

**In the balance:
Ten principles for how the NHS
should approach restarting
'non-Covid care'**



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Across the UK the NHS is beginning to restart work previously stopped or delayed due to the Coronavirus outbreak¹. This paper sets out key principles the BMA believes should be followed over the coming weeks and months to ensure that as this shift takes place, patient care is safeguarded and healthcare workers are given the support they need.

The BMA supports the aim of restarting more non-Covid care. Doctors are concerned about the impact of the current situation on patients who do not have the virus, with more than half telling the BMA that prioritisation of confirmed and suspected Covid-19 patients is having a worsening effect on the care available to those without the condition². It is vital that the NHS is supported to provide care to these patients, especially those who need urgent support for time-sensitive conditions such as cancer.

However, caution is also needed – the NHS is still dealing with the incredibly difficult task of responding to Covid-related demand, and there will be risks and challenges in pivoting back to more routine care. Politicians and healthcare leaders must be realistic about how much capacity the NHS has, given that services have been stretched thinly in many areas to deal with coronavirus. Doctors and other healthcare workers have been going above and beyond to ensure the NHS can cope with the pandemic, and this means they have been working in intense and stressful environments for many weeks. Bank holidays have been cancelled for many doctors. It is vital therefore that steps are taken to safeguard the wellbeing of healthcare workers as part of this phase of the NHS's response.

Ultimately, the NHS will only be able to cope with balancing Covid and non-Covid work if there is an accompanying strong focus on tracking and containing the virus in the community, and if local public health services are supported to lead this.

The following ten principles must be followed as the NHS restarts more non-Covid care:

1. A realistic and cautious approach to balancing Covid and non-Covid capacity is needed
2. There must be adequate PPE for health and care workers, and measures in place to prevent the spread of the virus within the NHS
3. Decisions about staffing levels and redeployment must be safe and made in consultation with employee representatives
4. Measures must be taken to safeguard staff wellbeing
5. Clarity must be given to healthcare workers about their future contractual position, and plans to restore training and career development
6. There must be effective and transparent public communication so that patients understand what they can and cannot expect from the NHS at this time
7. Increased remote working, where clinically appropriate, and use of technology to empower patients should be supported
8. Local decisions must be guided by clinical expertise and the experience of those working at the frontline
9. The government must support and significantly enhance local public health services and ensure there is adequate capacity to test, trace and quarantine
10. A strategy is needed to ensure that restarting non-Covid work does not exacerbate health inequalities

1. A realistic and cautious approach to balancing Covid and non-Covid capacity is needed

The coming months will require the NHS to maintain a difficult balance between continuing to provide care for patients with Covid-19 whilst ensuring that as far as possible, services stopped or delayed due to the outbreak can begin again. This will be challenging due to the scale of the changes that have been required so far to ensure the NHS can cope with the pandemic, and there are a number of risks and challenges that will need to be carefully navigated.

Firstly, services must be careful to ensure they do not underestimate the ongoing need for critical care capacity, both for Covid and non-Covid patients. Any return to elective treatment and other types of care is likely to require some shift of workforce and technical capacity (including physical spaces e.g. theatres/recovery areas that have been turned into surge ICUs) away from critical care back towards other clinical areas. There will be a simultaneous increase in non-Covid critical care demand if elective care is restarted due to requirements of post major and complex surgery, and depending on what steps are taken to ease the lockdown hospitals could also see an increase in people presenting with trauma as more road journeys, social events and sports start up again. It is also likely there will be an increase in people presenting with sub-critical acute conditions who have been self-managing at home with conditions that prior to the outbreak would normally have required care in hospital. These non-Covid critical care patients will clearly need to be kept physically separate from those with the disease, so separate zones or even sites (each with their own staff) will be needed, further stretching resources. Planning will therefore need to be robust to ensure that critical care units do not become rapidly overwhelmed by coincident reductions in capacity and increases in elective and urgent care demand.

More broadly, there is a risk that the NHS could see significant increases in demand as services reopen, due to unmet need having built up in communities since the beginning of the lockdown. We know that fewer patients have been seeking care from the NHS during the pandemic. For example, in April 2020 there were 1.2 million fewer attendances at A&E departments than the same month last year (a 56% decrease). In primary care, data suggests there were nearly two million fewer GP appointments in March compared to last year. Depending on how quickly this level of demand returns, we are likely to see rising pressure in both primary and secondary care in the coming weeks and months. Services may also feel under pressure to make progress on reducing backlogs of work where these have built up in recent weeks but may not realistically have capacity to do this without putting healthcare workers under unsustainable levels of pressure. It is also highly likely that an increasing number of patients will need mental health support due to a combination of factors including prolonged social isolation, increased rates of domestic violence, the impact of economic hardship and those coping with losing loved ones during the pandemic. Many psychological therapy services have been put on hold during the pandemic and even before this had long waiting times for care.

