Written evidence submitted by The British Orthopaedic Association (CBP0008)

Summary

1) The British Orthopaedic Association welcomes the opportunity to respond to the Health & Social Care Committee Inquiry on 'Clearing the backlog caused by the pandemic.'

2) **The British Orthopaedic Association (BOA) is the Surgical Specialty Association for Trauma and Orthopaedics (T&O) in the UK, with 5000 members**. We provide national leadership, a unifying focus, and charitable endeavour by: Caring for Patients; Supporting Surgeons, Transforming Lives. T&O surgery provides highly cost effective treatments for numerous (bone and joint) conditions that restore pain-free mobility and improve occupational and recreational activities for our patients. T&O surgery helps people stay active for longer delivering significant economic savings; enabling people both young and old to work and live more independently with an improved quality of life.

3) T&O surgeons diagnose and treat a wide range of conditions affecting the musculoskeletal system. These include congenital joint problems that the patient is born with as well as painful conditions that develop and restrict function perhaps due to trauma, infection or arthritis. The musculoskeletal system includes bones and joints and their associated structures that enable movement - ligaments, tendons, muscles and nerves. Commonly performed procedures include those needed to treat fractures (broken bones). Other examples are hip and knee replacements, with a total of over 200,000 taking place each year in the UK. Each is a life-changing procedure for patients with end-stage arthritis. Without surgery, these patients will typically experience debilitating pain, stiffness and a loss of mobility impacting the most basic tasks,[1] but with surgery, pain is reduced dramatically, mobility is increased and function improves, allowing people to return to their day-to-day domestic, occupational and (even) recreational activities, caring for themselves or indeed for others.

4) This submission focuses on two areas, summarised here:
    a. **<u>The 'demand' situation (Q1) regarding T&O surgery and waiting lists</u>**.
    Waiting lists in our specialty were already a concern prior to the pandemic and had been consistently climbing over recent years. They have been severely affected by the Covid-19 pandemic, when so few operations took place – orthopaedics has been disproportionately affected as long-term musculoskeletal conditions were mostly given the lowest priority. As things stand, **our specialty not only has the greatest total number of patients waiting, but also the greatest number – 64,000 – who have been waiting more than one year. This represents a huge volume of people, of all ages, truly living in agony and misery as they await their treatment.** Against that background the number of outpatient referrals to T&O has reduced markedly during the pandemic, by more than a million, perhaps due to understandable public concerns about attending healthcare services. Many of these patients are expected to come forward shortly and they will also require treatment, further adding to the backlog.

    b. **<u>The capacity to tackle the waiting lists (Q2).</u>**
    In order to tackle waiting lists, many more operations will need to be undertaken than prior to the pandemic (one published report suggests 10% extra for five years, others suggest greater numbers that would allow a quicker return to pre-pandemic list sizes but which are much more ambitious).

    We are supportive of initiatives that improve the efficiency of theatre lists and these should contribute to some increased throughput, but many services have already instigated these improvements and this alone will not provide any significant wholesale improvement in the figures. Our response covers five areas relevant to capacity: Facilities capacity and splitting hot/cold sites, Orthopaedic staff – current capacity, Orthopaedic staff – future capacity, Non-surgical staff and Other efficiency issues. **We make the following key points and recommendations for further action:**

[1] As described in recent media coverage, for example in the I newspaper: https://inews.co.uk/news/covid-delayed-arthritis-operations-jobs-benefits-1149575

- **Constantly 'stopping and restarting' orthopaedic services (e.g. during 'winter pressures') is highly inefficient and it is one of the major issues that must be addressed to facilitate any true sustainable recovery of the backlog. We believe there must be urgent investment in elective orthopaedic centres to address this backlog and to allow ongoing efficient and timely access to these highly-cost effective procedures.**
- **Improving issues regarding NHS culture and management, pensions/taxation, and morale, are key issues in relation to workforce capacity; based on our recent survey addressing these issues would greatly help in both reducing the numbers of early retirees and increasing the willingness of staff to do extra work. We urge the Government and NHS to look further at these issues to ensure adequate workforce capacity within orthopaedics over the coming years.**
- **Training of future orthopaedic surgeons has suffered serious setbacks due to the pandemic. It is essential that the plan to tackle the backlog of procedures also prioritises the training of future surgeons, again to promote adequate workforce capacity in future.**
- **Delivery of surgery depends not only on the orthopaedic surgeon workforce but on a multi-disciplinary team, with highly skilled team members from different professional backgrounds. Workforce/capacity issues in those other professional groups need also to be reviewed.**
- **It is essential that all NHS staff are supported as they recover from the challenges they have faced during the pandemic.**
- **Improvements to IT interconnectivity, better waiting list management, and well supported pre-habilitation and peri-discharge care all could have a role to play in improving efficiency of patient care, and therefore maximising throughput of operations.**

Q1: 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?

