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Rt. Hon. Jeremy Hunt MP
Chair, Health and Social Care Committee
House of Commons
London SW1

14 December 2020

Dear Mr Hunt,

Core NHS services during the Covid pandemic

Thank you for your letter of 26 November 2020 on core NHS services during the Covid pandemic. As requested, this note is to provide a further update on item 1 (waiting times and the backlog). NHS Chief People Officer Prerana Issar has already responded on items 2-4 of your letter, and DHSC may wish to reply further on the wider workforce questions you raise and which fall within their purview.

Impact of the pandemic on non-Covid health services: international comparisons

I know that the committee has been interested in comparisons with the international covid experience, so it is noteworthy that knock-on impacts to non-covid health services have also been widespread in other European countries. As the OECD's just-published 2020 edition of 'Health at a Glance: Europe' sets out:

> "In response to the COVID-19 crisis, many countries postponed *elective surgery* to free up human resources and hospital beds. This was the case, for example, in Germany and Portugal for all non-urgent elective surgeries. In France, the Académies de médecine et de chirurgie estimated around 1.1 million non-urgent surgical acts were postponed during the pandemic."
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> "There have also been fewer visits to *emergency departments*. In France, fewer emergency visits were observed early in the crisis for people requiring urgent care for cardio- and neuro-vascular pathologies. Moreover, a study in Paris found that the incidence of out-of-hospital cardiac arrest doubled during 16 March to 26 April, as compared to the equivalent time period in previous years. In Germany, the COVID-19 pandemic was associated with a significant decrease in all-cause admissions (30% lower than for the same period in 2019) and admissions due to cardiovascular events in the emergency department (41% lower). In Italy, paediatric emergency department visits were down by 73-88% in March 2020 as compared with March 2019 and 2018."
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> "Beyond acute care, large reductions in the use of *outpatient services* have been reported in some countries, including Belgium, France, Germany (Bavaria), Norway and the United Kingdom (England), though the number of teleconsultations has increased substantially. France also reported fewer specialist care appointments."

> "Disruptions to *cancer care* have also been evident. In the Netherlands, data from the Cancer Registry show a notable decrease in cancer diagnoses as compared to before the COVID-19 outbreak. In France, the number of cancer diagnoses decreased by 35-50% in April 2020, as compared to April 2019. In Italy, an estimated 1.4 million fewer screening exams were performed during the first five months of 2020 compared to the same period in 2019, leading to fewer cancer diagnoses. In Spain (Madrid), outpatient visits in oncology departments decreased by 23% between 9 March and 13 April 2020, as compared with the same period in 2019. New oncology referrals and the number of patients enrolled in clinical trials also fell, suggesting treatment delays.
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> "Many countries saw peaks in discharges from *mental health* care in March and April, linked to the recommissioning of inpatient beds or staff for COVID-19 wards, as well as to the risk of COVID-19 transmission. In Madrid (Spain), in March 2020 the number of inpatient psychiatric beds was reduced by 60%, outpatient units were closed, and the number of patients attending emergency psychiatric services fell by 75%. Multiple reports from OECD countries also suggest significant reductions in the number of referrals to mental health services, mental health services contacts, and active community caseloads during the peak of the spring COVID-19 outbreak. In the Netherlands, for example, the impact has already been significant: the number of referrals to mental health care fell by 25-80% after the outbreak; demand for treatment dropped by 10-40%; billable hours decreased by 5-20%; and bed occupancy dropped by 9%."

The overarching inference to be drawn from this Europe-wide evidence is that the best way of ensuring comprehensive health services can continue to function well is to ensure effective public health measures keep SARS-COV-2 infections under control.

The second covid wave now under way

In practice, however, we have again had to respond to a rapid increase in covid-positive hospital inpatients - from fewer than 500 at the start of September to nearly 15,000 in late November. Despite intense pressures in some parts of the country, the NHS in England has generally been able to adapt its response to this second covid wave, meaning less disruption to other non-covid services than during the first.

