

Written evidence submitted by The Royal College of Surgeons of Edinburgh (CSV0054)

Executive summary.

- It must be noted that the majority of cancer patients are treated with surgery rather than with radiotherapy or chemotherapy. Therefore, it is not possible to separate cancer services from the issues of the elective backlog and surgical workforce shortages.
- Increasing survival rates requires improving early diagnosis and improving treatment capacity.
- Improving early diagnosis requires educating the public to come forward when they find symptoms and encouraging GPs to refer on. Improvements to diagnostic capacity, especially staff, are also necessary. Community diagnostic hubs are a good step towards this.
- Improving treatment capacity can be split into workplace and workforce issues. Resolving workplace issues require prioritisation and efficient use of facilities, improved facilities, and a more 'community' feel.
- Workforce issues are more difficult to resolve. The absolute priority needs to be retaining existing clinicians, which requires above all support for staff mental health and wellbeing and allowing more flexible work options or sabbatical leave as alternatives to early retirement or leaving the profession. Protecting training and upskilling surgical practitioners are important.
- Improving cancer outcomes needs to look at a broader scope than just healthcare. Tackling health inequalities linked to deprivation is also needed.

Introduction to the RCSEd.

1. The Royal College of Surgeons of Edinburgh (RCSEd) is the oldest of the medical Royal Colleges. First incorporated as the Barber Surgeons of Edinburgh in 1505, the College is now one of the world's largest surgical bodies, with almost 30,000 members and fellows in over 100 countries worldwide.
2. Despite our Scottish roots and international reach, around half of our members and fellows are based in England. We therefore support the professional development of a significant part of NHS England's surgical, dental surgical and perioperative capacity.
3. The sole focus of RCSEd is patient care, so we actively engage with policy makers and influencers to improve outcomes for clinicians and patients, providing valuable clinical expertise and frontline experience alike. This forms the basis for our response below.

Background information.

4. The best way to increase cancer survival rates is to diagnose earlier. Diagnosis at stage 1 or 2 in all cancers has considerably better survival rates than stage 4 diagnosis. There is however a wide range of survival rates, depending on the type of cancer. As of 2015, according to ONS data, stage 4 cancer 1-year survival rates varied from a low of 15% (men with lung cancer) to 83% (men with prostate cancer). Cancers which are frequently diagnosed early, such as malignant melanomas and uterine cancer, have the highest survival rates.
5. A key point to note is that the majority of cancer patients are treated with surgery rather than radiotherapy or chemotherapy. Therefore, the issues with the backlog of elective surgery and surgical workforce shortages cannot be separated from the issue of improving cancer outcomes.
6. As a result, our recommendations will be split into two sections. The first will explore how to improve early diagnosis of cancers. The second will focus on recommendations around improving surgical treatments.
7. Another point to note is the impact of the pandemic. Overall cancer treatment has been kept at 91% of pre-pandemic levels during the pandemic, but there are variations – lung cancer in particular has seen rates decline. A study published in *The Lancet Oncology* in July 2020 estimates there will be between 3291 and 3621 additional, avoidable deaths in England just from breast, colorectal, lung and oesophageal cancer due to delays to diagnosis caused by the pandemic between March 2020 and March 2021.¹ For example, there was a 63% drop in colorectal cancer referrals during the pandemic. Although this has now recovered to pre-pandemic levels it has not exceeded them, meaning there are over 3,500 fewer patients who have been diagnosed and started treatment than would be expected for colorectal cancer alone.²
8. We would sound a note of caution on comparisons with other health jurisdictions. NHS data covers the entire UK population, whereas not all other health systems data does. Care must be taken to ensure comparisons are on a like-for-like basis.

Recommendations on early diagnosis.

9. The UK public are culturally more reticent to come forward (don't want to "waste the doctor's time") than other comparator nations. Public knowledge and perceptions of the strain that GPs are under contributes to this. Further, because diagnostics are also under great strain, GPs are more reticent to order tests than their counterparts in other jurisdictions. These two factors lead to delays in diagnosis and therefore treatment.
10. Consequently, a key priority is educating the public, including children, on how to avoid cancer and what symptoms or factors ought to prompt them to engage with primary care practitioners. Early diagnosis is critical and shifting the culture of not going to see the doctor is therefore paramount.

¹ *Lancet Oncol.* 2020 Aug;21(8):1023-1034. doi: [10.1016/S1470-2045\(20\)30388-0](https://doi.org/10.1016/S1470-2045(20)30388-0). Epub 20th Jul 2020.

² *Lancet Gast. & Hep.* 2021 Mar;6(3): 199-208. Doi: [10.1016/S2468-1253\(21\)00005-4](https://doi.org/10.1016/S2468-1253(21)00005-4). Epub 14th Jan 2021.

