



# **The NHS ‘road to recovery’: ethical guidance for endemic COVID-19**

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In light of the changes made by the NHS in response to the COVID-19 pandemic, the Committee on Ethical Issues in Medicine of the Royal College of Physicians (RCP) has developed the following guidance for NHS staff negotiating the NHS ‘road to recovery’ as COVID-19 moves towards becoming an endemic disease.

The COVID-19 pandemic has necessitated several changes and pauses to NHS services, such as screening programmes, non-vital and elective surgery; changes in practice, such as the switch to telemedicine for relevant primary and secondary care; and, during the vaccination campaign, the use of GPs’ time and resources to support the third dose ‘booster’ delivery programme. In recent months, many vital NHS services have ‘restarted’ and we have now moved into a new phase where services are being ‘reset’ after they were paused to prevent the NHS from going beyond surge capacity – although this process has been interrupted by the arrival of new variants of SARS-CoV-2. The transmission of COVID-19 is proving hard to halt, despite the offer of vaccination to all adults and young people, and increasingly fewer social distancing, self-isolation and stay-at-home prevention measures are being undertaken now that they are optional. We now need to consider how the NHS can respond to the challenges of providing non-COVID-19 services, while still responding to COVID-19 in the medium to long term.

The government has named this the ‘road to recovery’ of the NHS. This period covers both the cycle of stopping and starting services as waves of COVID-19, with new SARS-CoV-2 variants such as Delta and Omicron, necessitate deprioritising non-COVID-19 services, as well as changes needed as we move into the ‘new normal’ of endemic COVID-19. The NHS ‘road to recovery’ is not only the recovery of services that were suspended during the crisis phase, but also encompasses periods of transition as the NHS shapes how it can continue to respond as COVID-19 becomes endemic and the longer-term implications for health and social care provision become clearer. An important part of this period is that it gives us the opportunity to reimagine the NHS, and to strive for a better way of doing things, not simply to return to how we did things before the pandemic. The ‘road to recovery’ is an opportunity to implement new, evidenced-based ways of working to make the NHS more effective and resilient.

The practical ethical challenges will change as different pathways for the NHS ‘road to recovery’ are outlined by the Department of Health and Social Care. This should be taken into account when reviewing this document and using this advice to inform and support ethical decision-making. This guidance has benefited from the input of multiple stakeholders, including research from the [NHS Reset Ethics project](#) led by Dr Lucy Frith at the University of Manchester. It provides guidance for the difficult and distinctive ethical issues that NHS staff will face while caring for their patients during the NHS ‘road to recovery’ period and beyond. The Committee on Ethical Issues in Medicine reserves the right to change this advice at any time to reflect the current situation with the COVID-19 pandemic.

## The ethical framework that informs the guidance

This guidance is intended to be read alongside our existing guidance for NHS staff.<sup>1</sup> As is its usual practice, the RCP will continue to take a practical approach to guidance for healthcare staff, guided by relevant approaches from empirical ethics and the social sciences. Clinical ethics best supports the NHS ethos in normal times: that is, to provide person-centred care for patients that prioritises their values, beliefs and needs. However, in line with public health ethics, the pandemic has shifted the focus away from the individual and towards individuals within communities.

This shift has also highlighted existing and deepening health inequalities and disparities in our communities across the UK that will need to be addressed in the NHS ‘road to recovery’ and endemic response. As such, it follows that the focus of ethics during the ‘road to recovery’ period should continue to be on individuals within communities. The input from patients, groups and service users remains vital to ethical practice. We propose that a relational approach to ethics is the most appropriate perspective from which to build ethical guidance for decision-making during this period.<sup>2</sup>

The ethical framework that informs this guidance starts from this perspective, along with the values that informed our guidance specific to the COVID-19 pandemic.<sup>1,3</sup> Several values remain the same, while some speak to the specific challenges of the NHS ‘road to recovery’.

