NHS Providers

Spotlight on...

THE NEW NORMAL
Balancing COVID-19 and other healthcare needs

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

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

This is the third in a new series of *Spotlight on...* briefings, aimed specifically at sharing key information on the impact of the coronavirus pandemic on NHS trusts.

Trust leaders are committed to reintroducing a safe balance between care for patients with coronavirus and other services. This briefing sets out the complexities NHS trusts will face in reintroducing more services safely alongside the sustained, continuing risk presented by COVID-19.

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Key messages

- The NHS has successfully navigated the first peak of demand created by coronavirus by concentrating on a clear objective to create the capacity to treat predicted levels of COVID-19 patients. During this peak, trusts have ensured that accident and emergency departments remained open and that emergency cancer and other vital, time critical, care continued. As a result, hospital trusts actually treated more patients without the virus than patients with COVID-19 during this first peak. However, the focus on coping with coronavirus has inevitably had an impact on the care the NHS has been able to provide to many other patients.

- NHS trust leaders are keen to resume their focus on treating all health care needs. However, this will be complex and difficult. Trusts will need to balance treating COVID-19 patients and retaining surge capacity to deal with further virus outbreaks alongside reintroducing care, meeting unmet demand from people unable, or choosing not, to access the services they required over the last 10 weeks and new demand triggered by COVID-19.

- NHS trusts were already grappling with rapidly growing demand for healthcare before the COVID-19 crisis started. After the longest and deepest financial squeeze in NHS history, the service had 100,000 workforce vacancies and NHS capacity growth had lagged a long way behind the growth in demand. Despite treating record numbers of patients, trusts were recording their lowest performance levels against elective surgery and emergency care in over a decade. Community, mental health and ambulance services were under similar pressure.

- Trusts now face a further set of extremely challenging demands including:

  - a significantly increased backlog of elective surgery

  - the rehabilitation and healthcare needs of patients discharged from hospital to create capacity for COVID-19 and patients who have survived COVID-19

  - significant additional new demand for mental health services from those affected by the economic, social and loss of life factors associated with COVID-19, and from health and care staff coping with the consequences of having to provide frontline COVID-19 care in extremely difficult circumstances – this is in addition to pent up demand from those who have, for a range of reasons, not accessed help during the early stages of the pandemic

  - the complex healthcare needs of nearly two million 'shielded' patients amid tight constraints on how healthcare professionals can interact with these patients

  - significant 'pent up demand' that has accumulated over the last ten weeks as GP referrals and patient presentations have dropped significantly – this delay means patients will have more complex and advanced needs than would otherwise have been the case, in terms of their physical and mental health

  - the need for the NHS to support a social care system currently in crisis and, in some places, overwhelmed by the impact of COVID-19, notably the care home sector

  - the requirement to support a comprehensive test, track, and trace approach to identify and contain the virus.

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- Trusts stand ready to meet these challenges, however, they face a number of constraints including:

  - the difficulty national NHS bodies and trusts face in accurately forecasting future levels of COVID-19 and uncertainty as to how the virus behaves

  - the need for a fully dependable supply of personal protective equipment (PPE) which still cannot be guaranteed despite best efforts nationally and locally

  - reliance on a government-led testing regime that, currently, cannot consistently test all health and care staff and patients with COVID-19 symptoms within the required timeframe, let alone systematically test asymptomatic staff and patients

  - capacity constraints in community and social care services that are under huge pressure given the extra demands placed upon them

  - physical capacity constraints created both by the need to retain surge capacity and to adhere to strict infection prevention and control (IPC) measures which remain vital during the outbreak and beyond

  - significant shortages of drugs, supplies and equipment likely to last for some time – for example, access to the most up to date anaesthetic drugs and kidney dialysis machines meaning some treatments will need careful prioritisation

  - workforce capacity constraints and a need to safeguard the wellbeing of NHS staff – many frontline staff are exhausted after a difficult winter and the relentless pressure of treating COVID-19 patients, in addition to those staff who fall ill themselves. Many have delayed taking leave and need time to rest and recover.