11. However, the education campaign needs to be carefully phrased. One factor which we know prevents people coming forward is fear and a desire to avoid hearing bad news. Education campaigns should stress survival rates and reassure people who are worried.
12. As well as encouraging the public to come forward we also need to encourage GPs to refer on to diagnostic testing. We need to build incentives into the healthcare system to encourage GPs to refer. An Australian model of pay-per-treatment is unlikely to be simple to implement and its introduction would be highly disruptive, so it is not the answer, but other methods should be explored.
13. Increasing referrals to diagnostics is insufficient if there is not enough capacity to process them. For example, the UK has considerably fewer CT scanners per head of population than comparator countries. These and other diagnostic equipment must be increased. However, as with the majority of healthcare, the factor which limits capacity the most is not the equipment but having sufficient qualified staff to utilise it. There is no quick fix to staffing issues. This is discussed further in the following section.
14. The RCSEd is very supportive of the community hubs model for diagnostics, as recommended by the Richards Report, and we are pleased to see the model being rolled out. A refinement we would propose however is to focus the rollout initially in areas of high deprivation, as we know that for a variety of reasons cancer mortality is considerably higher amongst the quintile living in the most deprived areas.

Recommendations on cancer treatment.

15. Our recommendations on surgical cancer treatment divide into those related to the workplace and those related to the workforce. The priority is to increase the capacity within the system to perform surgical procedures and there is no difference in this between cancer surgery and any other elective surgery. This submission will look first at the workplace and then turn to workforce issues.
16. Careful planning and management of rotas needs to happen to ensure surgical suites and facilities are in use as efficiently as possible. Reducing the cancer backlog specifically will require having ringfenced, separate facilities for cancer surgery where this is clinically viable, subject to the points made in paragraph 18. This will also require managing beds for recovery.
17. Investment to increase the number of beds available, which at present are less than half the number they were in 1988, will also improve overall NHS resilience and its ability to cope with any unexpected future crises. However, this also requires staffing levels to increase to ensure the staff/bed ratio does not compromise patient safety.
18. Facilities need to be improved. NHS Providers estimated the maintenance backlog in the NHS stood at £9billion as of 2020 – far higher than the £600million pledged by the government towards this. Further, facilities need to be set up in such a way as to support staff mental health and wellbeing. The provision of quiet and recreational areas where staff can take a break away from both patients and colleagues has been a positive development during the pandemic and should be kept. The provision of spaces where clinicians can relax and discuss a procedure they have just performed, to decompress, explore any learning

points and educate trainees is also important. Many hospitals have moved away from these under pressure of space, but they are vital for encouraging a community feel within a hospital staff team. Good staff community cohesion has been proven to benefit both staff wellbeing and patient outcomes across the board, including on cancer, and the facilities available must support this.

19. Given the size of waiting lists, prioritisation will be inevitable to ensure those with the most clinical need are given precedence. There is an understandable concern around the number of patients waiting for cancer surgery, but a nuanced approach based on robust data and clinical experience is required. For example, studies indicate that a six-month delay to some prostate cancer surgeries can have less adverse outcomes than a much shorter delay to the removal of large kidney stones. Cancer surgery should be judged on its clinical needs and merits not just prioritised because it is cancer, although the nature of cancer is that it will be high priority in the majority of cases.
20. Delays to the management of all cancer types were pervasive during the pandemic and more so for those who required surgery. Most centres suffered significant delays, but some centres without acute admissions, such as the Royal Marsden Hospital and the Christie Hospital, were able to continue elective work, including cancer surgery. Regional networks tried to divert patients within cancer networks to any service with capacity, including elective only sites, but there is no adequate system to allow this to work effectively. Creating such a system would enable any spare capacity to be used efficiently.
21. In countries such as Australia, New Zealand and the USA where elective surgery is routinely performed in hospitals without acute admissions, we did not see the same level of backlog develop. This is a problem beyond Covid, elective surgery was paused in January 2018 because of an outbreak of seasonal flu. Most hospitals already have separate day case units that run independently of the acute service. The challenge is to ensure, when the hospitals fill up with acute patients, that these areas are not used as spill-over due to the shortage of beds. Mandatory ring-fencing of these beds could help but would force difficult decision onto managers faced with the inadequate inpatient bed base. The creation of more elective only regional hubs to conduct simple, high-volume surgery such as cataract surgery, minor orthopaedic surgery or general day-case surgery can free up hospital capacity for more complex cases, like cancer, where patients need longer post-operative stays and intensive input after the initial operation. This is an option that could be explored by an inquiry, similar to the Richards inquiry, or by the Select Committee itself.
22. Surgery is a multidisciplinary process with anaesthetists, operating department practitioners (ODPs), ward nurses, theatre nurses, physiotherapists, radiographers and other diagnosticians, occupational therapists and dieticians all playing a role alongside surgeons. Administrative staff are vital to manage the logistics of bringing in a patient. Primary care has an important role in assessing, referring and preparing patients for surgery as well as providing community support in the post-operative period. We simply cannot consider only surgeons when looking at how to increase workforce capacity, rather it must be a systemic approach across all medical disciplines. We are pleased to see this being prioritised more. However, our remit as a Royal College is specific to surgeons and perioperative staff, therefore in this evidence we will focus on those roles.

