

## Written evidence submitted by The Royal College of Physicians (CBP001)

### Summary

The Royal College of Physicians (RCP) welcomes the committee's inquiry into clearing the backlog caused by the pandemic. We are pleased to be able to share evidence on the extent of backlogs, what needs to be done to address the challenge, and what important changes seen during the pandemic should be embedded long-term - such as more remote care and better use of data.

The RCP believes that workforce capacity is the key limiting factor in tackling backlogs and keeping pace with patient demand in the long-term. We urgently need to take steps to expand the health and care workforce, including through doubling medical school places.

### Recommendations

- Workforce capacity is the key limiting factor in tackling backlogs and keeping pace with patient demand in the long-term. Government must take steps to expand the medical workforce, including through doubling medical school places, and the Health and Care Bill should be amended to **include provisions for regular, independent, assessments of future health and care workforce requirements to be published.**
- **Virtual outpatient appointments should become the norm** – barring specific circumstances – given the general favourable patient view towards them and the appetite among physicians to embed this way of working. To facilitate this, **the NHS must ensure that clinicians have access to the right equipment to deliver remote care.**
- The delivery of diagnostic services in the community through **“diagnostic hubs” should be expanded to enable people to receive multiple tests at the same time closer to where they live, freeing up capacity in hospitals.**
- **System design needs to enable clinicians to access patient information and data more easily.** This will avoid patients repeating information in different parts of the system and to enable clinicians to more easily diagnose.
- In order to facilitate innovation, **the Department of Health and Social Care should ensure the NHS health and care workforce has the right capacity in place to reduce pressure and allow more time for staff to take part in research and other activities that drive innovation.**

### **1. What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?**

1.1 RCP members have been at the forefront of delivering care to COVID-19 patients on general medical wards. They are now starting to tackle the backlog of diagnostic and outpatient care across a range of specialties including gastroenterology, cardiology and respiratory medicine. In April 2021, the RCP [surveyed its members](#) as pressure from the second COVID-19 wave was easing and attention was beginning to turn to recovery. This survey found that the majority (59%) of physicians expected that it would take at least 18 months for the NHS to get back to an “even keel” and clear the backlogs. 30% thought it would take over two years to clear the backlogs.

1.2 There was significant variation between medical specialties in anticipated backlogs. In gastroenterology, two thirds (75%) expected backlogs of over a year, with almost half (48%) expecting it take over 18 months to return to an even keel. Other specialties where physicians expected it to take over a year included dermatology (82%), rehabilitation medicine (67%), respiratory (59%), medical oncology (58%) and cardiology (52%).

1.3 The last four months have borne out many of these concerns, with hospitals and other parts of the health and care system under significant pressure. There are a record 5.45 million people waiting for hospital treatment, with a [six week wait for outpatient appointments for 22% of the total number of patients](#) at the end of June.

## 2. What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?

2.1 The pandemic has shown that the health service has very little capacity to deal with emergencies while continuing to provide routine care. The biggest challenge now facing the NHS is clearing the backlog – and workforce is a key limiting factor. The medical workforce was already under pressure before the COVID-19 pandemic, and this has only become more acute over the course of the last 18 months. Staff are tired, and burnout is common. **The RCP is concerned that the pressure of prolonged pandemic working is leading to many experienced doctors considering early retirement, with our most recent member survey showing that 27% of consultants expect to retire within 3 years.**

2.2 [RCP's 2019 census](#) showed that before the pandemic close to half (43%) of advertised consultant posts in England and Wales were unfilled due to a lack of suitable applicants. Consultants estimated they worked 10% more than they were contracted to do due to their clinical workload, and consultants who had retired and returned constituted 15% of the workforce.

2.3 During the pandemic, pressure on the health and social care workforce increased hugely. In response to [a survey by the RCP in January 2021](#), almost a fifth (19%) of doctors reported that they had sought informal mental health support and 10% had received formal mental health support from either their employer, GP or external services. A third (33%) of trainees said that working in the pandemic had made them question medicine as a career. A large proportion of respondents (64%) felt tired or exhausted, and many felt worried (48%).

