Written evidence submitted by The Royal College of Surgeons of England (CBP0035)

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 Health and Social Care Committee's inquiry into clearing the backlog caused by the pandemic. Although summer is usually a quieter time for the NHS, there are currently record attendances in A&E departments, high staff absences due to COVID-19 isolation and delayed annual leave, and reduced capacity due to Infection Prevention Control measures. In addition, we are facing the prospect of a difficult winter with increased hospital admissions due to flu, COVID-19, and Respiratory Syncytial Virus (RSV) in children. These factors will seriously impact the ability of the NHS to tackle the backlog unless urgent action is taken.

3. A significant waiting list existed before COVID-19 and the NHS in England has not met the statutory 18 week waiting time target for planned hospital treatment for over five years[1]. The pandemic has exacerbated the situation. To restore timely access to NHS surgical treatment, RCS England is calling on government to provide a 'New Deal for Surgery', with investment in the workforce, bed capacity and surgical hubs, and make surgical services more sustainable for the future.

Summary recommendations

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

    4.1 To monitor NHS performance in reducing the backlog and identify localised problems, the collection and publication of statistics, such as the number of cancelled urgent and elective operations, should be resumed. To support patients facing long waits for surgery, Integrated Care Systems (ICSs) must urgently consider what measures can be put in place. There should also be a legal requirement placed on the Government to publish an annual report setting out its response to the elective backlog in England.

    4.2 Staff wellbeing and retention should be at the forefront of plans to tackle the backlog. Along with an expansion of the NHS workforce, there should be a statutory duty on the Government to publish a regular assessment of health and care workforce projections and requirements.

    4.3 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 and does not offer sufficient capacity. The government needs to support and invest in additional NHS surgical capacity to enable the service to cope with pandemic and seasonal pressures and achieve and maintain the levels of elective activity needed.

4.4 The £1bn annual 'Elective Recovery Fund' for England should be continued for a further five years. In addition, substantial investment is needed to increase the number of doctors and hospital beds, in line with the OECD average.

4.5 During the pandemic, COVID-light surgical hubs have provided vital extra capacity to enable the continuation of elective surgery. We urge the Committee to recommend the surgical hub model be adopted across England for appropriate specialties, such as orthopaedics and cancer.

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. All elective (planned) surgery was cancelled in the first wave and many surgical teams were redeployed to help treat COVID-19 patients. Latest figures show the largest ever recorded NHS waiting list in England of 5.45 million people, over a million more than in February 2020 before the pandemic hit. The number of patients waiting over a year for treatment has increased sharply with 304,803 people waiting over a year for elective treatment in June 2021, compared to 1,613 people waiting pre-pandemic in February 2020. [2]

6. We welcomed NHS England's recent decision to publish data for patients waiting up to two years for treatment. However the figures are concerning, with 5,727 waiting over two years for treatment in June 2021, a 46% increase on the previous month when 3,927 people were waiting. This included 1,229 people on the list for trauma and orthopaedics procedures (e.g. hip and knee operations), 695 for general surgery (e.g. gallbladder and hernia operations) and 603 for ear, nose and throat (ENT) surgery. These 'non-urgent' operations are essential for people's mobility, quality of life and ability to work.

7. The collection and publication of some statistics, including the number of cancelled urgent and elective operations, was suspended during the pandemic to release capacity across the NHS to support the response. Although there are still over 7,000 patients in hospital with COVID-19, the service is managing in some areas to return to pre-pandemic levels of activity. Same-day cancellations are an indication of local issues that warrant investigation, and they are an important indicator of the experience of patients on the waiting list. It is critical therefore that real-time data collection now resumes, and that cancellation statistics are reported and monitored, to support the recovery of services through robust statistical information.

8. 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 forecast from the Institute of Fiscal Studies (IFS)[3] suggests in a 'worst case scenario', waiting lists could rise to 14 million by the autumn of 2022 and then continue to climb, as the number of those joining the waiting list continues to exceed the number being treated. In their most 'optimistic scenario', the number of people waiting for treatment would rise to over 9 million next year, and only return to pre-pandemic levels in 2025. The IFS has proposed that these figures are dependent on what happens to NHS capacity for non-COVID treatment over the coming years, so it is imperative that the Government takes action to expand both workforce and bed capacity.

9. Behind the monthly waiting time statistics are people waiting patiently for operations, but suffering. Some are in pain or psychological distress and delays to treatment can affect their ability to work, resulting in financial hardship. This contributes to an overwhelmingly negative picture of life, described as life "on hold" or being left in a "no man's land".[4] Prolonged waits for

surgery risk further deterioration in a patient's condition, which can mean more complex surgery later being required. Sadly there will be some instances where patients die while waiting for a procedure. The College urges Integrated Care Systems (ICSs) to consider how to support patients to maintain their physical and mental health while waiting for surgery. As the Centre for Perioperative Care has suggested, turning waiting lists into 'preparation lists' would help to ensure that patients are ready for their operations, which has been shown to help reduce the risk of complications and length of hospital stay following the procedure.

10. To ensure there is concerted action on this challenge, RCS England is calling on the Government to lay a report before Parliament on an annual basis setting out its response to the elective backlog in England. This should include key actions to alleviate the impact on those patients waiting a long time for treatment.

NHS workforce pressures impacting on the backlog

11. 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, have flagged the need for rest and recuperation after being redeployed to help treat COVID-19 patients.

12. Prior to COVID-19, the NHS workforce faced a perfect storm of consultants choosing to retire earlier, a significant proportion approaching retirement age and a growing trend 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 to highlight the risk these vacancies present.[5] 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 any plans for catching up with the backlog and continuing to deliver safe patient care.

