Written evidence submitted by The Department of Health and Social Care (CBP0087)

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. Covid-19 has caused unprecedented levels of disruption to health care provision in the UK over the last 18 months, with the NHS providing care for millions of people as a result of the pandemic. Brilliant NHS staff have provided care for over 500,000 patients admitted to hospital with Covid-19 in the UK, as well as rolling out the vaccine programme to over 48 million people across the country.

2. As a result, the capacity of the NHS to respond to less urgent, non-Covid related concerns has been significantly reduced, resulting in longer waiting lists and a backlog for many services across the healthcare system. The Government is committed to tackling backlogs and reducing waiting times for patients as a priority.

Elective services

3. Over the last 18 months, Covid-19 has had a compounding impact on routine and planned care. This is most evident in the size of the waiting list for elective treatment and in the length of time people have waited for treatment. In July 2021, the elective waiting list in England was 5.61 million. The number of patients waiting over 52 weeks to start treatment has increased from 1,600 in January 2020 to over 293,000 in July 2021.

4. The number of people being referred into the system reduced dramatically in the early pandemic. We estimate that over seven million people that ordinarily would have been expected to come forward to seek healthcare but stayed away over the course of the pandemic. There is uncertainty over whether and when these people will now seek help but, without action, return of this lost demand could see the waiting list for elective services potentially increase to up to 13 million. There is also the risk that some patients' conditions might have deteriorated due to the delay in seeking treatment, meaning more extensive or complex treatment is required.

5. The early stages of the pandemic brought significant disruption to elective services. On 17th March 2020, NHS England and Improvement (NHSE&I) wrote to all NHS trusts and requested the temporary postponement of all non-urgent elective operations from 15th April 2020. This was necessary to prevent the overwhelming of NHS services and to free up 30,000 beds nationally to assist with the Covid-19 response. Enhanced infection prevention and control (IPC) and social distancing measures necessary to keep staff and patients safe were put in place, significantly disrupting non-urgent care.

6. Urgent care, such as cancer treatment and emergency surgery, continued as much as possible, and thanks to the efforts of hardworking NHS staff, the NHS delivered nearly 16 million planned operations and procedures and over 25.5 million key diagnostic tests, while caring for Covid-19 patients.

7. In subsequent waves of Covid-19, the impact continued to be felt on elective care services, with outpatient services delivered virtually where possible, and significant volumes of planned patient treatment postponed. However, having learned lessons from the first wave, more elective services were maintained in later stages, with priority given according to clinical urgency, then by length of wait. Access to independent sector capacity was put in place to support the recovery and restoration of elective services.

8. The situation remains challenging, as activity levels continue to be impacted by IPC and social distancing measures which are in place to protect staff and patients. However, elective activity levels have increased significantly since early 2021, with services by the summer around 90% of pre-pandemic activity levels.

9. In September 2021, the Government announced an additional £1 billion this year to tackle the backlog, on top of £1 billion already provided for the Elective Recovery Fund. In addition, the Government announced plans to spend more than £8 billion in the three years from 2022-23 to 2024-25. This will fund the biggest catch-up programme in the NHS's history and could deliver the equivalent of around nine million more checks, scans and procedures. It will also mean the NHS in England can aim to deliver the equivalent of up to 30 per cent more elective activity by 2024-25 than it was delivering before the pandemic.

10. The increase in activity will be achieved through making best use of resources, including brilliant NHS staff, managing future demand and innovations in the way care is delivered. This includes the recent £160 million investment in the elective accelerator programme, funding 12 NHS trusts to explore new ways of delivering treatments to drive up activity levels faster, including virtual wards, artificial intelligence in GP surgeries and sharing learning with other systems.

11. The NHS has been finding new ways of delivering care through programmes such as Getting It Right First Time (GIRFT), which focused on a high-volume low complexity approach within the London region. GIRFT included the establishment of surgical hubs across London, as well as pathway improvements, improving how quickly and effectively patients receive healthcare. Systems are engaging with other regions and are planning for similar models, suitable to local needs. These new ways of working are delivering innovation, additional capacity, and greater patient experience.

12. Diagnostic services have also been affected by the pandemic, with over 1.38million people waiting for a test or scan. These services are essential in diagnosing diseases and conditions to determine elective treatment, and backlogs here affect wider waiting lists. The pandemic's disruption has led to a drop-in activity, from 23.3 million tests, scans and procedures in 2019-20 to 17.9 million in 2020-21, a decline of 23.1%. IPC measures continue to impact delivery of some diagnostic services, with significantly fewer invasive procedures taking place due to the risks involved.

