p. 2.

63 Cambridge and Peterborough Clinical Commissioning Group, 'CCG nurses reflect on COVID-19 deployments', Cambridge and Peterborough Clinical Commissioning Group, 9 July 2020, retrieved 15 October 2020, www.cambridgeshireandpeterboroughccg.nhs.uk/news-and-events/latest-news/ccg-nurses-talk-about-their-covid-19-deployments

64 Institute for Government interview.

65 Healthcare Financial Management Association, *The future NHS financial regime in England: a discussion paper*, Healthcare Financial Management Association, June 2020, www.hfma.org.uk/docs/default-source/publications/Briefings/the-future-nhs-financial-regime-in-england2020.pdf, p. 3.

66 Gainsbury S, *The bottom line: Understanding the NHS deficit and why it won't go away*, Nuffield Trust, August 2017, www.nuffieldtrust.org.uk/files/2017-11/the-bottom-line-final-nov-amend.pdf, p. 6.

67 Institute for Government interview.

68 Jones A, Wyatt S and Seamer P, *How will we know if Integrated Care Systems reduce demand for urgent care?*, The Strategy Unit, January 2020, www.strategyunitwm.nhs.uk/sites/default/files/2020-01/Establishing%20fair%20benchmark%20levels%20for%20the%20blended%20payment%20system.pdf

69 Institute of Public Care, 'Integrating health and social care: Croydon case study', Local Government Association, 23 September 2018, retrieved 15 October 2020, www.local.gov.uk/integrating-health-and-social-care-croydon-case-study

70 HM Government, 'COVID-19 Hospital Discharge Service Requirements', GOV.UK, 19 March 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf, pp. 22–24.

71 Illman J, 'Trusts told: Forget the rules, get people out of hospital', *HSJ*, 23 March 2020, retrieved 15 October 2020, www.hsj.co.uk/policy-and-regulation/trusts-told-forget-the-rules-get-people-out-of-hospital/7027204.article

72 Department of Health and Social Care and Ministry of Housing, Communities and Local Government, '£2.9 billion funding to strengthen care for the vulnerable', press release, 19 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/2-9-billion-funding-to-strengthen-care-for-the-vulnerable

73 NHS England, 'Bed Availability and Occupancy Data – Overnight', NHS England, (no date) retrieved 15 October 2020, www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight

74 Elias L and Scobie S, 'How did the NHS free up hospital capacity at the start of the pandemic?', Nuffield Trust, 6 August 2020, retrieved 15 October 2020, www.nuffieldtrust.org.uk/news-item/how-did-the-nhs-free-up-hospital-capacity-at-the-start-of-the-pandemic-and-what-does-this-mean-for-future-outbreaks

75 *Ibid.*

76 Institute for Government interview.

77 The Association of Directors of Adult Social Services, *ADASS Coronavirus Survey*, The Association of Directors of Adult Social Services, June 2020, www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 21.

78 Office for National Statistics, 'Deaths involving COVID-19 in the care sector, England and Wales: deaths occurring up to 12 June 2020 and registered up to 20 June 2020 (provisional)', Office for National Statistics, 3 July 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional#main-points

79 Hodgson K, Grimm F, Vestesson E, Brine R and Deeny S, *Adult social care and COVID-19: Assessing the impact on social care users and staff in England so far*, The Health Foundation, July 2020, retrieved 15 October 2020, www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-impact-on-social-care-users-and-staff-in-england-so-far, p. 13.

80 Office for National Statistics, 'Impact of coronavirus in care homes in England: 26 May to 19 June 2020', Office for National Statistics, 3 July 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/impactofcoronavirusincarehomesinenglandvivaldi/26mayto19june2020

81 Emmerson C, Adamson J, Turner D and others, 'Risk factors for outbreaks of COVID-19 in care homes following hospital discharge: a national cohort analysis', medRxiv, 26 August 2020, retrieved 15 October 2020, www.medrxiv.org/content/10.1101/2020.08.24.20168955v1

82 Institute for Government interview.

83 Forder J, Caiels J, Harlock J and others, *A system-level evaluation of the Better Care Fund: Final Report*, Quality and Outcomes of Person-Centred Care Policy Research Unit, Personal Social Services Research Unit, July 2018, www.pssru.ac.uk/pub/5424.pdf, p. 55.

84 Brennan S, 'Discharge guidance could lead to increased death and disability, warn senior clinicians', *HSJ*, 8 September 2020, retrieved 15 October 2020, www.hsj.co.uk/commissioning/discharge-guidance-could-lead-to-increased-death-and-disability-warn-senior-clinicians/7028402.article

85 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond', Questions 119–178, HC 320, 16 June 2020, https://committees.parliament.uk/oralevidence/513/pdf, p. 28.

86 The Association of Directors of Adult Social Services, *ADASS Coronavirus Survey*, The Association of Directors of Adult Social Services, June 2020, www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 19.

87 Forder J, Caiels J, Harlock J and others, *A system-level evaluation of the Better Care Fund: Final Report*, Quality and Outcomes of Person-Centred Care Policy Research Unit, Personal Social Services Research Unit, July 2018, www.pssru.ac.uk/pub/5424.pdf, p. 55.

88 The Association of Directors of Adult Social Services, 'Autumn Short Survey of Directors of Adult Social Services 2018 – Key Messages', The Association of Directors of Adult Social Services, October 2018, www.adass.org.uk/media/7342/autumn-short-survey-report_october_2018_final.pdf, pp. 2–3.

89 Atkins G, Davies N, Guerin B and others, *Performance Tracker 2019*, Adult Social Care, Institute for Government and CIPFA, 11 November 2019, retrieved 15 October 2020, www.instituteforgovernment.org.uk/publication/performance-tracker-2019/adult-social-care

90 Institute for Government interview.

91 Charlesworth A, Gershlick B, Firth Z, Kraindler J and Watt T, *Investing in* The NHS long term plan: *Job done?*, The Health Foundation, June 2019, retrieved 15 October 2020, www.health.org.uk/publications/reports/investing-in-the-nhs-long-term-plan, p. 3.

92 NHS Digital, 'Coronavirus programme updates', NHS Digital, 29 July 2020, retrieved 15 October 2020, https://digital.nhs.uk/coronavirus/nhs-digital-coronavirus-programme-updates/programme-updates-29-july-2020#document-content

93 NHS England and NHS NHS Improvement, 'Video consultations for secondary care', NHS England, 14 April 2020, retrieved 15 October 2020, www.england.nhs.uk/coronavirus/publication/video-consultations-for-secondary-care

94 NHS Digital, 'Messaging tool for NHS to support remote working during coronavirus outbreak', NHS Digital, press release, 19 March 2020, retrieved 15 October 2020, https://digital.nhs.uk/news-and-events/latest-news/messaging-tool-for-nhs-to-support-remote-working-during-coronavirus-outbreak

95 McCaughey H, Letter to Royal College of Ophthalmologists, Royal College of Pathologists, Royal College of Paediatrics and Child Health, and others, NHS England, 14 April 2020, retrieved 15 October 2020, https://web.archive.org/web/20200630004032/https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0161-letter-to-royal-colleges-14-april-2020.pdf

96 NHS Improvement, Response to request under the Freedom of Information Act, NHS Improvement, 23 June 2020, www.england.nhs.uk/wp-content/uploads/2020/07/FOI-Attend-Anywhere-system.pdf

97 Baynham D and Hudson M, 'Rollout of video consultation across general practice', Technology in the NHS blog, 26 March 2020, retrieved 15 October 2020, https://healthtech.blog.gov.uk/2020/03/26/rollout-of-video-consultation-across-general-practice

98 Reed S, 'What will it take to transform outpatient care?', The Health Foundation, 10 July 2019, retrieved 15 October 2020, www.health.org.uk/news-and-comment/blogs/what-will-it-take-to-transform-outpatient-care

99 Hill M, 'The Q community's insight on improving outpatient care', Q, 8 July 2019, retrieved 15 October 2020, https://q.health.org.uk/blog-post/the-q-communitys-insight-on-improving-outpatient-care

100 Hutchings R, *The impact of Covid-19 on the use of digital technology in the NHS*, Nuffield Trust, August 2020, www.nuffieldtrust.org.uk/files/2020-08/the-impact-of-covid-19-on-the-use-of-digital-technology-in-the-nhs-web-2.pdf, p. 4.

101 NHS England and NHS Improvement, 'Minutes of a public meeting in common of the boards of NHS England and NHS Improvement held on Thursday 25 June 2020 at 3.40pm by video conference', NHS England, 28 July 2020, www.england.nhs.uk/wp-content/uploads/2020/07/Agenda-item-1-Minutes-of-public-board-200625-FINAL.pdf

102 Stevens S and Pritchard A, Letter to chief executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, providers of community health services, and NHS 111 providers, NHS England, 31 July 2020, www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

103 NHS Digital, 'Coronavirus (COVID-19) increase in use of NHS Digital tech', NHS Digital, 27 July 2020, retrieved 15 October 2020, https://digital.nhs.uk/coronavirus/nhs-digital-tech-analytics

104 *Ibid.*

105 Healthwatch, National Voices and Traverse, 'The Doctor Will Zoom You Now: getting the most out of the virtual health and care experience', July 2020, www.healthwatch.co.uk/sites/healthwatch.co.uk/files/The_Dr_Will_Zoom_You_Now_-_Insights_Report.pdf, p. 4.

