

GETTING THE NHS BACK ON TRACK PLANNING FOR THE NEXT PHASE OF COVID-19

About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is a new NHS Confederation campaign to contribute to the public debate on what the health and care system should look like in the aftermath of the pandemic. Galvanising members from across the NHS Confederation and wider partners in health and social care, it aims to recognise the sacrifices and achievements of the COVID-19 period, rebuild local systems and reset the way we plan, commission and deliver health and care.

Find out more at www.nhsconfed.org/NHSReset and join the conversation #NHSReset

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter [@NHSConfed](https://twitter.com/NHSConfed)

Key points

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As part of our [NHS Reset](#) campaign, this report outlines the key challenges that local organisations will face over the coming months. It also suggests some changes in policy and practice that will be required as the NHS prepares to restart a wide range of services either paused or stopped when the pandemic struck. It is based on in-depth engagement with our members and is published to support and influence forthcoming guidance from NHS England and NHS Improvement on how the next phase of the NHS' response to the pandemic will be managed.

The key challenges we identify are:

- **Funding:** Local NHS organisations are facing an uphill battle. They are already having to manage ongoing demands from COVID-19, support exhausted frontline staff, cope with renewed demand in just about every area, and restart routine care, against a backdrop of increased unmet demand. All this is compounded by the need to create separate COVID-19 and non-COVID-19 areas and enforce social distancing for patients and staff.

Temporary arrangements, including the use of block contracts, are in place to ensure any 'reasonable' excess costs faced by providers are funded centrally. This arrangement needs to be continued for the rest of the financial year to take into account the profound impact on the NHS and its people of dealing with the pandemic.

- **Capacity:** NHS organisations across the service face capacity constraints, with hospitals, for example, having to run at much lower rates of occupancy than normal. Ongoing arrangements with the private sector should be put in place until the end of the financial year to support the NHS to manage the backlog of treatment.

For the NHS to respond effectively to COVID-19 while restarting other services, the test and trace system ideally needs to be fully operational. It is right to begin the process of resuming routine

care, but there are a number of operational challenges that need to be resolved with the test and trace system. This would provide more reassurance to health and care leaders. Similarly, there needs to be appropriate supplies of personal protective equipment (PPE).

- **Rehabilitation:** Focus and resources should now shift as we look ahead to a different kind of COVID-19 response – one based on ongoing care and rehabilitation for those patients who require social care, respiratory and psychological treatment. Our members are clear that local government, private and voluntary, community and social enterprise (VCSE) sector organisations delivering care need to be supported as equal partners during this next, longer-term phase of the recovery.
- **Health inequalities:** The pandemic has revealed and further exposed the level of health inequalities throughout England – further guidance needs explicitly to tackle this with specific goals to reduce health inequalities using population health data and strategies.
- **Regulation and inspections:** Lighter-touch regulation and performance management have allowed clinicians to redesign services at pace. We must not return to the pre-COVID-19 models of Care Quality Commission (CQC) inspections and other forms of regulation. We also need to know when local NHS organisations and systems will be handed back greater autonomy as we move from Level 4 to Level 3 of the COVID-19 alert system.
- **System working:** COVID-19 has accelerated transformational change, much of it enabled by effective partnership working. Now is the right time to empower health and care systems to drive change, with greater clarity about how we can deliver ‘system by default’ in ways that support effective partnerships and integrated services. This is a key area that future legislative reform will need to look closely at in the months to come.

NHS systems will need to be able to design and implement a recovery that is right for their populations at that moment in time, allowing for local variations in infection rates, facilities and capacity and any future outbreaks. We should be sharing performance data across NHS regions to help providers benchmark recovering services.

Up until now, the approach to transformation has been too NHS orientated. In spite of positive words, the reality has been to regard other parts of the system as something different and separate. There is an opportunity now to reset this set of relationships and to regard the NHS, local government, private and voluntary, community and social enterprise organisations all as equal partners during the next phase of the recovery.