By these we mean:<sup>1,2</sup>

Value	Description
<b>Accountability</b>	Measures are needed to ensure that there is accountability, ideally nationally, in ethical decision-making throughout the ‘road to recovery’ period. Accountability includes an expectation of clarity about who is responsible for making decisions, governance arrangements, assessment and evaluation of the outcomes, and a willingness to share information to help others.
<b>Inclusivity</b>	All stakeholders should be involved in decision-making where possible, and decisions should be taken with stakeholders’ views in mind.
<b>Transparency</b>	Decisions should be publicly defensible and publicly explained. Transparency of the values that underpin decisions and how any prioritisation and reconfiguration decisions are made is important, as is an acceptance of the need to adapt plans to new circumstances and information.
<b>Equality and equity</b>	Decisions should be taken that ensure, prioritise and facilitate inclusivity in providing NHS services. This includes working explicitly to reduce health inequalities and inequities. Any decision to alter what was considered ‘normal’ provision of service due to ‘road to recovery’ pressures should consider and attempt to mitigate disproportionate negative impact on any particular group.
<b>Proportionality</b>	Patient safety, staff safety and the capacity of NHS staff should inform decisions to change provision of services. However, physical safety should be balanced against the potential impact of infection control measures on the experience of <i>care</i> as a key component of medical treatment. Where appropriate, new ways of working should be facilitated. Decisions on the priorities during the ‘road to recovery’ should allow ‘enhanced crisis responsiveness’ (eg redeployment of staff) and accelerated preventative health programmes that could ease the burden on NHS services as COVID-19 becomes endemic.

## A relational approach to the NHS 'road to recovery'

A relational understanding of ethics promotes individual values, beliefs and rights for patients, while recognising that these are developed and influenced by our relationships and our wider social world. While a consequentialist approach may be tempting for its ease of application, at the policy level consequentialism should be tempered by a recognition of the relationality of individuals. COVID-19 has not only been a pandemic, but has also been described as a syndemic – highlighting the way that social and biological interactions may act together to increase an individual's susceptibility to ill health.<sup>4</sup>

Successive COVID-19 lockdowns have shown us that our collective individual rights are impossible to disentangle from the needs of society and the common good. However, clear communication as to how potentially competing rights, values and societal needs are being balanced is crucial to identify shared and compatible goals. As such, valuing the common good within the 'road to recovery' strategy for the NHS should be predicated upon an idea of an equitable society and the recognition that interpersonal and social relations are key factors in personal, societal and institutional decision-making going forward.<sup>5</sup> A relational ethics approach supports these goals, while recognising the impact of COVID-19 on longstanding and embedded inequalities in our society.<sup>3</sup>

A relational framework also recognises the intersectionality of health, and the many ways that the pandemic has disproportionately negatively impacted certain groups in society, such as people with disabilities, vulnerable and older people, people living in deprived circumstances and people from certain ethnic minority backgrounds.<sup>6</sup> Throughout the pandemic, there has been a focus on 'fairness' in both ethics and policy writing; however, this focus has largely not considered the full and unequal impact of COVID-19, and measures put in place to control the virus, on the population.<sup>7</sup> The impact of infection prevention measures on family-focused services, such as general practice, maternity and paediatrics, is a good example. A disabled pregnant woman whose first language is not English might, for example, have been disproportionately negatively impacted by COVID-19 protocols if she was unable to take a friend, or her partner, to an antenatal screening appointment, especially if the scan revealed complications or concerns. In sum, a relational framework facilitates prioritisation of an important part of the NHS 'road to recovery', insofar as it is able to recognise and mitigate the role that COVID-19 has had on highlighting and exacerbating health inequalities and inequities in the UK and globally.<sup>5</sup>

# Specific recommendations for ethical practice and decision-making during the NHS ‘road to recovery’

The following specific recommendations for NHS staff making decisions relevant to the NHS ‘road to recovery’ have been developed from the values and principles set out above. The recommendations take into consideration statements released by the General Medical Council (GMC), the NHS and the chief medical officers in the UK. We hope that these practical recommendations will be of use to NHS staff when they are faced with decisions relevant to the ‘road to recovery’.

## Patient-centred care and decision-making

As the NHS moves beyond the pandemic, it is likely that healthcare staff will encounter difficult situations and, as a result, have difficult decisions to make about appropriateness and prioritisation of care. Any decisions made to begin, withdraw or withhold care must continue to comply with the shared decision-making and patient-centred care policies of the NHS. This means that these decisions should include the patient and their wishes (as much as is feasible for the given situation) and, if appropriate, the patient’s carers, in consultation with relevant healthcare colleagues. This is true regardless of whether the patient has COVID-19.