106 Kilduff C, Thomas A, Dugdill J and others, 'Creating the Moorfields' virtual eye casualty: video consultations to provide emergency teleophthalmology care during and beyond the COVID-19 pandemic', *BMJ Health & Care Informatics*, 2020, vol. 27, no. 3, https://informatics.bmj.com/content/27/3/e100179?rss=1

107 Kang S, Thomas P, Sim D and others, 'Oculoplastic video-based telemedicine consultations: Covid-19 and beyond', *Eye*, 2020, vol. 34, pp. 1193–5, www.nature.com/articles/s41433-020-0953-6

108 Gilbert A, Billany J, Adam R and others, 'Rapid implementation of virtual clinics due to COVID-19: report and early evaluation of a quality improvement initiative', *BMJ Open Quality*, 2020, vol. 9, no. 2, https://bmjopenquality.bmj.com/content/9/2/e000985.full

109 Rapson J, 'Trusts have "lost focus" on patients who cannot use the internet', *HSJ*, 31 July 2020, retrieved 15 October 2020, www.hsj.co.uk/technology-and-innovation/trusts-have-lost-focus-on-patients-who-cannot-use-the-internet/7028152.article

110 House of Commons Health and Social Care Committee, 'Oral evidence: Delivering Core NHS and Care Services during the pandemic and beyond', Questions 119–178, HC 320, 16 June 2020, https://committees.parliament.uk/oralevidence/513/pdf, p. 32.

111 Scott J and Hill M, 'Improving quality and tackling inequalities: emerging insights about video consultations', Q, 8 June 2020, retrieved 15 October 2020, https://q.health.org.uk/blog-post/improving-quality-and-tackling-inequalities-emerging-insights-about-video-consultations

112 Technology Enabled Care in Scotland, *Attend Anywhere Progress Report*, Technology Enabled Care in Scotland, May 2019, https://tec.scot/wp-content/uploads/2019/08/Attend-Anywhere-review-2019-v10.pdf

113 Greenhalgh T, Wherton J and Shaw S, 'Interim summary of key literature and our evaluation of Attend Anywhere in Scotland', Q, 9 March 2020, retrieved 15 October 2020, https://q.health.org.uk/document/interim-summary-of-key-literature-and-our-evaluation-of-attend-anywhere-in-scotland; Health and Social Care Alliance Scotland, 'First evaluation of "Attend Anywhere" / "NHS Near Me" published', Health and Social Care Alliance Scotland, 19 August 2020, retrieved 15 October 2020, www.alliance-scotland.org.uk/blog/news/first-evaluation-of-attend-anywhere-nhs-near-me-published

114 Royal College of Physicians, 'Outpatients: the future – adding value through sustainability', Royal College of Physicians, 9 November 2018, retrieved 15 October 2020, www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

115 Campbell D, 'Software problems thwart patient consultations with NHS specialists', *The Guardian*, 14 May 2020, retrieved 15 October 2020, www.theguardian.com/society/2020/may/14/software-problems-thwart-patient-consultations-with-nhs-specialists-coronavirus-crisis

116 Department of Health and Social Care, 'The future of healthcare: our vision for digital, data and technology in health and care', GOV.UK, 17 October 2018, retrieved 15 October 2020, www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care

117 Rapson J and Carding N, 'National NHS chiefs plan end to "messy" covid tech deal', *HSJ*, 20 July 2020, retrieved 15 October 2020, www.hsj.co.uk/technology-and-innovation/national-nhs-chiefs-plan-end-to-messy-covid-tech-deal/7028067.article

118 Institute for Government interview.

119 Hignett K, 'Trust rankings put on hold over "unprecedented" covid-19', *HSJ*, 17 March 2020, retrieved 15 October 2020, www.hsj.co.uk/finance-and-efficiency/trust-rankings-put-on-hold-over-unprecedented-covid-19/7027135.article

120 Discombe M, 'Trusts will still be monitored on A&E targets during covid-19 crisis', *HSJ*, 30 March 2020, retrieved 15 October 2020, www.hsj.co.uk/coronavirus/trusts-will-still-be-monitored-on-aande-targets-during-covid-19-crisis/7027259.article

121 Care Quality Commission, 'Routine inspections suspended in response to coronavirus outbreak', Care Quality Commission, 16 March 2020, retrieved 15 October 2020, www.cqc.org.uk/news/stories/routine-inspections-suspended-response-coronavirus-outbreak

122 NHS England, 'COVID-19 and the production of statistics', NHS England, (no date) retrieved 15 October 2020, www.england.nhs.uk/statistics/covid-19-and-the-production-of-statistics

123 Institute for Government interview.

124 NHS Providers, 'Positive developments on inspections', NHS Providers, 24 August 2020, retrieved 15 October 2020, https://nhsproviders.org/news-blogs/news/positive-developments-on-inspections

125 Discombe M, 'CQC "breaking law" by suspending inspections', *HSJ*, 6 May 2020, retrieved 15 October 2020, www.hsj.co.uk/coronavirus/cqc-breaking-law-by-suspending-inspections/7027587.article

126 Department of Health and Social Care, 'Reducing bureaucracy in the health and social care system: background and questions', GOV.UK, 30 July 2020, retrieved 15 October 2020, www.gov.uk/government/consultations/reducing-bureaucracy-in-the-health-and-social-care-system-call-for-evidence/reducing-bureaucracy-in-the-health-and-social-care-system-background-and-questions

127 Department of Health and Social Care, 'Coronavirus (COVID-19): notification to organisations to share information', GOV.UK, 1 April 2020, retrieved 15 October 2020, www.gov.uk/government/publications/coronavirus-covid-19-notification-of-data-controllers-to-share-information

128 NHSx, 'Ask the IG Professional: FAQs', NHSx, (no date) retrieved 15 October 2020, www.nhsx.nhs.uk/covid-19-response/data-and-information-governance/information-governance/copi-notice-frequently-asked-questions

129 Institute for Government interview.

130 Golding N, 'NHS data sharing failure "exasperating and could cause error"', *HSJ*, 21 April 2020, retrieved 15 October 2020, www.hsj.co.uk/technology-and-innovation/nhs-data-sharing-failure-exasperating-and-could-cause-error/7027463.article

131 'TPP assists leading epidemiologists in ground-breaking COVID-19 study', TPP, press release, 1 June 2020, www.tpp-uk.com/news/tpp-assists-leading-epidemiologists-in-ground-breaking-covid-19-study

132 'Risk factors for COVID-19 death revealed in world's largest analysis of patient records to date', University of Oxford, 7 May 2020, www.ox.ac.uk/news/2020-05-07-risk-factors-covid-19-death-revealed-world-s-largest-analysis-patient-records-date

133 Chivers T, 'Finally! A way to analyse NHS data from 17 million people', UnHerd, 9 July 2020, retrieved 15 October 2020, https://unherd.com/thepost/finally-a-way-to-analyse-nhs-data-from-17-million-people

134 Understanding Patient Data, 'Health data and Covid-19: taking action while maintaining trust', Understanding Patient Data, 17 April 2020, retrieved 15 October 2020, https://understandingpatientdata.org.uk/news/health-data-and-covid-19-taking-action-while-maintaining-trust

Adult social care

1 Ministry of Housing, Communities and Local Government, 'Local authority COVID-19 financial impact monitoring information round 5', GOV.UK, Table 23, 19 August 2020, retrieved 15 October 2020, www.gov.uk/government/publications/local-authority-covid-19-financial-impact-monitoring-information

2 Association of Directors of Adult Social Services, *Budget survey 2020*, Association of Directors of Adult Social Services, 2020, www.adass.org.uk/media/7973/no-embargo-adass-budget-survey-report.pdf, p. 11.

3 Ministry of Housing, Communities and Local Government, 'Comprehensive new funding package for councils to help address coronavirus pressures and cover lost income during the pandemic', GOV.UK, 2 July 2020, retrieved 15 October 2020, www.gov.uk/government/news/comprehensive-new-funding-package-for-councils-to-help-address-coronavirus-pressures-and-cover-lost-income-during-the-pandemic

4 Ogden K, Phillips D and Spiliotis JC, 'COVID-19 and English council funding: what is the medium-term outlook?', Institute for Fiscal Studies, 2020, www.ifs.org.uk/publications/15041

5 Association of Directors of Adult Social Services, *Coronavirus survey*, Association of Directors of Adult Social Services, 2020, www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 18.

6 National Care Association, *June Update: Covid-19 and your care service impact survey*, National Care Association, 2020, https://nationalcareassociation.org.uk/content/images/uploads/headers/Covid-19-and-your-care-service-JUNE-UPDATE-survey-results.pdf

7 Local Government Association and Association of Directors of Adult Social Services, *COVID-19: Financial pressures in adult social care Information provided to the Minister of State for Care*, 2020, www.adass.org.uk/media/7929/covid-19-financial-pressures-in-adult-social-care-web.pdf

8 Crew J, 'Coronavirus: Number of empty beds in English care homes almost doubles in a year, survey finds', *The Independent*, 5 August 2020, retrieved 15 October 2020, www.independent.co.uk/news/uk/home-news/coronavirus-care-homes-beds-england-year-survey-a9654826.html

9 Care Quality Commission, *Covid-19 insight Issue 3*, Care Quality Commission, 2020, www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf, p. 14.

