Written evidence submitted by the Centre for Perioperative Care (CBP0032)

The Centre for Perioperative Care (CPOC) is a cross-specialty collaborative of nine leading Royal Colleges and healthcare organisations dedicated to the promotion, advancement, and development of perioperative care. CPOC's multidisciplinary centre is hosted by the Royal College of Anaesthetists (RCoA).

We welcome the opportunity to respond to this inquiry and would be happy to be contacted if the Committee requires any further information or would like to discuss anything we include in this submission. Please contact Alice Simpson at asimpson@rcoa.ac.uk for more information.

Executive Summary

1. The pandemic's impact on waiting times has been profound. Latest NHS RTT waiting time figures show the elective backlog now stands at over 5.5 million people, around 10% of England's adult population. Over 80% of those people (4.2 million) are awaiting a decision on treatment. Covid continues to have a very significant impact on the NHS's ability to robustly undertake planned care. This is likely to be worse and more widespread over winter.

2. The way the NHS manages the waiting list exacerbates health inequalities. Any national backlog strategy will need to take this into account and actively take steps to mitigate against it.

3. To tackle the backlog in a reasonable time, estimates suggest that the NHS will have to operate elective services at 120 – 130% pre-pandemic levels. There is a consensus that this will not be achievable if the NHS continues to operate with 'the same old ways of doing things.'

4. While capacity is a key issue that will require long-term solutions and funding, in the short to medium term the Government should prioritise funding for the workforce directly involved in delivering elective care. Critically, this also includes funding for the training and development of the multidisciplinary perioperative team.

5. Perioperative care is the integrated care of patients before, during, and after an operation. It is a highly cost-effective way of improving outcomes for surgical patients and reducing the NHS waiting list, delivering benefits that matter to patients – more patient choice, better quality of care, and extra years spent in good health.

6. To tackle the backlog in a reasonable time, the NHS must radically transform how it delivers perioperative care services along the entire surgical pathway.

7. CPOC research has identified the 'top 3' perioperative care interventions that health and care system leaders say will most likely help accelerate elective recovery efforts in their local area. They are optimising the use of day surgery, implementing initiatives – such as enhanced care units – that will reduce time spent in hospital, and supporting shared decision-making between patients and healthcare professionals.

8. The NHS and patients must also transform how they view the waiting period before an operation. This time should be used to empower patients to proactively prepare physically and mentally for their operation, including through dedicated prehabilitation programmes. We urge

the Government to support waiting patients by committing to provide prehabilitation as part of an elective backlog plan.

9. Considerable additional resources will be required to enable the NHS to continue to strive towards the aspirations laid out in the NHS Long Term Plan while also making up ground on the backlog. To help achieve both of those aims, we are calling on the Government to provide dedicated funding for the transformation and delivery of perioperative care interventions in the upcoming Spending Review.

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. There are many different 'backlogs' across health, public health and care services. We are limiting our response to this consultation to the elective, or planned, surgery backlog overall – which latest NHS RTT figures show now stands at over 5.5 million people. It's important to emphasise that more than 4.2 million (80%) of these patients are awaiting a decision on treatment. Over 300,000 patients have been waiting over a year for surgery – about 100 times more than at the start of the pandemic.[i]

2. These figures, alarming as they are, do not include the 'hidden patients' who have been deterred from the pandemic from coming forward to use NHS services. There could be over 6 million people who fit into this category.

3. Covid continues to have a very significant impact on the NHS's ability to robustly undertake planned care. This is likely to be worse and more widespread over winter.

4. Different patient groups and different regions of the UK are also experiencing the elective backlog differently. For example, research suggests that those living in areas with lower educational attainment wait up to 14% longer for elective care, even when they are being treated in the same hospital as those with higher attainment.[ii] Any national backlog strategy will need to take these inequalities of experience and access already baked into the waiting period into account and mitigate against them.

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?

1. Due to the heroic efforts of NHS staff, the NHS is continuing to battle another Covid wave while maintaining elective services at around 90% of pre-pandemic levels (well ahead of NHSE's 75% target set out in official guidance). However, in order for the NHS to recover services in a reasonable amount of time, estimates show that trusts will need to operate at 120-130% of 2019 activity levels. There is a consensus that this will not be achievable with current funding and capacity if the NHS continues to follow 'the same old ways of doing things.'[iii]

2. Even operating at that increased level of activity, the BMA estimates that it will still take several years to clear the backlog.[iv] Research conducted by CPOC supports that view, with our polling of health and care system leaders suggesting that it will take between 2-5 years to clear the backlog with current resource and capacity levels.[v]

Capacity

3. Committee members will be aware of the long-standing workforce gaps across the NHS and their impact on the ability of NHS teams to carry out their roles. We remain deeply concerned that these workforce shortages will hinder elective recovery efforts and we support this Committee's recommendations to Government regarding the need for long-term, independent workforce planning.

4. In the short to medium term, we would urge the Government to prioritise funding for the workforce directly involved in delivering elective services.

5. No matter where the work is undertaken, it is the same stretched and exhausted workforce that is doing it. Retaining our skilled and committed NHS workforce is paramount and any backlog strategy must include support for staff health and wellbeing.