- Trusts will always seek to provide the best and safest possible care for all patients and service users, prioritising on the basis of clinical need. They will continue to support frontline staff to give their best. However, given the scale of these challenges and constraints, it is already clear that NHS trusts will be unable to deliver all that is expected. We must, therefore, have an open and honest debate about priorities.

- Trusts need the following from government and NHS England and Improvement:

  - the best possible estimate of the future pattern of COVID-19 demand

  - as much advance notice of, and the opportunity to contribute to, thinking on major policy shifts that will affect NHS demand, e.g. lockdown easing measures

  - a consistent, reliable, supply of PPE

  - a rapidly improved testing regime including clarity on the role trusts will play in the new test, track and trace approach that will accompany lockdown easing

  - clear national prioritisation of where to focus, with appropriate flexibility to adapt to local circumstances

  - clarity of approach to capacity planning including regional surge capacity plans, the use of the Nightingale hospitals and whether private sector capacity will be contracted beyond the end of June

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- more national-level, public communications that it is now safe and important to use all NHS services building on the existing *Help us to help you* campaign

- clarity on how any extra funding to sustainably expand services over the mid- to long-term to meet new demand will work – for example crisis mental health services

- realism and honesty on how much can be done and how quickly, given the challenges and constraints trusts now face.

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Background

On 17 March, NHS England and Improvement wrote to NHS bodies asking them to enact a number of measures to free up capacity to cope with the unprecedented demand caused by COVID-19, such as postponing core services, including non-urgent elective care, in order to look after critically ill patients.[1]

Trusts rapidly prepared their hospitals for an influx of patients requiring treatment for the virus. Community and mental health services prepared to support the swift discharge of thousands of patients into the community. Much of the day-to-day business of trusts was put on hold, with routine appointments, planned surgery, and non-urgent procedures postponed alongside a range of community services, which were temporarily deprioritised. Staffing shortages, challenges procuring the right amount of PPE for staff, and the need to create additional intensive care capacity, all added to the imperative to streamline day-to-day operations to keep staff and patients safe, and avoid the NHS becoming overwhelmed.

Urgent and emergency care has continued to be available, and many outpatient appointments have been conducted online or over the phone. However, amid evidence that fewer people are accessing care in medical emergencies, and signs that the nationwide lockdown is having an impact on people's physical and mental health, on 29 April, NHS England and Improvement wrote to NHS bodies to set out its response to the second phase of COVID-19 asking them to assess their capacity for "at least" some services which had been deprioritised to be reintroduced.[2]

As the UK emerges from the peak of this outbreak, trusts are planning their trajectory towards a 'new normal'. This will involve tackling a backlog created by cancelled and postponed elective care, a rise in additional demand created by the effects of isolation and economic hardship, and a spike in presentations from people who have developed health concerns at home but either chosen not to seek help, or not known what services were available, during the lockdown.

The next phase of managing COVID-19 will involve careful consideration of how trusts can return to delivering more of the services people need and remain responsive to the potential ongoing threat of coronavirus.

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1   https://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

2   https://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

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What has been the impact
of COVID-19 on other services?

Trusts were already grappling with rapidly growing demand for healthcare before the COVID-19 crisis started. After the longest and deepest financial squeeze in NHS history, the service had 100,000 workforce vacancies and trusts had wards regularly operating above 90% occupancy. These pressures have become even more acute in the wake of high levels of staff sickness absence, and a rapid increase in the number of patients needing inpatient, often intensive, care.

Trusts have worked hard throughout the pandemic to ensure that people with and without COVID-19 receive the care they need. However, challenges related to workforce capacity, available PPE and the requirements of effective IPC have limited what services trusts can continue to run safely while ensuring the increased number of beds for COVID-19 can be safely staffed.