13. Again, innovation is an important part of reducing waiting times for diagnostics. Supported by a £325 million investment in diagnostics at the 2020 Spending Review and a further £250m announced in September 2021, Community Diagnostic Hubs are being established to improve diagnostic capacity across systems, through new facilities and equipment, training new staff, creating new partnerships and innovative models of delivery, and reducing pressures on acute sites. Improving access to diagnostic services will support elective service

recovery and particularly cancer care, with approximately 20% of cancer diagnoses being made through a routine referral rather than a specific GP referral for suspected cancer.

Cancer

14. Early diagnosis and treatment are crucial to improving survival rates for cancer. While cancer care has continued throughout the pandemic, there have been challenges in constrained activity and patient demand.

15. Data shows that 3.13 million urgent referrals were made and over 760,000 cancer treatments (first and subsequent) were carried out between March 2020 and July 2021.

16. In some instances, care has not been delivered due to concerns about patient safety (for example, where patients with lower immune systems would have been at increased risk of contracting Covid-19.

17. To address the need of these more at-risk cancer patients, the NHS established cancer hubs across the country, so that people could receive the treatment that they needed. These hubs deliver cancer care in Covid-19 secure environments, to ensure reduced risk of infection.

18. As with elective care, we think that some patients with cancer symptoms did not come forward for help over the course of the pandemic. The latest data suggests there have been 300,000 fewer GP urgent cancer referrals throughout the pandemic than expected, compared to pre-pandemic referral levels. Further data shows that 36,000 people have not started their first treatment for cancer that we otherwise would have expected to see. We have encouraged the public to come forwards with symptoms through the "Help Us, Help You" media campaigns, making it clear that the NHS is there for those who need it.

19. Despite the campaigns, we acknowledge that a number of people have still not felt able to come forward for cancer care over the pandemic period. This has risked cancers being detected at a later stage, with repercussions for patients' health and also for emergency services, when patients present at A&E with cancer symptoms.

20. Following the early dip in referrals, urgent cancer referrals have since recovered strongly. Referrals have been at record high numbers since March 2021, with the highest recorded number of referrals in March 2021 and the second highest in June 2021. In July 2021, GP urgent referrals for suspected cancer per working day were 6% higher than the July 2019 baseline.

21. The NHS is putting in place extra capacity to diagnose and treat cancer patients and with the aim of clearing the cancer backlog of patients waiting over 62 days from referral to first treatment by in 2022. Data for July 2021 shows fewer than 19,000 people waiting longer than 62 days from an urgent referral for suspected cancer in England. This has come down considerably from a peak of around 35,000 in May 2020 and is just above the pre-pandemic level.

22. Improving cancer survival is a government priority, with ambitions set out in the NHS Long Term Plan. We have introduced a new 28-day Faster Diagnosis Standard, designed to help patients get an outcome as soon as possible. The standard will help to ensure that people

with cancer are diagnosed more quickly and effectively, helping to reduce uncertainty for patients about their diagnosis, in line with our goals set out in the NHS Long Term Plan.

Mental health

23. Even with record levels of investment and a substantial transformation programme through the NHS Long Term Plan, we are still only predicted to provide psychological therapies to 25% of adults with common mental health problems. With demand much higher than supply, many people who need support either do not currently receive it or have to face long waits in some parts of the country.

24. The pandemic has increased pressure on mental health services, particularly in acute settings. Waiting times for routine and urgent eating disorder services for children and young people have increased due to an unprecedented increase in demand. The number of urgent cases accepted for treatment almost doubled between 2019-20 and 2020-21. Inpatient mental health services are feeling the strain, with average bed occupancy remaining over 90%, with many patients with a mental health need waiting over 12 hours in A&E, and people who need a mental health inpatient bed continuing to be sent to an inpatient unit far from their home.

25. Across adult and children's services, including Improving Access to Psychological Therapies (IAPT), NHSE&I have estimated that 1.6 million people are waiting for mental health treatment (open referrals waiting for either first or second appointment, where the second appointment taken as proxy for full access to services).

26. Referrals for mental health services have now risen above pre-pandemic levels, for improving access to psychological therapies services (12.1% above February 2020 baseline in April 2021) and secondary mental health and learning disability services, both for children and young people (7.6% above February 2020 baseline in April 2021) and for adults (6.7% above February baseline in April 2021).