There will also be practical limitations to how quickly the NHS can return to routine work due to the pandemic, and these must be factored into any ambitions to increase services. For example, the new requirements for PPE and additional cleaning have markedly slowed down operating theatres and general practice hubs seeing patients. Extensive rapid pre-operative SARS-CoV-2 testing of patients coming for elective surgery (see point 9 below) may help to reduce this. The need to create and maintain clean zones (and in some cases separate sites altogether) within clinical settings across the NHS will have knock on effects on flexibility of use not just of healthcare workers, but also of facilities. In addition, the NHS continues to experience considerable shortages of drugs commonly used in both critical care and anaesthesia (such as propofol and muscle relaxants), which will also impact on the provision of elective surgical care.

Expanding critical care capacity has involved discharging large numbers of patients back into the community, and there needs to be careful consideration of how general practice, social care and other community services will be supported as part of this phase of the government's response. Clarity is needed on how referral pathways from GP surgeries into secondary care will now work, given that currently they have been significantly disrupted by the changes made to deal with Covid. GPs should be able to refer patients where they feel this is clinically appropriate, and clarity is needed on how such patients will be triaged and managed given the services they need to access may not have resumed yet. In particular there will be a backlog of referrals that do not fall under the 2-week waiting time target. Previous national plans to restructure how care is managed in the community did not envisage this being done at unprecedented speed, and it is too early to say how successful this has been. Achieving sustainable changes in primary and community care will require long term investment and building of trust.

In shifting some focus back to 'normal' NHS care it is also important that we retain the ability to scale up critical care capacity again should a second wave of the virus lead to a sudden spike in demand. Large temporary hospitals, such as NHS Nightingale London will reportedly be used for COVID-19 critical care in the event of a second surge in demand. However, it is unclear how these facilities will be properly staffed and equipped, given reports of London hospitals being unable to transfer patients to NHS Nightingale due to the facility having insufficient critical care nurses over the past few weeks. It is also unclear how these facilities will provide critical care for Covid-19 patients with high frailty scores or co-morbidities, given that most of these temporary hospitals have been set up to provide step-down care or critical care to fitter patients. Better coordination is needed across the country to move ICU patients around to make best use of critical care capacity, as wave one was characterised by some areas (mainly London) using surge ICU with low nurse/patient ratios and using anaesthetic machines as ventilators, while other areas had plenty of spare "normal standard" ICU capacity that went unused.

Finally, where private hospital capacity has been block booked to support the NHS, clarity is needed on how this capacity will be effectively used, and consideration should be given to whether contracts need to now be extended to ensure the NHS can continue to use private hospital capacity. Recognition is needed that the consultants providing this care continue to be (as always) mostly the same people who are also providing NHS care, and it does not represent a wholly untapped medical resource.

2. There must be adequate PPE for health and care workers, and measures in place to prevent the spread of the virus within the NHS

Health care and other frontline workers have in a majority of cases not been supplied with the PPE they need to protect themselves and patients during the course of the outbreak. A sufficient, guaranteed supply of PPE for healthcare workers to account for COVID-work, and for restarting non-COVID care with additional precautions in our "new normal" world, is essential. For example, there will need to be sufficient PPE for staff use in general practice, outpatients and also for diagnostic, operating theatre, catheter laboratories and endoscopy suites. There also needs to be appropriate PPE available (such as masks and eye protection) for patients using non-Covid services, to reduce the risk of transmission within the NHS.

There will need to be new or updated guidance on the appropriate PPE and infection control procedures that are relevant to the settings in which non-COVID treatment will take place. In implementing new or amended guidance consideration needs to be given to the loss of trust that the failure to provide adequate PPE has caused amongst health and care workers. Communication and engagement will be imperative to build and restore confidence amongst staff.

3. Decisions about staffing levels and redeployment must be safe and made in consultation with employee representatives

Given pre-existing workforce shortages, the NHS will find it extremely challenging to balance the demands of Covid and non-Covid care. It is ultimately staff levels, rather than availability of beds, equipment and physical space that have been the most important factor in deciding how quickly the NHS has been able to increase capacity to respond to the pandemic.

