Royal College of Physicians

Submission

Health and Social Care Committee

Delivering Core NHS and Care Services during the Pandemic and Beyond

The Royal College of Physicians (RCP) welcomes this Health and Social Care Committee inquiry on 'Delivering Core NHS and Care Services during the Pandemic and Beyond'. The RCP has been tracking the impact of COVID-19 on frontline clinicians during the pandemic through membership surveys. The first of which took place on the 1-2 April, followed by a second on the 22-23 April, a third will run on the 13-14 May with a focus on the restart of non-COVID-19 services. These surveys alongside continued engagement with our members have informed the evidence in this submission.

Summary

The NHS has demonstrated its ability to adapt, change and innovate over the last few months. NHS staff have gone above and beyond to do their best by patients. While the last two months have been extremely challenging, the next few weeks and months are likely to be just as challenging as we seek to restart services that have temporarily stopped or been reduced while still managing the outbreak of COVID-19.

One of the key elements of 'restart and 'reset' will be the need to give NHS and social care staff the time and space to recuperate, restore and reflect. There must also be recognition by national NHS leaders, politicians, government and the public of the toll that this period has taken on staff both physically and mentally.

Across the UK our members expect to see additional demand as people return to the NHS with non-COVID-19 needs. While it is key that we do everything possible to meet this extra need, we mustn't forget the wellbeing of staff. Not least because 29% of respondents to our recent survey told us that they were working outside of their normal area.[i] In addition to those working outside of their usual area, plans being developed must also consider NHS staff that are currently part of the shielded group.

The pandemic has once again highlighted ongoing workforce shortages. It has been heart-warming to see recently retired doctors return to help and over 3300 final year medical students step forward to join the workforce early[ii] this isn't a sustainable approach.

The NHS People Plan must be brought forward without delay, supported by additional funding to place the NHS workforce on a stronger footing for the years ahead. The plan must involve a range of actions including

- The fast-tracking of physician associate regulation (including consulting on prescribing rights) supporting this new profession to work to their full potential
- The further significant expansion of medical school places
- Increased support for flexible working patterns e.g. less than full time working and working from home when appropriate
- Recognition of the contribution of international staff through the granting of indefinite leave to remain to all health and social care staff who have supported the UK's response to the pandemic
- A meaningful focus on staff wellbeing to ensure that practices which have changed during the pandemic are embedded, such as 24-hour access to food and drink and rest facilities

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A whole system approach to 'reset' is key. This approach must recognise the pinch points that are on the horizon. We know that our members will manage a significant proportion of the backlog as priority services start to reset. Plans to restart and 'reset' in secondary care must consider at least three patient cohorts:

- Resetting of 'normal' services including cancer referrals and management of the shielded population
- The recovery of patients that had COVID-19 and may well need further support from respiratory and renal services
- New patients with COVID-19 (who may well have additional need or multiple health conditions)

Inquiry questions:

1. How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand

1.1. There are no easy answers to this question: local settings will have to make local decisions to achieve this balance, depending on the local patient need at any one time. We also need to consider the cohort of patients who have had COVID-19 who may need further access to services to aid their recovery, as well as COVID-19 demand and 'ordinary' demand.

1.2. There will be a role for both regional and national leadership to support providers and systems as they work closely together to manage health at a population level. Clinicians have reported that during the pandemic there has been a real willingness to coordinate and collaborate across boundaries. This should continue to be encouraged as far as possible within the constraints of the Health and Social Care Act 2012. It will also be more important than ever for the NHS to produce regular data-led updates on patient numbers across all services so problems can be spotted as early as possible and mitigation put in place.

1.3. Plans need to look at a range of scenarios of the potential non-COVID-19 need which will soon return at pace to the NHS. The UK Government and NHS England/Improvement must build on their recent messaging to reassure members of the public that the NHS is still open for business. It is vitally important that we encourage people to access NHS services early. Clinicians are clear in their opinion that people are not accessing services either because they feel they may be a 'burden' on the NHS, or that it may increase their risk of exposure to COVID-19.