- **Managing public expectations:** Finally, we need to capture and channel the groundswell of public support we have seen for the NHS and care sector. Unless we do so it is likely to waver when patients and users experience delays in accessing care and treatment. As things stand, there is a real danger that expectations will run ahead of what we can deliver. We will need realism about what can and cannot be achieved, with clear and consistent communication from political leaders that it will take many months, possibly longer, to return to pre-COVID-19 levels of activity.

Looking to the next phase

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What key challenges do health leaders wish to see addressed in phase three guidance and beyond?

Since the outbreak of COVID-19, NHS England and NHS Improvement (NHSEI) has written twice to organisations across the NHS to provide guidance on the response to the pandemic. Updated guidance from NHSEI on how the next phase of the response will be managed is expected by mid-June.

This report outlines seven of the key challenges our membership of health leaders across the NHS wish to see addressed in this guidance and beyond. They have been identified through our close ongoing engagement with providers and commissioners during the pandemic, including a webinar held with members and the lead officials at NHSEI who are developing the phase three guidance.

1. Funding

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In the year before the outbreak of COVID-19, almost half (47 per cent) of NHS trusts were in deficit and as the pandemic hit, many were struggling to meet their end-of-year financial targets for 2019/20.

The recent short-term financial commitments to support providers, including the coronavirus emergency response fund and the '[writing off](#)' of provider debt, have been welcomed, but they have not addressed many of the underlying financial challenges. The position according to many of our members in secondary care is that their financial position is rapidly deteriorating.

The combination of responding to ongoing COVID-19 demands, restarting elective and other services and balancing budgets for 2020/21 is likely to prove impossible.

As one NHS leader told us: "It is highly unlikely that we have either the workforce or finances to deal with COVID-19 demands, business as usual and deal with the backlog. Something will have to give."

The government must make additional funding available to manage these pressures or indicate which of them it does not wish to make a priority. As part of this, we must establish realistic national expectations on what level of elective care will be brought back in 2020/21.

In mental health, our members have expressed concern about the implications of COVID-19 for patients, the public and NHS staff alike, with a significant surge in demand for mental health services expected over the coming months.

In primary care, similar choices must be made. Clinical directors of primary care networks (PCNs) have told us that the level of funding required over the coming months depends on the level of delivery expected. At present, many PCNs are overseeing a 'gold standard' COVID-19 response, including strict use of 'hot and cold' sites for patients.

However, this is not only labour intensive but also requires significant physical space across multiple sites. It is simply not

possible to retain this gold standard as well as increase consultations for non-COVID-19 patients and address backlogs. Either additional resources and funding are needed, or again something has to give.

Practical solutions for the phase three guidance and beyond

- An extension of emergency funding across all sectors of the NHS, in acknowledgement that services are expecting significant extra demand across all areas but especially in mental health. Temporary arrangements are in place until the end of July to ensure any 'reasonable' excess costs faced by providers would be funded centrally. This arrangement needs to be continued for the rest of the financial year to take into account the profound impact that dealing with the fallout of the pandemic will have on local NHS organisations.
- A continuation of block contracts until the end of the financial year. Several members across all sectors, including providers, clinical commissioning groups and integrated care systems (ICSs), recognise the pragmatic value of moving to block contracts and away from payment by results during the pandemic. This has significantly helped them to respond to the novel coronavirus, but this must be a short-term solution. Dialogue will be needed between providers and their commissioners about whether to return to pre-existing funding frameworks or if the COVID-19 experience has provided an opportunity a move to system-wide funding models.
- Urgent capital investment will be required, particularly in areas such as mental health where significant changes will need to be made to wards and other infrastructure as services are remodelled to deal with the ongoing impact of coronavirus.
- A recognition that additional funding is required for social care. The Local Government Association and Association of Directors of Adult Social Services have highlighted that [social care providers are likely to face more than £6.6 billion of extra costs](#) by the end of September this year. This is due, in large part, to the significant cost of PPE and cleaning services.

