Academy of Medical Royal Colleges

NHS Health and Social Care Committee

Delivering core NHS and care services during the pandemic and beyond

June / 2020

Introduction

The Academy of Medical Royal Colleges is the representative body for medical royal colleges and faculties in the UK. We speak on standards of care and medical education across the UK. By bringing together the expertise of the medical royal colleges and faculties we seek to drive improvement in health and patient care through education, training and quality standards.

The Academy position on the restoration of services

The Academy has directly contributed to NHSE/I's work on restoration of services by collating information from Colleges on clinical priorities in terms of restoration of services and the with the Chair, Professor Carrie MacEwen, being a member of the NHSE Restoring Critical Services Group.

In addition with the input and endorsement of all its members the Academy has produced a set of Principles for reintroducing healthcare services. These are:

- Principle 1. There should be clear messaging to the public stressing the need to seek medical help for serious conditions whilst encouraging appropriate self-care
- Principle 2. Patients should be offered virtual or remote care where safe and appropriate
- Principle 3. Through a shared decision-making process patients should be offered evidence based alternative management options, where practical
- Principle 4. Patients must feel safe and be protected when they need to access direct healthcare in all settings
- Principle 5. Staff should be enabled, safe and protected to deliver equitable and clinically prioritised care
- Principle 6. Staff should be supported and provided with training and education that will ensure adequate preparation of current and future staff to deliver services that meet the needs of the population

This was followed up by a suite of statements on specific issues arising from the principles which need to be taken into account in reintroducing healthcare services. These cover,

Professional and public responsibilities for health protection

Staff support

Equalities

Medical education and training.

College submissions to the Committee Inquiry

The Committee will be aware that several Academy members have already submitted written evidence to the Committee. Members told us that their submissions sought to address the Committee's question of how their specialty will meet the wave of pent-up demand for health and care services that have been delayed due to the coronavirus outbreak.

Set out below are links to the evidence submitted by individual Colleges and Faculties:

Faculty of Sexual and Reproductive Healthcare

RC Emergency Medicine

RC Obstetricians and Gynaecologists

RC Paediatrics and Child Health

RC Pathologists

RC Physicians

RC Psychiatrists

RC Radiologists

RC Surgeons England

The Royal College of Surgeons of England and the Royal College of Emergency Medicine jointly gave evidence on 16 June. Their joint RCEM and RCS England submission also sought to address the specific questions raised by the Committee.

Information on likely demand for services and how it will be met

The Committee asked the Academy if its members had data on the likely level of demand for services in the light of care delayed in treating the acute phase of the COVID-19 pandemic and what this means in terms of waiting lists for treatment or procedures. In addition, the Committee was keen to have an estimate from the perspective of Colleges on the length of time it might take to get the NHS back to the position it was in before the pandemic hit.

We have engaged with all our members. However, as was indicated at the time of the request, colleges and faculties do not collect or have access to operational data of this detail. Whilst individual specialists will have an idea of their own waiting lists, aggregated data will be collected by trusts and then in turn fed up through national reporting mechanisms to NHSE/I.

Unfortunately, it is not therefore possible to provide detailed data across specialties on the likely waiting list size or the time and resources required to tackle them.

Colleges are consistently receiving information and data from their members and we will forward any relevant information we receive to the Committee.

Two Colleges, however, have provided additional data and this is attached as Annexes. The Royal College of Ophthalmologists has provided detailed data information on activity and backlogs. The Royal College of Pathologists has supplemented its original evidence to the Committee with information on screening capacity and backlogs.

General questions

The Academy's Principles document referred to in Section 2 sets out the general requirements for effective restoration of services. However, there are some specific points that the Academy would make in terms in both of estimating the size of waiting lists and about the time it will take to tackle them.

Size of waiting lists

Clinicians report varied responses from patients who had been waiting for a procedure prior to COVID-19 as to their willingness to undertake the treatment. In essence patients have said,

— They want the procedure as soon as possible

— They want the procedure but not at this time because of concerns over COVID-19

— They do not want or need the procedure.