The NHS should set out clear and transparent plans for whether and how it intends to continue to deploy/redeploy staff across geographies and NHS services and sectors. Decisions on redeployment must always take into account staff individual circumstances and preferences, as well as skill mix and educational/training requirements. Redeployments are voluntary and therefore must have the express consent of the staff being asked to redeploy. Accurate workforce modelling should be conducted based on regular submission of staff data by providers and follow staffing guidelines from Royal Colleges as closely as possible. The NHS should seek to increase recruitment where understaffing persists. This includes for both COVID and non-COVID care, e.g. the urgent and elective backlog in secondary care and the hidden poorly staffed conditions within the community that are yet to be identified.

Staff should be risk-assessed against all transfer requirements, including for their personal safety and the clinical circumstances. This includes getting their individual consent first, not asking them to act outside of their competencies, giving reasonable notice of redeployment, giving staff the opportunity to confirm individual competencies before redeployment, undertaking any training staff feel they need before redeployment etc. See the BMA's [COVID-19: staff redeployment guidance](#) for the full range of good practice principles.

All doctors must be given a health and safety risk assessment taking into account evidence of risk factors associated with age, ethnicity, sex, comorbidities and for pregnant staff. Where staff are pregnant or otherwise determined to be at a high risk of COVID-related ill-health or death, they should not be deployed to potentially hazardous areas. Alternative clinical or non-clinical work should be found for them to do or they should be supported to work remotely where possible. The system – in both primary and secondary care – needs the resources and support necessary to make mitigation feasible and effective. Employers should consider the possibility that the failure to accommodate chronic health-related risk factors when working out someone's job plan might constitute discrimination on grounds of disability, particularly if it results in disadvantage financially or professionally compared to someone who is able to work safely in a potentially-hazardous area. In the longer term, clarity is needed from PHE on when such restrictions can potentially be lifted, based on the prevalence of the virus in the community.

If there is to be a period of further redeployment of those doctors who have returned to medicine in response to the outbreak to help with backlog there needs to be clarity around how this will work regarding their terms & conditions, performance management and health & wellbeing. In anticipation of a potential second wave of COVID or ongoing outbreaks, clarity is needed over how these returners will be managed in the long run. The GMC licence to practice of these doctors is dependent on the UK being in an official state of emergency. The government therefore needs to clarify if it intends to extend this state of emergency to offer these clinicians the option of continuing to support the government's response to the outbreak and to help non-Covid services resume. The BMA would like to see this happen provided there is agreement on the terms and conditions through which these doctors will be employed.

4. Measures must be taken to safeguard staff wellbeing

Following intensive levels of high workload employers need to ensure that staff are able to take time off and those who would like to work flexibly are supported. A consistent and fair policy for staff using annual leave entitlement is needed which ensures that those who have worked for an extended period during the pandemic are able to take a break when they need it most. In secondary care, staffing rosters must have cover for annual and sick leave built in to prevent unrealistic expectations of service capacity being built up. This should include appropriate consideration of the staffing required to meet adjustments to services and working patterns, as hospitals and other care settings return to providing routine and elective care. GP practices should be supported to ensure staff are able to take leave allocations, including bank holidays which were recently cancelled for many practices.

Staff who are presenting with complex mental health conditions, such as PTSD-like symptoms, will need to be assessed by their GP and where appropriate have an occupational health medicine assessment for time off work and rapid access to appropriate treatment. Any wellbeing support initiatives introduced to support staff during the pandemic should be available in the medium and long-term as take up may not be immediate. Peer support and mentoring schemes should be available to ensure staff have a safe space to reflect on their experiences and raise any issues of concern³. Pregnant staff should be risk assessed and supported to safeguard both foetal and maternal well being.

5. Clarity must be given to healthcare workers about their future contractual position, and plans to restore training and career development

Many doctors and other healthcare workers have had to change their working patterns as part of the NHS's response to Covid. Some of these changes – because they were in response to a true emergency – have been extraordinary, including prolonged periods of duty, short notice changes without any predictability and involving extended periods away from home life, and most junior doctors having their training effectively put on hold. Many doctors had to move to a completely different speciality very quickly and this created significant additional anxieties and problems for these doctors.

The pandemic has seen healthcare staff frequently go above and beyond to help deal with the crisis, but it would be unsustainable and unacceptable for this to become the 'new normal'. Where possible, healthcare workers should now begin to return to more 'normal' working patterns with leave being taken – and employers and governments should agree binding commitments regarding the timetable for return to normal contractual conditions where this is not immediately possible, in consultation with doctors. Where contractually agreed elements of doctors' roles have been temporarily suspended due to the pandemic – including vital elements of education and training, academic research, study leave, and professional development – wherever possible these should be reinstated.