2. Capacity and performance

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Providers across all settings will face restrictions on their capacity to deliver patient care by the need to separate COVID-19 and non-COVID-19 patients, maintain social distancing and guard against any potential second wave of infections. These factors mean that hospitals are by necessity having to run at significantly lower rates of occupancy than normal. This is set to constrain how quickly trusts can begin to recommence non-COVID-19 services. With over 4 million people on the waiting list for NHS treatment, it is key that secondary care capacity is expanded as much as possible. It should be noted that backlogs are likely to vary significantly by area and so system-wide solutions may be helpful for alleviating pressure on particular providers.

Throughout the pandemic the community and primary care sectors have significantly alleviated pressures on acute services and secondary care more broadly. As one PCN clinical director told us recently, we now must recognise the need to support nursing homes, community and voluntary services, and the many processes relating to long-term follow up. This is where, for many patients, additional capacity will be needed. Our members have been quick to emphasise that care for COVID-19 must not end once they are discharged from secondary care. This is detailed further in the next section on rehabilitation.

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Key to ensuring that we are best placed to boost capacity and improve care across all settings will be a robust test and trace system.

Finally, there is a need to set realistic expectations about what is possible with staff who are exhausted and who may need to continue to self-isolate as we live alongside COVID-19.

Practical solutions for the phase three guidance and beyond

- Putting in place ongoing arrangements with the private sector to provide the health service with the capacity to deal with the major backlog of treatment that has built up since COVID-19. An arrangement is due to finish by the end of June and should be ongoing until the end of the financial year. The waiting list stood at 4.2 million before COVID-19 – it will rise much further without this extra capacity from the private sector. In addition, the Nightingale Hospitals should also be maintained in case of any further spikes in infections. NHSEI should also ensure that private sector providers are using and offering the same data flows as NHS trusts (such as weekly capacity and activity information) to maximise their impact.
- Assurances of longer-term PPE provision to ensure the NHS can confidently resume routine operations as quickly and efficiently as possible, with supply lasting more than 48 hours so that trusts can plan longer in advance for elective operations.
- A robust system of test and trace in all areas of the country, with clear understanding between local government and health and care services. It is right to begin the process of resuming routine care, but there are a number of operational challenges that need to be resolved.
- A review of 'burnout' and wider wellbeing across the NHS and social care workforce.
- A recommencement of the Evidence-Based Interventions programme (EBI), which reduces interventions considered by consensus to be of low clinical value. This would capitalise on the significant reduction in such interventions during COVID-19. Patients on previous waiting lists for any EBI procedures should be removed and we should proceed to phase two of the programme to redirect much-needed capacity.

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- A longer-term capacity building programme to ensure that we have sufficient space for care that is safe and socially distanced. This in turn may help stimulate the economy and model the NHS as being an anchor institution locally, as we face down an anticipated recession.
- An ongoing focus on digital technology that maximises use of capacity (for example, to enable remote working for socially isolating staff who could still provide remote consultations to support patients waiting for follow up or information on elective procedures).
- System-level solutions to capacity issues and addressing backlogs will be beneficial. An example of such a solution is system waiting lists, allowing backlogs to be pooled and addressed across a system of providers, and ensuring that burdens are shared to support those facing the most severe pressures.

3. Rehabilitation

There is a growing need to provide rehabilitation to those who have had coronavirus and who may require social care and/or respiratory, neuromuscular and psychological treatment. However, there will also be significant numbers of people who will require rehabilitative treatment due to months of self-isolation and loneliness, not least in terms of mental health support. Our members have already reported increased presentation of psychosis patients to mental health services, as well as members of the general population who have been impacted by the manifold effects of the crisis on their lives.

These needs will manifest differently across the COVID-19 patient population and wider public and will require intervention across the entire health and care system, with equal emphasis on acute, primary, community, mental health and social care services. At present, however, such services are unprepared for the significant expected increase in the number of people needing rehabilitation services.

