The King's Fund> Ideas that change health care

Written submission

Public Accounts Committee inquiry into NHS backlogs and waiting times

Who we are

The King's Fund is an independent charitable organisation working to improve health and care in England. Our vision is that the best possible health and care is available to all. We aim to be a catalyst for change and to inspire improvements in health and care by:

- generating and sharing ideas and evidence
- offering rigorous analysis and independent challenge
- bringing people together to discuss, share and learn
- supporting and developing people, teams and organisations
- helping people to make sense of the health and care system.

Introduction

The Public Accounts Committee inquiry into the NHS backlog and waiting times is timely and important . Elective care waiting lists were growing and performance targets being routinely missed before the start of the Covid-19 pandemic. Since then, the situation has significantly deteriorated, and will continue to worsen, as more people wait for treatment and wait longer than they did before the pandemic. The availability of data means that attention tends to focus on the acute sector, yet all areas of care are facing significant challenges including mental health, general practice, community services and social care.

At best, longer waits will mean inconvenience and discomfort for patients, but for some it will mean deteriorating health and more severe illness (The Lancet Rheumatology 2021). As our analysis has shown, there is also a significant inequalities dimension to this, and NHS operational planning guidance for 2021/22 sets an expectation that systems restore services in a way that is inclusive and helps address health inequalities (Holmes and Jefferies 2021; NHS England 2021a).

Tackling the backlog will be a huge operational challenge at a time when hospitals are still treating patients with Covid-19, adopting measures to limit infections in care settings and supporting exhausted staff who need time to recover. This will inevitably have an impact on productivity and the amount of health care that can be delivered in the near future.

In this submission, we have focused on elective care rather than cancer services as this is where our expertise lies.

Before the pandemic, what were the root causes of the NHS's deteriorating performance against the standards required for waiting times for elective care and cancer services?

It is now more than four years since the 18-week referral-to-treatment standard for planned care was last met (NHS England 2021*b*). In our view this has four underlying drivers.

- Workforce shortages: the pandemic has underlined how staff often work under enormous strain as a result of workforce shortages (West 2020). Prior to the pandemic the NHS had a shortfall of 100,000 nurses (Beech *et al* 2019). The NHS Long Term Plan recognised the need to address this but was not supported by a detailed workforce plan. Since then, a number of reports have highlighted the urgent need for action but this has been limited to stop-gap measures rather than the comprehensive strategy that is needed (Beech *et al* 2019).
- Funding squeeze: between 2010 and 2019 the NHS faced a sustained funding squeeze, as budgets rose by just 1.4 per cent per year over this period, compared to a historic average of 3.7 per cent (Anandaciva and Ward 2019).
- Equipment, diagnostic and capacity shortages: the number of beds in NHS hospitals more halved over the past 30 years, and while many health care systems around the world have reduced bed numbers the UK as fewer acute beds relative to its population than many comparable health systems (Ewbank *et al* 2021). Similarly, with medical technology and diagnostics the UK has limited capacity. Looking at MRI and CT scanners, the UK has one of the lowest number of machines among all Organisation for Economic Co-operation and Development (OECD) countries, with 7.2 MRI units per million people compared to an average of 19.6 and 9.5 CT scanners per million people compared to an average of 30.7 (Dayan *et al* 2018; OECD 2019).
- Rising demand for care: demand for services has grown due to a growing population, people living longer (often with multiple long-term conditions) and advances in technology and treatment. For example, over the decade preceding the pandemic total elective admissions increased by 35 per cent (NHS England 2021*d*)

While Covid-19 has contributed to growing waiting lists, the problem long pre-dates the pandemic. Previous funding shortfalls and staffing shortages meant the NHS did not have the resources to recover national performance standards while also developing new and better services.

This means there was little prospect of performance being quickly restored across the board, before the pandemic struck. It will be several years before access targets are met again so trade-offs are inevitable. Politicians and national leaders must decide which areas to prioritise and be honest with the public about the knock-on effects on the care they can expect to receive.

What did the NHS do well and what could it have done better in providing elective care and cancer services during the pandemic?