5) The orthopaedic surgery waiting lists have been particularly badly affected by the Covid-19 pandemic. Because a higher proportion of orthopaedic patients are categorised as 'non-urgent' or 'elective' than in other specialties, our specialty has been one of the worst affected by the shutdown of elective operating throughout the pandemic. While these procedures may be non-urgent in that they are typically not life-saving, they are truly life-changing, and currently hundreds of thousands of patients find themselves in very challenging circumstances in enormous pain and with limited mobility, many struggle with simple day to day activities and are unable to care for themselves or others whilst facing an uncertain wait for surgery.

6) The current waiting list situation is serious and, regrettably, expected to get worse:
   - The total number of patients on orthopaedic waiting lists in England is 668,763, the highest level for many years and greater than any other specialty.
   - This includes 269,204 waiting over 18 weeks, and 64,277 who have waited over 52 weeks; both these figures are also higher than for any other specialty.
   - *(NB Based on NHS England figures for end of June 2021 – Please note that the figures from NHSE comprise 234,871 who are definitely in need of surgery, while 433,892 have not been listed for surgery and are often awaiting assessment or clinic appointments which may or may not lead to an operation).*

7) We are expecting that more patients will come forward to join the waiting list in the near future. Many people avoided healthcare settings during the pandemic. Referral rates have not yet returned to their pre-pandemic levels and in total over a million fewer referrals have been made; of whom usually a quarter would have gone on to have surgery. While T and O surgeons have supported many successful initiatives to manage some of these patients effectively within primary/community care without referral, it is likely that there will be a delayed surge of patients presenting to primary care with more advanced musculoskeletal disease requiring more complex treatment and leading to a further increase in orthopaedic workload in the months and years ahead. It is likely that the immobility, pain and reduced activity resulting from orthopaedic conditions will lead to an increased healthcare demands of these patients in other areas, such as Accident and Emergency and acute medical services.

8) To add to the challenging 'demand' factors, the patients currently being seen for surgery who have had an extended wait may well have seen their orthopaedic condition deteriorate, and their overall health and fitness has often declined too: this is true for both adults and children. Those with co-morbidities such as cerebral palsy or rheumatoid arthritis have been particularly disadvantaged by this wait. Their surgery has often become more complex and time consuming (meaning fewer operations can happen per day). In some situations implants required to manage that increased complexity are more involved and costly. Patients recovery is more prolonged and requires additional rehabilitation resource. All can result in a longer stay in hospital. The complication rates may also be greater in these circumstances and outcomes have been shown to be worse when surgery is delayed and deformity and immobility worsens.

9) All in all, this makes for a situation where a large volume of elective surgery is required to be undertaken, against an ever ongoing requirement for emergency and trauma surgery, with a patient mix that has more complex needs than would have been the case prior to the pandemic.

10) The recovery period has been challenging, and while some hospitals have been able to return to pre-pandemic levels of operating and sustain this, many others have not. Some that have resumed operating have reduced or stopped again recently due to 'a volatile mix of pressures' as being reported in news coverage (discussed further later in this submission)[2] and by the Royal College of Surgeons of England.[3]

11) For England as a whole, the rate of operations across the country has not returned to pre-pandemic levels (June 2021 saw an overall level of 91% of the operations undertaken in 2019). There is also variability region by region (see table below) – from 80% to around 100% of usual activity. Those areas that have struggled to return to more normal levels of operating, are likely to experience even larger backlogs and thus the demand varies across the country.

NHS England region	Number of T&O operations		June 2021 operations as % of June 2019
	June 2021	June 2019	
SOUTH EAST	8,462	8,143	104 %
SOUTH WEST	4,732	4,771	99 %
LONDON	3,892	4,155	94 %
NORTH WEST	6,142	6,646	92 %
NORTH EAST AND YORKSHIRE	7,755	8,549	91 %
EAST OF ENGLAND	3,894	4,376	89 %
MIDLANDS	8,168	10,192	80 %

Q2: 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?

12) Prior to the pandemic, the waiting list situation was reaching crisis point with a year on year increasing number of patients waiting for surgery. It had been impossible to keep up with demand prior to the pandemic, and now with the increased scale of the waiting lists, it is an insurmountable problem unless there is a dramatic shift in the allocation and delivery of health and social care . We are supportive of initiatives that improve the efficiency of theatre lists and that should contribute to some increased throughput, but many services have already instigated these improvements and this alone will not provide any significant wholesale improvement in the figures. The task ahead must not be under-estimated.

