Royal College of Physicians

Setting higher standards

Returning the NHS to an even keel

The scale of the challenge facing the NHS after the first wave of COVID-19 in England is only just coming to light. The NHS adapted at speed to redeploy staff, change estate configurations, reduce non-COVID-19 face-to-face appointments and redesign patient pathways.

The deployment of the NHS physician workforce provides an insight into the NHS response. In the middle of May, 32% of our members reported working in a clinical area that was different from their normal practice.* By the start of June this had reduced by 10% to 22%,† but that still means one-fifth of the workforce were working outside their usual area. This has knock-on effects for patients and the resumption of services.

When asked how long it will take for the NHS to get back on an 'even keel' (defined as 'backlogs managed and services stabilised to a "new normal"'), 98% of our members think it will take at least 6 months, 70% believe it will take over a year and 39% more than 18 months.

These responses show there is a very clear collective opinion on the extent of the work that still lies ahead of the NHS workforce. And we must also remember the very real possibility of further COVID-19 outbreaks and additional waves, which would of course increase the challenge ahead.

A consultant gastroenterologist in north-west England articulated the challenges facing their service in our recent membership survey:

> **'We have a huge backlog of endoscopy work. This is in the context of having fewer rooms available (due to requirement for patients to socially distance while waiting and recovering) and being able to do fewer procedures in each room due to constraints of PPE donning and doffing plus room cleaning. We are now doing more clinics than usual and so the numbers of endoscopy requests are going up more than usual every month. We have had to place endoscopy at the highest level on the trust risk register. We need formal support to ensure that risk associated with endoscopy and other similar investigations/treatments that have been delayed during COVID are shouldered by trusts and ultimately by NHS England and central government to prevent individuals taking blame for delayed diagnosis/treatment.'**

The RCP, in partnership with our specialist societies, has been working with NHS England to plan specialty-specific restart activity. This is based on different scenarios regarding specialty capacity across the country, and the impact of COVID-19 is being felt unevenly. Consultants in respiratory medicine and gastroenterology expect it to take 2 years to recover from the backlog created by COVID-19, while those in cardiology are expecting it to take 18–21 months.

* www.rcplondon.ac.uk/news/what-are-we- learning-workforce-about-impacts-covid-19

† www.rcplondon.ac.uk/news/covid-19-and-workforce-what-we-ve-learned

Specialty capacity

We asked specialties to estimate what capacity they expect to be working at over the next 12 months compared with pre-COVID-19 activity levels as services look to restart (if the COVID-19 'R' rate remains below 1). This snapshot shows significant variations by specialty.

Specialty	Currently working at:	Expecting to be working at in 3 months' time:	Expecting to be working at in 6 months' time:	Expecting to be working at in 9 months' time:	Expecting to be working at in 12 months' time:
Cardiology	<25%	26–50%	51–75%	51–75%	76–90%
Diabetes and endocrinology	26–50%	26–50%	51–75%	51–75%	76–90%
Dermatology	26–50%	26–50%	51–75%	51–75%	76–90%
Intensive care medicine	91%+	91%+	91%+	91%+	91%+
Medical oncology	76–90%	76–90%	91%+	91%+	91%+
Haematology	51–75%	76–90%	91%+	91%+	91%+
Geriatric medicine	76–90%	76–90%	91%+	91%+	91%+
Respiratory medicine*	91%+	91%+	91%+	91%+	91%+
Clinical neurophysiology	<25%	51–75%	51–75%	51–75%	51–75%
Immunology	51–75%	51–75%	76–90%	76–90%	76–90%
Allergy	51–75%	51–75%	51–75%	51–75%	76–90%
Sport and exercise medicine	26–50%	76–90%	91%+	91%+	91%+
Gastroenterology	<25%	26–50%	51–75%	51–75%	51–75%
Genitourinary medicine	51–75%	76–90%	76–90%	76–90%	91%+
Acute internal medicine	91%+	91%+	91%+	91%+	91%+
Rheumatology	51–75%	76–90%	76–90%	76–90%	76–90%
Palliative medicine	51–75%	51–75%	76–90%	91%+	91%+
Clinical genetics	26–50%	51–75%	76–90%	91%+	91%+

These estimates are projections based on a snapshot in time, but highlight how specialty provision might pan out over the next 12 months. These projections are based on there being no further significant outbreaks or waves of COVID-19. As a result of these estimates it is key that patients' expectations are managed. Clinicians will need to work through the unmet need from the first wave of COVID-19. Until we reach a point when services are able to return to pre-COVID-19 capacity levels, unmet need and waiting lists are likely to continue growing.