In addition, the sad fact will be that there will be a number of those on waiting lists who will have died in the intervening period.

This means that simply carrying forward the number on the pre-COVID-19 waiting lists may not be fully accurate.

Of course, the numbers of new patients who have developed conditions requiring treatment since the start of the pandemic has to then be quantified. Whilst this is beginning to happen, we certainly do not yet have a complete picture.

It is, therefore, going to be difficult to have an entirely accurate picture of likely demand at the present time.

Time to tackle the backlog

In ordinary circumstances calculating the time required to tackle a backlog should be relatively straightforward based on a knowledge of throughput and available workforce resources and physical capacity. However, these are not, of course, ordinary times.

It will be necessary to calculate the impact on productivity of

— The operational and organisational changes to meet the requirements of safe working in a COVID-19 context. Social distancing in terms of space requirements and timing of appointments, infection control activities, will all impact on the amount of activity that can be undertaken and the physical space required. This point was made by strongly by the Faculty of Intensive Care Medicine. In Emergency Department there may have to be fixed limits to the number of people who can be there at one time. These issues apply equally in primary and secondary care

— Workforce availability. The extraordinary efforts of the workforce have been recognised. But employers as well as staff organisation realise that many staff need a period of rest and recovery. It is not going to be possible to tackle the backlog at the same speed and intensity of work that was seen during the acute phase of the outbreak. The Academy certainly supports current efforts to utilise those ex-staff members who volunteered their services at the start of the outbreak but who have not, in the main, been used.

This makes modelling how long it will take to clear the backlog a complex and difficult task. We would welcome clarification from NHSE/I on the assumptions they are making in thinking about these issues.

Conclusion

The Academy will provide further information and data as it becomes available and is happy to answer any questions from the Committee

Annex A
RC Ophthalmologists data for Health Select Committee inquiry

Introduction

There are 135 NHS Trusts and Health Boards in the UK providing ophthalmology. We have used some national data and obtained specific data from five centres:

— Nottingham University Hospitals

— Oxford University Hospitals NHS Foundation Trust

— Royal Bournemouth Hospital

— James Paget University Hospital, Great Yarmouth

— Moorfields Eye Hospital, London

Just for these five departments, the elective surgery backlog was 18,656 and the total OP backlog for these five units was around 193,000 patients.

The bulk of ophthalmology falls under elective surgery and outpatient care as follows,

Elective surgery backlog

— No elective cataract surgery was carried out in the UK during the 3 months: around 127,000 operations across the UK[1]

— The five units reported new average waiting times for surgery of 18 – 32 weeks

— Their expected time to clear the backlog under social distancing is from 26 weeks to over a year.

Outpatients

— Their average wait for new outpatient referrals is between 18 and 29 weeks

— Their new time for OP follow up is between 3 – 6 months

— Their time to clear the OP backlog is mostly unknown, with suggestions of 9-18 months.

England

In England there are usually around 666,000 ophthalmology OP appointments per month[2] or 2 million over three months of lockdown. About 90% of all attendances for surgery and outpatients were cancelled between March – May.

1. Based on annual stats from NHS Digital, Information Service Division Scotland, NHS Wales Informatics Service and the Department of Health Northern Ireland

2. (7,861,990 2018-9, NHS Digital, https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2018-19)

AMD, diabetic retinopathy and injections in England

About 800,000 intravitreal injections are normally administered per year for wet AMD and diabetic retina and retinal vascular conditions.[3]

A conservative estimate of the number of patients who missed their injections is 10,000. This includes 8000 wet AMD patients + 1500 retinal cases and an uncertain number with other conditions.

Retinal detachments

Usually there are 14,000 retinal detachment operations per year[4] which is 3500 over 3 months. We estimate around 1500 patients with retinal detachment did not seek emergency care.

Do you have any contextual questions which would help Committee members to judge the accuracy of the basis on which NHSEI's own figures have been drawn up?