2.4 Even without the pressures of the pandemic, there are big challenges ahead for the NHS workforce that we need to take account of and prepare for now. The current consultant cohort is ageing. Even if senior experienced consultants do not take early retirement because of the pandemic, **it's still expected that 35% of current consultants will retire in the next decade as they reach mean age of retirement at 62.5 years.** At the same time, **the majority (56%) of medical trainees entering the NHS are interested in working part-time.** A fifth of doctors already work part-time, and it is expected that this trend will continue to grow as expectations around work/life balance change. This has significant implications for workforce planning, and requires mapping out the full-time equivalent (FTE) staffing levels required so that we can understand the sustainability of the NHS workforce over the next 20 years.

2.5 Increasing the capacity of the medical workforce is imperative to address both the immediate challenge of the backlogs and the longer term expectation of higher patient demand. The ONS estimates that by 2040 there will be over 17 million UK residents aged 65 and above, meaning the cohort of people potentially requiring geriatric care will make up 24% of the population. Many older patients will have multiple long term health conditions and

need holistic care. Increasing the number of doctors in training must be the priority, as well as doing more to retain our existing workforce.

2.6 The RCP believes that the Health and Care Bill is a vital opportunity to establish greater transparency and accountability on workforce planning, so that in future the NHS continues to have the right skill mix and numbers of healthcare staff to deliver the care patients expect. The Bill should be amended **include provisions for regular, independent assessments of future health and care workforce requirements to be published** based on projected future patient demand. In the immediate term, **the RCP believes the government should commit to funding to increase the number of medical school places at this year's Spending Review.**

**3. How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?**

3.1 The current backlog, and pressures that the NHS faces every year, is symptomatic of the fact that we do not have sufficient workforce capacity to meet patient demand. We must act now to put the NHS workforce on a sustainable footing in the long term. The RCP has outlined the case for doubling medical school places and how this will be implemented in [Double or quits: a blueprint for expanding medical school places](#).

3.2 The estimated financial investment needed to double the number of medical school places from 7,500 to 15,000 is approximately £1.85bn annually. While this is not an insignificant investment, it is less than a third of what hospitals spent on agency and bank staff in 2019/20. Investing in expanding medical school places to train more doctors in the UK would represent a long term saving on locum costs and better equip the health system to meet increased patient demand.

3.3 We also have an opportunity to do this now, as there was a mini 'baby boom' around 2010. These people will be ready to go to university in 2028. If we make sure a significant number of them attend medical school, they will be in specialty training in 2035 and qualify around 2040. The increased focus on general medical skills, as demonstrated by the replacement of Core Medical Training with Internal Medicine Training (IMT), means they will be well equipped to care for the older population we will have by that time.

3.4 Expanding the medical workforce will also likely improve retention of the staff we already have by reducing the clinical burden shouldered by each clinician, therefore freeing up time to do teaching, research or a better work/life balance. There should be an increase in foundation places alongside medical school places.

**4. How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?**

4.1 Training more doctors is a key way we will tackle this problem. But we must also not forget that doing more to retain our existing staff is an important short-term policy change that does not require the same initial outlay. In the short-term, offering more flexible working practices will enable better retention. An [RCP member survey](#) conducted in June 2021 found that for a majority (56%) of physicians, the experience of the pandemic had made them want to work more flexibly.

4.2 In the medium term, the delivery of healthcare can be improved and made more efficient by breaking down the divisions in care delivery, which can make the experience a slow and frustrating one for patients. These divisions exist not only between primary, secondary and social care, but also between specialties in hospitals. There are many good examples of integrated care that should be replicated across the system. For example, making greater use of integrated health and social care teams, virtual integrated clinics, and designing in 'one-stop visits' where multiple tests are done on the same day, will all help. As England moves towards having statutory integrated care systems in 2022, responsible for designing and delivering many services in their respective region, this presents a fantastic opportunity to ensure that services are reformed to deliver genuinely patient-centred integrated care.

4.3 But in the long-term, the key reform required to effectively deal with backlogs and waiting lists is to invest in the NHS workforce.

