
NHS RESTART: BRIEFING DOCUMENT

ABHI

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FOREWORDS

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Our society, health and care systems and industry have never experienced anything like the COVID-19 pandemic in recent history.

Our sector is dominated by small companies, many of whom are vulnerable to the economic shock that the cessation of elective care has delivered to our sector. The sector has stepped-up during the pandemic with the common purpose to support the NHS deliver care to its patients, and we can take great pride in how we have responded to this unprecedented emergency so far.

As the restrictions and burdens imposed by COVID-19 slowly, but steadily, recede, our thoughts turn to the many patients that have had their care delayed or disrupted. It is vital to address the significant increases in waiting lists and lack of referrals as quickly as possible to prevent patient outcomes deteriorating, storing up longer-term health problems for our citizens.

This is intertwined with the need to also ensure our sector can continue delivering the products, services and innovations that support patient care. At this time, businesses, and in particular SMEs, need a strong and effective trade body like never before, and the ABHI Board is fully committed to driving forward the activity to accelerate the restart of planned care.

Whether you are a small UK company, or a global corporation, this restart matters to all of us, because it matters for patients.

From the outset of COVID-19, ABHI has pivoted resources to address the dramatic impact the pandemic is having on patients, our health and care systems and industry.

With the progress we have seen in managing the crisis, it is time to redirect and redouble our efforts to focus on the restart of planned care. There is a general sense of frustration with the pace of reopening the system to planned care and we are conscious of the adverse effects on patients and the growing waiting list as a consequence.

This document provides an outline of the current situation, how it has progressed, and describes our extensive activities to date.

In my weekly meetings with Ministers I have stressed the significant impact current delays to the restart are having on patients, their health, and their families. I have asked for clarity on the approach to restart and for information to be provided that can form the basis of how industry can plan its business to assist the health system. The current problematic nature of the situation has been acknowledged, and we continue to press for more structure and practices to be in place to enable planned care to restart.

Your engagement and collaboration with the team at ABHI is critical to our ability to expedite the restart.

EXECUTIVE SUMMARY

The restart of planned and elective care has slowly begun, led through local and regional planning within a national framework that provides guidance on prioritisation of services. Activity will depend on local circumstances and clinical prioritisation, but capacity will be significantly limited in the early days due to a combination of increased infection prevention measures, a reduction in patient presentations, due to societal concerns, social distancing and the cessation of screening and diagnostic programmes. The availability of PPE remains a critical and fundamental constraint.

It is expected that the activity will gradually increase, but it is possible that the NHS will not reach its pre-COVID-19 capacity until late in 2021 if at all, which combined with a doubling of waiting lists has led the Royal College of Surgeons to call for a 5-year strategy to address the issues.

The most clinically urgent cases are being prioritised for restart. ABHI is providing almost daily updates on the latest information coming from the NHS on its restoration and recovery plans. We continue to work across our network of stakeholders to press the urgency of the matter with government Ministers, officials and NHS leaders. This activity is centred on providing as much transparency as possible on activity and advocating for an acceleration of the restart programme.

“Each part of the NHS has been asked to begin bringing back other services safely, balanced against maintaining enough flexible critical care capacity should it again be needed, and expanding community and rehab care!”

NHS Spokesperson 02/06/20

STATISTICS & INSIGHTS



Routine referrals decreased by **90%**

500,000 operations cancelled due to COVID-19

Theatres estimated to operate at **50%** capacity

Endoscopy capacity could be reduced to **20%** of normal

97% of pathology labs are understaffed

Waiting list could double to **10 million** by end of 2020

Independent sector capacity: **680** theatres, **140** endoscopy rooms and **31** Cath Labs



Recovery is **locally-led** and based on local and regional circumstances

Short-term **PPE** and **testing** capacity will be critical limiting factors

Systems will reorganise into COVID-19 and '**COVID-19 protected**' pathways or sites

Independent sector will be critical to providing 'COVID-19 protected' capacity

No sudden 'stand-up' of elective care, increase will be **gradual**

The progression of services restarting will generally follow **RCS guidelines**

INTRODUCTION

On 30th January 2020, NHS leaders declared COVID-19 a serious, level 4, incident. This led to a five-pronged strategy to address the crisis:

1. Discharging medically fit patients
2. Diverting/postponing planned care
3. Creating extra critical care capacity
4. Emergency training staff to support COVID-19 patients
5. Incorporating private sector capacity into the NHS.