23. The most important priority for the NHS needs to be retaining its existing workforce. We have called for a doubling of the number of medical school places, and do so again here, but given the time it takes to train a surgeon this is not a short-term solution to the current staff shortages. Overseas recruitment is expensive and sees the NHS competing with other healthcare systems such as the United States who can offer globally mobile clinicians higher rates of pay. Covid has also disrupted overseas recruitment. Given these constraints replacing clinicians who surrender their medical licence is increasingly difficult, and the NHS must focus attention and resources on retaining the existing workforce.
24. This requires investment in the mental health and wellbeing of clinicians. The GMC's recent State of Medical Education and Practice in the UK Report showed that only 27% of doctors who surrendered their medical licence did so in order to retire. Rather, the majority - 68.5% - cited burnout, stress, bullying and poor working culture as their reasons for leaving.³ 7% of doctors surrendered their licence for these reasons within three years of qualifying. The provision of rest spaces, access to counselling, taking breaks mid-shift and annual leave to recover, rotation out of high-stress shifts and tasks and prosaic matters such as the availability of hot food and drinks and free parking are all ways which the NHS can help protect staff from mental and emotional harm.
25. Further, the NHS should allow clinicians who are feeling burnt out the option of taking sabbatical leave rather than see them leave the profession altogether. This might be a particularly attractive option for consultants nearing the end of their careers whose alternative would be overly complex retire and return arrangements.
26. Trusts should also explore flexible and less-than-full-time working options for staff who would otherwise retire or leave the profession. We have picked up multiple incidents, albeit anecdotal, of senior clinicians taking early retirement because they felt unable to continue with on-call evening, night and weekend shifts and no option was open to them to work on an elective only, weekday pattern. Whilst we understand the importance to patient safety of having senior consultants available for acute out of hours work, and for staff togetherness for senior consultants to share in difficult work patterns, the workforce shortage is grave enough to warrant allowing senior consultants to work an easier schedule at less-than-full-time rather than retire. Flexible and less-than-full-time working also allows those clinicians with young children or other caring responsibilities the flexibility to continue working without needing to find overnight childcare or carers.
27. There are four options for those clinicians who choose to do so to work more hours:
 - a. Bank shifts for NHS Trusts
 - b. Agency shifts for NHS Trusts or private hospitals
 - c. For consultants, part-time appointments in the private sector
 - d. 'Insourcers' – a relatively new model where a business delivers elective services out-of-hours utilising a Trust's premises and resources.

For obvious reasons, clinicians will prioritise the path which gives them most professional and financial rewards, whereas Trusts will look to the pathway that best delivers staff to

³ GMC; [The state of medical education and practice in the UK 2020](#). (November 2020)

work, with value for money as a potentially secondary consideration. The agency price cap and the NHS tariff limit how much Trusts can spend on options b and c, with routine elective work unlikely to meet the threat to patient safety threshold to increase agency rates. Option d meanwhile is currently outside of regulation and has potential tax and conflict-of-interest concerns. Bank shifts are attractive for junior surgeons, but pension tax rules mean many consultants will not undertake them. Resolving the long-running pensions tax issue would allow consultants who wish to do more hours to do so on bank shifts.

28. We must stress the importance of training to prevent gaps in the workforce pipeline. Reduced exposure to surgery during Covid has diminished the scope for training - in orthopaedics for example, there were an estimated 212,000 fewer training opportunities between March and November 2020 – undercutting the ability of many trainees to develop the competencies they need to move on to the next stage of their career. The movement of many elective surgeries to the private sector – who rarely allow trainees to be present – exacerbated this trend during the pandemic. Surgery is a hands-on craft skill, so there is limited scope for online training and assessment to make up the gap. This needs to be factored into all discussions around workforce planning, training and development.
29. We also advocate a larger role for perioperative and surgical care practitioners within surgery, with their valuable skills and experience recognised through regulation by the GMC. Whilst care needs to be taken to ensure this does not undermine overall surgical training, as surgery is a collective effort all members of the surgical team need to be nurtured and developed. Training and enabling surgical practitioners to undertake low-risk, high-volume procedures such as hernia repair would increase capacity and free up surgeons for more complex cases.

Recommendations other.

30. Preventing cancer needs to go beyond healthcare alone and look at the impact of deprivation, with factors such as poor quality or overcrowded housing, inadequate nutrition caused by cheap diets, occupational exposure to carcinogens and other risk factors associated with lower socio-economic status.
31. Cancer Research UK data⁴ shows cancer mortality rates of 262.0 per 100,000 for men and 182.7 per 100,000 for women in the most deprived quintile of society. In contrast, cancer mortality rates for the least deprived quintile are 164.1 per 100,000 for men and 123.7 per 100,000 for women. This equates to approximately 19,000 excess deaths per year caused by socio-economic variation.
32. There therefore needs to be effort and, importantly, resources put into public and environmental health, housing, local authorities and access to Primary Care facilities in deprived areas to combat health inequalities more broadly, to make an impact on these excess cancer mortality figures.

⁴ Cancer Research UK and National Cancer Intelligence Network. *Cancer by deprivation in England: Incidence, 1996-2010, Mortality, 1997-2011*. [Deprivation gradient for cancer mortality | Cancer Research UK](#) London: NCIN; 2014.

