Royal College of Surgeons of England

ADVANCING SURGICAL CARE

A NEW DEAL FOR SURGERY

CONTENTS

KEY RECOMMENDATIONS

1	Continue the £1 billion annual 'Elective Recovery Fund' for England for a further five years to tackle the elective surgical backlog.
2	Publish an annual report setting out the government's response to the elective backlog in England.
3	Ensure all Integrated Care Systems (ICSs) urgently consider what measures can be put in place to support patients facing long waits for surgery, including the best and most efficient use of new technologies to support this.
4	Adopt a long-term aim to increase the number of hospital beds from 2.5 to 4.7 per 1,000 people, in line with the OECD average.
5	Build NHS capacity to reduce our reliance on the independent sector in the event of future pandemics or crises.
6	Consolidate COVID-light sites in every region: ensure at least one NHS hospital acts as a COVID-light site in each ICS, with more than one site in larger ICSs.
7	Widen adoption of the 'surgical hub' model across England for appropriate specialties, such as orthopaedics and cancer.
8	Adopt a long-term aim to increase the number of doctors (including surgeons and anaesthetists) from 2.8 to 3.5 per 1,000 population, in line with the OECD average.
9	Publish a regular assessment of healthcare workforce projections and requirements.
10	Enable surgical trainees to catch up on missed training opportunities as soon as possible with bespoke programmes of training that include enhanced theatre time.
11	Introduce statutory regulation for surgical care practitioners to enhance their role and attract more people to the profession.
12	Continue to ensure that staff wellbeing and retention is at the forefront of plans for elective recovery; all trusts to support less than full time working for surgical teams.

INTRODUCTION

The COVID-19 pandemic has had a devastating impact on NHS surgical services in England. All elective (planned) surgery was cancelled in the first wave and many surgical teams were redeployed to help treat COVID-19 patients. Latest figures show the largest ever recorded NHS waiting list in England of 4.95 million people, including more than 430,000 waiting over a year.[1] In addition, there is a 'hidden waiting list' of people who have not yet come forward or who have not yet been referred for hospital treatment. Estimates vary, but could mean the waiting list growing to a figure of 9.7 million by 2023/24.[2]

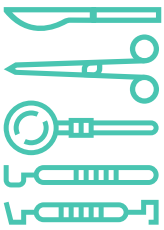
Even before the pandemic, some patients faced long waits for operations. Provision of surgery across England was patchy and seasonal. For example, in the winter of 2018, NHS England advised hospitals to cancel all elective surgery for a month when a spike in flu cases led to bed shortages. This policy contributed to a significant backlog of elective surgery from which the NHS was unable to recover. The NHS in England has not met the statutory 18 week waiting time target for planned hospital treatment for five years,[1] so the problem pre-dates COVID-19. The pandemic has made this a chronic problem, for which we need a long-term solution. Surgical services need to be more sustainable, instead of the 'stop start' model, where thousands of planned operations are cancelled or postponed in response to crises. Any stoppage means a waste of expensive resource and when the system is 'switched back on', surgical teams find it impossible to catch up due to a lack of spare capacity.

In view of the COVID-19 pandemic, The Royal College of Surgeons of England (RCS England) is calling for a New Deal for Surgery to help restore timely access to surgery for patients. This involves addressing workforce shortages (particularly of anaesthetists and nurses), and being open to changes in how local services are organised. Restoration efforts have to factor in the current challenges of staff burnout, infection prevention protocols such as testing and PPE and the continued presence of COVID-19 patients in hospitals.

As part of a New Deal, the NHS needs to embrace change, improve collaboration and make wider use of different service models, some of which pre-date the pandemic. Surgical hubs separate elective/planned surgical services from emergency services, to help services withstand infectious outbreaks. We need more of them. During the pandemic, hospitals worked together to redirect patients to the nearest COVID-light centre.

This collaborative approach was key to keeping urgent surgery going through COVID-19 surges. We need more of it. Flexibility and collaboration both improves the productivity of services, and helps them to withstand future shocks. But if there are not sufficient operating theatres or staff, then we will still never catch up on the backlog. Therefore, sustained government investment is also needed to bring both physical and human resources up to a par with our international equivalents.

You can read our specific recommendations for Wales in our **Action Plan for the Recovery of Surgical Services in Wales**. Our recommendations for the restoration of surgery in Northern Ireland will also be published soon.