* Respiratory medicine is currently working at 90%+ due to COVID-19 acute care and COVID-19 follow up, this is in in addition to their 'usual' services restarting. Demand continues to outstrip capacity and will for the foreseeable future.

How will adaptations needed because of COVID-19 affect the ability to provide services?

In addition to variations in capacity across specialties, the way that they deliver care while COVID-19 remains in community transmission will also change. The most common changes are moves to reduced face-to-face outpatient activity while increasing remote outpatient activity, such as the use of telephone or video appointments (although there is still some way to go to ensure that clinicians have access to the technology they need, with 51 % of respondents to a recent membership survey reporting that they were unable to access a computer with a web camera for video appointments).* While COVID-19 community transmission remains, clinicians and trusts will have to reduce procedure list sizes to implement infection control measures effectively and reduce risks to patients and staff.

We asked specialties what impact(s) they expect COVID-19 factors such as infection control and testing to have on the way they deliver services.

Specialty	Impact				
	Less inpatient care	More inpatient care	Less face-to-face outpatient activity	Increased remote outpatient activity (eg telephone or video appointments)	Reduction in procedure list sizes (if yes, by how much)
Diabetes and endocrinology		Y	Y	Y	
Cardiology			Y	Y	Y – by 26–50 %
Neurology			Y	Y	Y – by 26–50 %
Dermatology					Y – by 26–50 %
Intensive care medicine		Y			
Medical oncology	Y		Y	Y	Y – by 26–50 %
Haematology	Y		Y	Y	Y – by 51–75 %
Geriatric medicine			Y	Y	
Respiratory medicine		Y	Y	Y	Y – by 0–25 %
Clinical neurophysiology		Y			Y – by 76–90 %
Immunology			Y	Y	Y – by 26–50 %
Allergy	Y		Y	Y	Y – by 26–50 %
Sport and exercise medicine			Y	Y	
Gastroenterology			Y	Y	Y – by 26–50 %
Genitourinary medicine			Y	Y	Y – by 26–50 %
Acute internal medicine		Y			
Rheumatology			Y	Y	Y – by 26–50 %
Palliative medicine	Y			Y	
Clinical genetics			Y	Y	

* https://www.rcplondon.ac.uk/news/giant-leaps-digital-progress-have-we-missed-small-steps-along-way

Co-dependencies

Planning for restarting services and increasing capacity highlights the various co-dependencies between different services. We asked specialties to highlight which services they will need to support the recovery of their specialty. The answers highlight how restart planning must be integrated, specialties will quickly run into difficulties if these support services are not available. The relationships between specialty provision and supporting services will have a direct knock-on effect for patients, whose care will be impacted.

Specialty	Dependency					
	Imaging	Other diagnostic tests	PPE	COVID-19 testing	Primary care capacity	Community services
Diabetes and endocrinology	Y	Y	Y	Y	Y	Y
Cardiology	Y	Y	Y	Y	Y	Y
Neurology	Y	Y	Y	Y	Y	Y
Dermatology	N	Y	Y	Y	Y	N
Intensive care medicine	N	N	Y	N	N	N
Medical oncology	Y	Y	Y	Y	N	N
Haematology	Y	Y	Y	Y	Y	Y
Geriatric medicine	Y	Y	N	N	Y	Y
Respiratory medicine	Y	Y	Y	Y	Y	Y
Clinical neurophysiology	N	N	Y	Y	N	N
Immunology	Y	Y	Y	N	N	N
Allergy	N	N	Y	N	Y	N
Sport and exercise medicine	Y	N	Y	N	Y	N
Gastroenterology	Y	Y	Y	Y	Y	Y
Genitourinary medicine	Y	Y	Y	Y	Y	Y
Acute internal medicine	Y	Y	Y	Y	Y	Y
Rheumatology	Y	Y	Y	Y	Y	Y
Clinical genetics	Y	Y	N	N	N	N

Potential scenarios

The NHS at all levels and clinicians are going to have to make difficult decisions about priorities, based on the available capacity. These choices are best illustrated by considering individual specialties and how different scenarios might impact what services can be provided. To illustrate these choices, specialties have been working with NHS England to develop models based on potential capacities. To help understanding of what these choices could look like, genitourinary medicine and rheumatology capacity scenarios are described in Appendix 1. These are provided just to demonstrate how services may have to be prioritised. The RCP and specialties are hopeful that, with the right support and resource allocation, services will be able to manage unmet demand in a controlled way, but this will not be easy and without difficult decisions.