GP services

27. While there is not a 'waiting list' in primary care in the same way as for other services, the level of deferred demand (i.e. appointments that did not take place during the pandemic, and are still likely to happen in the future) is significant, as people who may have been reluctant to visit their GP during the height of the pandemic are now returning.

28. General practice has seen increased demand resulting from the pandemic. Appointment numbers per working day for June 2021 are 2.8% higher than they were in June 2019 (excluding Covid-19 vaccination appointments), increasing from 1.19 million in June 2019 to 1.22 million in June 2021.

29. Alongside appointments, GPs and their teams have delivered over 60% of all Covid-19 vaccinations to date. Long Covid and the treatment of patients with Covid-19 will place further demands on practices.

30. GPs are also reporting that elective care backlogs are having an impact, with patients who need to wait longer for secondary care often continuing to need ongoing support from their GP while they wait for their consultation following referral, during which time their health can worsen, requiring more interim care.

Dental

31. Throughout the pandemic we have seen reduced access to dentistry because of the additional risks associated with aerosol generating procedures (AGPs) requiring additional Infection Prevention and Control (IPC) measures to protect patients and staff.

32. As a result of this reduced access, NHSEI issued guidance setting out the priority order in which patients should be seen – focusing on urgent treatment, treatment for vulnerable groups, followed by any routine care which is overdue.

33. IPC requirements continue to reduce the numbers of patient's practices are able to see per day compared to before Covid-19. This is causing a significant continued backlog of treatment in primary and community dental services (CDS) and this backlog is likely to increase. It is likely that backlogs in primary care will have an impact on secondary care.

34. Since services reopened on June 8th 2020, access has increased in line with adjusted dental activity thresholds for full contractual payment set by NHS England. However, activity remains significantly supressed. Approximately 12 million courses of treatment were delivered in 2020/21, a decrease of over 68% compared to the previous year.

35. The proportion of band 1 courses of treatment (the least complex dental treatments) decreased from 60% of all treatment in 2019/20 to 40.8% in 2020/21, while the proportion of urgent courses of treatment increased from 9.5% to 29.9%, demonstrating that the available capacity has been targeted at patients most in need.

36. Whilst activity in the first half of 2021-22 continues to be constrained, practices are now required to deliver a minimum of 60% of contracted activity in order to be eligible for income protection. On average, contractors are on track to deliver at this threshold.

37. IPC guidance continues to be monitored on an ongoing basis, with the safety of healthcare staff and patients remaining the top priority. The potential for further increases in activity thresholds are dependent on changes to this IPC guidance or changes to dental environments and ways of working.

38. Urgent care has remained stable with a reversion to pre pandemic levels and the bulk of all dental related calls to NHS111 is now regarding non-urgent requirements. NHS 111 handled 638,455 dental calls between April and November 2020 which is over 49,000 more calls than the whole of 2019.

39. The department continues to work with NHS England and the sector, including the British Dental Association, on the recovery of NHS dental services and the future of the dental system in England.

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?

Workforce capacity

40. The government is committed to ensuring the NHS has the skilled staff it requires in the right number and in the right places. As of April 2021, there are over 72,000 full-time equivalent (FTE) Allied Health Professionals employed in NHS trusts and CCGS. This is an increase of almost 2,900 FTE (4.2% increase) more since April 2020 and almost 13,100 FTE more (22.2% increase) since April 2010.

41. Since May 2020, there are now over 18,900 (3.1% increase) more professionally qualified clinical staff working in NHS trusts and CCGs, including over 2,600 (2.2% increase) more doctors and over 8,600 (2.9% increase) more nurses [May 2020 to May 2021].

42. The Government is committed to delivering 50,000 more nurses in our NHS by the end of this Parliament. We will achieve this through a combination of investing in and diversifying our training pipeline, recruiting and retaining more nurses in the NHS. In 2021 we saw a third consecutive year of growth in the number of applicants to nursing and midwifery courses in England.

43. There were 20,930 acceptances to nursing and midwifery courses in England on A-level results day 2021 according to UCAS data. This is the highest number of acceptances on results day in the last ten years and a 12% increase when compared to last year (2020). The number of acceptances will continue to increase as universities recruit students in clearing.

44. We are also growing the diagnostic workforce through investment in new roles, training academies and skill mix optimisation.

45. Further, Health Education England (HEE) leads a national programme of work to encourage and support nurses who wish to return to practice in the NHS. Nurses wishing to return to practice after a break from nursing may do so by undertaking a return to practice training course and reapplying for their registration, or through successfully undergoing a Test of Competence examination.