One of the striking features of the response to the initial wave of the Covid-19 pandemic was the speed with which the NHS and its partners adopted innovation. This includes the roll out at pace and scale of digital technologies; collaborative working across systems; moving at speed to procure additional private sector capacity and support from the voluntary, community and social enterprise sector; and recruiting rapidly to key roles (Charles and Ewbank 2021; The King's Fund 2021). Several factors enabled this to take place including a clear common purpose, greater flexibility over funding and changes to governance that allowed local leaders and clinicians to make change happen.

As such, an important area for the inquiry to consider will be how the health and care system managed surges in demand caused by Covid-19, including sharing of resources like staff and equipment, and how national bodies and government supported local systems to do this (Warren and Murray 2021). Beyond this, the NHS should continue to focus on improving productivity by tackling variations in care and improving clinical practice – including holding onto the innovations developed throughout the pandemic. However, without the changes to the operating environment that supported innovation during the pandemic, it is hard to see why there should be any step change in NHS productivity and forecasts should not be based upon them.

We would make two further observations to contextualise the NHS's response to the pandemic. First, the response of the health care system to Covid-19 – including its ability to deliver elective and cancer services – can only be understood when set within the context of community infection, which determines the increase in patients critically ill with Covid-19. This is largely beyond the influence of the NHS itself. This would mean, for example, comparing the interruption in care provided for non-Covid-19 patients between England and a country that avoided large-scale community infection would not provide insight into the quality of the NHS response as it ignores the surge in Covid-19 patients that the NHS had to admit.

Second, the pandemic has been a dynamic situation with a large degree of uncertainty. For example, during the early waves of the pandemic the health care system was operating in a situation without precedent and dealing with forecasts of surges in emergency admissions (which partly transpired). Even in later stages of the pandemic, where more services could be maintained because of the lessons that had been learned over how to deliver services with appropriate infection control for example, it remained difficult to predict the propensity of patients to come forward for care (Ipsos MORI and The Health Foundation 2021). Given these factors and the under-resourced state of the NHS as it entered the pandemic, the main issue we would highlight is the remarkable efforts of the NHS to deliver Covid-19 and non-Covid-19 services during the pandemic.

What are the biggest challenges faced by local healthcare providers in recovering performance on waiting times for elective care and cancer services?

The current NHS operational planning guidance sets out expectations for systems to increase activity levels over the coming months, rising to 130 per cent of pre-pandemic levels by 2024/25 (NHS England 2021a; Cabinet Office 2021). The rationale for focusing on activity levels, as opposed to reducing the waiting list to a specific number or setting a waiting-time target, is that the scale and type of demand that the NHS will face over the next three years is unclear. Estimates suggest that the waiting list could reach 13 million, but it is still difficult to predict how many patients will come forward for care, and over what period of time, after the disruptions caused by Covid-19 to elective services gradually ease (Department for Health and Social Care 2021).

The unpredictability of future demand is a key challenge. However, the principal rate limiting factor on the ability to increase activity and treat more patients is the availability of staff. Any plan to reduce waiting times needs to build explicitly from an analysis of existing staff and the potential for workforce growth alongside a realistic assessment of any scope for productivity.

There may be a temptation to run the system 'hot', for example by attempting to use existing capacity to create a one-off reduction in waiting times. Without extra staff or equipment this essentially means asking staff to work harder (such as in overtime, additional time spent working in the independent sector, or extra hours supplied to agencies) and running existing equipment for longer hours. Yet these one-off waiting list initiatives cannot deal with any longer-term mismatch between supply and demand and tend to have only short-term effects. As they are likely to rely on overtime, agency staff and independent sector activity, they can also be expensive. It is in this context that the lack of a funded plan for the health and care workforce, both in the short term and long term, remains a key weakness.

NHS staff are exhausted with high levels of burnout as a result of the pandemic. Leaders at all levels need to recognise the importance and value of supporting staff to recover (Cream *et al* 2021). If the system does not focus on workforce wellbeing and making the NHS a more compassionate and inclusive workplace, then there is a risk that falling staff retention rates will undermine efforts at recovery.