13) Hip and knee replacements constitute a major component of the backlog. A recent paper identified that overall the number of joint replacements was 50% lower than normal for the year April 2020 to March 2021.[4]

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[2] Examples: Patients in Sutherland told orthopaedic elective surgery at NHS Highland is 'suspended' for August (northern-times.co.uk), https://www.bbc.co.uk/news/uk-scotland-south-scotland-58273658, In-patient surgery Dewsbury Hospital suspended amid overcrowding, but operations still on at Pinderfields and Pontefract | Yorkshire Evening Post; Surgeries suspended at Lincolnshire hospitals amid rise in the number of coronavirus patients - Lincolnshire Live

[3] https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/rtt-stats-june-2021/

[4] Derek Pegg *et al.* (June 2021) Effects of COVID-19 pandemic on hip and knee joint replacement surgery in 2020 as

The paper suggested that in order to recover **over 5 years** this would require 110% of normal activity to be sustained. Even if this were feasible with increased access to both staff and non-staff resources, the recovery plan only takes us back to the already failing position we were in at the start of the pandemic. It will require more to recover to a more satisfactory and stable position. It is no small undertaking to increase capacity by 10% (or more) and it will be impossible without significant investment.

14) Undertaking surgery requires a range of facilities and staff to be available and operational in order for delivery. In this section we discuss capacity issues under the following headings:

- Facilities capacity and splitting hot/cold sites
- Orthopaedic staff – current capacity
- Orthopaedic staff – future capacity
- Non-surgical staff
- Other efficiency issues

Facilities capacity and splitting hot/cold sites

15) Orthopaedics is very familiar with 'winter pressures' which regularly lead to reduced operating in the winter months. Scaling back or stopping elective orthopaedics is a common occurrence in many hospitals when pressure builds elsewhere in the system. We mentioned above that in some regions of the NHS 'summer pressures' (rather than the usual 'winter pressures') are now leading to suspension of elective surgery. Orthopaedic patients are typically considered 'non-urgent' and it is felt that delaying their procedures does not cause any additional harm: this perception is misplaced. Delay causes harm.

16) Currently, the NHS operates with very little 'surge capacity' to cope with peaks in demand, and so orthopaedics effectively becomes the most frequent casualty of that situation. Cancelling orthopaedic procedures provides the surge capacity for other services and as this has now occurred in the summer, not just in the winter, it highlights how unsustainable the current system is. With waiting times for orthopaedics now in a dire situation, changes must be made. Other parts of the NHS need to be adequately resourced to ensure there is sufficient surge capacity without regularly encroaching on elective orthopaedic care.

17) Constantly 'stopping and restarting' these orthopaedic services is highly inefficient and it is one of the major issues that must be addressed to facilitate any true sustainable recovery of the backlog. We believe there must be urgent investment in elective orthopaedic centres to address this backlog and to allow ongoing efficient and timely access to these highly-cost effective procedures. Unless elective surgery is delivered in cold (elective) sites remote from A&E and other acute services, it will always be easy to prioritise almost every other medical need above elective orthopaedic surgery when there are pressures in other areas. Elective surgery is ***not*** optional surgery. These patients need surgical treatments and delaying their operations is costly.

18) When planning and establishing cold/elective sites, it is important to recognise that many elective patients have complex problems and high levels of co-morbidity. These patients will require high dependency support peri-operatively. It will not be sufficient for these facilities to only be able to manage 'simple' cases. As such, future reorganisation will also need the provision of additional and high levels of medical, nursing, physiotherapy and anaesthetic support in some situations.

<u>Orthopaedic staffing - current capacity</u>

19) We have recently assessed the orthopaedic staffing situation through a survey of members in July/August. We received responses from 571 T&O consultants (of an estimated 3,000 in the UK ~ 19%), 60 SAS surgeons and 409 trainees about their current working patterns and future career intentions. The findings from this survey are highlighted in several sections below.

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demonstrated by data from the National Joint Registry (NJR), available online at: https://www.boa.ac.uk/resources/knowledge-hub/jto-june-2021.html (p.38)

20) This survey highlighted that overall consultant and SAS respondents are doing 28% **less** elective operating lists now than they were prior to the pandemic. It is essential that hospitals return swiftly to allocating specialty theatre space at the pre-pandemic levels, so that the capacity of these surgeons to operate is maximised.

