Public Accounts Committee inquiry: NHS backlogs and waiting times
Written evidence submitted by The Royal College of Surgeons of England

Introduction

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. We welcome the opportunity to provide evidence to the Public Accounts Committee's inquiry into NHS backlogs and waiting times. Over the summer, the NHS saw record attendances in A&E departments, high staff absences due to COVID-19 isolation and delayed annual leave, and was left with reduced capacity due to Infection Prevention Control measures. These pressures have intensified, and we now face one of our most challenging winters on record, with increased hospital admissions due to COVID-19, unsustainable pressure on ambulance services and the cancellation of thousands of elective procedures. These factors will seriously impact the ability of the NHS to tackle the backlog, and require urgent attention. .

3. A significant waiting list existed before COVID-19. The NHS in England has not met the statutory 18 week waiting time target for planned hospital treatment for over five years.[i] However, the pandemic has exacerbated this situation. To restore timely access to surgical treatment, RCS England is calling on government to implement the recommendations in our 'New Deal for Surgery', with investment in workforce, NHS bed capacity and surgical hubs, to make surgical services more sustainable for the future.

Summary recommendations

4. RCS England urges the Public Accounts Committee to consider the following four summary recommendations to address the huge elective backlog, and ensure the sustainability of surgical services. These are expanded upon below:

    4.1. During the pandemic, COVID-light surgical hubs provided vital segregated, safe capacity to enable the continuation of surgery. We urge the Committee to support the expansion of the surgical hub model across the country, to help tackle the elective backlog and reduce waiting times.

    4.2. To address the spiralling list of people waiting for elective (planned) the Government needs to take action both to expand workforce and bed capacity, and adopt a longer term goal to reach the OECD average.

    4.3. Staff wellbeing and retention should be at the forefront of plans to tackle the backlog. Along with an expansion of the NHS workforce, the Government needs to address persistent staff shortages and vacancies by amending the Health and Care bill to create a statutory duty to publish a regular assessment of health and care workforce projections and requirements.

    4.4. While the NHS should continue to have the ability to use the independent sector to provide separate and safe elective capacity during times of high pressure, this is only a short-term solution and does not offer sufficient capacity across the country. The Government needs to invest in additional NHS-owned surgical capacity to meet

the levels of elective activity needed, and keep planned surgery going through pandemic and seasonal pressures.

Size of the backlog and pent-up demand for elective surgery

5. The COVID-19 pandemic has had a devastating impact on NHS surgical services in England, and indeed across the whole of the UK. All elective (planned) surgery was cancelled in the first wave of the pandemic, and many surgical teams were redeployed to help treat COVID-19 patients. The latest figures (for September 2021) show the largest ever recorded NHS waiting list in England of 5.83 million people, over a million more than in February 2020, before the pandemic hit. The number of patients waiting over a year for elective treatment reached 300,566 people in September 2021, compared to 1,613 people in February 2020.[ii]

6. RCS England shares the Committee's concerns over pent-up demand for elective surgery from people who have not yet come forward or who have not yet been referred for hospital treatment. A recent report from the National Audit Office (NAO)[iii] suggests that waiting lists could rise to 12 million by March 2025 if 50% of 'missing' referrals return to the NHS and activity grows only in line with pre-pandemic plans. In a more optimistic scenario, if 50% of missing referrals return and the NHS can increase activity by 10% more than was planned, the waiting list will still be seven million in March 2025. The NAO points out that these figures are dependent on what happens to NHS capacity for non-COVID treatment over the coming years. We agree, and believe it is imperative that the Government takes action to expand both workforce and bed capacity.

7. At the start of the pandemic in April 2020, RCS England and the Federation of Surgical Specialty Associations (FSSA) produced guidance on how to prioritise patients waiting for surgery. To enable the prioritisation of resources towards those with the most urgent clinical need, four categories were created: P1, P2, P3 and P4, with P1 being the most urgent. This guidance was intended to be a temporary measure, otherwise there is a risk that patients in the P4 category could be consigned to indefinite waits. Whilst prioritisation still remains necessary, we should be aiming eventually to retire the prioritisation guidance. Although it may take years, our common goal should be getting back to meeting the 18-week referral to treatment (RTT) target in the NHS Constitution, which represents the principle of timely treatment for all.

8. RCS England has asked the government to set out a clear long-term strategy, supported by funding commitments, to restore timely access to surgery. We welcomed the increase in the Elective Recovery Fund, and recent confirmation of funding for the establishment of surgical hubs in the current financial year. However, we hope to see longer-term commitments made in the government's forthcoming Elective Recovery Plan.

NHS workforce pressures impacting on the backlog

9. The pandemic has put NHS staff under huge pressure, and seriously impacted their psychological wellbeing. The exhaustion of working in PPE, re-deployment, cancelled leave and the emotional impact of COVID-19, has taken its toll. Many anaesthetists and

nurses, who play a key role in the surgical team, need rest and recuperation after being re-deployed to help treat COVID-19 patients.