13. 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.[6] We are also 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'.[7]

14. 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.[8] 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.

15. Improved workforce planning is critical to increasing 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 mount. RCS England has joined with other Medical Royal Colleges in recommending that forthcoming NHS legislation includes a statutory duty for 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.

NHS bed capacity to deal with the backlog

16. The NHS has periodically looked to 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. Funding for the independent sector in 2021/22 is essential, because it provides separate COVID-light hospitals to safely undertake operations.

17. 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. We recommend government supports and invests in additional NHS surgical capacity, to enable the service to manage both pandemic and seasonal pressures, so the NHS can both achieve and then maintain the levels of elective activity needed to meet demand.

18. In the years prior to the pandemic, it was already a concern that the NHS was run too 'hot', i.e. too close to capacity. While this approach was understandable given the desire to make maximum use of infrastructure, it is unviable in an environment characterised by infectious diseases, where the separation of different services, patients and staff is paramount. Having physical capacity that is separate, but still not too far away, is key to keeping services running. Currently, the UK simply had too few hospital beds to ensure infection prevention control and meet demand.

19. 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.[9] 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.[10] While RCS England welcomed the Government's plan to build a number of new hospitals by 2030, we remain concerned that there may still be a shortfall in beds, particularly for planned operations.

Financial investment needed to tackle the backlog

20. RCS England welcomed the Government's announcement in the 2020 Comprehensive Spending Review of an extra £1bn of funding through the Elective Recovery Fund. The funding can be accessed by hospitals that achieve high levels of elective activity and meet 'gateway criteria' including tackling the longest waits and transforming outpatient services. [11] The Fund is proving successful, and should not be limited to a one-year commitment. To make a lasting impact on the elective backlog and provide continuing support for transformation of services, we urge the Government to continue to allocate a £1bn Elective Recovery Fund annually, for the next five years.

21. However an extension of the Elective Recovery Fund alone will not suffice. The continuing presence of COVID-19 necessitates ongoing infection prevention control measures that add further staff and infrastructure costs. Furthermore, the service faces higher demand as patients who stayed away during the pandemic return for treatment, and as delayed or cancelled operations are rescheduled. So the total funding allocation for the NHS needs to be raised to meet increased demand for services and provide them safely.

22. Even before the pandemic, patients faced long waits for operations, and provision of surgery was often dependent on winter pressures. For example, in January 2018, NHS England advised hospitals to cancel all elective surgery for a month when a spike in flu cases led to bed shortages. This policy contributed to a significant backlog of elective surgery that the NHS was unable to recover from. Surgical services need to be more sustainable, instead of returning to a stop-start' model, where thousands of planned operations are cancelled or postponed when the system comes under pressure. Any stoppage means a waste of expensive resource, and when the system is 'switched back on', surgical teams find it impossible to catch up due to a lack of spare capacity.

23. Therefore in the long term, RCS England believes investment is needed to increase the number of doctors and hospital beds in line with the Organisation for Economic Co-operation and Development (OECD) average. As detailed in the previous section, we believe this would help the NHS to reduce the backlog, meet the growing demand from an ageing population and ensure the sustainability of surgical services.

Reform and redesign of surgical services to deal with the backlog

24. During the pandemic, RCS England recommended the establishment of COVID-light 'surgical hubs' where elective surgery is separated from emergency admissions, and COVID-19 transmission is limited. 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.[12] 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.

25. 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.

26. 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, while others have been established on different sites. Groups of hospitals have collaborated to keep services going safely and avoid stoppages. For example, The Royal National Orthopaedic Hospital NHS Trust has acted as a hub to treat adults and children with complex spinal and orthopaedic conditions across north central London.

27. 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.[13]

28. 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.

29. 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.[14]

30. We welcomed NHS England's £160 million investment in May 2021 for 'accelerator sites' to explore and test new ways to reduce the elective backlog. Devon ICS' initiative involves investing in Exeter's NHS Nightingale hospital, which was decommissioned as a COVID-19 hospital earlier this year, to provide extra capacity for orthopaedic surgery, ophthalmology, rheumatology and diagnostic services. The facility will include two operating theatres for day case elective orthopaedic procedures, such as hip and knee replacements.[15]

31. RCS England believes that widening the adoption of surgical hubs in appropriate specialties, with support for local infrastructure and staffing, will help ensure surgical services are more sustainable and better protected against future COVID-19 waves or 'winter pressures'. This will require both substantial investment and local support, but is key to achieving and exceeding pre-pandemic levels of activity, and maintaining activity year-round. Without this investment and support, we will be unable to reduce the record backlog in surgical care the NHS now faces.

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

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[1] NHS England, 'Consultant-led referral to treatment waiting times', 12 August 2021
[2] NHS England, 'Consultant-led referral to treatment waiting times', 12 August 2021
[3] Institute of Fiscal Studies, 'Could NHS waiting lists really reach 13 million?' 8 August 2021
[4] National Voices, 'Improving our understanding of the experience of waiting for elective care', February 2020
[5] 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
[6] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 173
[7] Health Foundation, 'Building the NHS nursing workforce in England', December 2020
[8] 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/
[9] Organisation for Economic Co-operation and Development (2019), 'Health at a glance 2019', p 195.
[10] NHS England bed availability and occupancy data (Q3 2020/21)
[11] NHS England, '2021/22 priorities and operational planning guidance', March 2021
[12] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31182-X/fulltext
[13] SW Londoner, 'Croydon Elective Centre paves way for future of London hospitals', 16 May 2021
[14] 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
[15] Exmouth Journal, 'Nightingale hospital will help reduce NHS waiting lists', 17 August 2021

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