21) In our survey we asked surgeons about working more hours in the NHS than they are currently contracted to do:
    - Working extra is not a feasible option for some of the orthopaedic surgeon workforce (52% in our survey), often for very good reason such as caring responsibilities and other roles. It is not appropriate that all surgeons should be expected to take on more.
    - Encouragingly, 48% of surgeons surveyed did feel able to take on more (42% willing to take on 1-2 sessions and 6% willing to take on 3+ sessions extra per week), on the basis that they would be remunerated for doing so.
    - This could amount to a significant additional capacity, although clearly, it would require additional infra structure and would require similar levels of additional work for all the other staff groups involved in surgery. Unfortunately theatre/recovery and anaesthetic staff availability has been a major challenge to date in returning to a more normal service.

22) Our survey did, however, identify significant frustrations expressed by surgeons that impact surgeons' morale in the workplace and their willingness to take on more work: it is important to highlight these. Firstly, surgeons need to be assured they will not face punitive additional tax liability as a result of changes to the pension scheme when they take on extra work. Secondly, a significant proportion of staff responding to our survey raised their concerns about a lack of appreciation, burnout and wider issues relating to culture at work. Where staff feel undervalued or frustrated in their work, they see little incentive to prioritise additional workload over other commitments and calls on their time.

23) <u>We urge the Government to look particularly at pension implications, workplace culture and the morale of the entire work force as part of its work on the backlogs.</u>

<u>Orthopaedic staffing – capacity in the future</u>

24) Our recent survey identifies potentially serious problems in the next 3-5 years regarding orthopaedic staff capacity, with two significant trends: consultant losses to retirement growing (see para 25-26) while delays to training reduce the number of newly qualified surgeons (see paras 27-28).

Early retirement issues

25) According to our survey, a quarter of consultants aged 45 and over intend to retire in the next three years, with 28% saying they will retire earlier than intended due to the pandemic. In comparison, in a 2019 survey by RCP[5], only 12% of consultants over 45 intended to retire in the subsequent 3 years. While more work may need to be done to understand the motivating factors and whether these intentions are likely to be borne out in practice, this is a serious concern. It suggests significant losses to a crucial portion of the working staff, with skills and knowledge lost both to operating and training. We must ensure these losses do not occur.

26) Our survey went on to ask 'If you are considering fully retiring from the NHS in the coming 3 years, do you think you would delay to help with the NHS backlog if any of the following were introduced or more accessible'. The top answer (with over 70% of respondents saying it would moderately or significantly affect their decision), was 'improvements to organisational culture and management'. The second most supported answer was 'reform of pension taxation system'. The third was 'improvements to NHS settings, safety and throughput'. These echo some of the issues discussed in paragraph 21 regarding willingness to take on more work. **It is clear to us that improving issues regarding NHS culture and management, pensions, and morale, are likely to have a doubly positive effect – in both reducing the numbers of early retirees and increasing the willingness of staff to do extra work. We urge the Government and NHS to look further at these issues.**

[5] *Focus on Physicians*: the census of consultant physicians in the UK

Training issues

27) The pandemic has impacted training for an entire cohort of surgical trainees, some of whom will not qualify and take up consultant posts at the rate that would normally be expected. The vast reduction in operations performed has meant far fewer training opportunities for trainee surgeons. There are serious educational and service consequences that result from this. In our survey, most (89%) trainees at all stages reported having fewer training opportunities than usual during the pandemic overall, 10% have already had to delay their CCT (Certificate of Completion of Training) date, and nearly half (45%) are expecting to do so in the future. It is important to identify that despite increased activities **more than half (52%) of trainees are still experiencing reduced training opportunities.**

28) We also have seen data from trainee logbooks, which again point to a very significant issue with trainees not achieving the numbers of operations that would normally be expected at each stage of training. This is not universal as it will depend on each trainee's circumstances (e.g. those on trauma rotations have typically seen less impact as this surgery has been less affected). One of the procedures with the biggest drop in training numbers, knee replacement, is also one of the procedures most affected by the backlog. We urgently need to address this. **It is essential that the plan to tackle the backlog of procedures also prioritises the training of future surgeons.**

Overall size of T&O workforce

29) The surgical workforce is dependent on the expected number of trainees completing training in order to fill the posts made vacant by retirees. **If retirees increase and supply of newly qualified consultants falls, as our survey suggests, we could face a shortfall of surgical workforce at a time when there is greatest demand. This is a very significant concern for us, and we recommend urgent attention to these issues.**

Job prospects for those who have recently completed training

30) One final issue to raise in this section is reports of fewer consultant posts being recruited in the NHS over the past 18 months. NHS England job vacancy information online describes the situation as follows:
"During the COVID-19 pandemic, there has been significant disruption to recruitment activity within the NHS. This is apparent from the significantly lower reported advertised vacancies between March and June 2020 as the NHS was fully focused on dealing with the first wave of the pandemic. Whilst pressures on the NHS caused directly by the pandemic have fluctuated since March 2020, it remains apparent that recruitment activity has similarly been disrupted. Whilst some critical recruitment increased in response to the situation, other elements were significantly reduced – this is particularly the case for certain Staff Groups."