**5. What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?**

5.1 There are a number of ways in which the pandemic sped up or forced changes in service delivery – some of which were long overdue. One example is the use of remote outpatient appointments, which were rare before March 2019. COVID-19 forced most face-to-face outpatient appointments to be replaced by remote appointments, mostly by telephone but some by video. This shift has overall been positive for patients, although we recognise that some appointments will always need to be done face-to-face. A [report by National Voices](#) found that many patients 'appreciate quicker and more efficient access, not having to travel, less time taken out of their day and an ability to fit the appointment in around their lives. Most people felt they received adequate care and more people than not said they would be happy with consultations being held remotely in future'. **The RCP believes that this change should be maintained post-pandemic.** As the RCP report '[Outpatients: the future](#)' found in 2018, Did Not Attend (DNAs) are closely linked with patient dissatisfaction following late-running in person clinics.

5.2 Clinicians have similarly welcomed the shift. An [RCP member survey in April 2021](#) found that physicians want to continue delivering a much greater proportion of their appointments remotely in future. A majority (55%) said that at least a quarter of their outpatient appointments should be virtual, and more than a third (35%) thought that at least 35% of their outpatient appointments should be virtual. Making sure staff have the right equipment and guidance is still a challenge that needs to be addressed though by hospitals – 41% said they did not have everything they need to deliver good remote care. **The NHS must ensure that clinicians have access to the right equipment to deliver remote care, so that virtual appointments for outpatient care become the norm going forward.**

5.3 Secondly, virtual wards have played an important role in providing care during the pandemic and should continue to do so in future. As [highlighted by Nuffield Trust](#), virtual wards provide care virtually in the patient's own home – usually following discharge from hospital or after referral from A&E to primary care after an accident.

5.4 Thirdly, **the delivery of diagnostic services in the community through "diagnostic hubs" rather than in hospitals, should be expanded.** If implemented well, this would allow people to receive multiple tests at the same time quicker and closer to where they live, as well as freeing up capacity in hospitals.

5.5 A fourth lesson from the pandemic relates to better data sharing. **To create a more seamless experience for patients across the health and care system, we need to design systems where clinicians can access patient information more easily.** This helps to avoid patients having to explain the same information to staff in different parts of the system, and will enable clinicians to more easily diagnose conditions and care for patients.

5.6 The pandemic has seen many examples of positive action on better data sharing. For example, [Greater Manchester greatly accelerated the development of its single care record system](#) for almost 3 million people in the region. Up until March 2020, each of the 10 localities in Greater Manchester could only access patient records from their own area. The Greater Manchester (GM) Care Record joins up health and care data from across Greater Manchester. The project was already planned before the pandemic, but when the control of patient information (COPI) notice was introduced in response to COVID-19, it mandated that NHS organisations shared data as part of the COVID-19 response. This helped to unlock some of the information governance barriers, although the clinicians involved reported that they still had to negotiate with over 500 data controllers. Now 99% of patients in Greater Manchester are covered by the GM Care Record, and clinical decision making is much simpler as there is up-to-date information on test results, care plans, medications and social care support.

## **6. What can the Department of Health and Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?**

6.1 Innovation requires time. For example, the COVID-19 pandemic has shown how important clinical research is to keep the NHS innovative and make key improvements to patient care. [When we asked our members](#), 57% said that they wanted to be more involved in clinical research. However, the biggest barrier to becoming more research active was a lack of time, with over half (53%) of respondents reporting it as a problem.

6.2 Consultants estimate they work 10% more than they are contacted to do, mainly due to their clinical workload. In order to facilitate innovation, **the Department of Health and Social Care should ensure the NHS health and care workforce has the right capacity in place, to reduce pressure and allow more time for staff to take part in quality improvement, research and other activities that drive innovation.**

## **7. To what extent is long-covid contributing to the backlog of healthcare services? How can individuals suffering from long-covid be better supported?**

7.1 While we continue to learn more about the impact of long COVID, it will no doubt exacerbate the strains on the system. Cases of long COVID should generally be managed in the community, with input from specialist services as needed. This will of course need adequate funding for services and the staff to deliver those services.

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### **About the RCP**

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We represent doctors from over 30 medical specialties from cardiology and gastroenterology to infectious disease and respiratory medicine. We provide physicians in the UK and overseas with education, training and support throughout their careers. As an independent

body representing over 40,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

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