Additional revenue and capital funding made available to us has allowed some capacity strengthening. Our 'Help us Help You' public information campaign has encouraged people to continue to come forward for needed care. And improved community testing and infection surveillance has meant the NHS has been provided with more granular and timely information on covid prevalence. This has allowed individual hospitals, local areas and regions to deploy mutual aid, and flex covid and non-covid service provision, in close to real time.

As a result, during the second covid wave this Autumn, for every <u>one</u> covid inpatient in hospital at any one time, hospitals have been able to look after <u>at least five</u> other inpatients for other health conditions. This compares with the Spring peak of first covid wave hospitalisations, when the ratio was one covid inpatient to two non-covid inpatients.

Outlook for winter and 2021

There are – to state the obvious – major unknowns about the wider demands that will be placed on the NHS over the coming months. These uncertainties are a function of the effectiveness of wider public measures to control covid infection rates, including through the Government's test and trace programme as well as the approach to geographical tiering and related measures. We are currently not seeing the hoped for fall in covid inpatients following what was assumed to have been the second November peak. Instead, overall inpatient numbers have continued to increase, and are now higher than a fortnight ago. The Government have today identified the position in parts of the south east and in London as particularly concerning.

In the absence of knowledge about covid infection rates and therefore covid inpatient numbers over the coming months, forecasts of waiting lists and backlogs of care are therefore at this point unlikely to be accurate. For example, the Health and Social Care Committee's report of 1 October 2020 referenced at paragraph 24 a third party forecast that "the overall waiting list could grow from 4.2 million to 10 million, or possibly more, as a result of the pandemic" by Christmas. It is now clear that this is extremely unlikely to be the case. The most recent official statistics published last week (for October 2020) show 4.5 million people on the waiting list, still below the same time last year. The overall waiting list is currently increasing relatively slowly and last month the median wait for planned care again fell. And since July, the number of people waiting over 18 weeks has fallen by around 620,000 people, or nearly 30%.

Furthermore, while the number of Referral to Treatment 'clock starts' have rebounded from around one third of their usual level in April to over four fifths in October, there is uncertainty as to how that will net out over the coming months.

Despite this, we believe there are a number of important 'no regrets moves' which we are putting in place to reduce waits for elective and other care over the coming months. These include:

- **Maximising effective treatment capacity** both in NHS hospitals and through the independent sector, including - where locally feasible - dedicated non-covid treatment hubs. Prior to the second covid wave, we had seen strong elective recovery across the NHS, with overnight elective operations approaching 80% - 90% of their usual levels.

- **Increasing funding for elective care** going into 2021/21, making use of the additional £1bn allocated for this purpose in the November Spending Review. There is a cohort of patients waiting for non-urgent but important routine care who have, or will have, been waiting over 52 weeks. They - together with those needing urgent surgery - are a clear priority for hospitals (not least given the pre-covid success of the NHS in all but eliminating this type of wait).

- Investing in **expanded diagnostics**, including deploying an extra £325 million of capital investment next year to kick-start implementation of the new diagnostics model set out in the report I recently commissioned from Professor Sir Mike Richards.[1] Despite infection prevention and control impacts, we have seen strong recovery in diagnostic imaging volumes which are now in many cases running at over 100% of usual levels.

- Total **cancer treatment** volumes on the 62 day pathway are now reported to be back to and in a number of cases above usual volumes. A specific cancer care recovery plan (enclosed) has been developed by the national cancer team in conjunction with partners in the sector.

- A specific plan is also being drawn up with our partners in the **mental health** sector to allocate the extra £500 million made available in the November Spending Review to respond

[1] https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/

to additional needs which have arisen during the pandemic. This funding will be in addition to the real terms mental health funding growth already programmed in for next year in line with the NHS Long Term Plan.

We will be taking stock across the NHS on all these programmes early in the New Year in order to set appropriate operational goals for 2021/22. We will of course be happy to keep the Committee updated as we do so.

With best wishes,

Yours sincerely,

Simon Stevens
NHS Chief Executive