10 *Ibid*

11 Carterwood, 'Latest COVID-19 research: care home occupancy to recover in 2 years', Carterwood, 21 May 2020, retrieved 15 October 2020, www.carterwood.co.uk/latest-covid-19-research-care-home-occupancy-to-recover-in-2-years

12 Bottery S, 'How Covid-19 has magnified some of social care's key problems', The King's Fund, 25 August 2020, retrieved 15 October 2020, www.kingsfund.org.uk/publications/covid-19-magnified-social-care-problems

13 Care Quality Commission, *Covid-19 insight Issue 3*, Care Quality Commission, 2020, www.cqc.org.uk/sites/default/files/20200715%20COVID%20IV%20Insight%20number%203%20slides%20final.pdf, p. 14.

14 Association of Directors of Adult Social Services, *Coronavirus survey*, Association of Directors of Adult Social Services, 2020, www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 12.

15 Carers Week, *Carers Week 2020 Research Report*, Carers Week, 2020, www.carersweek.org/images/CW%20 2020%20Research%20Report%20WEB.pdf, p. 8

16 Carers UK, *Caring behind closed doors*, Carers UK, 2020, www.carersuk.org/images/News_and_campaigns/Behind_Closed_Doors_2020/Caring_behind_closed_doors_April20_pages_web_final.pdf, p. 6.

17 Abrahams C, 'Will the Treasury block social care reform again?', Age UK, 19 August 2020, retrieved 15 October 2020, www.ageuk.org.uk/discover/2020/08/will-treasury-block-social-care-reform-again

18 Griffiths D, Fenton W, Polzin G and others, *The state of the adult social care sector and workforce in England*, Skills for Care, 2019, www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf, p. 59.

19 Davies N, Atkins G, Guerin B and Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf, p. 36.

20 Department of Health and Social Care, 'Regular retesting rolled out for care home staff and residents', GOV.UK, 3 July 2020, retrieved 15 October 2020, www.gov.uk/government/news/regular-retesting-rolled-out-for-care-home-staff-and-residents

21 Telegraph reporters, 'Government 'drops pledge to test everyone in care homes for coronavirus'', The Telegraph, 2 August 2020, retrieved 15 October 2020, www.telegraph.co.uk/politics/2020/08/02/government-drops-pledge-test-everyone-care-homes-coronavirus/

22 Hardy J, 'No regular tests for social care staff for five weeks at dozens of homes, relatives told', *The Telegraph*, 30 July 2020, retrieved 15 October 2020, www.telegraph.co.uk/news/2020/07/30/no-regular-tests-social-care-staff-five-weeks-dozens-homes-relatives

23 Fenton W, Polzin G, Price R, *The size and structure of the adult social care sector and workforce in England*, Skills for Care, 2020, www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2020.pdf, p. 7.

24 Office for National Statistics, 'Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 20 July 2020', 7 August 2020, https://bit.ly/37JML18

25 Office for National Statistics, 'Impact of coronavirus in care homes in England: 26 May to 19 June 2020', Office for National Statistics, 3 July 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/impactofcoronavirusincarehomesinenglandvivaldi/26mayto19june2020#covid-19-surveillance-study-in-care-homes-vivaldi

26 Comptroller and Auditor General, *Readying the NHS and adult social care in England for COVID-19*, Session 2019-21, HC 367, National Audit Office, 12 June 2020 www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19.pdf, p. 48.

27 Griffiths D, Fenton W, Polzin G and others, *The state of the adult social care sector and workforce in England*, Skills for Care, 2019, www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/State-of-Report-2019.pdf, p. 67.

28 *Ibid.*, p. 70.

29 Office for National Statistics, 'Deaths involving COVID-19, England and Wales: deaths occurring in June 2020', Office for National Statistics, 17 July 2020, retrieved 15 October 2020, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinjune2020#characteristics-of-those-dying-from-covid-19

30 Public Health England, *Disparities in the risk and outcomes of COVID-19*, Public Health England, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf, p. 6.

31 Ministry of Housing, Communities and Local Government, 'Councils given greater financial relief against cash flow pressures', GOV.UK, 16 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/councils-given-greater-financial-relief-against-cash-flow-pressures

32 Ministry of Housing , Communities and Local Government, 'Government confirms allocations of £1.6 billion funding boost for councils', GOV.UK, 28 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/government-confirms-allocations-of-1-6-billion-funding-boost-for-councils

33 Department of Health and Social Care, 'Care home support package backed by £600 million to help reduce coronavirus infections', GOV.UK, 15 May 2020, retrieved 28 October 2020, www.gov.uk/government/news/care-home-support-package-backed-by-600-million-to-help-reduce-coronavirus-infections

34 Ministry of Housing, Communities and Local Government, 'Comprehensive new funding package for councils to help address coronavirus pressures and cover lost income during the pandemic', GOV.UK, 2 July 2020, retrieved 15 October 2020, https://www.gov.uk/government/news/comprehensive-new-funding-package-for-councils-to-help-address-coronavirus-pressures-and-cover-lost-income-during-the-pandemic

35 Ministry of Housing, Communities and Local Government, 'Government confirms allocations of £1.6 billion funding boost for councils', GOV.UK, 28 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/government-confirms-allocations-of-1-6-billion-funding-boost-for-councils

36 Association of Directors of Adult Social Services, *Budget survey 2020*, Association of Directors of Adult Social Services, 2020, www.adass.org.uk/media/7973/no-embargo-adass-budget-survey-report.pdf, p. 12.

37 Pope T, 'Coronavirus: government support for businesses and individuals', Institute for Government, 9 June 2020, retrieved 15 October 2020, www.instituteforgovernment.org.uk/explainers/coronavirus-government-financial-support

38 Bullion J, 'Letter to Minister of State for Care', Association of Directors of Adult Social Services, 29 May 2020, www.adass.org.uk/media/7909/200529-adass-letter-to-minister-of-state-re-infection-control-fund.pdf

39 UNISON, 'Care worker pay deductions must be tackled to stop hardship and control virus spread', UNISON, 15 June 2020, retrieved 15 October, www.unison.org.uk/news/press-release/2020/06/care-worker-pay-deductions-must-tackled-stop-hardship-control-virus-spread

40 Department of Health and Social Care, 'Written evidence submitted by the Department of Health and Social Care (SCF0069)', House of Commons Health and Social Care Committee, 2020, https://committees.parliament.uk/writtenevidence/7686/html

41 Davies N, Atkins G, Guerin B and Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf

42 Johnson B, 'Boris Johnson's first speech as Prime Minister: 24 July 2019', GOV.UK, 24 July 2020, retrieved 15 October 2020, www.gov.uk/government/speeches/boris-johnsons-first-speech-as-prime-minister-24-july-2019

43 Association of Directors of Adult Social Services, *Budget survey 2020*, Association of Directors of Adult Social Services, 2020, www.adass.org.uk/media/7973/no-embargo-adass-budget-survey-report.pdf, p. 20.

44 Department of Health and Social Care, 'About the Adult Social Care Infection Control Fund', GOV.UK, 21 September 2020, retrieved 15 October 2020, www.gov.uk/government/publications/adult-social-care-infection-control-fund/about-the-adult-social-care-infection-control-fund

45 NHS England and NHS Improvement, 'Digital tool to help reduce avoidable lengthy stays in hospital', NHS England and NHS Improvement, 15 April 2019, retrieved 15 October 2020, www.england.nhs.uk/2019/04/digital-tool-to-help-reduce-avoidable-lengthy-stays-in-hospital

46 North of England Commissioning Support, 'User guide for care homes', North of England Commissioning Support, 2020, www.derbyshire.gov.uk/site-elements/documents/pdf/social-health/health-and-wellbeing/health-protection/capacity-tracker-user-guide-for-care-homes.pdf, pp. 7-9.

47 Massey E, 'Majority of care home providers in England now using Capacity Tracker', Digital Social Care, 8 June 2020, retrieved 15 October 2020, www.digitalsocialcare.co.uk/majority-of-care-home-providers-in-england-now-using-capacity-tracker

48 Brown S, 'Capacity Tracker takes centre stage (#DoingOurBit)', Healthcare Financial Management Association, 4 June 2020, retrieved 15 October 2020, www.hfma.org.uk/news/news-list/Article/capacity-tracker-takes-centre-stage-supporting-health-and-social-care-(-doingourbit)

49 Institute for Government interview.

50 Department of Health and Social Care, 'About the Adult Social Care Infection Control Fund', GOV.UK, 21 September 2020, retrieved 15 October 2020, www.gov.uk/government/publications/adult-social-care-infection-control-fund/about-the-adult-social-care-infection-control-fund

51 Institute of Public Care, *The Impact of Technology in Adult Social Care Provider Services*, Institute of Public Care, 2020, https://ipc.brookes.ac.uk/publications/Technology%20action%20research%20report%2028July2020.pdf, p. 36.

52 *Ibid.*, p. 2.

