Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Public Accounts Committee Inquiry: NHS backlogs and waiting times in England

Written evidence submitted by the Royal College of Surgeons of England

November 2022

Background

1. The Royal College of Surgeons of England (RCS England) is a professional membership organisation and registered charity that exists to advance patient care. We support nearly 30,000 members in the United Kingdom and internationally by improving their skills and knowledge, facilitating research, and developing policy and guidance.

2. RCS England supplied evidence in December 2021 to the Public Accounts Committee inquiry on NHS backlogs and waiting times. We welcome this opportunity to provide further updated evidence on issues related to managing NHS backlogs and waiting times, to this follow up inquiry.

3. Since submitting our evidence in December 2021, the waiting list has continued to grow. The elective care backlog has increased to beyond 7 million, with month-on-month increases in the total waiting list for planned hospital treatment. The latest published data (September 2022) show over 50,000 people waiting for 18 months or more for their treatment.

4. We anticipate a challenging winter for the NHS, due to a range of reasons including high demand, dealing with Covid-19 and challenges discharging patients from hospital into social care services. However, there would need to be a very substantial and sustained increase in activity over the winter to eliminate waits of over 18 months by April 2023, in line with elective recovery targets.

5. This challenging picture is further exacerbated by the large number (132,000) of NHS staff vacancies. Pay erosion, punitive pension taxation arrangements and dwindling staff morale are all contributing to productivity issues, and hindering the elective recovery.

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6. Improving productivity is important, and RCS England has been foremost in promoting the surgical hub model as a key enabler to increase levels of planned surgery. Surgical hubs entail separation of elective and emergency care, so that emergency and winter pressures do not lead to cancellations and postponements of planned operations. We contributed to the NHSE Delivery Plan for tackling the Covid-19 Backlog of Elective Care, published in February 2022, which places surgical hubs at the centre of transforming the delivery of elective surgical services. The Plan recognises that the NHS needs more surgical capacity; more operating theatres and more beds. Crucially, the Plan supports our recommendation to establish surgical hubs across the country, where planned operations are protected from winter pressures and outbreaks of COVID-19.

7. Whilst the underpinning theory for surgical hubs is sound, and there are examples of good practice, we recognise the need for more empirical evidence to confirm the extent to which surgical hubs can increase productivity, and also to consider their wider impacts. Furthermore, there are different types of surgical hub, as we set out in our July paper, 'the case for surgical hubs'. Local systems will need access to all three types of hub (High Volume Low Complexity, Integrated and Specialised hubs) in order to provide their local populations with the full range of surgical services.

Summary Recommendations

8. We recommend that the UK new Hospitals Programme considers where surgical hubs feature in its plans and that it works with integrated care systems to identify underserved parts of the country and develops plans to address gaps in provision.

9. In order to properly assess the potential of surgical hubs, it is vital that they have truly protected ring-fenced resource. Hubs must not be created at the expense of other services that are equally under pressure. Instead the ambition of surgical hubs is to enable surgical teams to get on with what they do best: transform lives through timely, safe surgery.

10. Surgical hubs will only operate efficiently if adequately staffed. Workforce plans must be granular, reflect the operating models for surgical hubs and take account of current staff shortages (for example, among anaesthetists and theatre nurses), and include surgical trainees. We recommend that trusts' plans should be assembled at a national and regional level to inform Health Education England's training plans, and that they reflect GIRFT's guidance on workforce requirements for surgical hubs.

11. Current data shows significant variations in elective surgical activity across England. The government should consider whether Integrated Care Systems (ICSs) in the most challenged areas should be prioritised for support to create surgical hubs, as part of a national strategy to address regional inequalities in access to surgery.

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12. While the NHS should continue to use the independent sector during times of high pressure, this will not offer sufficient capacity across the country. There should be more investment in NHS owned surgical capacity to efficiently and sustainably deliver the increased levels of elective services needed by the population.