46. HEE has launched an Employer support package where employers will be reimbursed £2,000 for returners who successfully complete the Test of Competence and return to the NHS or NHS commissioned service.

47. To become a model employer, we are transforming the experiences of NHS staff through the NHS People Plan. Published in July 2020, the NHS People Plan sets out a range of actions to transform people's day to day experience of working in the NHS, focusing on the things that matter to staff, including support for their wellbeing, improving flexible working opportunities, and building a supportive and inclusive workplace culture. This will be an important step forward in helping our health system retain more staff.

48. The NHS Retention Programme is continuously seeking to understand why staff leave, resulting in targeted interventions to support staff to stay whilst keeping them well. Retention of the current workforce is above expected levels, but it is anticipated this is temporary and due to the impact of COVID. We are not complacent about the success of this year's retention programme and are exploring options to support nurses and other staff to stay on. NHSE&I are leading a comprehensive retention programme which includes a new recruitment, retention and support package, a programme looking specifically at those nurses over 50 years old and newly qualified nurses entering the workforce.

49. The NHS has established a People Recovery Task Force, which is focused on supporting staff recovery and ensuring they feel supported and have time to rest as we plan and deliver the restoration of services.

50. In terms of general practice need, the NHS is working with the government on how best to support general practice to deliver an extra 50 million appointments a year by March 2024, and on expanding its workforce so that practices have more capacity to deliver better care.

51. Part of that workforce expansion is enabled by the Additional Roles Reimbursement Scheme (ARRS). The ARRS is open to all Primary Care Networks to reimburse 100% of the employment costs of a wide range of primary care professionals, such as pharmacists and physiotherapists. At least 7,300 of these primary care professionals have been recruited as of March 2021.The government has remained committed to supporting the NHS with whatever it needed throughout the Covid-19 pandemic, and is continuing to do so to restore services and tackle backlogs.

<u>Other capacity</u>

52. Ongoing IPC and social distancing measures continue to impact NHS capacity. The need to ensure patient and staff safety as a result of Covid-19 is affecting the ability of some services to operate at full pre-pandemic capacity.

53. The NHS is providing additional capacity through a number of means, including the establishment of dedicated cancer and surgical hubs so that capacity can be expanded while also protecting against Covid-19 infection. Some hospitals have extended their working hours, with many services open for longer or delivering weekend services.

54. To improve diagnostic capacity, NHSE&I is accelerating the rollout of diagnostic networks, a digital infrastructure that will enable load-balancing of imaging and pathology reporting, speed up clinical decision making, reduce waste and improve staff productivity.

55. Additionally, NHSE&I are expanding diagnostic capacity through investment in Community Diagnostic Hubs, delivered by NHS and Independent Sector providers with the aim of establishing the equivalent of one hub per Integrated Care System by March 2022. NHSE&I have also extended until September 21st the national mobile computerised tomography, or Computerised Tomography (CT), contract that the independent sector provides to boost CT capacity.

56. In terms of specialist cancer capacity, NHS Planning Guidance 2021-22[1] outlines the cancer recovery priorities and the key actions to encourage patients to come forward and ensure capacity is in place to treat them. Local systems, drawing on advice and analysis from their Cancer Alliance, are asked to ensure that there is sufficient diagnostic and treatment capacity in place to meet cancer needs.

57. Cancer Alliances bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment, and care for cancer patients in their local area. These partnerships enable care to be more effectively planned across local cancer pathways, to ensure consistency.

58. Throughout the pandemic and beyond, the department and NHSE&I have worked with the independent sector to secure all appropriate inpatient capacity and other resource across England is being utilised. In July 2021, 190,000 treatments and diagnostic tests were provided by independent providers to NHS patients, helping people get the treatment they need and helping the NHS reduce waiting times. The independent sector has also bolstered NHS capacity through the addition of around 6,500 additional beds. However, we are aware that there is regional variation in where this care is delivered and who is able to access it. Engagement with the independent sector is ongoing to deliver comprehensive capacity.

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?

Investment

59. The government is delivering on its historic long-term settlement for the NHS, which will see NHS funding increase by £33.9 billion by 2023-24. This has been enshrined in law.[1] In September the goverr 5 year Long Term Plan settlement). This funding will place the NHS on a sustainable footing and make an extra £8 billion available to help tackle the elective backlog in the biggest catchup programme in the NHS's history.

