Part 1 – Summary and recommendations

Health and Social Care Select Committee inquiry submission: Clearing the backlog caused by the pandemic

NHS Confederation: 3 September 2021

About us

1. The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

2. This document constitutes our main submission to the Committee's call for evidence. We have also submitted a supplementary version detailing our responses to each of the questions posed by the Committee.

Summary

3. The COVID-19 pandemic has resulted in a huge increase in the number of people waiting to receive planned NHS care, rising to a record high of 5.45 million in June 2021.[1]

4. However, the elective backlog was increasing well before the onset of the pandemic. The number of people waiting to receive planned care rose steadily in the five years to December 2019, with 4 million people waiting before the pandemic. The service has failed to meet the 18-week standard since 2016.[2]

5. The number of patients yet to present for treatment may exceed 7 million,[3] but it remains difficult to predict when and if they will come forward for treatment. NHS colleagues report increases in the complexity of conditions as patients present, representing a significant and growing risk to patient safety as these 'missing' patients arrive in at their GP or A&E department.

6. The NHS is currently experiencing a surge in demand for services, with many NHS leaders reporting winter levels of demand in summer. NHS acute, mental health, community, ambulance and primary care services are all seeing more patients with more complex needs. Some hospitals are having to stand down some elective and cancer care as a result of rising COVID-19 numbers, which will hamper recovery efforts.[4]

7. Although staff absence has stabilised back down towards pre-COVID-19 levels,[5] the pandemic has exacerbated workforce supply issues and there are renewed challenges in mobilising an exhausted and demoralised workforce to meet demand across the system. The mental health and wellbeing of staff must be supported through ongoing funding for initiatives like mental health hubs. A long-term strategy

for social care exacerbates the pressure on health services and requires urgent attention.

8. The scale of innovation seen in the NHS has been a defining feature of the pandemic. Staff have been redeployed, patient services have been delivered in new ways, there has been greater use of digital technology for clinical purposes, and local organisations have enhanced the way they work together. NHS staff and teams will need adequate funding and support to scale such initiatives, which will help to reduce the elective backlog more quickly and equitably.

9. Addressing the elective backlog and recovering from COVID-19 will demand reform and better integration of services. The health and care bill provides the right direction of travel, facilitating a cultural shift that will allow local leaders to develop strategies for their local communities. But the pandemic has shown that the performance management and regulatory approach are not fit for purpose. Reforms of constitutional standards will also be necessary to provide the NHS with a long-term solution to tackle the backlog that substantively addresses health inequalities.

10. In the same way that early COVID-19 cases disproportionately impacted black and minority ethnic and more deprived communities, our analysis of available data has shown a relationship between levels of local deprivation and waiting time trends.[6] Radical approaches are therefore needed to build back fairer, including proactively adding people to the waiting list in the short term to ensure those who need care receive it promptly and to prevent conditions from worsening unnecessarily.

11. Alongside reform, the government will also need to provide honesty and transparency about the scale of the problem, anticipated waiting times, and the time it will take to recover elective care.

12. It is far from clear whether the current approach works fairly or effectively for elective care. There are good reasons to believe that treating people in the order they present for care exacerbates inequalities and worsen health outcomes. Similarly, while there is uncertainty about precisely how large the waiting list will become, the current 5.45 million-long waiting list is likely to grow considerably in the coming months. Attempts to get back to ‘normal’/pre-pandemic levels of activity simply by ‘pedalling faster’ are likely to be futile. We believe it is time for ten radical changes to how the NHS handles its approach to waiting:[7]

a. **Proactively growing the waiting list (in the short term)**

By reaching out to people who should be waiting for care, the NHS can fully understand the scale of the problem and plan accordingly. While growing the waiting list may be politically uncomfortable as it will lead to ballooning figures over the short term, it is a necessary step to achieve equity in health outcomes. This can be done by:

- Using existing local data and evidence, aligned with targeted communications campaigns, to drive increased access. This should specifically target areas of deprivation, diverse ethnicity, underrepresented socio-economic groups and occupations that the NHS would expect to appear on the waiting list that are currently underrepresented. Partners such as Healthwatch, patient groups,

the voluntary, community and social enterprise sector, local authority partners and primary care are all skilled in getting targeted communications to patients. By harnessing local print and social media channels, and engaging with community and faith leaders, the NHS can reach underserved communities.
- Investing in population health management at primary care network level – for example, comparing actual with expected prevalence (and therefore expected number of patients requiring specific procedures) for a GP registered list.
- Actively supporting those who may be avoiding care to tackle their fears and concerns while taking measures to help prevent them falling through existing gaps in service provision. If we are serious about health inequalities, integrated care systems (ICSs) should be actively supported to focus on the 'missing' members of their waiting lists.

b. **Developing tools to scan for early symptoms of life-threatening conditions, such as cancer, as part of routine interactions with patients.**

Spotting symptoms at an earlier stage will reduce the number of people falling through the gaps, especially among underrepresented groups, and improve outcomes. Earlier interventions will also improve efficiency by avoiding the need for more complex treatments as conditions deteriorate. This can be done by:

- Making more of routinely scheduled interactions – such as vaccinations, existing screening programmes, health checks and repeat prescriptions – by offering services that can identify serious, life-threatening conditions.

c. **Using diagnostic hubs to optimise resources in deprived populations**

Intended as one-stop shops for life-saving health checks, community diagnostics hubs can increase engagement and participation from within deprived communities and demonstrate a commitment to levelling up. This can be done by:

- By locating new community diagnostic hubs in deprived areas, ICS can make a clear statement of their intent to prioritise health inequalities.

d. **Committing to consistent workforce planning to support population health goals**

The NHS entered the pandemic with nearly 90,000 vacancies. This shortfall has contributed to the elective backlog and will continue to have an impact unless there is consistency in the supply and development of healthcare professionals. To enable this and develop a workforce that can meet community-based population health goals, and provide acute and primary care, the NHS needs to move beyond political cycles and planning workforce around what financial parameters allow us to. This can be done by:

- We strongly support amendments to the health and care bill that ensure that the Secretary of State for Health and Social Care undertakes detailed assessments of future workforce requirements to avoid this situation in the future. These should be:

- based on the projected health and care needs of the population across England for one to five years, five to ten years and ten to 20 years.
- undertaken at least every three years in response to changing population needs
- take full account of workforce intelligence, evidence and plans from integrated care systems
- fully available in the public domain.

e. **Promoting active waiting**

Waiting to grade a patient clinically until after the first outpatient appointment is unsustainable, particularly as more missing waiters return. Many ICS are promoting the principle of 'waiting well', maintaining a positive dialogue with patients, encouraging health promotion and positive lifestyle choices while patients wait for care. This can be done by:

- Prioritising rapid access to diagnostics and smarter triaging.
- Conducting clinical status reviews on referral to systematically prioritise patients with comorbidities or whose conditions would significantly worsen with long delays. This includes selecting patients at the highest risk when slots come up at short notice.
- Supporting patients with comorbidities to improve their outcomes while they wait. For example, helping orthopaedic patients to manage their conditions while waiting for surgery with physiotherapy and other health advice and support.
- Providing ongoing patient advice and guidance during waiting. These are too often the first thing to go when pressure mounts on services, but they are even more important as waiting pressures develop.

f. **Closer working across local healthcare ecosystems and a dynamic approach to lists**

COVID-19 has shown how the system can work together effectively across primary and secondary care, independent sector providers and specialist care. It has also exposed the importance of working effectively with social care providers.