13. Following the recent fiscal statement, whilst it appears that NHS funding is protected in cash terms with an additional £3.3 billion in each of the next two years, it is vital that capital funding for surgical hubs continues to be made available. This will depend both on future spending rounds and also on spending decisions made by NHS England and local systems. Sufficient capital investment will be needed in the coming years to create surgical hubs in every area.

The design of national recovery plans

14. We welcome the Chancellor's announcement this week that a long term work force plan will be published next year. This is something our College, in coalition with other Medical Royal Colleges, has been advocating in recent years. Without a long-term plan to address shortages in the NHS workforce, it is not clear how NHSE can be confident of achieving its ambition to increase elective activity to 129% of the 2019-20 level in 2024-25.

15. The NHS is currently carrying 132,000 vacancies, with nursing and anaesthetic vacancies a particular issue for planned surgery. Continuing staff vacancies contribute to low morale and result in delayed and cancelled operations, as surgeons lack the theatre staff or anaesthetic support to operate.

16. The impact on surgical training of reduced surgical activity is a key concern of the surgical profession. Despite best efforts to increase surgical activity following the pandemic, surgical trainee log books still show a reduction in operations where trainees are the primary operating surgeon. If trainees are unable to progress, this impacts on the future surgical workforce, as well as elective recovery efforts.

17. In July 2022 RCS England, with the Strategy Unit, published 'the case for surgical hubs' - our policy response to tackling the elective backlog. Our report identifies three categories of surgical hub: integrated (or 'hub within a hospital'), stand-alone and specialist. These are illustrated in the report by case studies of trusts that have successfully established surgical hubs, achieved high levels of surgical activity, or succeeded in keeping planned surgery running, while other systems have struggled.

18. We recognise that whilst the underpinning theory of separating planned and emergency care to keep services running is well-established, empirical evidence on the impact of surgical hubs is currently limited. Surgical hubs should be independently evaluated to assess whether the anticipated benefits accrue and to ensure the early detection of any unintended consequences. A particular challenge will be understanding the extent to

which workforce shortages hinder the success of the model, or whether hubs create workforce problems in other parts of the service.

19. To understand the impact of surgical hubs, RCS England is working with the *Getting It Right First Time* Team (GIRFT Team) in NHS England to pilot an Elective Hub Accreditation Scheme during the second half of 22/23.The scheme will allow trusts to seek formal assessment of their hub sites and external recognition that they work to a defined set of clinical and operational standards.

20. RCS England welcomed the government's recent announcement to open over 50 new surgical hubs across the country, having identified 91 already up and running. This will create a total of 148 Elective Surgical Hubs across the country, including in areas where access to surgical care has been poor. We call on the government to continue the expansion of surgical hubs and to focus on areas where there is poor access to surgery, and where modelling shows future demand pressures.

21. 57 new hubs are being developed with funding via the Targeted Investment Fund (TIF) process. To enable planning, trusts need urgent clarification on how future spending rounds will make additional funding available, to ensure the future development of the surgical hub programme.

Implementation of the recovery programme and early results achieved

22. Currently, the UK has too few hospital beds to meet demand. Bed numbers in England have reduced over the past decade, official NHS data from October 2022 shows the number of acute beds have fallen from 108,00 in 2010-11 to 97,350 in October 2022.

23. The NHS has periodically relied upon the independent sector to provide additional elective capacity to the NHS in times of need. However, as referenced in the report of the National Audit Office[1], independent sector elective activity remains a relatively small proportion of all NHS activity.

24. The NHS should continue to have the ability to use the independent sector to provide additional elective capacity, but this is only a partial solution. The independent sector does not have enough the capacity that is needed, and also it is overly concentrated in the South East. This means the sector is not well placed to help other geographical areas, where access to surgery is already poorer.

Ends 18 November 2022

[1] Managing NHS backlogs and waiting times in England; Report – Value for money; Date: 17 Nov 2022

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