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Primary care will play a vital role in the continued rehabilitation of COVID-19 patients in the community. For many, rehabilitation will last long after their discharge from secondary care and as such primary care teams will require access to up-to-date information on their patients. The social care sector will also be key to supporting the most vulnerable in our society over the coming months, but there are concerns over the stability of the social care market for providers due to financial instability.

Practical solutions for the phase three guidance and beyond

- Extra focus and resources on community-based rehabilitation services, recognising that we now face a different, longer-term battle with COVID-19 that will require a far bigger role for mental health and social care services, as well as the community, primary care and voluntary sectors.
- A commitment that discharge of patients includes consideration of rehabilitation, in coordination with social care, primary care and community services, with ongoing access to specialist advice for those discharged.
- A recognition of the huge financial strain that the care sector is under and a commitment that the government will support care providers through short-term funding if necessary, in addition to what has been provided so far.
- A commitment to a comprehensive and sustainable plan to reform social care funding and delivery, alongside a commitment to a new compact between health and care during the difficult months ahead.

4. Health inequalities

COVID-19, and the approach to managing the virus, have revealed pre-existing health inequalities as well as exacerbated them. Of particular concern during the pandemic has been the impact on black and minority ethnic (BME) populations, who have been disproportionately affected by infection and mortality. In addition, the shielded population and vulnerable children who have not benefited from health visiting services remain a concern. We must acknowledge that stepping down services will have caused harm – and we must seek to remedy this as we work through waiting lists, backlogs, and decide which services we prioritise in resuming at a system level.

In restoring services and resetting the NHS, there is an opportunity to learn from how individuals, families and communities have been impacted differently by the coronavirus outbreak and to move to a population-based approach to the planning and design of services.

The COVID-19 period has revealed concerning trends that the NHS and the government must recognise and face up to, including through the phase three guidance. As an organisation, we have longed talked about inclusive growth and the NHS as an anchor institution. It is critical that systems and providers are supported to play this role. As a recession hits with the risk of exacerbating health inequalities, there is an opportunity for the NHS as a major employer and buyer of services to model inclusive employment and growth.

Practical solutions for the phase three guidance and beyond

- A renewed commitment to acknowledge and address health inequalities wherever possible through upcoming guidance and policy reform.
- Support for initiatives and programmes that are seeking to research, analyse and develop solutions to the links between COVID-19 and health inequalities. We have already seen welcome commitment from NHSEI with the recent launch of the NHS Race and Health Observatory, which will be hosted by the NHS Confederation.

5. Regulation and inspections

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One of the positive changes to have arisen from the pandemic has been lighter-touch regulation and performance management. This has required less paperwork and allowed providers to spend more time on providing care for patients – crucial at a time of unprecedented challenge.

Our members acknowledge the importance of governance and regulation, but also note that it can stifle innovation and increase the length of time it takes to get work done. Following our calls in March 2020 for a [suspension to planned inspections during the pandemic](#), we have been pleased to see that this has been beneficial to providers, reducing bureaucracy and allowing trusts to be more responsive and flexible in how they provide patient care. However, this has not been the case in all parts of the country.

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Given we are still in a Level 4 incident, the autonomy of local NHS organisations has been reduced during this period. In many ways, this is understandable. However, while this has not been universal across the country, we understand from many members that the amount of top-down performance management from NHSEI and its regional offices has reduced. This needs to precipitate a wider change in culture on the issue of regulation.

Practical solutions for the phase three guidance and beyond

- Clarity on when local NHS organisations will be handed back greater autonomy as we prepare to move from a Level 4 incident to Level 3.
- A commitment that the NHS will not simply default to the pre-COVID-19 model of CQC inspections.
- A new pattern of assurance/performance monitoring for CCGs that is enabling.
- The CQC to be encouraged to consult with providers and others across the health and care system to learn what has worked well during this period and explore what aspects of regulation should be carried forward, rather than an assumption of returning to business as usual.
- A reconsideration of whether we have the right balance and approach to inspections and regulation more broadly. There is a need to instigate a shift to more local autonomy, with less central command and control, when we emerge from what remains a Level 4 incident.