60. Health and care services have spent an estimated £45 billion of additional revenue funding due to Covid-19 in 2020-21, with around £34 billion provided for 2021-22. The funding in 2021-22 includes:

    - a £3 billion boost to support the NHS recovery from the impact of Covid-19 and tackle waiting lists given at Spending Review 2020;
    - a further £6.6 billion for new funding to support the ongoing NHS response to the pandemic for the first half of 2021-22 – including continuing funding for the hospital discharge programme, infection control measures, Long COVID services, and NHS staff support services; and

[1] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

[1] https://www.legislation.gov.uk/ukpga/2020/5/enacted/data.htm

- an extra £4.9 billion for similar purposes announced in early September for the second half of 2021-22.

61. £2 billion of that £34 billion of funding is being used to drive increased elective activity this year and tackle the elective backlog. Systems that achieve activity levels above set thresholds are able to draw down from it through the Elective Recovery Fund.

62. This package is supported by £325 million capital funding this year, which was announced at Spending Review 2020. This will modernise NHS diagnostic equipment, such as CT and MRI scanners, to improve clinical outcomes. On top of this, there is an additional £500m of capital investment funding included on top of the £4.9 billion of revenue funding to make an overall package of £5.4 billion for October 2021 to March 2022. Together these will help the NHS by providing extra theatre capacity and productivity-boosting technology, to increase the number of surgeries able to take place.

63. The government has also made a £5.4 billion multi-year commitment until 2024-25 for new hospitals and hospital upgrades.

64. Local health systems have received confirmation of their capital envelopes for 2021-22, and the settlement from HM Treasury has enabled us to protect the level of capital funding for trusts. This enables them to progress priority investments agreed with local health partners.

65. To ensure general practice can continue to provide the necessary care for all patients during the pandemic and recovery period, we have made available an additional £270 million from November 2020

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?

66. The health and care system's response to the pandemic has demonstrated what can be achieved when different parts of the system work together in the best interests of the people they serve. The pandemic hastened a trend towards more joined-up working that was already underway.

67. Innovation has been key throughout the pandemic and a number of short-term changes have been made to NHS systems to help speed the delivery of care and protect people from Covid-19. These changes are discussed further, in the section below on innovation.

68. The proposals for reform outlined in the Health and Care Bill will help the NHS and local government in the immediate work of dealing with the backlog as part of our recovery from the pandemic by making joint planning and delivery of services easier, and over the long term by helping to address the needs of everyone, from children to older people, at different stages of their lives.

69. The new legislation will increase integration between health and social care by removing barriers to data sharing, enabling joint decision-making, and increasing workforce-level integration.

70. The Bill's proposals are underpinned by the desire of this Government and NHS England to empower local health and care leaders to pursue new and innovative ways of delivering for people and communities. To do this we need to learn the lessons of the last 30 years of health legislation and, in some cases, pare back some of the overly prescriptive requirements. This Bill will be enabling, permissive and flexible, allowing the NHS and the wider health and care system to meet the challenges of the future.

71. The Health and Care Bill will encourage more integrated system working that will ensure service provision matches local population need, by building on the work of existing non-statutory Integrated Care Systems (ICSs), establishing new NHS bodies known as Integrated Care Boards (ICBs), and requiring the creation of Integrated Care Partnerships (ICPs) in each local system area.

72. This will empower local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities, and help deliver more person-centred and preventative care.

73. These reforms were originally proposed by NHS England and have been further developed with system partners including the Local Government Association (LGA). Existing ICSs, in their non-statutory form, are already helping to foster system working.

74. Developing the existing model and creating new ICBs on a statutory basis will support working through the backlog as part of our recovery from the pandemic, cutting bureaucracy that currently hinders integrated working and allowing staff to get on with their jobs and provide the best possible treatment and care for their local populations.

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?

75. As a result of learning from the experiences of the pandemic, NHSE&I have developed new models of care that separate elective services from emergency services where possible, improving efficiency and patient safety. Elective hub sites allow the use of existing estate to the maximum benefit, enabling focus on clearing backlogs at a system level.

76. The NHS has increased its use of technology, providing more virtual appointments, digital triaging, remote monitoring, and services such as digital eye hubs. These advancements provide patients with more convenient and efficient options to access the care they need, while helping the NHS to avoid unnecessary appointments. This means less time travelling to hospital appointments and in waiting rooms, and better access to follow-up hospital care when needed.

