The King's Fund

Ideas that change health care

Written submission

Submission to the Health and Social Care Select Committee inquiry into clearing the backlog caused by the pandemic

Introduction

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.

This is a timely and important inquiry. Elective waiting lists were growing and performance targets being routinely missed prior to the start of the Covid-19 pandemic. Since then, the situation has significantly deteriorated, and will continue worsen, as more people wait for treatment and people wait longer than they did before the pandemic. However, we should also be mindful that the availability of data draws attention to the acute sector with waiting times routinely measured in both elective and emergency care. Prior to the pandemic, patients faced challenges in accessing high quality care in other areas such as mental health, general practice and community services and as with acute care, many of these challenges have worsened due to Covid-19.

At best, longer waits will mean inconvenience and discomfort for patients, but for some, it will mean deteriorating health and more severe illness. There is also a significant inequalities dimension to this, and current NHS operational planning guidance sets an expectation that systems restore services in a way that is inclusive and helps address health inequalities (NHS England 2021*a*). Tackling this backlog will be a huge operational challenge, at a time when continuing measures to prevent Covid-19 infections in hospital

will limit productivity and staff, exhausted by Covid-19, will need time to recover before confronting this new challenge.

While the current backlog is large, its scale is not without precedent. Through the 2000s, the NHS successfully worked to reduce waiting times that were longer than those we currently experience at the same time as reducing waiting times in other areas (such as A&E) and investing in mental health and other clinical priorities (Murray 2021).

1 Taking a whole system approach to access and quality

The large-scale collection of routine data on hospital waiting times tends to focus attention on the acute sector. It can be compared to the relative scarcity of data in other key sectors including primary care, community care and mental health. Too great a focus on the acute sector risks undermining efforts to improve health and care more widely and may be self-defeating.

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 matter in themselves and to patients. It is also because the health and care system is 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 access pressure on other parts of the system and may contribute to the elective waiting list growing further.

It is also important that timeliness does not become the only measure of success. In the 2000s, the drive to reduce hospital waiting times came alongside wider action to improve quality and reduce variations in care, across primary and secondary services, in the form of National Service Frameworks (Department of Health and Social Care 2000). These frameworks provided a counterbalance to the national focus on access from the early 2000s. Later in the 2000s when the waiting lists had been successfully reduced and concerns over the quality of care increased, the national policy focus shifted further to quality.

2 Building capacity takes time, workforce, and infrastructure

Waiting times increase when the growth in NHS activity fails to keep pace with rising demand. Prior to Covid-19, the NHS was routinely missing key performance targets and England was experiencing a slow increase in waiting times as supply failed to keep up with demand. Rising waiting times are not a problem the pandemic has created; it is one that it has accelerated and exacerbated. To create a sustained fall in waiting times, the NHS needs to both meet the ongoing increases in demand generated by an aging population and, for a period, increase activity over and above underlying demand to reduce the backlog. Given there was insufficient capacity to meet demand growth prior to Covid-19, it will take time to build up capacity such that it can both catch-up with demand (which will stop waiting getting any worse) and also have sufficient additional capacity to reduce the backlog.

The key 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. Other longer-term investments will also be necessary, such as in operating theatres and large-scale diagnostic equipment.

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.

It is also important to remember that the NHS workforce is currently 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, there needs to be sufficient diagnostic equipment and facilities, along with staff trained to use them (NHS England 2021*b*). 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 Organisation for Economic Co-operation and Development (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).

For both staff and equipment, although finding efficiencies could make existing resource go further, with some existing capacity already needed to deal with continuing Covid cases, it is important to avoid heroic assumptions over productivity growth that will merely lead to failure. Increasing capacity will then take time and additional investment, and this should come as no surprise. The NHS Plan was published in 2000 and first set out route map to tackling long waiting times, it was not until 2008 that the 18-week waiting time target was finally met.

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.

3 Continue to find productivity gains and innovation

While the success of reducing waiting times in the 2000s was achieved in part by rapid increases in spending and a growing workforce, there were also concurrent productivity gains that made important contributions. For example, evidence shows that an increase in the proportion of surgery undertaken as day-case surgery from 2004 saved the NHS money and resources at the same time as improving patient experience (Appleby 2015).

The NHS can continue to explore opportunities to deliver services more productively to make best use of its resources. Recent experiences should build confidence in the NHS' ability to innovate at pace. One of the striking positives about the response to Covid-19 was the speed with which the NHS and its partners adopted innovation, such as the roll out at pace and scale of digital technologies (Charles and Ewbank 2021; The King's Fund 2021). Indeed, the experience of Covid-19 has generated many such examples. It is important not to forget the key factors that enabled this innovation to take root, and these included a clear common narrative among stakeholders (admittedly driven by a global pandemic); greater flexibility over funding; and changes to governance that allowed local leaders and clinicians make change happen. 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.

Finding a balance

The NHS is in the early stages of implementing wide ranging reforms in how care is delivered with the development of integrated care systems. The long-term goal of this change is far broader than elective recovery, it is also about improving the health and wellbeing of the populations they serve and reducing health inequalities. It is essential that the approach to reducing waiting times is mindful of this. 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 and prioritisations 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.

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