53 Local Government Association, Institute of Public Care, Association of Directors of Adult Social Services, *Digital innovation in adult social care: how we've been supporting communities during COVID-19*, Local Government Association, Institute of Public Care, Association of Directors of Adult Social Services, 2020, www.local.gov.uk/sites/default/files/documents/25.172%20Digital%20innovation%20in%20adult%20social%20care_3.pdf, p. 17.

54 *Ibid.*, p. 17.

55 *Ibid.*, p. 12

56 Institute of Public Care, *The Impact of Technology in Adult Social Care Provider Services*, Institute of Public Care, 2020, https://ipc.brookes.ac.uk/publications/Technology%20action%20research%20report%2028July2020.pdf, p. 15.

57 *Ibid.*, p. 36.

58 Local Government Association, Institute of Public Care, Association of Directors of Adult Social Services, *Digital innovation in adult social care: how we've been supporting communities during COVID-19*, Local Government Association, Institute of Public Care, Association of Directors of Adult Social Services, 2020, www.local.gov.uk/sites/default/files/documents/25.172%20Digital%20innovation%20in%20adult%20social%20care_3.pdf, p. 14.

59 Department of Health and Social Care, 'Digital innovations tested to support vulnerable people during COVID-19 outbreak', GOV.UK, 24 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/digital-innovations-tested-to-support-vulnerable-people-during-covid-19-outbreak

60 Editor, 'Aylesbury care home appeals to local community for iPads and tablets', Care Industry News, 7 May 2020, retrieved 15 October 2020, https://careindustrynews.co.uk/2020/05/aylesbury-care-home-appeals-to-local-community-for-ipads-and-tablets-coronavirus-social-care-news-care-home-news

61 Wigan Council, ''Lifeline' iPads help care home residents stay in touch throughout lockdown', Wigan Council, 17 August 2020, retrieved 15 October 2020, www.wigan.gov.uk/News/Articles/2020/August/Lifeline-iPads-help-care-home-residents.aspx

62 Evans S and Bray J, 'The iPad Project: Introducing iPads into Care Homes in the UK to Support Digital Inclusion', *Gerontechnology*, 2017, vol. 16, pp. 91-100, www.semanticscholar.org/paper/The-iPad-Project%3A-Introducing-iPads-into-Care-Homes-Evans-Bray/51f4b493f9d756b38a01beba438ab407d6ff33bd

63 Think Local Act Personal, 'Gig Buddies in Lockdown', Think Local Act Personal , 20 August 2020, retrieved 15 October 2020, www.thinklocalactpersonal.org.uk/covid-19/social-care-provision-stories-of-promise/Gig-Buddies-in-Lockdown

64 Topol E, *The Topol Review: Preparing the healthcare workforce to deliver the digital future*, Health Education England, 2019, www.hee.nhs.uk/our-work/topol-review

65 Marshall J, Nice A, Haddon C, Hogarth R, 'Coronavirus Act 2020', Institute for Government, 26 March 2020, retrieved 15 October 2020, www.instituteforgovernment.org.uk/explainers/coronavirus-act

66 Department of Health and Social Care, 'Care Act easements: guidance for local authorities', GOV.UK, 1 September 2020, retrieved 15 October 2020, www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

67 Foster D, *Coronavirus: Local authorities' adult social care duties (the Care Act easements)*, House of Commons, 9 October 2020, https://commonslibrary.parliament.uk/research-briefings/cbp-8889, p. 8.

68 Institute for Government interview.

69 Samuel M, 'Eight councils have triggered Care Act duty moratorium in month since emergency law came into force', Community Care, 30 April 2020, retrieved 15 October 2020, www.communitycare.co.uk/2020/04/30/eight-councils-triggered-care-act-duty-moratorium-month-since-emergency-law-came-force

70 Foster D, *Coronavirus: Local authorities' adult social care duties (the Care Act easements)*, House of Commons, 9 October 2020, https://commonslibrary.parliament.uk/research-briefings/cbp-8889

71 Samuel M, 'Eight councils have triggered Care Act duty moratorium in month since emergency law came into force', Community Care, 30 April 2020, retrieved 15 October 2020, www.communitycare.co.uk/2020/04/30/eight-councils-triggered-care-act-duty-moratorium-month-since-emergency-law-came-force

72 Association of Directors of Adult Social Services, 'Coronavirus survey', 2020, www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 12.

73 Mind, *Written evidence from Mind (RCC 03)*, House of Commons Health and Social Care Committee, 2020, https://committees.parliament.uk/writtenevidence/7039/pdf, p. 6.

74 Association of Directors of Adult Social Services, 'Coronavirus survey', 2020, https://www.adass.org.uk/media/7967/adass-coronavirus-survey-report-2020-no-embargo.pdf, p. 16.

75 Department of Health and Social Care, 'About the Adult Social Care Infection Control Fund', GOV.UK, 21 September 2020, retrieved 15 October 2020, www.gov.uk/government/publications/adult-social-care-infection-control-fund/about-the-adult-social-care-infection-control-fund

76 Institute for Government interview.

77 Institute for Government interview.

78 Topol E, *The Topol Review: Preparing the healthcare workforce to deliver the digital future*, Health Education England, 2019, www.hee.nhs.uk/our-work/topol-review

Schools

1 Department for Education, 'Guidance - School funding: exceptional costs associated with coronavirus (COVID-19) for the period from March to July 2020', GOV.UK, 10 July 2020, retrieved 15 October 2020, www.gov.uk/government/publications/coronavirus-covid-19-financial-support-for-schools/school-funding-exceptional-costs-associated-with-coronavirus-covid-19-for-the-period-march-to-july-2020

2 Sharp C, Nelson J, Lucas M, Julius J, McCrone T, and Sims D, *The challenges facing schools and pupils in September 2020*, National Foundation for Educational Research, September 2020, www.nfer.ac.uk/media/4119/schools_responses_to_covid_19_the_challenges_facing_schools_and_pupils_in_september_2020.pdf, p. 30

3 Department for Education, 'Guidance - School funding: exceptional costs associated with coronavirus (COVID-19) for the period from March to July 2020', GOV.UK, 10 July 2020, retrieved 15 October 2020, www.gov.uk/government/publications/coronavirus-covid-19-financial-support-for-schools/school-funding-exceptional-costs-associated-with-coronavirus-covid-19-for-the-period-march-to-july-2020

4 *Ibid.*

5 House of Commons, 'Schools: Coronavirus: Written question – 76047', parliament.uk, 17 July 2020, retrieved 15 October 2020, www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2020-07-17/76047

6 Department for Education, Academic Year 2019/20: Schools, pupils and their characteristics, GOV.UK, 21 September 2020, https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics

7 Education and Skills Funding Agency, 'Guidance: Exceptional costs associated with coronavirus (COVID-19)', GOV.UK, 22 July 2020, retrieved 15 October 2020, www.gov.uk/government/publications/claiming-exceptional-costs-associated-with-coronavirus-covid-19/exceptional-costs-associated-with-coronavirus-covid-19--2

8 Department for Education, 'Guidance - School funding: exceptional costs associated with coronavirus (COVID-19) for the period from March to July 2020', GOV.UK, 10 July 2020, retrieved 15 October 2020, www.gov.uk/government/publications/coronavirus-covid-19-financial-support-for-schools/school-funding-exceptional-costs-associated-with-coronavirus-covid-19-for-the-period-march-to-july-2020

9 Department for Education, *Coronavirus (COVID-19) schools fund claim*, GOV.UK, (no date), retrieved 15 October 2020, https://form.education.gov.uk/service/coronavirus-schools-fund-claim

10 Scientific Advisory Group for Emergencies, *SPI-M-O: Consensus view on the impact of school closures on Covid-19*, 17 March 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888390/s0063-spi-m-o-consensus-view-school-closures-170320-sage17.pdf

11 Department for Education, 'Schools, colleges and early years settings to close', press release, 18 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/schools-colleges-and-early-years-settings-to-close

12 House of Commons Education Committee, *Getting the grades they've earned Covid-19: the cancellation of exams and 'calculated' grades*, HC 617, 11 July 2020, https://committees.parliament.uk/publications/1834/documents/17976/default, p. 5.

13 Department for Education, 'Schools, colleges and early years settings to close', press release, 18 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/schools-colleges-and-early-years-settings-to-close

14 Children's Commissioner, *Briefing: Tackling the disadvantage gap during the Covid-19 crisis*, April 2020, www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-tackling-the-disadvantage-gap-during-the-covid-19-crisis.pdf

15 House of Commons Education Committee, 'Oral evidence: The impact of COVID-19 on education and children's services, HC 254', 29 April 2020, https://committees.parliament.uk/oralevidence/325/pdf, Q. 67

16 House of Commons Library, Coronavirus and schools: FAQs, briefing paper 08915, 11 September 2020, https://researchbriefings.files.parliament.uk/documents/CBP-8915/CBP-8915.pdf, p. 11.

17 Eivers E, Worth J and Ghosh A, *Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study*, National Foundation for Educational Research, www.nfer.ac.uk/media/4101/home_learning_during_covid_19_findings_from_the_understanding_society_longitudinal_study.pdf

18 TeacherTapp, *How things have got better in schools over the lockdown*, blog, 13 July 2020, retrieved 15 October 2020, https://teachertapp.co.uk/how-things-have-got-better-in-schools-over-the-lockdown

19 Coe R, Weidmann B, Coleman R, Kay J et al, *Impact of school closures on the attainment gap: Rapid Evidence Assessment*, Education Endowment Foundation, June 2020, https://educationendowmentfoundation.org.uk/public/files/EEF_(2020)_-_Impact_of_School_Closures_on_the_Attainment_Gap.pdf, p. 19.