6. System working

Our members, including across systems and PCNs, have told us that COVID-19 has accelerated transformational change, much of which has been enabled by the structures and ways of working created through partnerships. Examples include significant re-shaping of acute care services at pace into 'hot and cold' COVID-19 sites, triage of referrals, use of advice and guidance as an alternative to referral, huge uptake of online and video consultations, shared leadership from health and care leaders, as well as changes to clinical pathways on an unprecedented scale.

At PCN level, new links between general practice and community, voluntary and social care providers have led to a multitude of new services for communities, including food banks and the pooling of resources and equipment.

We have outlined such [examples and suggested how NHSEI may wish to support systems to embed transformation](#), in a recent report. Our members across STPs and ICSs – whether independent chairs, executive leaders or programme directors – are clear that systems must be central to the restoration and recovery process in their local areas. During an interview on who should make decisions on new ways of integrated working over the coming months, one system leader argued that “if you don't have ICSs leading this then who is going to?”. At the heart of system working must be a consistent focus on population health management.

The future of 'system by default', and how forthcoming primary legislation supports this, will be critical to the process of recovery and reset across the country. Our ICS Network is working closely with systems across the country to put forward a consensus vision for what system by default should look like, and we hope that NHSEI and the government work with us to ensure that we empower systems to lead local change.

This vision must recognise that until now the approach to transformation has been too NHS orientated. In spite of positive words, the reality has been to regard other parts of the system as something different and separate.

There is an opportunity now to reset this set of relationships and to regard the NHS, local government, private and voluntary, community and social enterprise organisations all as equal partners during the next phase of the recovery.

Practical solutions for the phase three guidance and beyond

- An acceleration of 'systems by default' – now is the right time to empower health and care partnerships to drive transformative change.
- An expectation that all phases of recovery will require plans to be at a system-level, with the system being held accountable for the effective use of capacity and demand.
- An acknowledgement that population health management will be a critical factor in ensuring that local populations' health and care needs are met, and in linking services across neighbourhood, place and system level.
- This must be underpinned by digital integration across systems and PCNs, ensuring that patient data is being used to recognise where health inequalities are adversely affecting health outcomes.

7. Managing public expectations

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The support and understanding the NHS has received from the public throughout the crisis has been remarkable.

That said, NHS leaders are concerned that as the realities of COVID-19 continue to impact on access to services, and as the time required to return to pre-crisis levels of delivery becomes apparent, there is a risk that public support may begin to waver. Yet this would be understandable if the public are not made aware of the reasons why it is not possible to simply 'switch back on' NHS services.

We know that the NHS is facing a slow, gradual recovery and we must be clear that we will not be able to return to pre-COVID-19 levels of activity for several months, possibly longer. This will be felt across all parts of the health service, but there is particular concern about the size of the waiting list – as mentioned, over 4 million pre-COVID-19 – and how this will grow further.

It is vital that we try to maintain public confidence, trust and understanding as we manage the fallout of the pandemic and so that the incredible efforts and sacrifice of staff throughout the crisis are not undermined.

Practical solutions for the phase three guidance and beyond

- A call for clear and consistent communication from the government, arm's-length bodies and politicians about the significant backlog faced by the NHS, the difficulties of the current circumstances and the time required to return to pre-COVID-19 levels of activity.
- There is also an opportunity to build on this with a more positive vision for how local services can be delivered in new ways following many of the positive examples of innovation and ways of working that we have seen during the pandemic.

Next steps

The challenges raised in this report will not be easy to address and will require strong leadership at national level. We will continue to play our role in supporting members and national leaders as we start to look beyond the emergency response to COVID-19, and towards the long-term process of recovery and reset.

Our NHS Reset campaign aims to recognise the sacrifices and achievements of the health and care system throughout the pandemic and look ahead to how we can rebuild local systems and reset the way we plan, commission and deliver services. [More information can be found on our website.](#)

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