10. Prior to COVID-19, the NHS workforce faced a 'perfect storm' of consultants choosing to retire earlier, a significant proportion approaching retirement age and reports too of younger doctors walking away from a career in the NHS. Persistent staff vacancies put additional strain on NHS services and teams. As part of the Academy of Medical Royal Colleges, we wrote to the Prime Minister in April 2021 to highlight the risk these vacancies present.[iv] Inadequate staffing has led to overworking and low morale, with doctors reducing their hours or outright leaving the medical profession. Staff wellbeing and retention are crucial to the success of plans for catching up with the backlog and the delivery of safe patient care.

11. An expansion of the NHS workforce would help to alleviate these pressures. Figures from the OECD show that England has the second lowest number of doctors among leading European nations, relative to its population, with just 2.8 doctors per 1000 population against the average of 3.5.[v] We are concerned by the Health Foundation's analysis that nursing is the most significant workforce shortage area in the NHS and represents a 'major long-term and growing problem'.[vi]

12. Surgical training has been severely affected by the pandemic. Many trainees have been redeployed away from their chosen specialism of surgery, to help on COVID-19 wards. Additionally, the reduction in levels of elective surgery has impacted on the amount of experience trainees have had in outpatient clinics, theatre, ward work and multidisciplinary meetings. Surgery is a specialism that depends on large amounts of practical experience, and surgical trainees who already have both a medical degree and several years' experience working in the NHS play a key and often leading role in NHS operations. Worryingly, trainee logbooks show a 50% reduction in operations from 2019 to 2020 with trainees as the primary operating surgeon.[vii] Over the coming months and years, every opportunity must be taken to free trainees from non-essential administrative work, and ensure job planning supports increased theatre time that speeds up training and supports trainees on their career path to becoming consultants. This would enhance morale and help the NHS retain trainees who are essential members of surgical teams that are working to address the backlog.

13. Improved workforce planning is critical to increase the number of operations that can be carried out in the coming years. Without it, planned surgery is likely to continue to be affected during periods of pressure, and the waiting list will continue to accumulate. RCS England has joined with other Medical Royal Colleges and medical organisations in supporting a workforce amendment to the Health and Care Bill. This would place a statutory duty on government to undertake an independently verified assessment of future health, social care and public health workforce numbers, based on the projected health and care needs of the population. We have urged the government to consider amending the Health and Care Bill to ensure the NHS has the workforce it needs.

NHS bed capacity to deal with the backlog

14. The NHS has periodically relied upon the independent sector to provide additional elective capacity to the NHS, in times of need. As a necessary step during the pandemic, hospitals in the independent sector were block-booked to give the NHS priority access to around 10,000 additional beds for urgent surgery or COVID-19 patients. The NAO report

estimates temporary contractual arrangements with a limited number of independent sector providers cost around £2.1 billion in 2020-21.[viii]

15. Although the NHS should continue to have the ability to use the independent sector to provide additional elective capacity, this is only a short-term solution. The sector does not offer sufficient capacity fully to address the backlog. Independent sector capacity is also concentrated in the South East, making it harder for patients in other parts of the country to access the care provided. In RCS England's New Deal for Surgery report,[ix] we recommend the Government supports and invests in additional NHS surgical capacity across the country, to enable the service to manage both pandemic and seasonal pressures. The NHS needs more capacity in order both to achieve and then maintain the levels of elective activity needed to meet demand.

16. Currently, the UK simply has too few hospital beds to ensure infection prevention control and meet demand. OECD data shows the UK has 2.5 hospital beds per 1,000 people, far below the average of 4.7, and lagging countries such as Turkey, Slovenia and Estonia.[x] In England, bed numbers have shrunk over the past decade, with official statistics published by NHS England showing the number of general and acute hospital beds fell from 108,000 in 2010/11 to 95,600 in 2020/21.[xi] While RCS England welcomed the Government's plan to build 40 new hospitals by 2030 and upgrade more than 70 hospitals, we remain concerned that there may still be a shortfall in beds, particularly for planned operations.

Reform and redesign of surgical services to deal with the backlog

17. During the pandemic, RCS England published its New Deal for Surgery report and recommended the establishment of COVID-light 'surgical hubs' where elective surgery is separated from emergency admissions, and COVID-19 transmission is limited.[xii] This was to reduce the risk of surgical patients contracting COVID-19 during or after surgery, and avert the associated increased risk of mortality and pulmonary complications.[xiii] COVID-light surgical hubs have proven essential for the continuation of planned surgery because they provide a protected environment for patients to be treated, and mean that staff and beds can be effectively ring-fenced from emergency care. They have also helped to expand capacity and improve efficiency by bringing skills and resources together under one roof.

18. For surgical staff, this can mean not working at the hospital they previously worked at, but instead following the surgical patients to the hub. For patients, this can mean that they do not get their operation in their nearest hospital, but in a nearby 'surgical hub' hospital. In a Savanta ComRes survey undertaken in May 2021 for RCS England, 73% of UK adults said that if they needed an operation, they would be willing to travel to a surgical hub if it was not their nearest local hospital.[xiv]

19. While the surgical hub model is not a 'one-size-fits-all' solution, in some areas, such as London and Northumbria, they have been crucial to establishing an elective recovery programme for high volume low complexity procedures (e.g. hip and knee replacements) and specialised procedures (e.g. cancer surgery). We have seen a range of different surgical hubs develop as local areas adapt the model to their needs. Some have been set up as separate areas within the main hospital, which supports more complex surgery, while others have been established on different sites, particularly to enable high volume, low complexity surgery. Also groups of hospitals have collaborated through 'mutual aid' to keep services going safely and avoid stoppages. For example, The Royal National

Orthopaedic Hospital NHS Trust acted as a hub to treat adults and children with complex spinal and orthopaedic conditions across north central London.