77. NHSE&I's Pathway Redesign Programme aims to deliver extra NHS capacity and assist service recovery through the transformation of the current delivery model and the removal of unwarranted variation in high volume elective pathways. NHSE&I are supporting Integrated Care Systems (ICSs) to recover elective services through improving end to end pathways in cardiac, eye and musculoskeletal (MSK) services, along with high volume, low complexity (HVLC) surgical pathways in orthopaedics, ophthalmology, Ear, Nose and Throat (ENT), urology, gynaecology and general surgery. This has supported greater cooperation and system working across NHS services through mutual aid initiatives and system level Patient Treatment Lists (PTLs), which were piloted with success in the London region.

78. NHSE&I have also set up the Beneficial Changes Network (BCN). This is a collaborative group of health and social care stakeholders and people with lived experience who want to harness and capture the benefits of changes that have taken place through Covid-19 and evaluate these changes, to share the knowledge and embed the learning of local experiences across the entire health and care sector. This work is progressing integration across sector boundaries to reduce duplication, improve access, and remove unnecessary steps in the patient journey.

79. During the pandemic, the NHS has significantly increased the use of new radiotherapy methods to deliver targeted treatment in fewer hospital visits. Maximising capacity and minimising patient time in hospital, particularly through the use of fewer fractions, remain important in the recovery of cancer services.

80. To help general practices meet demand safely, the government enabled the suspension of enforcement for some contractual requirements and lessened bureaucratic burdens to reduce pressures on GPs.

81. In response to the pandemic, general practice rapidly changed how services are delivered, offering face to face and remote consultations (video, online and telephone) and remote triage to see as many patients as possible while protecting staff and patients from avoidable risk of infection. As part of the Covid-19 response, over 40k laptops and 21k headsets were deployed into primary care to support remote working. NHSE&I estimate that 95% of general practices now have online consultation capability and 99% have video consultation capability.

82. While we work to improve services for patients, we continue to educate the public on their healthcare needs and on access to care. Part of this is accessing services in the right setting. Through the NHS 111 service, we now provide advice and referral to pharmacies, GPs, A&Es and ambulance services, thereby reducing pressure on frontline services. Another part of this is having realistic conversations with patients about their care options, including the length of time they might have to wait for elective treatment, and what they can do to manage their health.

83. Considerable progress has been made and we will continue to build on the lessons learned from the pandemic. While there is still further to go on the journey to recovering services, we will take opportunities to improve the patient experience and support the future work of the NHS and care services.

How effectively has the 111 call-first system for A&E Departments been? What can be done to improve this?

84. Following piloting from July 2020, the NHS 111 First scheme was launched nationally in December 2020. NHS 111 First is an extension of existing Integrated Urgent Care (IUC) Services that are accessed via NHS 111. Through encouraging the use of NHS 111, either by telephone or online, as the primary route to access urgent health care, 111 First aims to support the safe and effective streaming of non-urgent patients away from emergency departments into other IUC and primary care settings.

85. This initiative enhances the ability of NHS111 to offer people direct appointments with a variety of health services, including urgent treatment centres, a patient's GP, specialised mental health crisis services, dental services, and pharmacists for urgent repeat prescriptions and advice. By helping patients receive treatment in the most appropriate place, and reducing avoidable face-to-face contact with the NHS, these changes reduce inappropriate demand on emergency care and limit the spread of Covid-19.

86. The initiative was supported by £24 million of investment to fund IT development and increased call handling and clinical advisory capacity.

87. Given the impact of the pandemic on patient behaviour, demand and way NHS services are delivered, it is challenging to compare current and previous NHS111 performance and define the impact of NHS111 First. NHSE&I continues its formal evaluation which will inform future improvement efforts and will report these findings soon. In the meantime, available data suggests:
    - The proportion of booked appointments slots as a proportion of total A&E attendances has significantly increased, comprising 3.5% of all A&E attendances in July 2021.
    - Four-hour A&E performance for these booked patients is significantly better than overall performance – with 92.6% of booked patients being admitted, transferred or discharged within four hours in July 2021, compared to overall four-hour performance of 77.7%.

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

88. There are multiple mechanisms in place to ensure innovation is an integral part of service improvement to help meet emerging challenges.

89. The Academic Health Science Networks (AHSN) supports the NHS to adopt and spread innovative solutions to health and care challenges. The AHSNs work with industry to evidence the benefits of their new products and support their early implementation in the NHS.

