DAC BEACHCROFT

CATCHING UP:

A roadmap to managing the elective care backlog

Health adviser

CATCHING UP:

A ROADMAP TO MANAGING THE ELECTIVE CARE BACKLOG

After the intensity of handling the first virus peak in 2020, now the UK's health system faces a further pressure point in dealing with the backlog in elective care amidst the second major peak causing further surge capacity in secondary care. **Corinne Slingo** and **Udara Ranasinghe** consider the operational, regulatory and people issues at stake.

The first wave of the coronavirus pandemic may be in our rear-view mirror, but as the system manages the larger second wave of cases it is clear that the battle to keep health services from being overwhelmed is far from over. How to handle a resurgent Covid-19 on the one hand, while maintaining (and even increasing) 'business-as-usual' activity on the other, is a hard enough question on its own. Throw into the mix the fact that there is a sizeable backlog of elective care to be worked through, and healthcare providers have an unprecedented set of challenges currently and for the foreseeable future.

Many critical operational, regulatory and people issues will need to be navigated as the system tries to shift from emergency mode, to building an appropriate strategy for the long-term backlog clearance.

The need for strategic leadership on current backlog management also now comes at a time when significant system landscape changes are announced, with Integrated Care Systems and planned changes to the interface between health and social care to be debated in Parliament in the coming months. These seismic shifts present interesting timing, providing potential opportunities and solutions, albeit amidst a period of destabilisation.

> *"We were thrown into building a plane while flying it,"* **says the boss of one leading provider of the pandemic response in 2020.**

The challenge in the next few months is going to be to build extra capacity and services on board while keeping that plane in the air from a regulatory compliance perspective, despite challenging resource numbers and potential new flight paths to those destinations.

THE INDIRECT CONSEQUENCES OF COVID 19

The NHS Confederation report on the NHS in England alludes to the 'triple whammy' of rising Covid-19 cases, a significant backlog in treatment and reduced capacity due to infection-control measures, calling for more investment and pleading with political figures to be *"honest and realistic"* about waiting lists and times.

> *"During the pandemic, individuals' behaviour changed. 'Protect the NHS' meant some people didn't seek out and receive treatment they needed, which has led to a rise in heart attacks, for instance,"* **says Jonathan Pearson-Stuttard, Clinical Research Fellow at Imperial College London, as well as holding the position of Chair of the Royal Society of Public Health.**

The concern is that this means that dealing with the backlog has increasing significance for the wellbeing of patients and therefore should have higher priority.

> *"NHS behaviour also shifted, to focus on Covid, so we see a negative impact on cancer referral processes, diabetes diagnoses and the fallout of people not having good heart disease care may be seen over the next 5-10 years,"* **he adds.** *"Finally, the longer term mortality point is around the wider economic drivers. We know from the 2008-09 financial crisis led to 500,000 more working age people living with chronic diseases."*

On the backlog point specifically, there are a number of influencing factors:

- Essential (increased) infection control measures mean capacity is reduced due to increased safety measures (such as social distancing), and it is therefore challenging to return to pre-Covid-19 capacity levels, let alone increase resourcing to tackle the backlog directly.
- The (again essential) use of current capacity due to the high number of inpatient admissions with COVID, reducing capacity and resulting in reduction of elective admissions and procedures;
- The indirect effect of behaviour change in patients who may seek to delay attendance at appointments linked to chronic illnesses, creating addition build-up of numbers of patients for whom future appointments will be needed
- Linked to the above, is the as yet not revealed, cohort of patients who need medical intervention to diagnose health conditions but who are resistant to attend primary care for referral and investigation. Ultimately, this cohort will add to the post pandemic surge through primary care and referrals into secondary care, once people feel confident of seeking medical help.

Direct COVID 19 deaths understandably receive most of the media attention and represents the most frequently cited statistic attached to the pandemic, while the less visible impacts of coronavirus that naturally flow from the above challenges, will take longer to truly understand.

The size of the task of managing the backlog should not, therefore, be taken lightly. There is no doubt that for the NHS at least, the recovery phase from both the initial peak of this crisis and now the significantly more concerning second peak, will be tense in terms of resources. NHS Confederation chief executive Danny Mortimer acknowledged this with the same clear-cut message: *"No one can be in any doubt that the road to recovery for the NHS and social care services will be long."*

RESOURCING A BACKLOG RESPONSE

At the heart of the backlog conundrum are NHS staff; already stretched to the limit in the Herculean effort front-line, management and support staff have demonstrated since March 2020. NHS leaders know that this extraordinary response has been driven by enormous goodwill, sense of duty and team spirit on the part of those individuals, but they also know that the pressure is taking a toll and that working in such an extreme way cannot continue indefinitely.