430,000

people waiting over a year for surgical treatment

BACKLOG OF ELECTIVE CARE

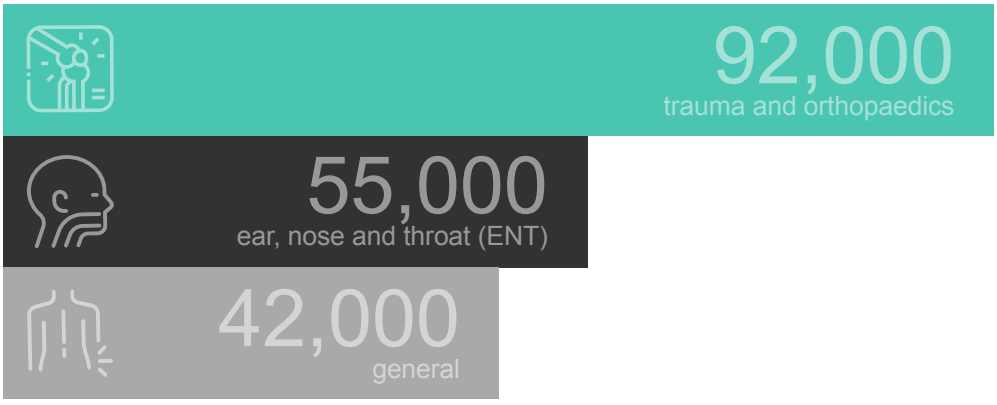
Despite the best efforts of frontline staff, planned surgery is still patchy and activity remains below pre-pandemic levels. Latest statistics show that in March 2021, only 64.4% of patients waiting for NHS hospital treatment in England were seen within 18 weeks. The government's target of 92% has not been met since February 2016. In total, more than 1.7 million patients were waiting over 18 weeks for treatment in March 2021. Among them, 436,127 were waiting over a year. By contrast, in the month before COVID-19 hit the NHS, such long waits were relatively uncommon. In February 2020 only 1,613 people were waiting over a year for hospital treatment.

Among those waiting over a year in March 2021, more than 92,000 were on the list for trauma and orthopaedics procedures (e.g. hip and knee operations), almost 55,000 were on the list for ear, nose and throat (ENT) surgery and over 42,000 were on the list for general surgery (e.g. gallbladder and hernia operations).[1] RCS England welcomed NHS England's recent commitment to providing additional data for patients waiting up to two years for treatment.[3] This will help us to better understand which surgical specialties and regions are struggling to address the backlog.

In addition to those patients already waiting, the Health Foundation estimated in November 2020 that 4.7 million 'missing patients' have not been referred for treatment (compared with 2019). If three-quarters of these patients are referred for treatment, the waiting list could grow to 9.7 million by 2023/24.[2] This issue may become prominent in cancer care as it has been estimated that almost half of people with potential symptoms did not contact their GP during the first wave of the pandemic and suspected cancer referrals consequently fell by 350,000 compared with the same period in 2019.[4] Modelling presented to SAGE has also suggested that the disruption to elective care, including surgery, caused by COVID-19 will lead to 18,200 excess deaths over the long-term. This figure encompasses 8,600 excess deaths caused by reduced elective services during the first wave, 3,200 in the second wave, as well a projection of 6,400 excess deaths that will be caused by less NHS activity throughout 2021–22 due to new infection prevention and control measures. However, analysts noted that these excess deaths in 2021–22 could be partly mitigated if hospitals are able to limit the impact that new infection and prevention control measures have on efficiency and if the vaccine is widely distributed.[5]

The Health Foundation has calculated that meeting the 18 week waiting time standard by 2023/24 would require an annual average 11% increase in the number of NHS elective procedures being performed, supported by 5,000 additional beds, 4,000 extra consultants and 17,000 extra nurses a year. As this will require a huge increase in staff and capacity, they have suggested it is more realistic to plan to achieve the waiting time standard and eliminate the backlog of long waits over a six-year period. To achieve this, NHS England would require an additional £900 million a year.[2]

People waiting over a year for surgery



With this in mind, we welcomed the government's allocation through the NHS planning guidance of an extra £1 billion of funding for an 'Elective Recovery Fund' for hospitals that achieve certain levels of elective activity. Hospitals can access the Fund if they meet 'gateway criteria' including tackling the longest waits and transforming outpatient services.[6] This cannot be a one-year commitment only.
To make a lasting impact on the elective backlog, we urge the government to continue to allocate a £1 billion Elective Recovery Fund annually for at least six years – meaning a further five years.
In addition, we are calling for an amendment in the upcoming Health and Care Bill to require the government to lay a report before Parliament on an annual basis setting out the response to the elective backlog in England. This should include key actions to alleviate the impact on those patients waiting over 18 and 52 weeks for treatment.