For reasons of practical and moral support, it is advisable that assessment and prioritisation decisions are carried out by more than one clinician colleague, where feasible. As is normally the case, it is recommended that decisions within ITU specifically involve the multidisciplinary team, where appropriate. All decisions must be appropriately documented, to ensure accountability and for the legal protection of NHS staff. To support these difficult and complex conversations, the RCP has developed the Ethical Care Decision-Making Record<sup>8</sup> (ECDMR): a framework to support discussion and documentation of decision-making for all levels of care in clinical practice, so that these are captured in the patient’s notes. Again, any decision to start, withdraw or withhold treatment must be made in accordance with existing national guidance. For surgery, surgeons and healthcare staff should follow the *Clinical guide to surgical prioritisation in the recovery from the coronavirus pandemic*.<sup>9</sup>

## Reducing health inequalities

The COVID-19 pandemic has highlighted the impact that health inequalities have on the health of our population.<sup>10</sup> For some groups, the pandemic has also worsened existing health inequities. Any ‘road to recovery’ plans should target those areas of healthcare that can immediately and positively redress existing health inequalities and inequities. Changes in service provision during the pandemic have not been as mindful of this goal as they could have been, eg programmes to support people to eat healthily as part of their home treatment plans. Data from the [Reset Ethics](#) project highlight how the health of long-term-ventilated children suffered when community services were stopped and replaced with food parcels. Some parents were often unable to manage their children’s diet without the support of community services, and food parcels that were offered in their place did not help weight management as they contained unhealthy food such as white bread and other processed foods. A specialist paediatric physiotherapist reported that the shutting down of community health and social care services contributed to increasing levels of obesity during the pandemic, which had a knock-on effect on ventilation needs for these children, negatively impacting their long-term clinical outcomes.

## Caring for COVID-19 and non-COVID-19 patients

Decision-making should not be disease specific – ie the presence or absence of COVID-19 should not be a limiting factor in treatment decisions. ‘Road to recovery’ plans should be predicated explicitly upon balancing the rights to care of patients with COVID-19 with the rights to care of patients with other conditions. In line with our previous guidance,<sup>1</sup> the RCP maintains that treatment within the NHS should be based on need, regardless of COVID-19 diagnosis. The implication of such equality is that, in reopening and providing other services, proportional allocation of resource should be a function of relative demand/need within the constraint of available resources, with COVID-19 services given no special priority. For surgery, surgeons and healthcare staff should follow dedicated cross-specialty guidance on the appropriate timing of elective surgery following COVID-19 diagnosis, for adults and for children.<sup>11,12</sup>

In staffing both COVID-19 and other services, decision makers will need to continue to be attentive to the circumstances and perceptions of healthcare staff as regards susceptibility to COVID-19, and how they balance those with the weight of the duty they feel to offer in-person *care* to their patients. Healthcare professionals’ individual risk assessments should be respected as far as possible. Data from the Reset Ethics project suggest that healthcare professionals, particularly those with community responsibilities, have negotiated these issues informally with their colleagues – so that those without vulnerabilities (or with a different attitude to their COVID-19 risk) might pick up others’ home visits, rather than only offering the option of an online consultation. The data suggest that, in offering to carry out a home visit for a colleague, a healthcare professional might be motivated by their personal feelings of duty or obligation to offer people the care they want, where it is within their power to do so.

## Resumption of ‘non-clinical’ *care* practices

During the COVID-19 pandemic, many non-clinical aspects of good clinical practice have been paused (eg partners or family members attending appointments). This has been very difficult for healthcare professionals, who report not being able to deliver the level of care to which they are normally accustomed, and want, as a provider of *care*, to offer.

‘Road to recovery’ plans should therefore prioritise the care relationships that are integral to good clinical practice, putting in place measures to allow NHS staff and patients’ families to begin caring again safely, including allowing staff to provide comfort care such as holding patients’ hands, allowing family members to attend patients in hospital and care homes, or allowing ‘home leave’ for children recuperating from serious traumas or burns. A specialist physiotherapist noted to the Reset Ethics team that being unable to access home leave significantly impacts on the rehabilitative process.