Non-urgent care ceased during the initial surge of COVID-19 cases.

Following the peak of the pandemic in the UK in early April, NHS England (NHSE) announced, on 29th April, steps towards the reintroduction of planned care¹, opening up the possibility for a resumption in screening, referral pathways, diagnostics, non-urgent cancer care and elective interventions.

This document has been compiled to support ABHI member companies in their planning and communications regarding the resumption of planned care in the NHS. It is a snapshot in time and members are recommended to review the latest information via the [ABHI 'restart of care' webpage](#).



SITUATIONAL ANALYSIS

The cessation of planned care and the general effect of COVID-19 on society has had a number of impacts:

- › An increase in waiting list times
- › A decrease in routine referrals by 90%. Urgent referrals and two-week referrals for suspected cancer fell by 78% and 67% respectivelyⁱⁱⁱ
- › A reduction in A&E attendances during peak, although this is now starting to return to pre-COVID-19 levels^{iv}
- › The reduction in patient presentation in primary care.

All these factors will need to be addressed to get patient flows back to normal levels.

It is estimated that almost two-thirds of Britons with common life-threatening conditions have had care stopped^v as hospitals focus on fighting COVID-19, and that over 2 million operations have been cancelled^{vi} due to the pandemic. The waiting list could take up to two years to clear^{vii} depending on system capacity, whilst the Royal College of Surgeons has called for a 5-year strategy to tackle the waiting list situation.

An analysis by Gooroo of NHSE/I data^{viii} highlights that in a strange quirk, the number of patients on a waiting list may be declining due to the lack of referrals from primary care, however it is expected that this is generally deferment and a surge will follow. There are concerns that this could cause the waiting list, which stood at just over half a million pre-COVID-19, to double by end of the year^{ix}.

Whilst there will be a national direction and framework for planning^x, resumption of planned care in the NHS (variously termed "stand-up" or "restoration") is going to be determined locally, based on a number of factors^{xi}:

- › Availability of theatre and ICU capacity and the need to maintain "surge capacity"
- › Additional capacity from treatment centres, independent hospitals and mobile facilities
- › Staffing levels due to sickness, shielding, COVID-19 impact, or other factors
- › Availability of equipment and consumables, particularly testing capability and PPE
- › Ability to create 'COVID-19 protected' sites or pathways.

The combined effects of these constraints on the system is difficult to estimate, however due to the need for enhanced infection prevention measures it is estimated that theatre capacity will be reduced significantly, with best estimates indicating 50%^{xii} of normal throughput. Diagnostics underpin much of the clinical activity in hospitals and it is projected there will be a backlog in MRI/CT scans, laboratory tests^{xiii} and endoscopy, which could possibly be operating at as little as 20% of normal capacity^{xiv}. One Trust has estimated that social distancing guidelines has also reduced its bed capacity by 20%^{xv}.

It is clear that the ability of the NHS to manage the continuing case load of COVID-19, protect surge capacity for any second spike and deal with a significant backlog of cases will be severely tested.

Two critical steps have been taken to address the situation. The first is a national agreement with the independent sector healthcare providers to secure all available inpatient capacity and resource^{xvi}.

This agreement is due to run until the end of June, but has a rolling month extension that can only be terminated by NHSE. At time of writing, it is understood that the NHS is looking at a further long-term agreement to retain capacity; estimates vary from 1 to 2 years^{xvii}. The independent sector is likely to be a critical element in bolstering the 'COVID-19 protected' capacity that the NHS requires. However, there is no agreement at present on funding for this continued arrangement^{xviii}. London is piloting a scheme to try to get elective capacity up to 80 per cent of pre-COVID levels, although other estimates for what is possible have been lower^{xix}. It should also be noted that London is far from representative of the UK in respect of private facilities.