1

Recommendation 1:
Continue the £1 billion annual 'Elective Recovery Fund' for England for a further five years to tackle the elective surgical backlog.

2

Recommendation 2:
Publish an annual report setting out the government's response to the elective backlog in England.

LONG WAITING TIMES

Behind the monthly waiting time statistics are people waiting patiently for operations, but suffering. Some are in pain or psychological distress, others may experience further deterioration in their physical health. Delays to treatment can affect their ability to work, resulting in financial distress, and can lead to reduced trust in care providers. This contributes to an overwhelmingly negative picture of life, described as life 'on hold' or being left in a 'no man's land'.[7] Prolonged waits for surgery risk further deterioration in a patient's condition, which can mean more complex surgery being required later. Sadly there will be some instances where patients die while waiting for a procedure. RCS England urges Integrated Care Systems (ICSs) to consider how to support patients to maintain their physical and mental health while waiting for surgery. As the Centre for Perioperative Care has suggested, turning waiting lists into 'preparation lists' would help to ensure that patients are ready for their operations, which has been shown to help reduce the risk of complications and length of hospital stay following the procedure.

While every effort has been made through the pandemic to keep time-critical or urgent surgery going, it was inevitable that a wide range of operations were delayed. A recent study found that during the second wave, 40% fewer pancreatic cancer operations were being performed nationally compared to before the pandemic.[8] This is of particular concern as pancreatic cancer is usually an aggressive disease that progresses rapidly if left untreated. Paediatric surgeons have expressed concerns about the impact of delays on children's developmental progress. Delays to treatments that improve the mobility, hearing or vision of children, can impact on their educational or social development. Examples include delayed operations for curvature of the spine, cochlear implants, squints and cleft lip palates.

During the pandemic, RCS England developed guidance, in conjunction with the surgical specialties, on prioritising patients for surgery based on their clinical need. We encouraged hospitals to establish committees consisting of surgery, anaesthesia and nursing leadership to develop prioritisation strategies.[9] RCS England also supported NHS England's 'clinical validation of surgical waiting lists' framework in October 2020.[10] This encouraged clinicians to check on a patient's condition and risk factors, including the possible level of harm should surgery be delayed, and communication with patients and GPs to make the best decisions about how to proceed. It would be useful for NHS England to reinforce this framework regularly to hospitals so that there is an ongoing dialogue with patients about their treatment, especially if they are on a long waiting list for surgery. Although we welcomed the recommendation in NHS England's *2021/22 priorities and operational planning guidance*[6] to prioritise the most clinically urgent patients, we would like to see further guidance about how to take forward the suggestion to 'address the longest waiters and ensure health inequalities are tackled throughout the plan'. It is important to ensure a robust, fair and workable system for prioritising patients who have been on the waiting list for a long time, as well as a need to manage expectations about when they will get their operation.

In order to manage long waiting lists and address the backlog, it may sometimes be necessary for surgeons to 'pool' resources so that consultants take over the care of patients who they have not seen before. RCS England recommends the following clear guidance on the principles by which surgeons should pool waiting lists:

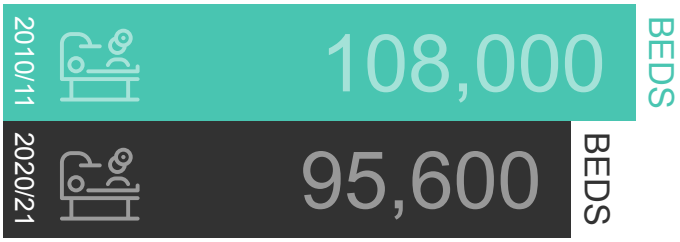
- Set protocols and agreed criteria for determining which procedures and patients are suitable for 'pooling' (i.e. sharing).
- A clear process to identify which surgeons can be assigned to each procedure based on their skills.
- Explicit patient consent for the pooling process and the opportunity for patients to meet the consultant responsible for their care at the pre-assessment stage of the procedure, as well as meeting their operating surgeon before admission to hospital.

3

Recommendation 3:
Ensure all Integrated Care Systems (ICSs) urgently consider what measures can be put in place to support patients facing long waits for surgery, including the best and most efficient use of new technologies to support this.