20 House of Commons Education Committee, 'Oral evidence: The impact of COVID-19 on Education and Children's Services, HC 254', 22 April 2020, https://committees.parliament.uk/oralevidence/299/pdf, p. 24.

21 Out of School Alliance, *Survey results: Impact of coronavirus on OSCs*, May 2020, www.outofschoolalliance.co.uk/coronavirus-survey-report

22 Department for Education, 'Guidance: Protective measures for holiday and after-school clubs, and other out-of-school settings during the coronavirus (COVID-19) outbreak', 15 October 2020, retrieved 15 October 2020, www.gov.uk/government/publications/protective-measures-for-holiday-or-after-school-clubs-and-other-out-of-school-settings-for-children-during-the-coronavirus-covid-19-outbreak/protective-measures-for-out-of-school-settings-during-the-coronavirus-covid-19-outbreak

23 Out of School Alliance, *Impact of Covid-19 on OSCs: follow-up survey*, August 2020, www.outofschoolalliance.co.uk/downloads/Covid-Survey-results-Aug2020.pdf

24 Department for Education, *Characteristics of children in need: 2018 to 2019 (England)*, 31 October 2019, retrieved 15 October 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843046/Characteristics_of_children_in_need_2018_to_2019_main_text.pdf

25 Institute for Government interview.

26 TeacherTapp, *What Are Teachers Doing At Home? (And Where Are You Doing It?)*, blog, 27 April 2020, retrieved 15 October 2020, https://teachertapp.co.uk/what-are-teachers-doing-at-home-and-where-are-you-doing-it

27 Sharp C, Sims D and Rutt S, *Returning pupils to school*, June 2020, www.nfer.ac.uk/media/4060/schools_responses_to_covid_19_early_report_final.pdf, p. 4.

28 Hazell W, 'Schools reopening: Head teachers report high attendance in week one — but first school closes due to Covid-19', *inews.co.uk*, 4 September 2020, retrieved 15 October 2020, https://inews.co.uk/news/education/schools-reopening-headteachers-attendance-week-one-first-school-closes-covid-19-632671

29 Coe R, Weidmann B, Coleman R, Kay J et al, *Impact of school closures on the attainment gap: Rapid Evidence Assessment*, Education Endowment Foundation, June 2020, https://educationendowmentfoundation.org.uk/public/files/EEF_(2020)_-_Impact_of_School_Closures_on_the_Attainment_Gap.pdf

30 Department for Education, *Guidance for full opening: schools*, 1 October 2020, retrieved 15 October 2020, www.gov.uk/government/publications/actions-for-schools-during-the-coronavirus-outbreak/guidance-for-full-opening-schools

31 Sharp C, Sims D, Rutt S, Schools' responses to Covid-19: Returning pupils to school, National Foundation for Educational Research, www.nfer.ac.uk/return-of-pupils-to-school-schools-responses-to-covid-19

32 Ferguson D, 'Class sizes in UK may rise to 60 as schools struggle to cover for self-isolating teachers', *The Guardian*, 27 September 2020, www.theguardian.com/education/2020/sep/27/class-sizes-in-uk-may-rise-to-60-as-schools-struggle-to-cover-for-self-isolating-teachers

33 Eivers E, Worth J and Ghosh A, *Home learning during Covid-19: Findings from the Understanding Society Longitudinal Study*, National Foundation for Educational Research, www.nfer.ac.uk/media/4101/home_learning_during_covid_19_findings_from_the_understanding_society_longitudinal_study.pdf

34 Department for Education, 'Guidance: get help with remote education', GOV.UK, 19 April 2020, retrieved 15 October 2020, www.gov.uk/guidance/remote-education-during-coronavirus-covid-19

35 *Ibid.*

36 Oak National Academy, *End of Term Report: Insights and reflections from Oak's first term*, 2020, https://assets.thenational.academy/reports/oak-national-end-of-term-report-summer-2020.pdf, p. 7.

37 Department for Education, 'New major package to support online learning', news story, 19 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/new-major-package-to-support-online-learning

38 BBC, 'BBC to deliver biggest push on education in its history', 3 April 2020, retrieved 15 October 2020, www.bbc.co.uk/mediacentre/latestnews/2020/coronavirus-education

39 Ellis-Thompson A, Higgins S, Kay J, Stevenson J, Zaman M, Remote Learning: Rapid Evidence Assessment, Education Endowment Foundation, April 2020, https://educationendowmentfoundation.org.uk/public/files/Remote_Learning_Rapid_Evidence_Assessment.pdf

40 Department for Education, *Guidance for full opening: schools*, 1 October 2020, retrieved 15 October 2020, www.gov.uk/government/publications/actions-for-schools-during-the-coronavirus-outbreak/guidance-for-full-opening-schools

41 Ellis-Thompson A, Higgins S, Kay J, Stevenson J, Zaman M, Remote Learning: Rapid Evidence Assessment, Education Endowment Foundation, April 2020, https://educationendowmentfoundation.org.uk/public/files/Remote_Learning_Rapid_Evidence_Assessment.pdf, p. 4.

42 House of Commons Education Committee, 'Oral evidence: The impact of COVID-19 on education and children's services, HC 254', 29 April 2020, https://committees.parliament.uk/oralevidence/325/pdf, Q. 67.

43 Department for Education, 'New major package to support online learning', GOV.UK, 19 April 2020, retrieved 3 September 2020, www.gov.uk/government/news/new-major-package-to-support-online-learning

44 Department for Education, *Guidance for full opening: schools*, 1 October 2020, retrieved 15 October 2020, www.gov.uk/government/publications/actions-for-schools-during-the-coronavirus-outbreak/guidance-for-full-opening-schools

45 Nickson S, Thomas A, Mullens-Burgess E, Decision making in a crisis: First responses to the coronavirus pandemic, Institute for Government, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/decision-making-crisis.pdf, p. 46.

46 Department for Education, Devices and 4G Wireless Routers Data, GOV.UK, 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/896820/Devices_and_4G_wireless_routers_progress_data_010720.pdf

47 Dickens J, 'DfE fails to meet target of delivering 230k laptops by end of June', *Schools Week*, 1 July 2020, retrieved 15 October 2020, https://schoolsweek.co.uk/dfe-fails-to-meet-target-of-delivering-230k-laptops-by-end-of-june

48 House of Commons Education Committee, 'Oral evidence: The impact of Covid-19 on education and children's services, HC 254', 17 June 2020, https://committees.parliament.uk/oralevidence/527/pdf, Q. 562.

49 Sharp C, Nelson J, Lucas M, Julius J, McCrone T, and Sims D, *The challenges facing schools and pupils in September 2020*, National Foundation for Educational Research, September 2020, www.nfer.ac.uk/media/4119/schools_responses_to_covid_19_the_challenges_facing_schools_and_pupils_in_september_2020.pdf, p. 30.

50 House of Commons Education Committee, 'Oral evidence: The impact of Covid-19 on education and children's services, HC 254', 3 June 2020, https://committees.parliament.uk/oralevidence/441/pdf, Q. 387.

51 Department for Education, Guidance: Get laptops and tablets for children who cannot attend school due to coronavirus (COVID-19), 1 October 2020, retrieved 15 October 2020, www.gov.uk/guidance/get-laptops-and-tablets-for-children-who-cannot-attend-school-due-to-coronavirus-covid-19

52 *Ibid.*

53 Contracts Finder, 'Get Help With Technology - Device Reserve', GOV.UK, 8 September 2020, retrieved 15 October 2020, www.contractsfinder.service.gov.uk/Notice/cad1182c-126f-4787-b447-60b6271bef2a?origin=SearchResults&p=3

54 Ferguson D and Walawalkar A, 'Laptop allocation for England's schools slashed by 80%', *The Guardian*, 24 October 2020, retrieved 28 October 2020, www.theguardian.com/education/2020/oct/24/englands-schools-to-receive-fewer-laptops-for-distance-learning

55 Institute for Government interview.

56 Phillips N, 'Schools turn to philanthropists for laptops as wait for DfE devices continues', *Schools Week*, 24 May 2020, retrieved 15 October 2020, https://schoolsweek.co.uk/schools-turn-to-philanthropists-for-laptops-as-wait-for-dfe-devices-continues

57 (No author), *Support for vulnerable pupils and the children of keyworkers*, National Foundation for Educational Research, June 2020, https://mk0nuffieldfounpg9ee.kinstacdn.com/wp-content/uploads/2020/06/schools_responses_to_covid_19_support_for_vulnerable_pupils_and_the_children_of_keyworkerspdf.pdf

58 Dickens J, 'The cost of lockdown: attainment gap widens by up to 52% for primary pupils', *Schools Week*, 24 July 2020, retrieved 15 October 2020, https://schoolsweek.co.uk/the-cost-of-lockdown-attainment-gap-widens-by-up-to-52-for-primary-pupils

59 Andrew A, Cattan S, Phimister A, Krutikova S, Kraftman L, Costa Dias M and Sevilla A, 'Primary school closures created substantial inequality in time spent learning between pupils from poorer and better-off families - and re-opening schools may be the only remedy', Institute for Fiscal Studies, 17 August 2020, www.ifs.org.uk/publications/14976

60 Coe R, Weidmann B, Coleman R, Kay J et al, *Impact of school closures on the attainment gap: Rapid Evidence Assessment*, Education Endowment Foundation, June 2020, https://educationendowmentfoundation.org.uk/public/files/EEF_(2020)_-_Impact_of_School_Closures_on_the_Attainment_Gap.pdf, p. 4.