31) Of CCT holders not yet in consultant positions in our survey (61 total), nearly two-thirds, (65%, n=40) were currently seeking a consultant post. A quarter of these had been looking for 6-12 months, and a further quarter had been looking for over a year. In free text response, two in five (41%) post CCT individuals commented on the lack of consultant posts advertised. We have heard anecdotally of trusts having posts they needed to fill but who had decided to delay recruitment. Replacing retired colleagues or increasing Consultant numbers at a time of perceived low elective surgical activity might not seem sensible. While the numbers of individuals affected is likely to be relatively small, this is a further incremental contribution that would contribute, in clinic and in theatre, to addressing an increasing backlog.
We urge a return to normal recruitment as soon as possible.

<u>Staffing the wider orthopaedic team</u>

32) While we are not able to comment in detail on other staffing groups, we would like to highlight three issues observed by us and our members:

- The surgical team includes anaesthetists, theatre nurses and others who have been frequently redeployed for extended periods to ITU and Covid wards during the pandemic. Where this has occurred they have found themselves working in very challenging environments. We have concerns about the observed levels of fatigue, burnout and low morale in these groups. We are aware of the far reaching impact of these issues on

service delivery. Within our clinical institutions we recognise increasing absenteeism, extended periods of sick leave and individuals leaving the profession.

It is essential that all NHS staff are supported as they recover from the challenges they have faced during the pandemic.

- Trainee anaesthetists is one group that has been particularly hard hit during the pandemic, and the flow of these through training and securing consultant posts is vital to the delivery of surgery. We draw the attention of the committee to a recent report on this issue, which highlights in particular low morale and lack of training progress in this group.[6]

- Physiotherapists are another group who are essential in the delivery of orthopaedic care in terms of pre-operative 'pre-hab' and post-operative rehab. Indeed some surgery, in children and young people with a disability for example, cannot be undertaken safely if community and outpatient physiotherapy is not available. Currently there are significant gaps in the support available in some areas, which hinders the delivery of effective care to these patients. Early-discharge schemes which reduce hospital stay which could aid in managing the backlog, typically rely on these allied health professionals to provide early post-op support: early discharge without adequate support is a false economy and results in poorer outcomes.

Other efficiency issues

33) As mentioned above we are supportive of any initiatives that could improve theatre efficiency and productivity. Many services have already instigated these kinds of improvements and this alone therefore will not provide sufficient wholesale improvement in the figures. However optimising each and every step of the operative pathway remains important.

34) We highlight particular system improvements we would support:
    - Improved interconnectivity of IT services to facilitate the transfer of clinical and clerical information within and between hospitals. This would facilitate communication promoting multidisciplinary networked services between heathcare services and providers. This could allow the option to transfer patient care when required clinically or to optimise activity, ensuring care is delivered effectively at the most appropriate facility. Better IT facilities would also free-up clinical and clerical time for other tasks.
    - Better waiting list management – by appropriate staff – with carefully defined and agreed prioritisation, ensuring a multidisciplinary approach to patient optimisation and 'prehab' ahead of surgery. Improving fitness in those that have become less active/mobile over the pandemic to enhance outcomes.
    - Well-resourced community teams for peri-discharge care in order for patient discharge to run smoothly and beds to be available for later patients.

Q3: 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?

35) We have not supplied a detailed response to this question as other organisations are likely to be better placed to do so. We do, in particular, support the findings of the Royal College of Surgeons of England in their 'Action Plan for the Recovery of Surgical Services in England' (May 2021).[7] This suggests that:
    - Continuing the £1bn annual 'Elective Recovery Fund' for England for a further five years to tackle the elective surgical backlog.

[6] The impact of the COVID-19 pandemic on training: a national survey of UK anaesthetic trainees, June 2021, https://anaesthetists.org/Home/Membership/Trainees/The-impact-of-the-COVID-19-pandemic-on-training

[7] https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-england/

- Adopt a long-term aim to increase the number of hospital beds from 2.5 to 4.7 per 1,000 people, in line with the OECD average.
- Build NHS capacity to reduce our reliance on the independent sector in the event of future pandemics or crises.

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