BED CAPACITY

In the years prior to the pandemic, it was already clear that the NHS was run too 'hot', i.e. too close to capacity. Data published by the Organisation for Economic Co-operation and Development (OECD) show the UK has 2.5 hospital beds per 1,000 people, far below the average of 4.7 and behind countries such as Turkey, Slovenia and Estonia.[11] In England, bed numbers have shrunk over the past decade and official statistics published by NHS England show the number of general and acute hospital beds fell from 108,000 in 2010/11 to 95,600 in 2020/21.[12] While RCS England welcomed the government's plan to build a number of new hospitals by 2030, we remain concerned that there may still be a shortfall in beds, particularly for planned operations.

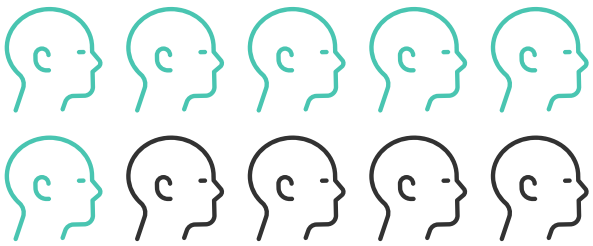


The NHS has often looked to the independent sector to provide additional elective capacity to the NHS. As a necessary step during the pandemic, hospitals in the independent sector were block-booked to give the NHS priority access to around 10,000 additional beds for urgent surgery or COVID-19 patients. Funding for the independent sector in 2021/22 is essential, because it provides separate COVID-light hospitals to safely undertake operations. However, this capacity alone is not sufficient to tackle the elective backlog, and questions have been raised over whether ongoing use of the independent sector provides the best value for taxpayers. Over the longer term, a plan is needed to build NHS capacity, alongside allowing the flexibility of using independent sector capacity. Additional capacity would give NHS hospitals greater flexibility to cope with annual winter pressures, as well as any other unanticipated peaks in demand, such as outbreaks of infectious disease or future pandemics.

RCS England also strongly supports the use of new technologies to improve efficiency and patient outcomes, which could in turn expand bed capacity. We commissioned an independent report on the 'Future of Surgery'[13] in 2017 to identify the advances likely to change surgical care over the next twenty years. The report found that innovations such as robot-assisted surgery, minimally invasive surgery and genomics will make surgery less invasive and more accurate, with faster recovery times and lower risk of harm. This will mean more effective use of resources, bigger savings for hospitals due to shorter stays and a reduced risk of infections. Therefore, we believe every ICS should develop a strategic approach to new technologies and consider how it could support this across the next five years, while ensuring any decision is made around the best interests of the patient and their needs. This should include the increased use of virtual outpatient clinic appointments which have been shown to work well during the pandemic.

Recommendation 4: 4
Adopt a long-term aim to increase the number of hospital beds from 2.5 to 4.7 per 1,000 people, in line with the OECD average.

Recommendation 5: 5
Build NHS capacity to reduce our reliance on the independent sector in the event of future pandemics or crises.



Six in ten (58%)

UK adults say that if they needed an operation, it would be **important** for them to be **treated in a surgical hub hospital**

NEW MODELS OF CARE

During the pandemic, RCS England advocated the establishment of 'green' or COVID-light sites where elective surgery is separated from emergency admissions within and across hospitals. There is clear evidence of the risks to patients if COVID-19 is contracted during or after surgery, including a greater risk of mortality and pulmonary complications.[14] COVID-light sites are essential for the continuation of planned surgery, because both patients and staff are segregated from environments where patients with the virus are treated. Patients are also expected to self-isolate and test negative before their surgery, while asymptomatic staff are tested regularly.

Over the course of the pandemic, hospital trusts and surgeons have collaborated remarkably, providing 'mutual aid' at times of extreme pressure to ensure urgent surgery continues. Through this collaboration, trusts have also been able to put agreements in place to designate certain hospitals as 'surgical hubs'. These hubs have helped to expand capacity and improve efficiency for specified types of elective procedures by bringing skills and resources together under one roof in COVID-secure environments. For staff, this can mean they do not work at the hospital they previously worked at, but instead follow the surgical patients to the hub. For patients, this may mean that they do not get their operation in their nearest hospital, but in a nearby 'surgical hub' hospital. The pandemic has resulted in huge behavioural changes in how patients use the NHS, in particular large increases in use of telephone and other remote consultation services, and people travelling to new sites to access COVID-19 vaccination or testing. In a Savanta ComRes survey undertaken this month for RCS England, seven in ten (72%) UK adults said that if they needed an operation, they would be willing to travel to a surgical hub if it was not their nearest local hospital.