Returning to an ‘even keel’

Staff wellbeing, expectation management and integrated planning are all going to be key to the successful restart of services. Providing accurate estimates and projections about what the next 12 months hold for the NHS is difficult, as we can’t be certain about whether there will be future outbreaks and waves of COVID-19. This highlights just why it is so important that the government, the NHS and politicians openly discuss the significant unmet need in the patient population.

There may come a time when the NHS needs to set national priorities, which means something that would have been dealt with quickly before COVID-19 may now take longer. These are likely to be difficult decisions for everyone involved, but the earlier we begin these conversations the better. COVID-19 has also impacted on the rhythm of training for specialties, which will require additional support for trainees from Health Education England and the NHS.

About the RCP

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. The RCP provides physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing 38,000 fellows and members worldwide, the RCP advises and works with government, patients, allied healthcare professionals and the public to improve health and healthcare.

Appendix 1: Genitourinary medicine and rheumatology capacity scenarios

Genitourinary medicine

Genitourinary medicine's scenarios*, not including HIV services, but including sexually transmitted infections (STI) and contraception, considering potential activity by available capacity show the choices that may have to be made.

Available – 25%	Available – 50%	Available – 75%	Available – 90%
Care only for: >life-threatening / life-shortening STIs > unbearable symptoms > significant public health risk Emergency contraception Basic universal provision (POP) and condoms Abortion care (medical)	Testing and management for symptomatic STIs Emergency contraception Limited range of contraception, injectable LARC only Abortion care – onward referral	Testing and management for most STIs and genital infections Emergency contraception Full range of contraception, including all LARC Abortion care – onward referral	Testing and management for all STIs, genital infections / conditions Testing for Mycoplasma genitalium if symptomatic Emergency contraception Full range of contraception, including LARC Complex contraception care Abortion care / onward referral
STI testing for syphilis and HIV contacts only. Epidemiological treatment for other STIs	STI testing for contacts of all STIs and HIV	✓	✓
Online STI tests† for chlamydia/gonorrhoea/ syphilis/HIV	✓	✓	✓
Sexual assault care	✓	✓	✓
Post-exposure prophylaxis after sexual exposure to HIV (PEPSE) provision only	HIV pre-exposure prophylaxis (PrEP) & PEPSE provision		
Modified STI treatments TOC only if symptomatic	Optimum treatment and TOC for certain STIs		
Vaccinations – hepatitis B for post-sexual assault only		Vaccinations – hepatitis B for those at risk / HPV for MSM	
Partner notification for STIs and HIV	✓	✓	✓
Remote consultations (telephone/video) for symptomatic STIs, emergency or basic contraception, abortion care		Remote consultations (telephone/video) for all requesting GUM/ contraception consultations	
F2F examination limited to symptomatic STIs, emergency contraception, basic contraception, abortion care. Injectable LARC possible at 50%		F2F examination including genital lumps	F2F examination including genital lumps and rashes
No choice of clinic			Choice of clinic – walk-in, booked, young people's clinics
No psychosexual service	Only if mental health concerns	Psychosexual service restored	
No outreach. Health promotion automated messages		Outreach and health promotion – full service	

F2F = face to face; GUM = genitourinary medicine; HIV = human immunodeficiency virus; HPV = human papillomavirus; LARC = long-acting reversible contraception; MSM = men who have sex with men; PEP = post-exposure prophylaxis; POP = progestogen-only pill; PrEP = pre-exposure prophylaxis; STI = sexually transmitted infection; TOC = tests of cure.

* https://members.bashh.org/Documents/COVID-19/Principles%20for%20Recovery%20of%20Sexual%20Health%20Draft%20 08.06.2020%20-%20for%20website%20upload.pdf

† Online services for STI testing and basic contraception provision are not consistent across geographical areas and this limits their use. They should be a key part of available provision as Digital First.