Skills mix

6. Evidence shows that a multidisciplinary team working across the surgical pathway can speed access to surgery (if that is an appropriate treatment option), improve people's clinical outcomes (such as reducing complications following surgery), and reduce the cost of surgical care (by helping people leave hospital earlier).[vi] This is essential to tackling the backlog. Multidisciplinary working is also essential to achieving the aspirations outlined in HEE's Future Doctor report and the NHS People Plan for a more flexible, generalist workforce.

7. CPOC research suggests that NHS organisations, teams, and individual staff all need more support to implement multidisciplinary working during the period around surgery.[vii]

8. Key barriers to multidisciplinary working include: lack of clear guidelines and processes, incompatible IT systems, lack of ring-fenced time, lack of clear expectations amongst team members, lack of formal function and structure for team meetings and activities, and lack of staff education around the benefits of multidisciplinary working.

9. While a long-term workforce strategy for the NHS and wider system is required, supporting and developing the existing multidisciplinary perioperative team will be essential to elective recovery efforts. The UK Government should work with HEE, and relevant third sector partners like CPOC, to prioritise the training and development of the multidisciplinary perioperative team.

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?

To tackle the backlog in a reasonable time period, the NHS must radically transform how it delivers perioperative care services along the entire surgical pathway. Below we briefly define what perioperative care is, how it can support efforts to accelerate elective care, and outline what is most required in the short to medium-term to make the most progress.

1. Perioperative care is the integrated care of patients before, during, and after an operation. It is a highly cost-effective way of improving outcomes for surgical patients and reducing NHS waiting lists, delivering benefits that matter to people – more patient choice, better quality of care, and extra years spent in good health.

2. Perioperative care involves many components along the surgical pathway, including support to help patients use the waiting period to get 'match fit' for their operation so they can have better outcomes and then recover and return home and back to their lives sooner.

3. Evidence shows that quality perioperative care can accelerate the pace of elective surgery and eliminate waste in in several important ways. Most notably, perioperative care can[viii]:

    I. Reduce the amount of time people stay in hospital after surgery by on average 1-2 days without extra complications, unpanned readmissions, or extra burden on primary care or social services
    II. Reduce the use of intensive care units after surgery, freeing up bed space
    III. Reduce complication rates after surgery – resulting in fewer resources and bed space spent managing this
    IV. Reduce the overuse of surgery - By practicing 'shared decision-making' patients can work with their healthcare team to choose the best treatment option for them. This may not be surgery.
    V. Increase the rate of surgery performed as 'day cases'
    VI. Avoid late or on the day cancellations of surgery

What change is required over the next 1-2 years to underpin the elective recovery?

4. CPOC recently polled health and care system leaders to ask them which perioperative care interventions would most help their local system tackle its backlog over the next 1-2 years. They told us the following three interventions should be prioritised:

    I. Optimising the rate of day case surgery

    Day case surgery is surgery that is conducted without an overnight stay. Increasing the proportion of day surgery to overall elective surgery is one of the simplest strategies that the NHS can employ to streamline elective services. Currently rates of day case surgery vary considerably by trust, hospital, and surgical specialty – some report only 36%-day case admissions, while others report as high as 77%. In some instances, neighbouring trusts with similar facilities and patient demographics are performing very differently.[ix]

    Reducing the backlog requires making day surgery the default option for more routine elective procedures across all specialties. We already know how to do this. Implementing new guidance from CPOC, GIRFT, and BADS could halve the numbers of

elective patients who currently stay in hospital overnight – this would be transformative for elective capacity.[x]

ii. Implementing initiatives that reduce time spent in hospital

Perioperative care pathways and their components reduce the amount of time that people stay in hospital after surgery by on average 1-2 days without extra complications, unplanned readmissions or extra burden on primary care or social services. Specific interventions that have an impact on length of hospital stay include good preoperative assessment[xi] (including surgery schools), prehabilitation programmes to help patients physically and mentally prepare for their operation, and the use of enhanced care units to provide an appropriate level of support for patients in the immediate post-operative period.[xii] It is noteworthy that one of the leading causes of late or on the day cancellation of surgery is a lack of a bed – so every reduced length of stay benefits all patients.

iii. Increasing Shared Decision-Making

Shared decision-making (SDM) is the process whereby patients and clinicians work together to decide the best treatment option based on evidence and the patient's wishes and values. This may be to select a test or intervention, such as going ahead with surgery. With increasing numbers of patients having multiple medical conditions and at higher risk of complications, it is important that the patient's views are listened to. This requires specific training and work practices.

Patients who are effectively involved in making decisions about their care have fewer regrets about treatment, better reported communication with their healthcare professionals, improved knowledge of their condition and treatment options, better adherence to the selected treatment and an overall better experience with improved satisfaction. As 1 in 7 patients experience 'surgical regret', getting shared decision-making right is essential to high quality care.[xiii]

Turning 'waiting lists' into 'preparation lists'

5. In addition to reforming how NHS services are delivered, there also needs to be a radical change in how the NHS and patients view and use the waiting period. One of the leading causes of late or on the day cancellations of surgery is because the patient is not fit for their operation. This is incredibly wasteful for the NHS and also can be devastating for the patient who faces the delay.