1.4. As part of this effort to demonstrate to the public the need to access services at the appropriate time, NHS estates will need to continue COVID-19 and non-COVID-19 zones. In the last few months lots of NHS estates have changed rapidly, often with the expansion of ITU capacity. As a result of this, NHS trusts will need to consider how to manage these spaces and return them to other specialities. Rehabilitation is one such speciality; it plays a crucial role in patient pathways and without the resources it needs problems will arise elsewhere in acute services.

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2. Meeting the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak

2.1. In the short-medium term, clinicians will need to focus on agreed national priorities. The RCP with NHS England and speciality societies has conducted a prioritisation exercise which considered critical time-dependant interventions, minimising nosocomial infection risk and retaining innovation. This exercise will shortly be published as a guide for clinicians. Clinicians will continue to triage patients as normal, working closely with colleagues to develop patient care and treatment plans appropriate to their situations. Some patients are likely to wait longer for routine treatment than would normally be acceptable. There will be a role for individual clinicians, NHS trusts, NHS England/Improvement and the UK Government in setting expectations around access to treatment and care.

2.2. A patient-centred approach with a real focus on good communication will be critical. One example of this is the management of patients who have been referred to specialists over the last 6-8 weeks who may have had interventions or procedures cancelled. There is a risk that these patients end up having to seek a second referral to a specialist. NHS trusts should seek to avoid this by doing everything they can to contact these patients and rebook appointments wherever possible without the need for the patient to seek another referral.

2.3. Practicalities are also key. We know that PPE supply has been a challenge and caused huge worry and concern both for our members and the wider health and care sector. Our members report that between the start of April and the end it may have got worse[iii]. The Government must now plan to further increase PPE supply. A return to a more balanced demand across patients with COVID-19 and non-COVID-19 need will only further increase the use of PPE in the acute sector whilst community and hospital transmission of COVID-19 continues.

2.4. The other aspect that needs consideration is the impact that wearing PPE all day has on staff. Planning should factor in the impact that the wearing and donning and doffing of PPE has on the total feasible size of patient lists on a daily basis. The number of patients that were previously seen on a daily basis before COVID-19 is no longer going to be feasible once this is considered.

2.5. PPE has also caused some problems with communication, particularly *for* doctors who are deaf or have a hearing loss, and *with* patients who are deaf or have a hearing loss. The main issue is that masks make lipreading difficult or impossible, and the government needs to consider alternatives such as see through masks or hoods with respirators which are transparent. The pandemic had also highlighted that we still need to do more to make sure every patient and clinician has access to the appropriate communication support, such as sign language interpreters, as they should under the Accessible Information Standard.

2.6. Practicalities are also key with respect to testing. We welcome the work undertaken to improve the capacity of testing available in the UK. The focus must now turn to ensure we are implementing an evidence-driven approach to testing both in and out of hospitals. For testing to be most effective for local decision making, fast turnaround of test results is key.

2.7. A further limiting factor will be the staff resource available across the whole system to meet patient need. While it is not sustainable to rely on those that have returned to the NHS from retirement to support the substantive workforce, there may be roles this group of clinicians can still play - whether that be remote consultations, providing educational opportunities or as mentors to the workforce. We have been concerned to hear from recently retired members who report offering their services and time to trusts only for them not to be taken up. Going forward NHS trusts must ensure they are maximising all offers of help. The NHS should also maximise its use of private providers while the COVID-19 contract is in place.

2.8. Another consideration is the emerging data that suggests that people with obesity develop more severe COVID-19. Coupled with a higher mortality rate (BMI 40 or more 58%). Whilst additional data are needed to disentangle the relationship between BMI, health disparities and COVID-19 infection severity, a similar association with obesity and severe infection was observed with SARS. It is essential to save lives and protect the NHS by having a healthier population with a lower prevalence of obesity. Obesity is not the fault of the person. Up to 70% of weight is genetically determined. These patients should therefore not be stigmatised. Increased commissioning of Tier 3 and Tier 4 services (utilising telemedicine where appropriate) is necessary to allow all people with severe obesity to access evidence-based healthcare in order to reduce the prevalence of obesity.