In addition, doctors should be paid appropriately for work above and beyond existing contractual agreements. Remuneration for additional work and work undertaken using work patterns that were not present pre-emergency should be the subject of negotiation between the BMA and employers.

Alongside this, clarity is needed on how and when training programmes and timely career progression will continue, not just to give certainty to affected doctors in training, but also to ensure ongoing sustainable service delivery. In particular, we need early reassurance that the summer rotation will happen, and how. A new cohort of FY1s need to be accommodated and trained, and their predecessors need to move on to free physical and training capacity, as well as to continue their own careers.

6. There must be effective and transparent public communication so that patients understand what they can and cannot expect from the NHS at this time

Government need to develop a clear and effective communication strategy to inform the public about how and when to access services. Any public facing information and guidance should be developed with input from both patients and clinicians to ensure effectiveness and relevance to all population groups.

The communication strategy should include information regarding self-care and utilising current strategies to access care, such as virtual consultations used in general practice and secondary care, to ensure increased strain is not put on the NHS. However, public safety must also be addressed by encouraging the public to access necessary services when needed, such as emergency care, where there has been a worrying trend towards patients staying away from GPs and A&E in large numbers and presenting later with emergency conditions that are then harder to treat. Clear and sustained communication is necessary to encourage use of and signpost to urgent treatment – in particular where there are only short-term windows for effective treatment of progressive conditions and notably some cancers.

Patients need to be reassured that it is safe and appropriate for them seek emergency care from the NHS if they need it, as many appear to be staying away due to concerns about contracting or spreading Covid, or even just not wanting to "burden the NHS" when they know services are stretched thinly. Sharing more information with the public about steps being taken to keep them safe if and when they need to use the NHS – such as the use of different zones to keep patients who have or potentially have the disease separate from those who don't – may help provide reassurance.

At the same time, early communication is needed to ensure patients accessing care understand how NHS service will be different to what they would have expected before the pandemic. Asking patients to undertake a period of social isolation before operations is likely to be an essential requirement that will need early communication. Clinics will need to adapt to allow social distancing in waiting areas. This is not just a matter of spacing seats (where that is physically possible) but may require lower throughput of patients and spacing appointments so that delays don't lead to unacceptable proximity of waiting patients. Much more telemedicine will need to be the norm for the immediate future, allowing scope for situations where close observation or physical examination is of the essence. Patients need to clearly understand where this is needed and where it is not.

It is important that the public understand there will not be a clearly defined end to the pandemic. Recovery of NHS services will be progressive and stepwise over potentially a very extended time period. The NHS will need to become adept on providing clear information to clinicians and patients alike on what services are open, the scope of services available and a timeline for restoration of further services and routes to access them, noting that this will be subject to ongoing change in either direction as the pandemic slows or regains pace.

7. Increased remote working, where clinically appropriate, and use of technology to empower patients should be supported

In primary care there has been an unprecedented shift to remote working, necessitated by the need to reduce face-to-face contact, with most GP consultations now taking place remotely. While this is set to continue for the foreseeable future, there must be consideration about how to facilitate greater and sustainable remote working across the NHS (including both primary and secondary care) and in social care, where clinically appropriate, even when social distancing rules are relaxed. It should be noted, however, that remote consultation is not necessarily more efficient or quicker than face-to-face consultation, due to limitations in the information available to the doctor and the restrictions of telephone or video conversations compared to in-person. There should be specialty by specialty consensus as to the clinical circumstances when face-to-face consultations with appropriate PPE are more clinically appropriate. More guidance should be provided to doctors undertaking remote consultations particularly over medico-legal risks.

Adequate technology will be needed as many settings do not have adequate hardware and bandwidth to undertake this work. This should be funded by the NHS.

Gains that have been made in helping people to cope with the pandemic and to empower patients – such as use of befriending apps to reach out to those at risk of having little social contact with others – need to be retained and built on for the future.

8. Local decisions must be guided by clinical expertise and the experience of those working at the frontline

Clinicians should play a central role in determining and guiding the response to Covid-19, to ensure that any response is credible, clinically sound, and based on the needs of both patients and the NHS workforce. Efforts both to tackle Covid and to restore wider provision of care need to reflect local circumstances, especially in relation to at-risk and vulnerable groups. Doctors have an invaluable understanding of the populations they serve and the pressures facing the hospitals, GP practices, and community services where they work, therefore, it is essential that they are centrally involved in deciding how local services should now be run. This will require open, inclusive and transparent leadership throughout the NHS. There are a range of sources of frontline clinical expertise that the NHS can draw on, such as through Directors of Public Health, Trust Infection Prevention and Control Teams, LMCs (local medical committees) and LNCs (local negotiating committees).