> *"Covid created a common purpose,"* **says Chris Thomas, Senior Research Fellow at the Institute of Public Policy Research (IPPR), the progressive think tank.** *"People understand what they're pushing towards and it has created urgency to put things into place. The centre has to trust local delivery – there's no time to hang around.*

Healthcare leaders and workers are striving to maintain momentum following 'opportunity-from-crisis' thinking and the resilient and extraordinary efforts of NHS staff, but now face a further serious pressure point in the form of lengthening waiting lists for treatment that has been put on hold for close to a year. As of the end of July, some two million non-urgent operations had been cancelled and urgent cancer referrals had fallen by 75%, while treatment referrals by GPs were down six million in 2020 compared with the year before.

Anecdotally, one healthcare provider has told DAC Beachcroft that, even if they were to double their capacity, addressing the backlog would take more than a year; and yet addressing the immediate needs of the population in the face of Covid, means that this is impossible anyway. This position is undoubtedly replicated across the vast majority of secondary care providers where the greatest pressure is felt at both crisis management and backlog planning levels.

When looking at how to build capacity into the system, managers will need to consider how to create a more sustainable pattern of service delivery while maintaining staff motivation and mitigating the mental health impact of the Covid-19 crisis. Dealing swiftly with the backlog requires a workforce that is fit and able, at a time when pandemic fatigue is a very real problem. Looking after the physical and mental wellbeing of staff and maintaining clear and open lines of communication and support, will be critical to ensuring that they can continue to provide the level of care required to serve patient needs. Maintaining momentum must involve an appreciation of, and action to protect, workforce wellbeing.

> *"This is an unsustainable cycle. Stress and burnout are all increasing in the workforce,"* **says Thomas.** *"When asked about their concerns, one in three were worried about Covid. But a higher proportion – one in two – worried about the mental health risk."*

There was a time when actively looking after the mental health of NHS staff was seen as a "nice to have" in an overstretched and under resourced system, but the Covid-19 crisis has shown that an active and effective mental and physical well-being strategy is critical from both a delivery and legal perspective.

The capacity crisis we are seeing for patients may also be mirrored by a staff crisis which has the potential to exacerbate the burnout issues described. Add to this the high numbers of NHS staff who are shielding or are off work due to Covid or mandatory isolation reasons, and the severity of the staffing pressures are clear. One provider advised us of 10% of staff off due to Covid in January 2021, at a time when peak levels of activity in their acute Trust demanded the greatest levels of staff resource.

> *"We could be on a trajectory where we have a worse capacity crisis in staff than we already had, coupled with the biggest activity load on the NHS we've ever seen,"* **says Thomas.**

Nurses have been taking action to try and secure pay rises, while a survey from Nursing Times sheds light on the form of support they would like to see from their employers to alleviate the load they are bearing. Informal peer support from colleagues and managers was cited by half of respondents, while a third listed telephone support via a dedicated helpline, and a similar number chose face to face support with a mental health professional. Thomas agrees that a range of support measures must be implemented.

> *"We need a support package to help workers stay in their role and thrive,"* **he says.** *This includes access to therapy, group and peer support, but also looking at the determinants of mental health, including support for sick pay, childcare benefits and issues that can contribute to stress and burnout."*

Financial resources also come into play here. From a worker morale standpoint, the amount of unpaid overtime staff are working may need to be addressed: in a recent survey, more than half of **NHS staff said** they work extra hours each week for no extra pay even before the pandemic hit. The irony is that at a time when more funding is urgently needed to pay for more staff, more equipment and more beds, the impact of what looks set to be a severe economic downturn is likely to be keenly felt in the NHS, despite the **emergency funding promised** by the Government. **According to the IPPR**, the NHS People Plan needs to be extended by recruiting 400,000 more NHS workers by the end of the decade. Health leaders who were already managing tight budgets before the crisis could well face an even harder task now, putting more strain on the workforce and potentially putting patient outcomes at risk as the backlog clearance becomes even more challenging.

CAN THE INDEPENDENT SECTOR TACKLE THE BACKLOG?