"Many in the NHS will be wrestling with the prospect of dealing with a second wave while also trying to restart normal services."

HSJ 23rd June 2020

SITUATIONAL ANALYSIS

The second approach taken to tackling the demand is to introduce a system of prioritisation. NHS England have worked with the Royal College of Surgeons who are recommending a 4-level prioritisation system based on level of clinical urgency^{xx}. Patients requiring surgery during the COVID-19 crisis have been classified in the following groups:

- › Priority level 1a Emergency - operation needed within 24 hours
- › Priority level 1b Urgent - operation needed with 72 hours
- › Priority level 2 Surgery that can be deferred for up to 4 weeks
- › Priority level 3 Surgery that can be delayed for up to 3 months
- › Priority level 4 Surgery that can be delayed for more than 3 months.

There is additional guidance for some sub-specialities such as [ophthalmology](#), [cancer](#), [obstetrics](#) and [dentistry](#).

Additionally, to support the system financially, block contracts were instituted and PbR suspended^{xxi}, this [payment mechanism](#) remains in place. The government also took steps to deal with the historic debt within the acute sector, with more than 100 NHS hospitals having a combined debt of £13.4billion effectively written off by converting existing loans to equity (Public Dividend Capital or PDC)^{xxii}. This move was undertaken to free-up Trusts to invest in maintaining vital services and longer-term infrastructure improvements. Each year Trusts will have to pay a dividend on their PDC at 3.5% of that balance into perpetuity. Future cash support will also be provided as PDC, and in this instance NHS Improvement have been clear that the 3.5% dividend will apply. This means that for future cash requirements Trusts will be charged 3.5% on the balance rather than the 1.5% loan interest they would have previously had to pay. Therefore, any loans required outside of planned Financial Recovery Fund (which is funding rather than loan or equity) would have an increased cost.

The other factor that needs to be taken into consideration is the public desire to engage with the health systems. As previously mentioned, A&E attendance is now back to pre-COVID-19 levels, however, referral rates remain very low and it is unclear how much of this is reticence on behalf of the public. Research^{xxiii} has shown that those already diagnosed and on a care plan were unlikely to cancel their care proactively, with only 1 in 10 doing so.

To maintain 'COVID-19 protected' status further, infection prevention processes have been implemented for new admissions^{xxiv xxxv}:

- › All emergency patients should be tested on admission. For patients who test negative, they should be re-tested between five to seven days after admission
- › Elective patients should only be admitted to hospital if they "remain asymptomatic having isolated for 14 days prior to admission" along with other members of their household
- › Where possible, elective patients should test negative for COVID-19 a maximum of 72 hours before they are admitted.

During the pandemic hospitals were initially closed to general visitors. However, as of 5th June, the national suspension was lifted. Visiting is now subject to local discretion by Trusts and other NHS bodies^{xxvi}. National guidance in this area has never specifically addressed the issue of industry visits, however many Trusts have issued notices^{xxvii} stating that industry representatives should not visit unless the visit is essential to the delivery of patient care. On this basis, industry access for critical maintenance work and to support complex interventions has continued during the pandemic. ABHI has issued [guidance on best practice](#) for industry access to NHS premises.

ABHI ACTIVITY

ABHI has been central to the sector's response to the pandemic, leading on issues such as the ventilator challenge, PPE supply and testing capacity. In doing so we have established joint mechanisms with government and the NHS, and we are now utilising these to ensure that the messages regarding the restart are communicated clearly to senior decision makers. Specifically, we are ensuring that government is aware that a rapid as possible restart of planned care in the NHS is of vital importance to patient care and the stability of our sector, particularly SMEs who are potentially more vulnerable to the economic impact of a prolonged constriction in NHS capacity. We have increased dialogue with government Ministers on the issue and future engagement is planned through standing forums:

- › European Union Relationship Group
- › Life Science COVID-19 Response Group
- › Life Science Council
- › Health Technology Partnership.

Our message to government is clear and concise; we need to ensure the wellbeing of our citizens, to protect the NHS from the long-term impact of the pandemic and to help stimulate economic recovery. It is vital that government does everything in its power to facilitate the rapid restart of planned care within the NHS. This should include:

- › Running a public information campaign to reassure citizens that it is safe to engage with the health system
- › Expediting the move to integrated care working, especially with regard to initiatives such as shared waiting lists and flexibility in payment mechanisms
- › Building sustainable local capacity in the supply of essential products such as PPE, critical care equipment and diagnostics tests
- › Ensuring that the capacity to deliver planned care is maximised by measures such as the designation of some hospitals as 'COVID-19 protected,' elective only centres and the continuation of funding to use independent sector capacity as necessary.

We have also increased communications across our network including NHS Confederation, NHS Providers, Royal College of Surgeons and the Patients Association.

This high level advocacy has been coupled with an exercise to gather [intelligence to support business](#) planning at the local level and a [tracker](#) to provide information on specifics of service restart.

We have started a coordinated programme of engagement, which will be run through our member groups, to develop models for safe sector restart activity, engaging with the appropriate professional and/or patient organisations to strengthen the recommendations. This will be supported by our on-going interactions with the Royal College of Surgeons, who are working closely with NHSE/I on restart planning.



PROGRESSION

Given the complex dynamics involved in the decision to restart services at a local level, it is impossible to predict which will start- first and , when or where it will happen. However, there are some clear principles:

- › The restart will be a locally led initiative with Trusts making decisions based on local and regional circumstances
- › In the short-term critical limiting factors will be include the availability of PPE and testing capacity for staff and patients
- › There will be greater regional coordination with pooled waiting lists across systems
- › ‘COVID-19 protected’ (also termed cold or green) sites and pathways will be created for elective care, either in separate locations where estates will allow, or through pathway reconfiguration on larger sites
- › The independent sector will be critical to providing ‘COVID-19 protected’ capacity
- › There will be a gradual increase in elective care, but no sudden ‘stand-up’ is anticipated
- › It is unlikely that sales activity will be welcomed in near future, but technical support for interventions and the resumption of planned maintenance routines will increase
- › It is expected that the progression of services restarting will generally follow [RCS guidelines](#) but local circumstances such as specialist, elective centres could help override this.

Based on the above it is still anticipated that the NHS will not return to normal operation until the end of 2021^{xxviii} if at all. However, the significant outstanding unknown is how the public will perceive the risks of going to hospitals and confidence in the measures put in place to reassure them. A recent (May 2020) Ipsos Mori survey showed that a majority of UK respondents felt nervous about leaving home post-lockdown^{xxix}. This is especially prevalent in older people.

The NHS and government are consistently putting out messages via briefings, text messages and social media that public should present to the health system if they are experiencing symptoms. As we have outlined, A&E attendance is returning to normal, so it is anticipated that less urgent conditions will also start to self-refer to their GP as general restrictions are eased. This has been confirmed anecdotally to ABHI.

In the longer-term we will see an acceleration in the changes to payment mechanisms and the instigation of integrated care systems, trends that were ongoing prior to the pandemic, and which have been crucial to the response.

“Restarting services more complicated than stopping them.”

HSJ 30th April 2020

RESOURCES & CONTACTS



[ABHI COVID-19 Hub](#)

[ABHI Trust Tracker](#)

[NHS England: Operating framework for urgent and planned services](#)

[HSJ analysis of waiting times](#)

[Royal College of Surgeons guide to surgical prioritisation](#)

[Procedures by Priority Level](#)

[Restarting planned surgery A strategy document from the RCA, AoA, ICS & FICM](#)

[Government Guidelines on PPE](#)

[Government Guidelines on Testing](#)

[NHS England Coronavirus guidance for clinicians and NHS managers](#)



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- xxvii [COVID-19 Trust Statements](#). LSI.
- xxviii ['Restarting services more complicated than stopping them,' say hospital bosses](#). HSJ.
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