6. Every patient who is on the waiting list should be encouraged to use the waiting period to prepare physically and mentally for their operation and recovery.[xiv] Perioperative interventions, such as prehabilitation programmes, can help empower patients during the waiting period to use this time to proactively address risk factors and underlying health conditions that can cause surgical complications. This can include exercise and psychological support, smoking cessation support, and weight management support.

7. Various approaches to 'prehabilitation' encompassing some or all those factors have been shown to reduce postoperative complications by between 30-80% and reduce hospital stays

by 1-2 days on average. Additionally, prehabilitation provides an opportunity to support the prevention agenda, helping patients use their time waiting for surgery as a 'teachable moment' to make positive lifestyle changes.

8. Recognising the critical role that patient preparation will play in tackling the backlog, Scotland's new elective recovery plan includes a commitment to provide cancer patients with prehabilitation. We urge the Committee to champion that approach with the UK Government, and support the NHS to change waiting lists for surgery into preparation lists by providing all high-risk and cancer patients with dedicated prehabilitation support.

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?

1. The time-limited financial investment received to date in the Elective Recovery Fund, while welcome, is inadequate to manage the backlog.

2. The Cabinet Office projects that it could cost between £2-£10 billion a year to reduce elective waiting lists back to manageable levels[xv], while the Health Foundation estimates that it could take an additional £6 billion over three years. Such a wide range of projections underscores the high level of uncertain demand for future services that the service is facing.

3. What is clear is that considerable additional resources will be required to enable the NHS to continue to strive towards the aspirations laid out in the NHS Long Term Plan and make up ground on the backlog.

4. To help achieve both of those aims, we are calling on the Government to provide dedicated funding for the transformation and delivery of perioperative care interventions in the upcoming Spending Review.

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[i] As of the latest *Referral to Treatment Waiting Times* (RTT) which are published monthly by NHS England. Latest figures cover period up to June 2021, https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/

[ii] Laudicella M, Siciliani L, Cookson R. Waiting times and socioeconomic status: evidence from England. Soc Sci Med. 2012 May;74(9):1331-41. doi: 10.1016/j.socscimed.2011.12.049. Epub 2012 Feb 21. PMID: 22425289.

[iii] Nick Kituno, Dave West, 'Elective recovery requires "very radical" service change.' *Health Service Journal*, 14 April 2021, https://www.hsj.co.uk/elective-recovery-requires-very-radical-service-change-says-stevens/7029886.article

[iv] British Medical Association (2021), Rest, recover, restore: Getting UK health services back on track, https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[v] Figures from forthcoming CPOC report into perioperative solutions to the backlog – we can provide more information if desired.

[vi] Centre for Perioperative Care (2020), Multidisciplinary working in perioperative care: rapid research review, https://cpoc.org.uk/sites/cpoc/files/documents/2020-09/Multidisciplinary%20working%20in%20perioperative%20care%20-%20rapid%20review.pdf

[vii] Figures from forthcoming CPOC report into perioperative solutions to the backlog – we can provide more information if desired.

[viii] Centre for Perioperative Care (2020), The impact of perioperative care on healthcare resource use: rapid research review, https://cpoc.org.uk/sites/cpoc/files/documents/2020-09/Impact%20of%20perioperative%20care%20-%20rapid%20review%20FINAL%20-%2009092020MW.pdf

[ix] Figures from forthcoming GIRFT report into perioperative care – we can provide more information if desired.

[x] GIRFT, CPOC, and BADS (2020) National Day Surgery Delivery Pack, National-Day-Surgery-Delivery-Pack_Sept2020_final.pdf (gettingitrightfirsttime.co.uk)

[xi] Preoperative Assessment and Optimisation for Adult Surgery (June 2021) Microsoft Word - Preoperative assessment and optimisation guidance_format.docx (cpoc.org.uk)

[xii] Centre for Perioperative Care and Faculty of Intensive Care Medicine (2020), Guidance on Establishing and Delivering Enhanced Perioperative Care Services, Enhanced Perioperative Care Guidance v1.0.pdf (cpoc.org.uk)

[xiii] Wilson, Ana & Ronnekleiv-Kelly, Sean & Pawlik, Timothy. (2017). Regret in Surgical Decision Making: A Systematic Review of Patient and Physician Perspectives. World Journal of Surgery. 41. 10.1007/s00268-017-3895-9.

[xiv] Jugdeep Dhesi and Lisa Plotkin, 'To tackle the backlog, we need to transform how we wait for surgery' *The BMJ Opinion,* 15 April 2021, https://blogs.bmj.com/bmj/2021/04/15/to-tackle-the-backlog-we-need-to-transform-how-we-wait-for-surgery/

[xv] Richard Murray. 'The NHS needs a comprehensive plan for recovery' *The BMJ Editorial,* 18 June 2021, https://www.bmj.com/content/373/bmj.n1555

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