61 House of Commons Education Committee, 'Oral evidence: The impact of Covid-19 on education and children's services, HC 254', 3 June 2020, https://committees.parliament.uk/oralevidence/441/pdf, Q. 417.

62 (No author), *Balancing the Risks of Pupils Returning to Schools*, Royal Society DELVE Initiative, 24 July 2020, retrieved 15 October 2020, https://rs-delve.github.io/reports/2020/07/24/balancing-the-risk-of-pupils-returning-to-schools.html#schools-and-learning-loss

63 Department for Education, Prime Minister's Office, 10 Downing Street, 'Billion pound Covid catch-up plan to tackle impact of lost teaching time', press release, 19 June 2020, retrieved 15 October 2020, www.gov.uk/government/news/billion-pound-covid-catch-up-plan-to-tackle-impact-of-lost-teaching-time

64 (No author), *National Tutoring Programme*, Education Endowment Foundation, 24 August 2020, retrieved 15 October 2020, https://educationendowmentfoundation.org.uk/covid-19-resources/national-tutoring-programme

65 Beaglehole, B., Bell, C. Frampton, C, and Moor, St., 'The impact of the Canterbury earthquakes on successful school leaving for adolescents', *Australian and New Zealand Journal of Public Health*, Vol 41 (1), 2017, pp. 70-73.

66 Portes, J, 'The lasting scars of the Covid-19 crisis: Channels and impacts', VOX-EU, 1 June 2020, retrieved 15 October 2020, https://voxeu.org/article/lasting-scars-covid-19-crisis

67 House of Commons Education Committee, 'Oral evidence: The impact of Covid-19 on education and children's services, HC 254', 3 June 2020, https://committees.parliament.uk/oralevidence/441/pdf, Q. 401.

68 (No author), *Small group tuition*, Education Endowment Foundation, (no date), retrieved 15 October 2020, https://educationendowmentfoundation.org.uk/evidence-summaries/teaching-learning-toolkit/small-group-tuition/

69 (No author), *One-to-one tuition*, Education Endowment Foundation, (no date), retrieved 15 October 2020, https://educationendowmentfoundation.org.uk/evidence-summaries/teaching-learning-toolkit/one-to-one-tuition

70 Education Policy Institute, 'EPI's Executive Chair, David Laws, has commented on the Department for Education's "catch up" package announced today', Tweet, 19 June 2020, retrieved 15 October 2020, https://twitter.com/EduPolicyInst/status/1273884925956153345

71 Staton B and Hughes L, 'England's school catch-up package is less than £80 per pupil, says IFS', *Financial Times*, 19 June 2020, www.ft.com/content/1bb7d2ae-e227-4df7-808f-2d1c81899f95

72 Children's Commissioner, *We're all in this together? Local area profiles of child vulnerability*, April 2020, www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-were-all-in-this-together.pdf, p. 5.

73 Department for Education, Academic Year 2019/20: Schools, pupils and their characteristics, GOV.UK, 21 September 2020, https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics

74 Dickens J, 'NTP won't be fully operational until Spring, plus 4 more catch-up funding details', *Schools Week*, 20 July 2020, retrieved 15 October 2020, https://schoolsweek.co.uk/ntp-wont-be-fully-operational-until-spring-plus-4-more-catch-up-funding-details

75 Dickens J, 'Teach First to target axed trainees for new catch-up mentor roles', *Schools Week*, 20 July 2020, https://schoolsweek.co.uk/teach-first-to-target-axed-trainees-for-new-catch-up-mentor-roles

76 Education Policy Institute, *Preventing the disadvantage gap from increasing during and after the Covid-19 pandemic: proposals from the Education Policy Institute*, May 2020, https://epi.org.uk/wp-content/uploads/2020/05/EPI-Policy-paper-Impact-of-Covid-19_docx.pdf

77 Coe R, Weidmann B, Coleman R, Kay J et al, *Impact of school closures on the attainment gap: Rapid Evidence Assessment*, Education Endowment Foundation, June 2020, https://educationendowmentfoundation.org.uk/public/files/EEF_(2020)_-_Impact_of_School_Closures_on_the_Attainment_Gap.pdf, p. 5.

78 Crawford C, Greaves E, and Rabe B, 'What difference will the COVID Summer Food Fund make to children's lives?', Economics Observatory, 4 July 2020, retrieved 15 October 2020, www.coronavirusandtheeconomy.com/question/what-difference-will-covid-summer-food-fund-make-childrens-lives

79 Department for Education, 'Guidance: Providing school meals during the coronavirus (COVID-19) outbreak', 23 September 2020, retrieved 15 October: 2020, www.gov.uk/government/publications/covid-19-free-school-meals-guidance/covid-19-free-school-meals-guidance-for-schools

80 Department for Education, 'Voucher scheme launches for schools providing free school meals', press release, 31 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/voucher-scheme-launches-for-schools-providing-free-school-meals

81 Institute for Government interview.

82 House of Commons, 'Free School Meals: Written question – 91683', parliament.uk, 17 September 2020, retrieved 15 October 2020, https://questions-statements.parliament.uk/written-questions/detail/2020-09-17/91683

83 Williamson G, letter to Robert Halfon, 1 July 2020, https://committees.parliament.uk/publications/1786/documents/17365/default

84 Whittaker F, 'Government sets up £120m 'Covid summer food fund' after free meal vouchers U-turn', *Schools Week*, 16 June 2020, https://schoolsweek.co.uk/government-sets-up-covid-summer-food-fund-after-free-meal-vouchers-u-turn

85 Hayter U, 'Free School meals extended to thousands more children', Deighton Pierce Glynn, 6 April 2020, retrieved 15 October 2020, https://dpglaw.co.uk/free-school-meals-extended-to-thousands-more-children

86 Department for Education, 'Guidance: Coronavirus (COVID-19): temporary extension of free school meals eligibility to NRPF groups', 23 September 2020, retrieved 15 October 2020, www.gov.uk/government/publications/covid-19-free-school-meals-guidance/guidance-for-the-temporary-extension-of-free-school-meals-eligibility-to-nrpf-groups

87 Crawford C, Greaves E, and Rabe B, 'What difference will the COVID Summer Food Fund make to children's lives?', Economics Observatory, 4 July 2020, retrieved 15 October 2020, www.coronavirusandtheeconomy.com/question/what-difference-will-covid-summer-food-fund-make-childrens-lives

88 Kitchen S, Tanner E, Brown V, Paune C, Crawford C, Dearden L, Greaves E, and Purdon S, *Evaluation of the Free School Meals Pilot: Impact report*, Department for Education research report, January 2013, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/184047/DFE-RR227.pdf

89 Holford A, Rabe B, *Going universal – The impact of free school lunches on child body weight outcomes*, Institute for Social and Economic Research, University of Essex, 6 March 2020, www.iser.essex.ac.uk/files/projects/FSM/UIFSM_Bodyweight_Outcomes_20200306.pdf

90 Education Policy Institute, *Preventing the disadvantage gap from increasing during and after the Covid-19 pandemic: proposals from the Education Policy Institute*, May 2020, https://epi.org.uk/wp-content/uploads/2020/05/EPI-Policy-paper-Impact-of-Covid-19_docx.pdf

91 Nickson S, Thomas A, Mullens-Burgess E, *Decision making in a crisis: First responses to the coronavirus pandemic*, Institute for Government, August 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/decision-making-crisis.pdf, p. 46

92 Institute for Government interview.

93 House of Commons Education Committee, 'Oral evidence: The impact of COVID-19 on education and children's services, HC 254', 29 April 2020, https://committees.parliament.uk/oralevidence/325/pdf, Q. 95.

94 House of Commons Education Committee, 'Oral evidence: The impact of COVID-19 on education and children's services, HC 254', 22 April 2020, https://committees.parliament.uk/oralevidence/299/pdf, Q. 42.