Survey findings

The Royal College of Surgeons of England commissioned Savanta ComRes to undertake a survey of public opinion. 2,203 UK adults were interviewed online from 7–9 May 2021. Data were weighted to be demographically representative of UK adults.

Key findings include:

- Approaching six in ten (**58%**) UK adults say that if they needed an operation, it would be important for them to be treated in a surgical hub hospital.
- Older adults are more likely than younger adults to say having an operation in a surgical hub is very important to them.
- Seven in ten (**73%**) UK adults say that if they needed an operation, they would be willing to travel to a surgical hub if it was not their nearest local hospital.
- Three quarters (**77%**) of UK adults think that an hour or less is a reasonable time for a person to be asked to travel to have an operation at a surgical hub hospital.
- Three quarters (**78%**) of UK adults agree that the government should continue to give the NHS £1 billion extra funding each year for the next six years to tackle long hospital waiting times.

Savanta ComRes is a member of the British Polling Council and abides by its rules.
Data tables available on request from **pressoffice@rcseng.ac.uk**

While the surgical hubs model is not a 'one-size-fits-all' solution, it is a useful approach for surgical specialties such as orthopaedics and cancer. In London and the North East, hubs have been crucial to establishing an elective recovery programme for both high volume low complexity procedures (e.g. hip and knee replacements) and specialised procedures (e.g. cancer surgery). Before the pandemic, the Getting It Right First Time (GIRFT) programme recommended the development of a network approach, similar to the surgical hub model. Evidence suggested that a number of specialties would achieve 'best outcome and best value' from this approach.[15] RCS England believes that widening the adoption of surgical hubs in appropriate specialties, providing due consideration is given to local infrastructure and staffing availability, will help ensure surgical services are more sustainable and better protected against future COVID-19 waves or 'winter pressures'.

6

Recommendation 6:
Consolidate COVID-light sites in every region: ensure at least one NHS hospital acts as a COVID-light site in each ICS, with more than one site in larger ICSs.

7

Recommendation 7:
Widen adoption of the 'surgical hub' model across England for appropriate specialties, such as orthopaedics and cancer.

WORKFORCE PLANNING

In order to cope with future demand, strengthen resilience to crises, and ensure the sustainability of NHS surgical services, RCS England urges better workforce planning and an expansion of the NHS workforce. Figures from the OECD show that England has the second lowest number of doctors in leading European nations relative to its population, with just 2.8 doctors per 1,000 population against the average of 3.5.[11] We are also concerned by the Health Foundation's analysis that nursing is the most significant workforce shortage area in the NHS and represents a 'major long-term and growing problem'.[16]

Staff vacancies were an issue before the pandemic and have caused a great deal of strain on NHS services and teams. As part of the Academy of Medical Royal Colleges, we wrote to the Prime Minister to highlight the very real risk that these vacancies present the greatest threat to the retention of NHS staff.[17] An increase in the NHS workforce would help to relieve these pressures, tackle the elective backlog and meet the growing demand from an ageing population. In particular, RCS England believes more surgical staff, such as anaesthetists and theatre nurses, would improve patient access to surgery. During the pandemic, some regions were keen to establish surgical hubs to keep surgery going, but were unable due to a lack of surgical staff. Workforce planning is therefore critical to increasing the number of operations that can be carried out, or planned surgery will continue to be suspended during periods of pressure and the waiting list will continue to mount. RCS England has joined calls with other healthcare organisations for the forthcoming NHS legislation to include a statutory duty for Health Education England to publish a regular assessment of health and care workforce projections and requirements, and for the government to respond to this assessment.

Recommendation 8: 8
Adopt a long-term aim to increase the number of doctors (including surgeons and anaesthetists) from 2.8 to 3.5 per 1,000 population, in line with the OECD average.

Recommendation 9: 9
Publish a regular assessment of healthcare workforce projections and requirements.