Alongside workforce wellbeing and support, sufficient diagnostic equipment and facilities are needed, along with staff trained to use them (NHS England 2021c). Historically, the UK has invested less in diagnostic equipment than comparable countries, and while MRI and CT capacity has increased recently, the UK still has one of the lowest counts of this type of diagnostic equipment among nations in the OECD (OECD 2019). For diagnostics there is a significant up-front cost and lengthy procurement process for equipment such as such as CT and MRI scanners, as well as a shortage of radiography staff across the NHS (The Home Office 2021). There are plans and funding to develop new community diagnostic hubs in England. While this investment is positive it too will be limited in its effectiveness by workforce shortages (Department for Health and Social Care 2021).

For both staff and equipment, although finding efficiencies could make existing resources go further, it is important to avoid heroic assumptions about productivity growth that will merely lead to failure, especially as capacity will continue to be needed to deal with Covid-19 cases. Increasing capacity will then take time and additional investment, and this should come as no surprise.

Essentially, the task is not just to clear the immediate backlog, it is to increase capacity in a sustainable way so that we do not see a resurgence of longer waiting times after any initial drive has ended.

How should the Department of Health and Social Care and NHS England support local providers to recover their performance?

It is essential that the approach to reducing waiting times is developed with the need to tackle health inequalities in mind. The 2021/22 NHS operational planning guidance recognises this by directing local systems to work towards restoring services in an inclusive way that helps address health inequalities (NHS England 2021*a*).

If tackling the elective backlog becomes the dominant focus of the NHS, there is a real risk that the wider transformation of the NHS is de-prioritised and delayed, with potentially long-term consequences for the quality of services and population health.

The pressures on public spending mean the government must make choices. Waiting times clearly matter to the public and shorter waits are better than longer ones, but reducing them is expensive and will compete with other objectives. This means government should think carefully about two key factors. First, how far does it want to go in cutting waiting times? For example, reducing waiting times back to levels consistent with the 18-week target will be more difficult and expensive than just returning to the pre-pandemic levels of 2019. Second, it can decide at what pace it wishes to cut waiting times. A faster pace will leave less room for other priorities and vice versa. Tackling health inequalities, improving cancer outcomes and truly delivering on parity of esteem between mental and physical health (as three examples) are all worthy priorities in their own right and should be considered alongside the push to deal with the elective backlog.

These choices are for ministers to make. In making these decisions, politicians need to be honest with the public about what they can expect in relation to waiting time standards and access to services, not only in the acute sector but across the whole system, including primary care, mental health, diagnostics and community care.

Are plans and funding announced to date enough to help the system recover or, if not, what in your view is still missing?

In our view, the current funding and operational plans are a necessary but insufficient step to help the system recover. Setting activity targets and committing additional revenue and capital funding are key, but with existing workforce pressures the lack of a detailed workforce plan for the NHS is a significant blind spot. While we welcome the additional funding provided by the government, the lack of workforce capacity will be the

key rate-limiting factor in tackling the elective backlog. There are no short-term solutions – building this additional capacity will take years.

Decisions on priorities post-2021 need to take account of the risks, challenges and opportunities facing the whole health and care system. This is not only because access to high quality general practice, mental health and other services, as well as acute care in hospitals, matter in themselves and to patients but because all services are interlinked. Changes to activity levels in one part of the system will have implications for other areas, for example if beds are ring-fenced for planned care, then fewer beds are available for emergency admissions. Similarly, rapid increases in hospital activity will have implications for post-surgical rehabilitation, discharge and other community-based services.

At the same time, operational challenges affecting other parts of the health and care system will have a knock-on effect on the acute sector. For example, the interaction between health and social care is well known (if difficult to precisely quantify). Equally clear is the impact on physical health and the costs of treatment that arise from having a concurrent mental health issue (Naylor *et al* 2016). Lastly, the quality and ease of access to primary care is clearly key for the management of long-term conditions and for timeliness of referral to secondary care.

This means primary care, community care, social care and mental health services are facing equivalent demand and access challenges, which if not addressed will cause additional pressure on other parts of the system and make tackling the elective backlog even more challenging.

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