95 (No author), 'UK: Children in England Going Hungry with Schools Shut', Human Rights Watch, 27 May 2020, retrieved 15 October 2020, www.hrw.org/news/2020/05/27/uk-children-england-going-hungry-schools-shut

96 Scottish Government, 'Helping communities affected by COVID-19', news, 18 March 2020, retrieved 15 October 2020, www.gov.scot/news/helping-communities-affected-by-covid-19

97 Welsh Government, 'Revised guidance for schools in Wales: supporting children eligible for free school meals', 22 June 2020, retrieved 15 October 2020, https://gov.wales/free-school-meals-coronavirus-guidance-schools#section-38527

98 *Ibid.*

99 (No author), 'UK: Children in England Going Hungry with Schools Shut', Human Rights Watch, 27 May 2020, retrieved 15 October 2020, www.hrw.org/news/2020/05/27/uk-children-england-going-hungry-schools-shut

100 Education Policy Institute, *Preventing the disadvantage gap from increasing during and after the Covid-19 pandemic: proposals from the Education Policy Institute*, May 2020, https://epi.org.uk/wp-content/uploads/2020/05/EPI-Policy-paper-Impact-of-Covid-19_docx.pdf

101 Whittaker F, 'Extend free school meal vouchers over summer holiday, says senior Tory MP', *Schools Week*, 5 June 2020, retrieved 15 October 2020, https://schoolsweek.co.uk/extend-free-school-meal-vouchers-over-summer-holiday-says-senior-tory-mp

102 Williamson G, 'Educational settings', statement, 18 March 2020, Vol. 673, retrieved 15 October 2020, https://hansard.parliament.uk/Commons/2020-03-18/debates/FCD4DEB2-86A8-4F95-8EB8-D0EF4C752D7D/EducationalSettings

103 Department for Education, 'Further details on exams and grades announced', press release, 20 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/further-details-on-exams-and-grades-announced

104 Ofqual, 'How GCSEs, AS & A levels will be awarded in summer 2020', news story, 3 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/how-gcses-as-a-levels-will-be-awarded-in-summer-2020

105 Department for Education, 'Further details on exams and grades announced', press release, 20 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/further-details-on-exams-and-grades-announced

106 Williamson G, 'Direction under S 129(6) of the Apprenticeships, Skills, Children and Learning Act 2009', letter to Sally Collier, 31 March 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877611/Letter_from_Secretary_of_State_for_Education_to_Sally_Collier.pdf

107 Ofqual, *Exceptional arrangements for exam grading and assessment in 2020*, May 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/887048/Summer_2020_Awarding_GCSEs_A_levels_-_Consultation_decisions_22MAY2020.pdf

108 House of Commons Education Committee, *Getting the grades they've earned Covid-19: the cancellation of exams and 'calculated' grades*, HC 617, 11 July 2020, https://committees.parliament.uk/publications/1834/documents/17976/default

109 Duong H, 'How bad were Ofqual's grades', Higher Education Policy Institute, 18 August 2020, retrieved 15 october 2020, www.hepi.ac.uk/2020/08/18/how-bad-were-ofquals-grades-by-huy-duong

110 Department for Education, 'GCSE and A level students to receive centre assessment grades', news story, 18 August 2020, retrieved 15 October 2020, www.gov.uk/government/news/gcse-and-a-level-students-to-receive-centre-assessment-grades

111 House of Commons Education Committee, *Getting the grades they've earned Covid-19: the cancellation of exams and 'calculated' grades*, HC 617, 11 July 2020, https://committees.parliament.uk/publications/1834/documents/17976/default, p. 7.

112 Nye P, 'GCSE results 2020: Did attainment gaps increase?', FFT Education Datalab, 18 September 2020, retrieved 15 October 2020, https://ffteducationdatalab.org.uk/2020/09/gcse-results-2020-did-attainment-gaps-increase

113 Department for Education, 'Students to be given more time to prepare for 2021 exams', GOV.UK, 12 October 2020, retrieved 15 October 2020, www.gov.uk/government/news/students-to-be-given-more-time-to-prepare-for-2021-exams

114 Cook C, 'Accidents and A-levels', blog, 27 August 2020, retrieved 15 October 20202, https://chriscook.news/normal-accidents

115 Ofsted, 'Ofsted suspends all routine inspections', press release, 17 March 2020, retrieved 15 October 2020, www.gov.uk/government/news/ofsted-suspends-all-routine-inspections

116 Ofsted, 'Ofsted to visit when schools and colleges return in the autumn', press release, 6 July 2020, retrieved 15 October 2020, www.gov.uk/government/news/ofsted-to-visit-when-schools-and-colleges-return-in-the-autumn

117 Spielman A, 'HMCI commentary: Our plans for the autumn', blog, 6 July 2020, retrieved 15 October 2020, www.gov.uk/government/speeches/hmci-commentary-our-plans-for-the-autumn

118 Ofsted, 'Ofsted visits to schools and colleges to begin this month', press release, 2 September 2020, retrieved 15 October 2020, www.gov.uk/government/news/ofsted-visits-to-schools-and-colleges-to-begin-this-month

119 Bush S, 'What happened when Ofsted came for a visit', *TES*, 24 September 2020, www.tes.com/news/coronavirus-schools-what-happened-when-ofsted-came-visit

120 National Association of Head Teachers, National Governance, Association of School and College Leaders, 'NAHT, NGA and ASCL call on Amanda Spielman to reconsider Ofsted's proposals for autumn term visits', news, 4 September 2020, retrieved 15 October 2020, www.naht.org.uk/news-and-opinion/news/structures-inspection-and-accountability-news/naht-nga-and-ascl-write-to-amanda-spielman-regarding-ofsteds-proposals-regarding-autumn-term-visits

121 Department for Education, *Guidance for full opening: schools*, 1 October 2020, retrieved 15 October 2020, www.gov.uk/government/publications/actions-for-schools-during-the-coronavirus-outbreak/guidance-for-full-opening-schools

122 Ofsted, *The education inspection framework*, May 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/801429/Education_inspection_framework.pdf

123 (No author), 'Amanda Spielman, Ofsted's Chief Inspector, introduces the new framework', YouTube, 14 May 2019, www.youtube.com/watch?v=byaUliCMi9E

Criminal courts

1 Office for National Statistics, 'Coronavirus and crime in England and Wales: August 2020', 26 August 2020, retrieved 15 October 2020 www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/coronavirusandcrimeinenglandandwales/august2020

2 *Ibid.*

3 Ivandic R and Kirchmaier T, 'Domestic abuse in times of quarantine', London School of Economics, 15 July 2020, https://cep.lse.ac.uk/pubs/download/cp578.pdf

4 Grierson J, 'Suspects to avoid criminal charges in UK during Covid-19 crisis', *The Guardian*, 14 April 2020, www.theguardian.com/law/2020/apr/14/suspects-to-avoid-criminal-charges-in-uk-during-covid-19-crisis

5 House of Commons Justice Committee, 'Oral evidence: Coronavirus: the impact on prison, probation and court systems', HC 299, 4 May 2020, https://committees.parliament.uk/oralevidence/337/pdf, p. 27.

6 HM Courts and Tribunals Service, 'HMCTS weekly management information during coronavirus – March to August 2020', 10 September 2020, retrieved 15 October 2020, www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-to-august-2020

7 HM Courts and Tribunals Service, 'Courts and tribunals data on audio and video technology during coronavirus outbreak', HM Courts and Tribunals Service, 30 April 2020, retrieved 15 October 2020, www.gov.uk/guidance/courts-and-tribunals-data-on-audio-and-video-technology-use-during-coronavirus-outbreak

8 HM Courts and Tribunals Service, 'HMCTS weekly management information during coronavirus – March to August 2020', 10 September 2020, retrieved 15 October 2020, www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-to-august-2020

9 Davies N, Pope T, Guerin B, *The Criminal Justice System: How government reforms and coronavirus will affect policing, courts and prisons,* Institute for Government and CIPFA, 28 April 2020, www.instituteforgovernment.org.uk/sites/default/files/publications/criminal-justice-system_0.pdf

10 HM Courts and Tribunals Service, 'HMCTS weekly management information during coronavirus – March to August 2020', 10 September 2020, retrieved 15 October 2020, www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-to-august-2020

11 Centre for Justice Innovation, 'Court system responses to coronavirus', Centre for Justice Innovation, June 2020, https://justiceinnovation.org/sites/default/files/media/documents/2020-06/court_system_responses_to_coronavirus.pdf

12 Justice.gov.nz, 'Types of trials', New Zealand government, retrieved 15 October 2020 www.justice.govt.nz/courts/criminal/charged-with-a-crime/types-of-trials

13 HM Courts and Tribunals Service, 'HMCTS weekly management information during coronavirus – March to August 2020', 10 September 2020, retrieved 15 October 2020, www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-to-august-2020

14 Ministry of Justice, 'Criminal court statistics quarterly: January to March 2020', Table C1, Ministry of Justice, 25 June 2020, retrieved 15 October 2020, www.gov.uk/government/statistics/criminal-court-statistics-quarterly-january-to-march-2020

15 House of Lords Select Committee on the Constitution, 'Uncorrected oral evidence: Constitutional implications of Covid-19', House of Lords, 22 July 2020, https://committees.parliament.uk/oralevidence/768/pdf, p. 15.

16 Ministry of Justice, 'Criminal court statistics quarterly: January to March 2020', Table C1, Ministry of Justice, 25 June 2020, retrieved 15 October 2020, www.gov.uk/government/statistics/criminal-court-statistics-quarterly-january-to-march-2020

17 *Ibid.*

18 *Ibid.*

19 HM Courts and Tribunals Service, 'HMCTS weekly management information during coronavirus – March to August 2020', 10 September 2020, retrieved 15 October 2020, www.gov.uk/government/statistical-data-sets/hmcts-weekly-management-information-during-coronavirus-march-to-august-2020

20 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 7.

21 *Ibid.*, p. 2.

22 *Ibid.*, p. 2.