3. Meeting the needs of rapidly discharged hospital patients with a higher level of complexity

3.1. There is a range of groups of patients who have been discharged in recent weeks. In the early stages of increased COVID-19 cases in the UK, hospitals sought to discharge patients to support the creation of surge COVID-19 capacity. Additionally, patients who had been admitted to hospitals more recently may have been discharged quicker than normal to help reduce the risk of nosocomial infection of COVID-19. There is then the group of patients who had been admitted with COVID-19 who have since been discharged. All these groups of patients will require follow up, and some will already have been receiving regular follow up as hospitals have adapted.

3.2. Patients who have been discharged following COVID-19 may require support from a range of specialities but it is expected that respiratory and renal clinicians will provide a significant amount of this support. This will need to be factored into plans as they are developed. Consideration should also be given to workforce allocation to support these patients. It is welcome that Health Education England (HEE) has announced an expansion of trainee places for intensive care medicine (ICM) [iv]. We would welcome a similar approach for respiratory medicine who have and will continue to manage a significant proportion of patients with COVID-19 and their recovery.

3.3. The pandemic has once again shown how fragile the social care system is in England. One of the overriding lessons of this pandemic must be the need to place social care on a sustainable footing working hand in hand with the NHS to meet the needs of the population. We will also need to review the lessons from the rapid discharges that happened as capacity was freed up. Additionally, we need to learn from the good practice that has and continues to happen across the country where primary and secondary care work closely with social care providers to meet patients' needs.

With funding and resource, these best practice examples can be one part of a new integrated national care system.

4. **Providing healthcare to vulnerable groups who are shielding**

4.1. As we learn more about COVID-19 from research happening across the world, along with specific research into UK outcomes, we will be able to refine the advice provided to vulnerable groups who are shielding. As we have mentioned before clear communications are key to supporting these individuals through a challenging and potentially worrying period.

4.2. Delivering services to these groups will require careful consideration to reduce risk and build confidence in this cohort of patients that NHS will still be there for them. The rapid roll-out of remote consulting will help with this, but there will still be a need for these patients to access face to face services. Local system plans should consider how this is best achieved locally and how all resources are available are used so care can be delivered in the community where possible.

5. **How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise.**

5.1. The past few months have shown how adaptable, flexible and innovative the NHS and its staff can be. Our members report that clinician leaders have worked well alongside NHS managers to ensure that the NHS was ready to meet the challenge it faced. This is something which should be championed in the next stages of managing this pandemic.

5.2. Responding to COVID-19 has also shown how much the NHS relies on the goodwill of its staff who time and time again go above and beyond. This must be a turning point for how we view the NHS and social care systems. Going forward the NHS must be fully resourced to meet population need supported by a strong public health and social care systems.

5.3. One of the positive changes that the pandemic and the need to rapidly adapt services has seen is the increased use of remote consultations via video and phone. This was something we set out as part of the RCP vision for rethinking outpatient services[v]. In the next few weeks, we will seek to understand the scale of this uptake which we can compare against a survey we undertook in December 2019 which showed that less than 10% of respondents said they had conducted more than 4% of their outpatient consultations by video in the last week. [vi] There will be a need in the next few weeks and months to embed this practice across the NHS as an option for patients and staff to use.

5.4. This crisis has also brought to the fore the importance of clinical research as we have sought to quickly learn about the virus and understand health outcomes to help us care for and treat patients in the best possible way. Going forward we should maximise opportunities across the NHS to embed time and resource for clinical research.

5.5. Finally, one of the reasons for the NHS's ability to respond to the crisis has been because all aspects of the NHS have sought to work together with each other to manage the situation. In time

there will be a need to reflect on the successes which should form a crucial part of the UK Governments thinking if it still plans on bringing forward the NHS Long Term Plan bill.

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About the RCP

The RCP plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the UK and overseas with education, training and support throughout their careers. As an independent body representing over 37,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high-quality care for patients.

References

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