The independent sector is far from immune to the workforce and commercial impact of the pandemic. As companies cut back on staff and perks in tough times, fewer private medical insurance policies and fewer patients self-funding treatments will inevitably have a knock-on effect on revenue. This can, in the short-term, be alleviated by partnering with the NHS to deal with some of the elective backlog, in accordance with the contracts now in place between the NHS and independent sector, but that solution is not a permanent one. Developing a roadmap to managing the post-Covid backlog will require public and private sectors to continue to work well together, but it needs strategic planning and careful co-ordination. Independent healthcare providers will need to re-think what is profitable and what is not in this 'new normal' and work closely together with NHS leaders to develop integrated public/private services that truly deliver for all parties: providers (of whatever stripe), staff and patients. This need, however, comes as Integrated Care Systems emerge, within which the role of the Independent sector is arguably less clear than it could be. Yet realistically, the capacity available in the independent sector for providing elective surgery backlog reduction, remains an essential limb of any recovery plan for the health system and backlog.

Mehdi Erfan, General Counsel at Ramsay Health, says that strategic planning, financial and clinical modelling are all far more challenging now, but that with time both public and private sector providers will see efficiency improvements that may indicate where we are on the road to managing the backlog.

> *"With time there will be more certainty and efficiency will rise as people get into new routines,"* **said Erfan at the end of the first wave in 2020.** *"But the time factor is huge and NHS and independent sector are both at 60% to 75% of pre-Covid levels of activity. Getting back to 100% is a long way to go."*

Erfan points out that small time drags add up to gain significance and that, irrespective of efficiency improvements, there will be irremovable limitations placed on providers as a result of the pandemic. We agree with him - whilst we are now well into the vaccination programme, resulting in greater confidence over time in relation to management of the virus spread, it is clear that a key limitation on throughput of patients will understandably remain, namely infection prevention and control measures, including continued social distancing, cleaning down between patients and between activities, all have an ongoing impact despite the excellent vaccine progress.

INNOVATION, REGULATION AND SOLUTIONS

The interplay between the public and private sectors is a critical operational issue on a macro level. On a more micro level, working through the backlog at a time when social distancing requirements must still be factored in, especially for the most physically vulnerable patients with acute health problems, creates logistical issues. Health leaders need to work out which parts of the care pathway can continue to be delivered remotely and what that looks like in practice. As was seen in January 2021's launch of the Care Quality Commission's 5 year strategy, the sector regulator is also live to the need to rethink how to regulate and factor in innovation in care delivery, for example where technology has provided solutions to remote healthcare management.

Wearable technologies that can monitor certain conditions and enable practitioners to observe patients remotely present an exciting new opportunity in a post-Covid world. However, not everything can be done this way, either because it is not a fit-for-purpose approach from a medical perspective or due to funding constraints. These technologies also cannot tackle the elective surgery backlog, although may support the pre and post-operative pathways to increase efficiency in those stages.

Virtual consultations, while proving extremely valuable during lockdown, may not be a problem-free panacea either. There are major question marks around the extent to which online options actually increase patient access. On the plus side it means that patients can be 'seen' without needing to come into surgeries or hospitals, but there is also the clear risk that those without adequate internet connectivity, home situations unsuitable for virtual consultations, or devices that can support video-conferencing, could be unable to access services. As the example of moving to mass home-schooling has shown, where many pupils simply have not had the technology at home to enable them to participate in virtual lessons or carry out schoolwork set online, it's a good idea in theory. In practice, digital inequalities may threaten to widen the healthcare divide and for all the known upsides, that risk cannot be ignored.

Appointments by telephone could also help, but they too can only go so far. Healthcare professionals rely heavily on being able to see their patients – not just for any specific physical problems they are being asked to examine, but also to get a general sense of a patient's overall wellbeing. For example, their pallor or their body language can be very telling, indicating if they are listless, agitated or appear to be in pain, or showing signs of visible physical deterioration. There may be non-verbal nuances too around mental health or safeguarding issues that they simply cannot pick up on over the phone or even in an online video consultation.

That said, there are circumstances where a virtual approach could help some types of patients feel more comfortable than they otherwise would in a 'real world' setting. For instance, clinicians and counsellors are seeing some patients with autism or those with severe anxiety, who have previously been unable to engage in physical appointments, start to open up when they can attend appointments at home where they feel calmer or safer.