23 House of Commons Justice Committee, 'Oral evidence: Coronavirus: the impact on prison, probation and court systems', HC 299, 4 May 2020, https://committees.parliament.uk/oralevidence/337/pdf, p. 12.

24 *Ibid.*

25 *Ibid.*, p. 13.

26 HM Government, 'Coronavirus Act 2020, explanatory notes', Legislation.gov.uk, retrieved 15 October 2020, www.legislation.gov.uk/ukpga/2020/7/pdfs/ukpgaen_20200007_en.pdf, pp, 19–20.

27 Philp C, 'New tech will help keep the criminal justice system moving during Covid-19 pandemic', HM Courts and Tribunals Service, 30 April 2020, retrieved 15 October 2020, www.gov.uk/government/news/new-tech-will-help-keep-the-criminal-justice-system-moving-during-covid-19-pandemic

28 Institute for Government interview.

29 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 4.

30 Comptroller and Auditor General, *Transforming courts and tribunals: a progress update*, HC 2638 Session 2017-2019, National Audit Office, 13 September 2019, www.nao.org.uk/wp-content/uploads/2019/09/Transforming-Courts-and-Tribunals.pdf

31 HM Courts and Tribunals Service, 'Courts and tribunals data on audio and video technology during coronavirus outbreak', HM Courts and Tribunals Service, 30 April 2020, retrieved 15 October 2020 www.gov.uk/guidance/courts-and-tribunals-data-on-audio-and-video-technology-use-during-coronavirus-outbreak

32 Institute for Government interview.

33 The Bar Council, 'Whole Bar Survey July 2020: Summary of findings', The Bar Council, July 2020, www.barcouncil.org.uk/uploads/assets/4fb6e80c-5e2c-4cb3-859547bf9f82d946/Bar-Survey-Summary-Findings-July-2020.pdf

34 Gibbs P, 'Is remote justice slowing the system down?', Transform Justice, 25 July 2020, retrieved 15 October 2020, www.transformjustice.org.uk/is-remote-justice-slowing-the-system-down

35 Institute for Government interview.

36 Fielding N, Braun S, Heike G, Mainwaring C, *Video enabled justice evaluation*, Sussex Police and Crime Commissioner and University of Surrey, May 2020, www.sussex-pcc.gov.uk/media/4862/vej-final-report-ver-12.pdf

37 Byrom N, Beardon S, Kendrick A, *Rapid review: the impact of Covid-19 on the Civil justice system*, Civil Justice Council and the Legal Education Foundation, 4 June 2020, www.judiciary.uk/wp-content/uploads/2020/06/FINAL-REPORT-CJC-4-June-2020.v2-accessible.pdf

38 Ryan M, Harker L, Rothera S, *Remote hearings in the family justice system: a rapid consultation*, Nuffield Family Justice Observatory, May 2020, www.judiciary.uk/wp-content/uploads/2020/05/remote-hearings-rapid-review.pdf

39 Ministry of Justice, 'Coronavirus recovery in Her Majesty's Court and Tribunals Service', Ministry of Justice, 1 July 2020, retrieved 15 October 2020, www.gov.uk/government/news/coronavirus-recovery-in-her-majesty-s-court-and-tribunal-service

40 Ministry of Justice, 'Major investment in small businesses through justice system improvements', Ministry of Justice, 30 June 2020, retrieved 15 October 2020, www.gov.uk/government/news/major-investment-in-small-businesses-through-justice-system-improvements

41 Fouzder M, 'Police forces pull support for virtual remand hearings', *The Law Society Gazette*, 19 October 2020, retrieved 22 October 2020, www.lawgazette.co.uk/news/police-forces-pull-support-for-virtual-remand-hearings/5106062.article

42 Institute for Government interviews.

43 House of Commons Justice Committee, 'Oral evidence: Coronavirus: the impact on prison, probation and court systems', HC 299, 22 May 2020, https://committees.parliament.uk/oralevidence/425/pdf, p. 14.

44 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 4.

45 HM Courts and Tribunals Service, 'Covid-19: Overview of HMCTS response', HM Courts and Tribunals Service, July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/896779/HMCTS368_recovery_-_COVID-19-_Overview_of_HMCTS_response_A4L_v3.pdf

46 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 6.

47 *Ibid.*

48 Ministry of Justice, '10 "Nightingale Courts" unveiled', press release, 19 July 2020, www.gov.uk/government/news/10-nightingale-courts-unveiled

49 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 1.

50 *Ibid.*, p. 8.

51 House of Lords Select Committee on the Constitution, 'Uncorrected oral evidence: Constitutional implications of Covid-19', House of Lords, 22 July 2020, https://committees.parliament.uk/oralevidence/768/pdf, p. 15.

52 Sturge G, *Court statistics for England and Wales*, Briefing paper CBP 8372, House of Commons Library, 16 December 2019, retrieved 15 October 2020, https://commonslibrary.parliament.uk/research-briefings/cbp-8372

53 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 8.

54 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf

55 *Ibid.*, p. 7.

56 Institute for Government interview.

57 Philp C, Answer to question from Richard Burgon, House of Commons UIN 4764, 17 January 2020, retrieved 15 October 2020 https://questions-statements.parliament.uk/written-questions/detail/2020-01-17/4764

58 HM Courts and Tribunals Service, 'Covid-19: Update on the HMCTS response for criminal courts in England and Wales', HM Courts and Tribunals Service, 1 July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/915493/HMCTS401_recovery_overview_for_crime_WEB.pdf, p. 10.

Methodology

1 Davies N, Atkins G, Guerin B, Sodhi S, *How fit were public services for coronavirus?*, Institute for Government and CIPFA, 3 August 2020,www.instituteforgovernment.org.uk/sites/default/files/publications/how-fit-public-services-coronavirus.pdf

2 The Week in Public Services, Institute for Government, https://medium.com/week-in-public-services

3 Ministry of Justice, 'Criminal court statistics quarterly: January to March 2020', Table C7, Ministry of Justice, 25 June 2020, retrieved 15 October 2020, www.gov.uk/government/statistics/criminal-court-statistics-quarterly-january-to-march-2020

4 *Ibid.*

5 *Ibid.*, Table C1.

6 Fouzder M, 'Crown court sitting days increase 'nowhere near enough', *The Law Society Gazette*, 5 February 2020, retrieved 15 October 2020, www.lawgazette.co.uk/news/crown-court-sitting-days-increase-nowhere-near-enough-criminal-bar/5102971.article

About the authors

Nick Davies
Nick is the programme director leading the Institute's work on public services, outsourcing and infrastructure. Before joining the Institute, Nick was public services manager at the National Council for Voluntary Organisations. He has also worked at Children England, London Youth and as a parliamentary researcher for an MP.

Graham Atkins
Graham is the senior researcher on the Performance Tracker team. Before joining the Institute in November 2016, he worked as a researcher at DragonGate, a public sector consultancy, working on a range of projects related to local government and the broader public sector.

Benoit Guerin
Benoit is a senior researcher at the Institute, working on public services, accountability in government and specialist skills in the civil service. Prior to that, he worked on cross-government reviews at the National Audit Office. He has also advised governments as part of the performance evaluation team at RAND.

Sukh Sodhi
Sukh was a research assistant at the Institute in 2019–20. He graduated from the University of Oxford in 2016 with a degree in Philosophy, Politics and Economics. He then studied for an MA in Politics and Contemporary History at King's College London. Prior to joining the Institute, Sukh worked for a community news agency.

Thomas Pope
Thomas is the Institute for Government's senior economist and works across its programme areas. He was previously an economist at the Institute for Fiscal Studies, working on tax and the public finances. Thomas has an MSC in Economics from UCL and a BA in Philosophy, Politics and Economics from the University of Oxford.

Acknowledgements

This project was undertaken in partnership between the Institute for Government and the Chartered Institute of Public Finance and Accountancy (CIPFA). Thanks to Gemma Williams, Jeff Matsu, Ellie Roy, David Caplan, Alison Dewhirst, Sarah Sheen and Joanne Pitt for their comments.

At the Institute, we would like to thank Emma Norris and Bronwen Maddox for their comments and advice, and Will Driscoll, Sam Macrory and Melissa Ittoo for their work in producing the report.

This work could not have been completed without the contributions of many experts who graciously gave up their time to review and comment on our findings. All views expressed, together with responsibility for any errors or omissions, are those of the authors.

The Chartered Institute of Public Finance and Accountancy (CIPFA) is one of the leading professional accountancy bodies in the UK and the only one which specialises in public services. It is responsible for the education and training of professional accountants, and for their regulation through the setting and monitoring of professional standards.

@CIPFA
www.cipfa.org

The Institute for Government is the leading think tank working to make government more effective. We provide rigorous research and analysis, topical commentary and public events to explore the key challenges facing government. We offer a space for discussion and fresh thinking to help senior politicians and civil servants think differently and bring about change.

@instituteforgov
www.instituteforgovernment.org.uk

Copies of this report are available at:
www.instituteforgovernment.org.uk
www.cipfa.org

Institute for Government
2 Carlton Gardens, London SW1Y 5AA
United Kingdom
+44 (0) 20 7747 0400

enquiries@instituteforgovernment.org.uk

October 2020
© Institute for Government 2020
The Institute for Government is a registered charity in England and Wales (No.1123926) with cross-party governance. Our main funder is the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts.