Executive summary

July and August must be a period of intense preparation for our reasonable worst-case scenario for health in the winter that we set out in this report, including a resurgence of COVID-19, which might be greater than that seen in the spring. The assumptions that we have made should be tested as new evidence emerges (including analysis of the evidence from the first wave) to enable prevention and mitigation strategies to be adapted and refined. Mitigation strategies should not pose further disadvantage to the most vulnerable in society or the highest risk patients or communities. To maximise their effectiveness (and to ensure they do not exacerbate inequalities), preparations for winter must be informed by engagement with patients, carers, public and healthcare professionals (as we have benefitted from in this report); and, whenever possible, be developed through co-production. Implementation of prevention and mitigation strategies requires enhanced coordination, collaboration and data sharing between central and local initiatives.

Challenges

The need for health and social care undergoes large seasonal fluctuations, peaking in the winter. The NHS and social care systems typically operate at maximal capacity in the winter months, with bed occupancy regularly exceeding 95% in recent years.[1] As recently as in 2017/18, England and Wales experienced approximately 50,000 excess winter deaths.[2,3,4] In the same year, there were approximately 4,800 and 1,500 excess winter deaths in Scotland and Northern Ireland, respectively.[5,6] Four additional challenges have great potential to exacerbate winter 2020/21 pressures on the health and social care system, by increasing demand on usual care as well as limiting surge capacity:

1. A large resurgence of COVID-19 nationally, with local or regional epidemics. Modelling of our reasonable worst-case scenario – in which the effective reproduction rate of SARS-CoV-2 (R_t) rises to 1.7 from September 2020 onwards – suggests a peak in hospital admissions and deaths in January/February 2021 of a similar magnitude to that of the first wave in spring 2020, coinciding with a period of peak demand on the NHS. We are already seeing local outbreaks. The modelling estimates 119,900 (95% CrI 24,500 - 251,000) hospital deaths between September 2020 and June 2021, over double the number that occurred during the first wave in spring 2020.

2. Disruption of the health and social care systems due to reconfigurations to respond to and reduce transmission of COVID-19 with a knock-on effect on the ability of the NHS to deal with non-COVID-19 care. The remobilisation of resources for COVID-19 (staff and facilities) that occurred during the first wave of COVID-19 is unlikely to be possible this winter, due to other winter pressures, urgent delayed care, and a likely increase in staff sickness absence, among others.

3. A backlog of non-COVID-19 care following the suspension of routine clinical care that is likely to result in an increased number of poorly-managed chronic conditions or undiagnosed diseases and be combined with a surge in post-COVID-19 morbidity (which needs to be quantified). Estimates suggest that the overall waiting list in England could