Rheumatology

A similar range of options by constraint and availability are presented in this potential scenario* for rheumatology.

Constraint	Availability and impact			
	25%	50%	75%	100%
Staff	Skeleton service Focus on existing patients with complex autoimmune diseases. Specialist nurses to support the management of these patients. Majority of appointments delivered by remote means (telephone or video) Intensive triage (telephone patient screening prior, and potentially contacting referrer) resulting in the majority of referrals being put on a waiting list Only able to see highly selected new patients with suspected early inflammatory arthritis or systemic disease Potential for reduced or no capacity to see patients referred from ED or provide in-reach to wards Severely restricted telephone advice line support/access to specialist advice Utilisation of trust/ board website to convey important information to patients	Restricted service Increasing focus on managing existing patients. Specialist nurses to support the management of these patients. Majority of appointments delivered by remote means (telephone or video) Enhanced triage (comprehensive review of referral reason), where necessary request for more information to allow remote decision making, resulting in the majority of referrals being put on a waiting list Promote use of advice and guidance if in place for GPs Limited capacity to see new patients. Focus on patients with suspected early inflammatory arthritis or systemic disease Restricted support to ED and in-reach to wards Restricted telephone advice line support/ access to specialist advice Utilisation of Trust/ board website to convey important information to patients	Reduced service Able to manage most existing patients adequately. Specialist nurses to support the management of these patients. Most appointments delivered by remote means (telephone or video) Normal triage and able to see majority of current outpatient referrals from GPs, although increasing focus on only inflammatory conditions, which may increase waiting times for new patient appointments Promote use of advice and guidance if in place for GPs Careful selection of new patients appropriate for remote consultations Potential for reduced support to ED and in-reach to wards Potential for reduced telephone advice line support/access to specialist advice Utilisation of trust / board website to convey important information to patients	Normal service
Admin support	Extreme service disruption Loss of patients in pathways, poor patient and GP communication, reduced outpatient activity and increasing clinical time spent on admin	Moderate service disruption Risk of losing patients in pathways, delays in patient and GP communication, disorganised outpatient services and increasing clinical time on admin	Limited service disruption	Normal service

* https://www.rheumatology.org.uk/Portals/0/Documents/COVID-19/Restarting_services_June_2020.pdf

Constraint	Availability and impact			
	25%	50%	75%	100%
Rehabilitation	Nearly all specialist rheumatology AHPs re-deployed Rely on whole rheumatology team for exercise, activity and self-management advice Deferred access to specialist occupational therapy, physiotherapy, podiatry and other rheumatology specific AHP services High risk of losing patients in pathways – keep a record of those referred in for rehabilitation services	Very limited specialist rheumatology AHP services Urgent need or newly diagnosed patient only Service delivered exclusively via remote means (phone or video) Heavy reliance on internet and app-based exercise resources – condition education and condition-specific exercise and activity advice. Deferred access for most with self-management in the interim Some risk of losing patients in pathways – keep a record of those referred in for rehabilitation services	Limited specialist rheumatology AHP services Most incoming referrals seen, but longer wait time, enhanced triage (comprehensive review of referral reason). Deferred access for some with self-management in the interim. Tools to decide on access including risk level of the patient, previous access to and input from AHPs and urgency of presenting complaint Slowly restart group and class-based activities, exploring online delivery as first option	Normal service Restart hydrotherapy at this stage – with appropriate social distancing measures and careful patient screening
Imaging	Extreme negative impact on ability to make appropriate diagnosis, assessments and treatment plans Increased waiting lists Restricted to patients with severe disease where imaging would help identify and manage life or organ-threatening disease	Severe impact on ability to make diagnoses and increased waiting lists	Increased waiting lists and delays in diagnosis	Normal service
Biopsies	Extreme negative impact on ability to make appropriate diagnosis and treatment plans Increased waiting lists Restricted to patients with severe life or organ-threatening disease	Severe impact on ability to make diagnoses and increased waiting lists	Increased waiting lists and delays in diagnosis	Normal service
Infusion services	Heavily restricted service only able to treat patients who have life threatening or organ-threatening conditions Pharmacists involved in updating protocols for IV administration	Restricted service prioritising those with life-threatening or organ-threatening conditions	Reduced service	Normal service

ED = emergency department; AHP = allied health professions