Decisions about balancing Covid and non-Covid capacity must be made on a clinical basis backed by the best evidence. Governments must assure the NHS that services will not be financially penalised for prioritising capacity to care for patients with Covid. In England, hospitals still rely heavily on elective care and other activities to generate funding, with these activities paid for according to locally or nationally agreed tariffs. Hospitals should not have to face reduced income as a result of deciding not to take up more of these activities. Now would be a good time to consult over different funding arrangements for elective care.

9. The government must support local public health services and ensure there is adequate capacity to test, trace and quarantine

As the restoration of non-covid services moves forward, the Government must put in place a credible and transparent strategy on testing.

This should include, but not be limited to, continuing to increase national testing capacity. The tests used (both serum antibody and nasopharyngeal RNA-PCR swab testing) will need ongoing assessment of their sensitivity and specificity as population prevalence of the disease changes, particularly as several of the tests used have questionable validity. This assessment needs to be made transparently available to NHS providers who are relying on the accuracy of the tests to manage the safety of staff and other patients.

Testing of patients must be expanded, particularly for vulnerable patients such as those in residential and nursing care homes, and for patients who are accessing routine care (such as elective surgery) to provide confidence that areas designated for the care of non-Covid patients are not exposed unnecessarily to asymptomatic spread of Covid.

Alongside this a further significant increase in capacity is needed to enable much more widespread testing of whole communities – including the ability to test potential asymptomatic carriers where evidence suggests there are pockets of infection. Capacity is also needed to effectively track and prevent further spread of the disease through quarantining those with the virus wherever possible.

To achieve this we need to see a significant change increase in funding for local public health services so that they can lead this next phase of the response to the outbreak. The BMA is concerned that outsourcing parts or all of these functions to the private sector will mean that the expertise and knowledge of local populations within public health services will be underutilised, and money will potentially be wasted. A conversation needs to occur over bringing public health back into the NHS family and remove it from the local authority control it now sits with.

Finally, for both staff and patients, it is crucial that a clear process is established for storing results consistently across primary and secondary care records as well as the Summary Care Record. As the scale of testing increases it is likely and increasingly apparent that tests will be administered by a range of different NHS and non-NHS providers. Clear guidance on how their systems interact with NHS systems will be necessary and safeguards in place to ensure both quality and consistency in performance of standards such as test reliability, sensitivity and specificity of tests used, quality of interpretation and reporting, turnaround times and the collection of adequate swab samples. Where private sector testing operations fall short of the information governance (IG) and quality assurance standards of the NHS, contracts should be reviewed to ensure compliance with IG laws and regulations.

10. A strategy is needed to ensure that restarting non-Covid work does not exacerbate health inequalities

As local areas begin to make decisions about whether to restart non-Covid care – e.g. how much elective surgery to schedule – there is a risk that this will create a postcode lottery for patients, with some services available in some areas but not others. This will exacerbate health inequalities, which are already a factor in the impact of Covid on the UK, and one that is likely to grow if the UK enters an economic recession as is predicted.

Measures should be considered to mitigate this risk. In the immediate term, national-level action is needed to ensure that where there is variation in access to non-Covid NHS services, mechanisms are in place to enable patients to access services in areas where capacity is available. Although this may not be appropriate for all patients (particularly if significant travel is involved) for some this could help ensure they receive treatment faster.

In the longer term, tackling health inequalities will require significant investment in public health services.

Endnotes

- 1 For example, on 29 April the Chief Executive of NHS England, Simon Stevens, wrote to NHS bodies in England setting out plans for the “second phase” of the NHS’s response to Covid-19. This letter asked NHS bodies to step up non-Covid urgent services and to make judgements on whether they have further capacity to restart at least some routine non-urgent elective care. Similar considerations are taking place across the UK. The letter from Simon Stevens is available online here: <https://www.england.nhs.uk/coronavirus/publication/second-phase-of-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/>
- 2 BMA press release, 4 May 2020: “Thousands of doctors unable to offer patients the desperate care they need as a result of COVID-19 pandemic, BMA survey finds”: <https://www.bma.org.uk/news-and-opinion/thousands-of-doctors-unable-to-offer-patients-the-desperate-care-they-need-as-a-result-of-covid-19-pandemic-bma-survey-finds>
- 3 Although the scale of the potential demand for these services will require action from government and NHS leaders, it is also important to note that the BMA itself provides a confidential 24/7 counselling and peer support services open to all doctors and medical students (regardless of BMA membership), plus their partners and dependents. Further information is available here: <https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/counselling-and-peer-support-for-doctors-and-medical-students>