Much of the day-to-day business of trusts was put on hold. From routine outpatient appointments to planned surgery, many people's appointments and surgeries have been cancelled or rescheduled. In mid-March, at the start of the UK-wide lockdown, people were advised to stay away from hospitals unless they had a serious health problem, and early in the epidemic, some GP surgeries, with limited staff capacity, temporarily closed as staff were forced to self-isolate. People were asked to consider postponing their appointments and urged to avoid seeing their GP in person.

To accommodate a new 'discharge to assess' model, a number of community services were deprioritised following an NHS England and Improvement letter to trusts in late March.[3] Mental health trusts set up mental health A&Es to help ease pressures on emergency departments while ensuring people in crisis are still able to access the support that they need. This has involved trusts identifying locations across their estates with suitable spaces for assessments and triage to be carried out, agreeing and deploying staff to support these new services, in addition to planning with local partners how diversion and transportation should work.

This effort was designed to free up staff to redeploy them to the frontline of the COVID-19 response and create additional capacity for a surge in ICU beds where necessary.

However, in recent weeks trusts have seen an unprecedented drop in the number of people accessing their services via the normal routes including GP referrals. Trusts are deeply concerned at the marked drop in demand for key services, including A&E attendances, cancer diagnostics, neurosurgery and urgent cardiology services. Trusts are receiving fewer referrals from general practice for conditions such as suspected cancer. For example, one trust chief executive told us their trust would normally diagnose around 20 colorectal cancers a month; however, in March, they diagnosed none.

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3   https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-public-change-log.pdf

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Mental health trusts have also seen a significant fall in the number of referrals for services such as CAMHS and IAPT. However, there has been a rise in the number of people presenting in crisis. One mental health trust told us they had seen a reduction in referrals from GPs, but a rise in young people presenting in crisis or having attempted suicide. Ambulance services have seen fewer 999 calls for conditions such as stroke symptoms.

Latest figures also show that there was a 29% fall in the number of A&E attendances in March 2020 compared with the same time last year, which suggests people are staying away from A&E, possibly either because of fear of catching the virus or because they do not want to overburden the service. We are concerned that decisions not to seek help could lead to a delay in diagnosis and deterioration in people's overall health.

A national campaign (*Help us to help you*), and local communications to encourage people to continue accessing care when they need it, has now led to more people seeking help at an earlier stage. This has seen a rise in two-week-wait cancer referrals since its launch but there is much more to do to reassure the public that the NHS is there to cater for their needs alongside its response to coronavirus.

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What impact will this have on trusts and patients?

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This change in the pattern of demand is concerning because it may indicate a risk of poorer outcomes for people who are not getting the help they need at the right time, and because it risks creating a spike in pent-up demand which could coincide with the easing of social distancing measures and overwhelm trusts just as they work towards reintroducing day-to-day care.

Mental health trusts tell us they have already seen a spike in the number of people seeking help, as the experience of living through a pandemic, the impact of social isolation, loss of income and potential grief and loss of friends and family members to the virus all begin to take their toll.

However, the stark drop in how many patients trusts are seeing arrive with serious health conditions has led to the concern that, far from being a welcome respite allowing trusts to prioritise their response to COVID-19, the drop in A&E attendances and GP referrals is a sign that more people are staying at home with deteriorating health. Simply put, trusts are acutely aware that COVID-19 has not replaced the usual case mix of cancer, heart disease, stroke and other acute and time-sensitive conditions they usually see. It has added to it, and where trusts aren't seeing the usual number of patients with these conditions, they're concerned that there are large numbers with life-threatening illnesses at home instead.

It is also worth flagging that the presence of coronavirus means that some people's conditions will need to be treated differently for some time to come. This is particularly relevant to cancer care where some patients due for surgery, chemotherapy or radiotherapy may be advised to delay (particularly if they have COVID-19) because the presence of the virus raises their risk of mortality further than the prospect of a delay in treatment which would usually be advisable. There is no doubt the presence of COVID-19 in our health and care settings will create difficult ethical and clinical decisions for patients, families and clinicians.

What are trusts doing to make more care available now?