90. Accelerated Access Collaboratives (AACs) improve the innovation ecosystem in the UK so that it benefits patients, industry, and the wider economy. AACs aim to improve patient outcomes by delivering better access to world leading diagnosis and treatment; to make the UK the best place in the world to design, develop and deliver innovative products, by improving the business environment for life sciences companies and; to deliver more efficient and high-quality NHS services by improving collaboration and partnership working across the innovation ecosystem.

91. NHSE&I Transformation Programmes enable this innovation and continue to explore service improvement, for example through new models of care such as Community Diagnostic Hubs (CDHs).

92. CDHs are being established to improve diagnostic capacity across systems by investing in new facilities and equipment and training new staff, creating new partnerships and innovative models of delivery and reducing pressures on acute sites. They will also improve productivity and efficiency by streaming provision of acute and elective diagnostic services

where it makes sense to do so; redesigning clinical pathways to reduce unnecessary steps, tests or duplication. They will also support the integration of care across primary community and secondary care and the wider diagnostics transformation programme.

93. The CDHs will also contribute to reducing health inequalities driven by unwarranted variation in referral, access, uptake, experience and outcomes of diagnostic provision, and delivering a more personalised diagnostic experience for patients through a single point of access to a range of safe, quality diagnostic services in the community. CDHs are projected to supply nearly 3.5 million more tests across the country by 2022-23.

94. The Department and NHSE&I are working together to innovate and find new ways to deliver care across systems, with £160 million already provided to 'elective accelerator' sites across England. These sites, which include pop-up clinics, virtual wards, 3D eye scanners, at-home antibiotic kits, AI in GP surgeries and Super Saturday clinics, are designed to help develop a blueprint for speeding up elective activity and share learning across the NHS.

95. NHSE&I is running an independent evaluation to understand the implications for staff, patients and the wider health and care system of using digital tools in primary care, including the effectiveness of online consultation systems and triage in general practice. Findings from this evaluation will support improvements to the services practices provide. This is an opportunity for government, the NHS, and professional representatives to ensure that remote working innovations in General Practice, such as triage, video, online and telephone consultations can be adapted into a sustainable model for the future. It aims to ensure that ways of working provide the best quality of care and ease of access for patients at their choice, and considers those who are unable to access or engage with digital services.

To what extent is long-Covid contributing to the backlog of healthcare services? How can individuals suffering from long-Covid be better supported?

96. Long Covid is already increasing demand for healthcare services and it is likely that the burden of long-term illness will mostly fall on primary, mental health and community care services. Current modelling assumes an estimate of approximately 2.9% of Covid-19 infections result in Long Covid symptoms at 12 weeks appropriate for clinic assessment. According to ONS data, approximately 835,000 people were still experiencing Long Covid at 12 weeks.

97. NHSE&I is currently gathering data and updating previous assumptions regarding the demand that Long Covid will place on primary care and other specialist services.

98. Initial modelling exercises developed clinically informed assumptions about broad follow up pathways after assessment and treatment in a Long Covid clinic:
    a. Tier 1 (self-management): approx. 30-50% of patients seen in clinic
    b. Tier 2 (primary and community care follow up): approx. 20-30% of patients seen in clinic
    c. Tier 3 (specialist services and rehab follow up): approx. 20-50% of patients seen in clinic

99. At this time, NHSEI is gathering data on Long Covid services and expect to publish data on onward patient referrals following assessment, patient flow into self-management, primary and community care, and specialist services, and assessment waiting times in September 2021.

100. Just as the NHS rapidly stood up specialist care for acutely ill Covid-19 patients at the start of the pandemic, it is now responding sensitively and effectively to Long Covid.

101. In October 2020, NHSE&I announced £10 million investment in a 5-point plan to support people with Long Covid. As part of this investment, 69 Post-Covid-19 assessment services were initially opened across England to assess people with long-term effects of Covid-19 and direct them to effective treatment pathways. In April 2021, a further £24 million of funding was announced to ensure the continued running of these services, whilst also increasing the number available. There are now 89 specialist clinics operating in England.

102. As our knowledge of COVID-19 has grown, we now know that few children and young people are at highest risk of severe illness due to the virus. Symptoms in children and young people are generally mild and hospitalisation rates much lower than adults with COVID

103. Nonetheless, paediatric services are beginning to receive a small number of referrals for children with symptoms suggestive of Long COVID and emerging research findings suggest that some children and young people do have continuing symptoms. As referenced above, the additional £100 million announced by NHS England includes funding to establish15 paediatric hubs to coordinate care for children and young people and NHSEI's Long COVID taskforce includes children and young people representatives.