2.8 doctors

in England per 1,000 people against the average of 3.5 in other European nations

SURGICAL TRAINING

Surgical training has been severely affected by the pandemic, as many trainees were redeployed and the reduction in elective surgery means there has been less experience in outpatient clinics, theatre, ward work and multidisciplinary meetings. Trainee logbooks show a 50% reduction in operations from 2019 to 2020 with trainees as the primary operating surgeon.[18] Over the coming months, every opportunity must be taken to free trainees from non-essential administrative work and ensure job planning supports increased theatre time to help speed up training experience. We are aware that hospitals are under considerable pressure to reduce waiting lists. However, training and safety must not be compromised by volumes, and incentives to reduce waiting lists should not make hospitals reluctant to support training.

10

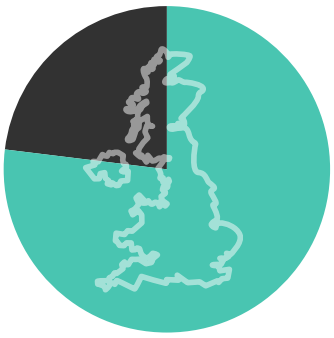
Recommendation 10:
Enable surgical trainees to catch up on missed training opportunities as soon as possible with bespoke programmes of training that include enhanced theatre time.

SURGICAL CARE TEAM

Surgical Care Practitioners (SCPs) provide support in surgical teams as they improve the coordination and continuity of patient care, providing a link between patients, consultants and trainees. They also help free up surgical trainees' time for training, enabling trainees to leave wards to attend theatres and teaching. However, as these roles are not formally regulated, SCPs cannot support patients and the surgical care team in tasks such as the prescription of medicines or delivery of out-of-hours care. Regulation would also assure the public, and help employers to be clear about accountability and indemnity arrangements. RCS England urges the government to appoint the General Medical Council (GMC) to regulate the SCP role and establish it as an attractive career in the NHS. SCPs will have a vital part in helping manage the backlog of elective surgical care and improving patient care over the next few years.

11

Recommendation 11:
Introduce statutory regulation for Surgical Care Practitioners to enhance their role and attract more people to the profession.



Over three-quarters (78%)

of UK adults agree that **the government should continue to give the NHS £1 billion extra funding** each year for the next six years to tackle long hospital waiting times

STAFF WELLBEING

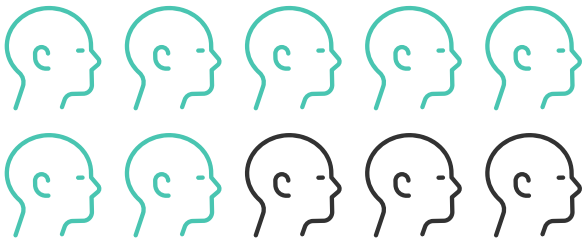
The pandemic has put NHS staff under huge pressure and seriously impacted their psychological wellbeing. The exhaustion of working in PPE, re-deployment, cancelled leave and emotional impact of COVID-19 has taken its toll. Many anaesthetists and nurses, who play a key role in the surgical care team, have flagged the need for rest and recuperation after being redeployed to help treat COVID-19 patients.

Surgeons' experiences over the last year are varied. Urgent operations for cancer, paediatric or cardiac surgery have continued, with surgeons having to don heavy and restrictive PPE. For lengthy operations – some operations can take 11 or 12 hours – the physical conditions can be challenging. Working throughout Christmas and other holidays, surgeons have of course been subject to the same limitations on interactions with family and friends as the rest of the country. Where planned surgery has been delayed, surgeons have volunteered their weekends as vaccinators or supported relatives of patients in intensive care units. Now, as this latest wave of COVID-19 lifts, surgeons are turning to the challenge of reducing lengthy waiting lists and worrying about the impact of delays on their patients. Many are concerned about the deterioration that will have occurred and are still struggling to secure the resources they need to fully restore their services. Ultimately, if we do not restore services in a sustainable way, supporting the wellbeing of every member of the surgical care team, we risk many more qualified staff leaving the profession altogether.

We strongly welcomed the focus on staff wellbeing in the NHS England 2021/22 priorities and operational planning guidance. In particular, RCS England supports measures to offer less than full time working and flexible working practices, which are key to retaining staff, including the senior workforce and those with caring responsibilities. We have also published a series of recommendations on how to support the surgical workforce and promote the wellbeing of staff.[19]

12

Recommendation 12:
Continue to ensure that staff wellbeing and retention is at the forefront of plans for elective recovery; all trusts to support less than full time working for surgical care teams.



Seven in ten (73%)

UK adults say that if they needed an operation, they would be **willing to travel to a surgical hub** if it was not their nearest local hospital

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