Trusts have worked hard to provide care to those who need it. Urgent and emergency care, acute admissions, and urgent treatment for cancer has continued. Trusts have put in place measures to keep patients and staff safe while this essential work continues. This includes social distancing and segregating wards into 'hot' and 'cold' areas to ensure patients with coronavirus do not come into contact with those who don't. Many outpatient clinics have been moved online or are being carried out over the phone, and trusts are increasingly looking at using technology to enable patients to access care remotely. Ambulance trusts responded to a record number of 999 calls in March 2020 and supported the influx of NHS111 calls due to COVID-19.

In some hospitals, this is being reinforced by plans to start routinely testing asymptomatic staff and patients on dedicated 'non-COVID' wards to keep these areas free of coronavirus.

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In others, A&E departments have been entirely reconfigured to create dedicated areas complete with floor-to-ceiling walls in place of curtains to minimise the risk of cross-contamination.

There are local efforts underway to provide local populations with reassurance that they are welcome and encouraged to seek help for serious health problems. Royal Berkshire NHS Foundation Trust delivered a message to local people on the radio that their services were still available, with one of the trust's cardiologists encouraging people to seek help for symptoms.

Trusts are also collaborating locally within their systems to ensure pathways of care continue to operate and meet people's needs. A specialist trust contacted GP surgeries within their system early in the outbreak to make clear they remain open to urgent and emergency referrals, and for routine referrals with longer waits.

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What will trusts have to deliver in this next phase of the NHS response to coronavirus?

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As the UK emerges from the peak of the outbreak, trusts are beginning to plan their trajectory towards a 'new normal'. This is a challenging task which must be undertaken while trusts and their staff are recovering from the impact of the outbreak following a gruelling winter.

Trusts must continue to manage an unknown number of ongoing COVID-19 cases and plan for the threat of future waves. This will be the new normal. As well as the backlog created by cancelled and postponed elective care, trusts will have to grapple with ongoing COVID-19 demand alongside retaining surge capacity for future outbreaks, a rise in additional demand created by the effects of isolation and economic hardship, and a spike in presentations from people who have developed health concerns at home but not known where to seek help during the lockdown.

Not only must trusts restart elective care and clear the existing backlog including face to face clinics, planned surgery, scans, tests and procedures, but they will be doing so with the need for social distancing for the foreseeable future. Trusts will need to continue to segregate COVID-19 patients, and many patients needing care for other conditions may test positive for the virus. Trusts will need to consider how they move staff between these 'hot' and 'cold' areas and maintain an adequate PPE supply on an ongoing basis.

With future COVID-19 demand an unknown, planning for this in detail is extremely challenging and requires sophisticated modelling as well as changes to the physical environment of hospitals and support for staff in all settings to allow for the appropriate separation of COVID-positive and negative patients. Trusts' ability to do this relies on a testing strategy which allows them to test widely as well as a sustainable workforce model that allows both types of ward to be staffed adequately without mixing between the two. Trusts also want to support contact tracing efforts to contain the virus.

COVID-19 has created a cohort of almost 200,000 people who have been unwell enough to need hospital treatment, in addition to the normal flow of hospital admissions. With anecdotal evidence that the effects of COVID-19 can linger, and patients discharged from ICU needing ongoing care in the aftermath, trusts will be closely involved in the rehabilitation of many of these patients in the community, including addressing mental health issues that arise as a result of their experience.

It's clear that far from being a return to the old ways of working, the next phase of trusts' response to the pandemic will look very different as they maintain readiness for future spikes of the virus as well as the potential for an ongoing number of patients being admitted with COVID-19.

While there is a real desire in the sector to reap the benefits of the rapid innovation prompted by the outbreak, including the increased use of technology, streamlining of discharge processes, and efficient models of care, trusts are mindful of the toll the pandemic response has taken on their workforce and are cautious not to move too fast. All trusts will need the autonomy to move at their own pace, given the outbreak has progressed at different rates in different regions, with different degrees of severity.

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What constraints do trusts face in continuing to provide non-COVID care?

