Parliamentary briefing: Current NHS pressures

The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020

House of Commons, 1 December 2020

Introduction

We recognise that government and parliament have difficult decisions to make in the fight against COVID-19. There is an important balance to strike between competing priorities: protecting people's liberties, livelihoods and their mental health, protecting the wider economy and protecting NHS capacity.

NHS Providers is the membership organisation for NHS trusts providing hospital, mental health, community and ambulance services. It is our role to share insights from the perspective of NHS trusts in support of these important decisions. We hope you find this briefing helpful ahead of tomorrow's vote.

The impact of restrictions to date

The sacrifices the public has made during the recent national lockdown have made a real impact. Interim figures from the REACT study for November show a 30% fall in infections nationally between 13 and 24 November, with 96 people per 10,000 infected, down from 132 per 10,000 between 26 October and 2 November 1. Alongside the promise of vaccines, therapeutic drugs and mass scale rapid turnaround testing, NHS leaders believe appropriately robust new tiered restrictions offer a clear way out of the pandemic in the spring.

Additional challenges and complexity due to COVID-19

The NHS faced a number of challenges before the outbreak of the virus, with a significant mismatch between demand and supply, insufficient hospital beds, and over 100,000 staff vacancies. Despite the best efforts of frontline staff, the NHS was delivering its worst A&E performance in over a decade and had 4.4 million patients waiting for elective surgery – the highest since records began in 2007. The NHS, in particular, has come under real pressure in each of the last five winters (January – March) when NHS capacity is at its most stretched.

Running a hospital trust is now significantly more complex because of COVID-19. Trusts have to treat three sets of patients: those suffering with COVID-19, patients awaiting planned care, including those whose treatment had to be postponed from the first COVID-19 wave, and emergency patients. Trusts are particularly focused on treating those whose care was delayed from the first phase, as many of these cases have now become urgent and cannot wait any longer. Trusts are striving to keep all services running, including cancer care, elective surgery and diagnostics, while adhering to rigorous infection prevention control measures. This requires trusts to cohort patients into three different zones: those with COVID-19, those awaiting a test result and non-COVID zones. Reductions in capacity because of these requirements vary by trust but all hospital trusts are reporting a reduction of between 5 and 20%.

The current lack of access to rapid turnaround testing, where patients can get their results back in 30 minutes or less, is also making the task of treating COVID-19, planned care and emergency patients more challenging. Although the supply of these tests is increasing, there is a need for many more of these tests to increase patient flow through the system and avoid overcrowding in emergency departments.

The NHS workforce, many of whom are exhausted from coping with the initial wave of the virus, are now having to juggle an extremely complex and challenging workload. For example:

- Planning elective surgery has become more complicated for a range of reasons, despite trusts' best efforts to work collaboratively together and make full use of private sector capacity. Patients need to be tested and isolated prior to their operation and surgery is now taking longer due to the need to don, doff and work in PPE. The demand for theatre space is significantly outstripping supply. As soon as the number of COVID-19 positive cases rise, hospitals have to turn their wards into COVID wards, taking away precious capacity which could otherwise be used for those recovering from elective surgery.

- Similar difficulties can be seen in urgent and emergency care. Despite the fact that A&E attendance is slightly lower than this last time last year, emergency admissions have continued to increase each month since April. Trusts report higher numbers of the sickest patients with many needing admission. They are seeing greater numbers of patients in emergency departments with complex mental health needs. As a result, some hospitals are already reporting levels of 12-hour waits that we would not usually see until the peak of winter.

- Finally, COVID has created additional complexities in how trusts support and manage their workforce and keep them safe. NHS staff working in areas with high infection rates face the same challenges as the wider population – for example, catching the virus, needing to self-isolate and caring for family members. While vast improvements in the availability of staff testing will be beneficial to staff and patient safety, staff absences inevitably have a knock-on impact on the NHS' ability to staff beds safely

and often reduce capacity further. When COVID-19 cases rise, redeploying staff to COVID beds reduces trusts' capacity to offer other forms of care (elective etc).

This briefing focuses on hospital capacity as this is where the current public debate on NHS capacity is concentrated. But community service, mental health and ambulance trusts report similar levels of overall pressure.

Interpreting the data

These pressures on hospitals are not accurately reflected in the national data on hospital demand and bed occupancy, which also fail to take account of regional variations in the numbers of COVID-19 patients:

- Latest figures show that on 22 November the NHS had 9% fewer beds than last year. Trust chief executives are concerned that despite current bed occupancy rates of around 85%, the reality on the ground is much closer to the 95% bed occupancy levels usually seen in the peak of winter.
- Suggestions that capacity in intensive care is not being fully utilised do not accurately reflect the pressure in hospitals. Many more COVID-19 patients are thankfully now being treated on general wards, without mechanical ventilators and ICU beds are a small proportion of a hospital's overall bed capacity.
- Clear evidence of the pressures on hospital capacity can be seen in the number of people waiting over 52 weeks on the routine care waiting list. This increased to 139,545 at the end of September 2020 - an increase of 26% since August and an increase of 1164% since April[2]. We also know that those waiting in A&E over 12 hours after the decision to admit (often described as trolley waits) has nearly tripled, rising from 333 in September to 1,267 in October (a rise of 280%).

Other key questions

What are NHS trust leaders' concerns?

Until the population has been appropriately vaccinated in the spring, restrictions on social contact are the only way to prevent the spread of COVID-19. Trust leaders are concerned that failure to adopt a sufficiently robust set of a restrictions would leave the infection rate unchecked. This would, in turn, lead to a rapid increase in patients needing treatment for COVID-19 next January to March, the winter period when the health and care system is routinely under greatest pressure. As we have already seen over the last few months, larger number of COVID-19 patients would inevitably mean having to cancel planned care, including those who have already had their care delayed.

Why are these restrictions necessary when my hospital has plenty of capacity/when there is plenty of intensive care capacity available/when there is plenty of NHS capacity available?

As this briefing sets out, NHS trusts across the country, particularly in areas of high COVID-19 infection, report that they are extremely busy and pressured with exhausted staff working at full pace, before we have even reached winter. The current national data on bed occupancy and demand does not properly capture this pressure which is driven by lost beds, staff absences and the extra complexity of ensuring proper infection control. Intensive care bed usage data only covers a small

proportion of a hospital's bed capacity. The risk to the NHS lies in a third surge of COVID-19 cases next January and February coinciding with the winter peak when the NHS is at its busiest. Current capacity usage does not measure this risk.

Why are the Nightingale hospitals not being used?

The Nightingale hospitals are best viewed as a 'last resort insurance policy' to prevent hospitals becoming overwhelmed by COVID-19 patients. They are not purpose-built hospitals able to cater for a range of conditions and their operation critically relies on redeploying NHS staff from existing hospitals. The patient experience within the Nightingales would likely be inferior to that of a ward in a hospital, and the deployment of the Nightingales would have a direct impact on trusts' ability to run their existing services safely. While the creation of the Nightingales was, in our view, essential, it is incorrect to assume that there is latent capacity within the NHS because the Nightingales have not been put into use.

In summary

The combination of vaccine rollout, rapid testing and therapeutic drugs genuinely offers the country a way out of the current COVID-19 challenges in late spring or early summer 2021. However, until we reach that point, the only way to reduce the spread of the virus is to limit social contact. We understand the difficult priorities to be balanced, but we believe that government and parliament should err on side of caution in setting restrictions on social contact. NHS leaders and their staff know it is their job and duty to treat all patients who need care, but in order to do this safely, it is vital to reduce the number of COVID-19 patients. The new tiered restrictions are currently the only viable way to achieve this.