104. As part of the £50 million research funding referenced above, £1.4 million has been granted to the 'Non-hospitalised children and young people with long COVID (The CLoCk Study)'. The study led by Professor Sir Terence Stephenson, UCL Great Ormond Street Institute of Child Health seeks to track the mental and physical impact of COVID-19 on children and young people aged 11-17.

105. Preliminary results published via a pre-print[2] show that 35.4% of those testing positive and 8.3% of those testing negative had any symptoms and 30.6% (test positive) versus 6.2% (test negative) had three or more symptoms. At 3 months post-testing 66.5% of test positive and 53.3% of test-negatives had any symptoms, whilst 30.3% and 16.2% had three or more symptoms. This led the researchers to suggest that up to one in seven (14%) children and young people who caught SARS-CoV-2 may have symptoms linked to the virus 15 weeks later. Other findings have suggested a lower prevalence. For example, the King's College London (Zoe) study found that prolonged illness in children (aged 5-17) can occur but is infrequent with 1.8% of children experiencing ongoing symptoms after 8 weeks. [3]

106. Following the second call for research on Long COVID, the Department of Health and Social Care (DHSC) convened an expert group in August to identify remaining research gaps with respect to children and Long COVID. DHSC is currently considering the recommendations of this group alongside the preliminary results that are coming out of the ongoing CLoCk research project.

[2] Long COVID – the physical and mental health of children and non-hospitalised young people 3 months after SARS-CoV-2 infection; a national matched cohort study (The CLoCk Study) 8322114d-03ed-42ad-8fdb-883a05a64643.pdf (researchsquare.com)

[3] Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV-2 (thelancet.com)

107. In addition to the CLoCK project, a project commissioned through the second Long COVID research call ('Immune analysis of Long COVID to inform rational choices in diagnostic testing and therapeutics') will be looking at a cohort of children as part of its work.

108. NHSE&I has also published commissioning guidance to assist local healthcare systems in establishing these clinics. These services play an invaluable role by helping medical experts assess, diagnose and treat thousands of people suffering with the debilitating long-term health implications of this virus.

109. The 'Your Covid Recovery' online service was announced on 5 July 2020 and developed by NHSE&I with the University of Leicester NHS Trust. It provides a digital, interactive, personalised recovery programme for people recovering from Covid-19. Phase 1 is already available as a public website containing general information on all aspects of recovering from Covid-19, including physical, emotional and psychological wellbeing. Phase 2 of the 'Your Covid Recovery' package was launched last winter and rollout is underway. This will provide access to a tailored rehabilitation plan, enable people to set goals for their mental and physical health, receive peer-to-peer support through social community forums, offer an 'ask the expert' facility for patients to contact their local rehab service, and allow patients to be monitored by their local rehab teams to ensure that they are on track with their care.

110. On 15 June 2021, NHSE&I published a new 10-point plan and announced an additional £100 million expansion of care for patients with Long Covid. The £100million additional investment includes £70 million which will be used to expand other NHS long Covid treatment and rehab services and establish 15 paediatric hubs to coordinate care for children and young people. The remaining £30 million will be used for an enhanced service for general practice to support Long Covid care and enable consistent referrals.

111. NHSE&I intend to improve Long Covid support by developing rehabilitation pathway packages to support patients, installing care coordinators to support the running of assessment clinics, and collecting and publishing data to support operational performance and research. NHSE&I is committed to ensuring equity of access, outcomes, and experience for all Long Covid patients and is working to support their own staff who have contracted Long Covid, through a package of comprehensive support resources.

112. To date over £50 million of funding is being invested to fund research into Long Covid. Two rapid UK-wide research calls have been run to identify projects that will:

- help define and better understand the underlying mechanisms of the condition;
- provide support to those suffering long-term symptoms following Covid-19 infection;
- look at developing and testing a broad range of innovative interventions/rehabilitation strategies; and
- includes a drug-platform to test pharmacological therapies for non-hospitalised people, to complement the platform already in place for hospitalised people.

The National Institute for Health Research (NIHR) and UK Research and Innovation (UKRI) have also invested £8.4 million in the 10,000 participant Post-Hospitalisation Covid-19 study (PHOSP-Covid) being carried out at the University of Leicester. This study is one of the

world's largest comprehensive research studies of previously hospitalised patients and will enable the study of novel interventions within the rehabilitation pathway.

113. The HEAL-Covid therapeutic platform is testing a number of safe, existing drugs on post-hospitalised patients across the UK.

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