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The onset of the COVID-19 outbreak presented major constraints to continuing non-COVID care provision, relating to the availability of staff, supplies, and bed space to both caring for the number of COVID-19 patients needing treatment, and carrying on with day-to-day routine services. Trusts had to prioritise urgent and emergency care, and were asked by NHS England and Improvement to scale back their routine operations, outpatient clinics, and face to face testing and procedures, as well as free up capacity in the community to support a discharge to assess model. Trusts have now been asked to consider resuming some activity they had paused and are considering how to go about doing so while balancing capacity restraints and ongoing COVID-19 related demand. They will now be facing challenges in four main areas as they begin to plan for future services.

Workforce constraints

The COVID-19 outbreak hit the NHS at the end of the most challenging winter period on record. NHS staff were tired after a demanding winter and, at the peak of the crisis, some trusts had as many as 50% of their workforce off sick or self-isolating. While absence levels will begin to recover, the wellbeing of staff will be of paramount importance to trusts as they seek to return to providing normal services. There is a risk that a rapid return to 'business as usual', on top of lingering COVID-19 demand, and pent up demand caused by the lockdown, will lead to the burn-out of an already tired and stressed workforce.

The skills of staff working in certain specialties, such as anaesthetics, intensive care nursing, and respiratory clinicians have been in particularly high demand and will continue to be so if, as expected, the NHS must prepare for further peaks of the outbreak. Services which rely on these groups of staff, including major surgery, may face unique challenges in resuming 'business as usual' without their usual staffing levels, particularly in light of guidance that requires trusts to assess staff for COVID-19 risk factors.

PPE challenges

The supply of PPE in trusts has been a consistent issue throughout the pandemic. There have been points where certain supplies, such as sterile gowns, were at risk of running out entirely. Where PPE has been in short supply, trusts have had to minimise the number of non-essential procedures that require it so that staff caring for COVID-19 patients had access to scarce gowns, masks and visors they need to work safely. Operating theatres and surgery recovery areas have been repurposed to accommodate ventilated coronavirus patients, reducing capacity for non-urgent operations. In order to resume normal services, trusts will need reliable access to enough PPE to both care for COVID-19 patients, and safely run other services, particularly those that are considered 'aerosol generating procedures'.

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Capacity

In their initial response to the outbreak, trusts rapidly repurposed theatres, wards and post-operative recovery areas into COVID-19 units, with extra ventilator capacity. Staff were redeployed with the relevant training to care for patients outside of their usual specialties. Without this flexible reconfiguration of facilities, trusts simply would not have had the capacity to treat the number of patients in intensive care settings required.

However, the task of flexing additional capacity at short notice in response to local spikes in demand is complex and disruptive. There is still considerable uncertainty about what capacity will be needed on an ongoing basis: as trusts move into a new phase of planning for future coronavirus-related demand, they will need to retain 'surge' capacity in the system so that future outbreaks don't substantially compromise other services. This is a significant challenge, particularly considering trusts were routinely operating at 85-90% bed capacity before the outbreak. Trusts adhere to strict IPC procedures, including physical distancing, with an impact on productivity in areas where this restricts capacity such as A&E. The practicalities of ward space with the right infection control barriers in place as a permanent fixture will require investment and empty space that trusts have not historically had access to. There are also considerations for how patients in 'shielded' groups, including cancer patients, are cared for safely.

Not only are there substantial unknowns surrounding the future of COVID-19 care, but the challenge of modelling the impact of hidden demand on future capacity is significant. In light of the drop in demand they have seen across services including A&E and cancer diagnostics, trusts expect much of this pent-up demand to emerge in the weeks and months following the relaxation of social distancing measures, and will be cautious to avoid crowding out any capacity to care for these individuals by overestimating how much planned activity can take place early on.

Any planned surge in activity in the acute sector will need to carefully take into account the stretched community and social care sectors, both of which took on considerable extra workload to prepare the acute sector for the outbreak. Many community providers have supported a large number of patients with complex needs at short notice, and care homes are in the midst of severe COVID-19 related pressures of their own and in need of support to manage outbreaks.