Clinical prioritisation must drive the way the NHS manages lists, with a focus on reducing harm to patients, irrespective of the length of wait. The NHS will need to proactively support patients, investing in communications so that care can be expedited or indeed postponed as needs change. Waiting time on its own is an insufficient measure of the success or failure of elective recovery. This can be done by:

- Supporting GPs to manage day-to-day pressures to avoid lower threshold referrals as a pressure release mechanism.
- Developing peer-review support and closer working between generalists and specialists to provide direct access to rapid diagnostics and direct to procedure referrals for some procedures.
- Managing high volume, low complexity work separately from fast access cancer pathways and pathways likely to be disrupted by further COVID-19 waves.

The key to making this work is to gain the support and active buy-in of clinicians, especially when these reforms change existing working patterns. This is another reason why consistent workforce planning and support is so important.

g. **Providing funding consistency and autonomy**

To plan, invest and develop new services, the NHS needs consistent approaches to funding and genuine autonomy given to local decision-makers. This can be done by:

- The government and NHS England and NHS Improvement should avoid changing or removing promised funding. Such moves are disruptive, wasteful, damage morale and directly affect patients. There has never been more a more important time to avoid these patterns of behaviour.
- Supporting local autonomy – empowering local systems that are best placed to understand their pressure points to make funding decisions, rather than creating specific 'pots' that too often miss their targets.

h. **Developing a new commitment to openness, transparency and public engagement**

Significant short to mid-term rises in the waiting list are now inevitable. Rather than shying away from the issue, the government should be open with the public about the demands on the health service. This should be done by:

- Advocating the importance of coming forward when symptoms worsen.
- Being realistic about waiting time expectations.
- Explaining how approaches to prioritisation protect the most vulnerable and improve overall outcomes to support the NHS in the longer term.
- Producing data disaggregated by population stratifiers such as ethnicity / deprivation
- Issuing proactive communications to increase patient attendance rates for booked appointments and procedures
- Investing to assess patient experience of current pathways.
- Publishing data on access and clinical prioritisation alongside outcomes to avoid unwarranted local variation and support public dialogue.

i. **Reforming constitutional standards**

Current NHS Constitution commitments to treat 92 per cent of patients within 18 weeks and ensure no waits beyond a year no longer work for the circumstances the NHS now faces. New constitutional commitments are needed that focus on the quality of care and equity of access, not just in seeing patients as a number. This can be done by:

- Reviewing the NHS Constitution to include duties to improve outcomes and reduce health inequalities.
- Focusing resources on deprived populations to support them entering planned pathways much earlier thereby reducing non-elective admissions.
- Prioritising early diagnostics and active waiting as part of the elective pathway.
- Reducing the elective backlog by building long-term sustainable capability.

j. **Letting local leaders lead**

The impact of the pandemic on the elective backlog will differ across England, meaning that local solutions will be the best course of action. Nationally

mandated strategies are not the way to produce equitable solutions for local communities. Nationally mandated strategies are unlikely to produce equitable solutions for local communities. The health and care bill 2021 proposes a cultural shift in the NHS that allows local leaders to develop strategies that are right for the people they serve – this has never been more relevant than in the recovery of the elective and diagnostic backlog. This can be done by:

- Supporting and promoting local strategies to reduce care backlogs, with capitated allocations that recognise the size and scale of the issue in each area and a reduction in central policy directives.

References

[1] NHS England (2021), *Consultant-led referral to treatment waiting times*: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
[2] NHS Confederation analysis of NHS England (2021) *Consultant-led referral to treatment waiting times*: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
[3] Institute for Fiscal Studies (2021), *What could happen to NHS waiting lists in England?* https://ifs.org.uk/nhs-waiting-lists
[4] NHS Confederation (2021) *A system approach to the demand crunch*: https://www.nhsconfed.org/publications/system-approach-demand-crunch
[5] NHS Digital (2021), *NHS Sickness Absence Rates – April 2021 Provisional Statistics: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates/april-2021-provisional-statistics*
[6] NHS Confederation (2021), *Building back inclusively: Radical approaches to tackling the elective backlog* [In press].
[7] Ibid.