> *"There are, rightfully, fears around digital exclusion,"* **says Thomas.** *"But overall the shift to digital should increase access to primary care."*

These solutions around access and efficiency in healthcare, at a time of unprecedented pressure on the system, are particularly relevant to primary care and in the outpatient setting for secondary care (save for when physical examination is essential). But they are only part of a solution for backlog management in the patient pathway: increased secondary care capacity remains the pinch point. The pressure on NHS Trusts to manage increased capacity is also not eased by a relaxation of regulatory scrutiny. It is, of course, right that the health and social care system regulator remains vigilant and active irrespective of a pandemic. However, what we are not seeing is sufficient degree of understanding of the context in which that scrutiny is exercised. Quality and safety for patients must be maintained, but there is a degree of inevitability that waiting times, resourcing levels, and some operational compliance will struggle in the pandemic and in the post-pandemic period where backlogs will become the prime concern post the gold command phase.

There is a balance to be struck in how regulatory scrutiny can support the current effort by providers, whilst encouraging maintenance of standards and safety.

The latest 5 year strategy being consulted on by the CQC adds refreshing focus on whole system oversight and local system improvement, but also carries the intention to move more quickly to manage individual provider compliance issues. At a time when the entire system needs to solve the huge backlog for patients, providers making difficult decisions on priorities will need to ensure compliance remains high on that list.

GOVERNANCE AND OVERSIGHT

Decision-making by providers has never been more important, nor conducted at a greater pace than over the last 12 months. This will continue as solutions for the backlog, and indeed as 'work arounds' implemented in haste, are tested for sustainability and effectiveness before permanent embedding: the importance of robust governance and assurance supporting decisions made by leaders, will be paramount.

All health providers and commissioners have made decisions in crisis, and many of those decisions will have unexpectedly moved the pace of change in the system in a positive way. There will however be a period to come where the decisions made will need to be reviewed and considered, as the design of the new health and social care landscape rolls out.

Many organisations will have taken short cuts in their usual governance processes to arrive at necessary, urgent responses to operational and strategic issues created by the pandemic response. Healthcare leaders and regulators will need to start asking themselves whether decisions made out of necessity during the pandemic were the right ones and moreover, whether they remain right for the future.

As the pipeline of delays builds up, the strain on an infrastructure that is already close to capacity cannot be allowed to cause irreparable cracks in the system. What is required is close collaboration between the public and private sectors, co-ordinated strategic planning by leaders who are themselves fatigued and require central support on management of backlog solutions, adequate funding and a rapid yet thorough re-evaluation of governance at an organisation level, alongside a system of regulation that enables progress and solutions where possible. Just as important is the people piece – supporting staff who are giving care in different and demanding circumstances, and engaging with patients who may be receiving care in new and unfamiliar ways. On the engagement piece, the CQC's proposed 5 year strategy is also very clear that a failure to have effective systems of engagement and feedback with patients and service users, will be "unacceptable" from the regulator's perspective. Therefore, in designing backlog solutions across the sector and locally, providers are well advised to have specific regard to also engaging patients in potential solutions and pathways.

The coronavirus crisis has demonstrated how adaptable and resilient the healthcare sector can be. As time goes on, processing the backlog it has created will continue to test both of those qualities – and requires an extra dose of rigour and effective leadership for good measure.

Corinne Slingo
Partner, Healthcare Regulatory and Public Law

T: +44 (0)117 918 2152
cslingo@dacbeachcroft.com

Corinne leads the national Healthcare Regulatory team advising on all aspects of healthcare law from patient care and consent issues through to statutory powers, governance and assurance. Her advice work includes assisting both the public and independent health and social care sector on governance, commissioning and consultation.

Udara Ranasinghe
Partner, Employment

T: +44 (0)20 7894 6727
uranasinghe@dacbeachcroft.com

Udara is a market-leading employment lawyer, based in London. He has a broad skills base covering contentious and non-contentious matters. On the contentious side he has worked on cases at ET, EAT, High Court and Court of Appeal levels. On the non-contentious side, Udara has advised on numerous transactions in both the private and public health sector.

dacbeachcroft.com

DAC Beachcroft publications are created on a general basis for information only and do not constitute legal or other professional advice. No liability is accepted to users or third parties for the use of the contents or any errors or inaccuracies therein. Professional advice should always be obtained before applying the information to particular circumstances. For further details please go to www.dacbeachcroft.com/en/gb/about/legal-notice. Please also read our DAC Beachcroft Group privacy policy at www.dacbeachcroft.com/en/gb/about/privacy-policy. By reading this publication you accept that you have read, understood and agree to the terms of this disclaimer. The copyright in this communication is retained by DAC Beachcroft. © DAC Beachcroft.