Testing

A consistent and clear testing strategy will enable trusts to carry out the crucial capacity planning needed to confidently maintain the level of services to meet demand while also retaining slack in the system for future waves. This includes the maintenance of segregated ward layouts, PPE stocks, and supply of essential drugs used to treat COVID-19. The current lack of clarity about how future testing and tracing will work presents a challenge to trusts looking to comply with the national mandate to resume some level of normal service provision.

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An approach which focuses too closely on meeting arbitrary national-level targets will fail to meet the local needs of trusts which, in the future, may face localised outbreaks where they need to resume widespread testing. Avoiding these localised outbreaks will require ongoing testing capability, to keep spread to a minimum, ensure staff and patients are kept safe, and maintain the integrity of 'hot' and 'cold' wards.

Testing is fundamental if trusts are to protect patients onsite, and their staff. Symptomatic and asymptomatic staff and patients will need to be regularly tested, so that trusts can be confident that lives will not be put at risk by resuming day-to-day business. The current lack of clarity about how future testing and tracing will work presents a challenge to trusts looking to comply with the national mandate to resume some level of normal service provision.

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What do trusts need to rise to the challenge?

Trusts are keen to resume paused services, and lock in the benefits of the innovations they have put in place to tackle COVID-19. They will not seek to return to a status quo which struggled to innovate when faced with the serious operational pressures which characterised the period before the pandemic.

They also feel a strong sense of responsibility to provide the services patients need and they are moving as fast as possible to meet national priorities to resume more care as soon as it's safe to do so. In the coming weeks and months, we will see a gradual ramping up of activity as coronavirus-related pressures recede.

Trust leaders will need to make difficult decisions in the aftermath of the pandemic, including what services are safe to resume, to what degree, and what should be prioritised. These decisions will be evidence-based and aim to minimise the impact on individual patients.

Successfully achieving a sustainable balance of service provision and COVID-19 responsive capacity will rely on the support of national leaders with clear priorities set out for resuming core activity within a framework which is flexible to local needs. Trusts need government and national bodies to issue clear communications to the public about their behaviour during the outbreak, and with regard to accessing NHS care. They also need a robust supply of PPE and a comprehensive approach to testing.

While the nature of COVID-19 means that local variation in demand is likely, trusts will need a clear approach to capacity planning on a regional basis to enable a coordinated response to outbreaks as and when they arise, including agreement on how independent sector capacity and the Nightingale hospitals will be used. Their insight into what can be realistically achieved should be taken into careful consideration in national discussions about setting priorities and easing lockdown measures, so that trusts are presented with realistic expectations and a sustainable route back to normality which avoids further waves of the outbreak.

The financial cover provided to trusts to enable the rapid and comprehensive response to the COVID-19 outbreak has been welcomed. In the medium and longer-term, where spikes in demand inevitably do arise after social distancing measures ease, trusts will need clarity on how expanded services will be funded to continue to respond to new challenges as they arise and meet the needs of patients.

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NHS Providers' view

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The NHS has successfully navigated the first peak of coronavirus and coped well with the demand created by the virus. By focusing on a clear objective, and working with local partners to create additional capacity, trusts were able to manage the influx of COVID-19 patients. This had an impact on the care the NHS has been able to provide to other patients and trusts are now keen to resume their focus on meeting the needs of all patients regardless of their condition.

While a number of key challenges remain around workforce capacity, staff wellbeing, PPE and testing, trust leaders are committed to delivering national priorities, to keeping their staff safe and to providing the best and safest possible care for patients.

However, trusts need realism and robust prioritisation about what can be delivered in what timescales, and a coordinated national effort to ensure they have the right national framework and support in place to deliver the complex task of returning to more normal service provision in the presence of coronavirus, and retaining the ability to respond quickly to future outbreaks of COVID-19.

**Your feedback
is very welcome.**

**For any comments
or questions
please contact**
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For more information:
www.nhsproviders.org/coronavirus

NHS PROVIDERS **Coronavirus briefing**

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