Policies to support therapeutic relationships should be developed, paying attention to the tensions between infection prevention and offering *care* and, in so doing, to the key values mentioned above. Such policies should ensure, in particular, that:

- > staff are involved in decision-making, and that the working practices of different clinical specialties are reflected or allowed for
- > patient groups are consulted and listened to
- > there is transparency about why staff and/or patient suggestions are not followed
- > there is clarity for staff as to when and how there will be a return to previous care practices
- > there is, particularly in highly relational specialties such as general practice, maternity, paediatric, geriatric, mental health and palliative care services, a renewed focus on the role of the family (and other informal carers) as a key part of the healthcare team



- > there is clarity for staff as to how make exceptions to particular rules if/when that might be appropriate
- > the wellbeing of staff is considered when developing policies, taking into account the support of good mental health for staff and space for reflection, supervision, coaching and the taking of rest and recovery time through leave entitlement.

The role of non-clinical carers (formal and informal) should also be considered, as it reduces the burden of care on NHS staff. In maternity care, for example, midwives have noted the additional burdens imposed on them when partners were not allowed to be present at appointments and, in some trusts, during labour.

## Taking a nationwide approach

The COVID-19 pandemic has shown that there is no unified approach across the NHS for delivering services. While each trust and each of the four nations have unique approaches to meet the needs of the populations they serve, this diverse approach has also worked to widen health inequalities and inequities. A general lack of transparency in decision-making, particularly during the early part of the pandemic, exacerbated the lack of unity. To avoid worsening the existing health gaps across the UK, and to play to the individual strengths of different services and regions, it is recommended that 'road to recovery' plans be UK wide, with all trusts and nations working together, within the context of a transparent decision-making framework, to provide a coordinated 'continuity of care' that is responsive to the changing pandemic/endemic context.<sup>2</sup> It has been reported that regional and inter-trust collaboration and cooperation markedly increased during the pandemic, particularly during the acute phases, with the importance of mutual aid being stressed. Healthcare professionals and decision makers who participated in the Reset Ethics research, recognising the co-dependence of services, have indicated that this is something they would like to continue.

The positive impact of reduced bureaucracy during the pandemic has also been noted. We therefore recommend that 'road to recovery' plans consider how successful collaborative practices involving different trusts and services can continue to be utilised, or be further developed, to provide short- and long-term provision of care for those areas lacking in services, capacity or both. Collaboration might involve anything from the continued use of telemedicine services to facilitate specialist consultations or the convening of virtual specialist conferences, to the continued redeployment of staff between cooperating hospitals or trusts, ambulance diverts or patient transfers, where appropriate. The involvement and integration of community provision, social care providers and integrated care systems are also recommended as part of this collaboration. However, we note that telemedicine is not a panacea. It is not welcomed by all areas of medicine and does not represent a way to make medicine more accessible, as overreliance on telemedicine results in those same health inequalities that we argue the 'road to recovery' is striving to reduce.

## The 'road to recovery' must mean striving for something better

There were significant difficulties facing the NHS before the pandemic, and COVID-19 has added to and exacerbated these. The goal of any decisions relevant to the 'road to recovery' should not be to return to where we were, but to learn from what has worked well and to review what did not, with a view to creating a better, fairer and more equal health service for all NHS staff and all patients, families and communities.

This may look different across the NHS. For example, individual trusts may wish to review their existing policies and procedures against this guidance and consider whether and/or how they are striking an appropriate balance between benefiting different groups of patients. Or it may be helpful, in light of this guidance, to consider how certain patient groups may be disproportionately affected



by the 'road to recovery' period within a trust or region, and seek to mitigate that impact with direct policy and action. The guidance presented here provides an ethical framework against which to develop and justify these actions locally, regionally and nationally, such that the NHS best supports its patients and staff beyond the pandemic.

## Further guidance

Further ethics guidance is available here:

[www.rcp.ac.uk/news/ethical-guidance-published-frontline-staff-dealing-pandemic](http://www.rcp.ac.uk/news/ethical-guidance-published-frontline-staff-dealing-pandemic)

- > Ethical guidance on the COVID-19 vaccination programme is available in Appendix 1.
- > Ethical dilemma scenarios for ambulance-based clinical assessments during COVID-19 are available in Appendix 2.

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