20. In Croydon University Hospital, an 'elective centre' was launched at the hospital to restart surgery following the pandemic, with 10 theatres and 28 beds ring-fenced for surgical patients. The centre has strict infection control policies and controlled access to protect staff and patients from COVID-19. In a separate part of the hospital, emergency admissions and COVID-positive patients are treated. Through this model, elective productivity returned to over 100% of pre-lockdown levels for routine procedures and Croydon Hospital's waiting times were the second lowest compared to eight other London hospitals in February 2021.[xv]

21. Elsewhere, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) deployed a three-pronged approach of (i) increasing the number of surgical procedures through extended weekend operating, additional staff to pre-assess patients and dedicated ITU beds to avoid last-minute cancellations (ii) enhancing outpatient services with additional weekend clinics and targeted drives to reduce waits for first appointments and (iii) workforce innovation (an Enhanced Surgical Team bolstered by training programmes and Surgical Advanced Nurse Practitioners). The Elective Recovery Fund was key to supporting this approach.

22. Meanwhile, St George's University Hospitals NHS Foundation Trust built a modular unit in the car park of Queen Mary's Hospital in Roehampton. It was constructed in less than four months and started treating patients in June 2021. The hub is available for patients from across south west London requiring day surgery procedures, such as urology, vascular and general surgery procedures. It has four dedicated operating theatres along with a recovery area, and can facilitate approximately 120 procedures a week.[xvi]

23. We welcomed the Government's £1.5 billion investment for new surgical hubs, increased bed capacity and equipment to help elective services recover in the Autumn Budget and Spending Review. Future spending rounds will need to allocate further capital funding specifically to establish surgical hubs in those parts of the country that lack these facilities.

24. RCS England has called for the establishment of at least one surgical hub per ICS region, recognising both high-volume low complexity capacity is needed, and also capacity for more complex surgery (surgical hubs within hospitals, with Intensive Care facilities). Support both for local infrastructure and staffing for hubs, will help ensure surgical services are more sustainable and better protected against future COVID-19 waves or 'winter pressures'. This will be key to achieving and exceeding pre-pandemic levels of activity, and maintaining surgical activity year-round.

25. Trusts need urgent clarification on how the government's stated support for the principle of surgical hubs will be backed up through future spending rounds, to enable planning. The recent NAO report revealed there are significant variations in NHS performance across England, and some areas will require more investment in their physical estate than others. Among the worst performing areas in September 2021, Birmingham and Solihull had 51% of patients on the elective waiting list waiting for longer than 18 weeks (against a target of 92%), and 57% of cancer patients waiting longer than 62 days for treatment after an urgent GP referral.[xvii] The Government should consider whether ICS' in these regions should be prioritised for support to create surgical hubs as part of a national strategy to address regional inequalities in access to surgery.

Contact: For further information about this response please contact the Royal College of Surgeons of England's public affairs team at publicaffairs@rcseng.ac.uk

[i] NHS England, 'Consultant-led referral to treatment waiting times', 26 November 2021.
[ii] NHS England, 'Consultant-led referral to treatment waiting times', 26 November 2021.
[iii] National Audit Office, NHS backlogs and waiting times in England, December 2021.
[iv] Academy of Royal Medical Colleges, NHS Confederation, NHS Providers, the British Medical Association, the Royal College of Nursing and Unison letter to the Prime Minister, 19 April 2021.
[v] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 173.
[vi] Health Foundation, 'Building the NHS nursing workforce in England', December 2020.
[vii] Joint Committee of Surgical Training, Association of Surgeons in Training, British Orthopaedics Trainees' Association, Confederation of Postgraduate Schools of Surgery. 'Maximising training: making the most of every training opportunity. 2021' https://www.jcst.org/key-documents//
[viii] National Audit Office, NHS backlogs and waiting times in England, December 2021.
[ix] The Royal College of Surgeons of England, A New Deal for Surgery, May 2021.
[x] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 195.
[xi] NHS England bed availability and occupancy data (Q3 2020/21).
[xii] The Royal College of Surgeons of England, A New Deal for Surgery, May 2021.
[xiii] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31182-X/fulltext
[xiv] The Royal College of Surgeons of England, A New Deal for Surgery, May 2021.
[xv] SW Londoner, 'Croydon Elective Centre paves way for future of London hospitals', 16 May 2021.
[xvi] St George's University Hospitals NHS Foundation Trust press release, 'New surgery treatment centre to open at Queen Mary's Hospital Roehampton', 10 June 2021.
[xvii] National Audit Office, NHS backlogs and waiting times in England, December 2021.