Ophthalmology data is not broken down nationally by disorder or risk and follow up delays are not recorded or reported nationally. The data collection system is designed for payment rather than planning. Will the suitability of this data for service planning be evaluated?

Estimates were difficult due to uncertainty about social distancing measures. How will this be taken into account?

Do you have any other comments or observations you think we should be making?

This exercise highlights the importance of having quality data and the need to review and invest in how we measure NHS activity and use this information to plan services that meet patient demand.

Elective surgery backlog data

- Nottingham: 1,800 patients
- Oxford: 2,526 patients
- Bournemouth: 1,555 patients
- James Paget: 1,734 patients
- Moorfields: 14,866 patients

Patients on wait list

- Notts: 12,000
- Oxford: 22,050
- Bournemouth: 3644
- James Paget: 9,938
- Moorfields: 145,164

3. NHS digital reports 400,000, but many are not coded accurately. NHSE/I regional lead pharmacist who negotiates the national prices on intravitreal high cost drugs, Robin Hamilton Med Retinal Lead Moorfields Eye Hospital who works with Commercial Medicines unit and other national advisory roles and Declan Flanagan ex MD of Moorfields and VP of Royal College and Retinal consultant advised on this section.

4. Calculated by BEAVRS specialist society runs the national retinal detachment audit

Average wait time for surgery

- Notts: unknown
- Oxford: 32 weeks
- Bournemouth: 18-25 weeks
- James Paget: 30 weeks
- Moorfields: unknown

Estimated time to clear backlog

- Notts: 26 weeks, not including new referrals
- Oxford: 1 year +
- Bournemouth: 12 months
- James Paget: 51 weeks
- Moorfields: 30 weeks

Average wait for new OP referrals

- Oxford: 29 weeks
- Bournemouth: 18-25 weeks
- James Paget: 20 weeks
- Moorfields: N/A – median new patient waits on waiting list is 14 weeks currently. However, main priority is seeing high/medium risk patients.

New time for OP follow up appointment

- Oxford: 6 months
- Bournemouth: 4 months
- James Paget: 13 weeks
- Moorfields: 5 months – this may adjust depending on clinical stratification.

Time to clear OP patient backlog

- Notts: Unknown. There was a 6,000 backlog before Covid19. Depends on waiting time and whether 2m rule changes.
- Oxford: Unknown. Depends on whether we get COVID capital funding or not
- Bournemouth: est 18 months
- James Paget: under review
- Moorfields: 9 months

Estimated DNA rate for injections in England

- March 30%: 3,000
- April 30%: 3000
- May 20%: 1,820

Estimate of patients with retinal detachment who did not seek emergency care

- March 50%: 583
- April 50%: 583
- May 30%: 350

Annex B
Response for the Academy from the Royal College of Pathologists to Delivering Core NHS and Care Services during the Pandemic and Beyond

The College has serious concerns over preparations to deal with the backlog of patient need and the surge of expected demand for pathology services, especially in cancer diagnosis and treatment. There are huge anxieties about going back to even greater backlogs for cancer care, and seeing patients wait and wait for their diagnosis. No pathologists want to see this.

Our transfusion medicine colleagues tell us that there will be challenges in responding to the increasing blood requirements when 'normal' or near-normal service resumes. The blood services will need to be kept informed of plans at a local and national level to reinstitute elective surgery in order that blood collection can be adjusted accordingly. Increasing chemotherapy is also likely to increase demand for blood. This is going to be on a backdrop of a potentially reduced donor base due to ongoing COVID-19 infection/ social distancing requirements. The blood services will be continuing to collect and issue convalescent plasma for use in clinical trials alongside this.

We are deeply worried by the announcement of track and trace 14 days' isolation rule for healthcare staff in England. We have been told that it cannot be changed, with no prospect of a rapid return of staff even if testing is provided at this time. The NHS faces a monumental challenge over the coming months in dealing with the millions of patients whose tests and treatments have been postponed because of the pandemic.

Whilst many of our services can be put a risk through lack of staff at this critical time, we have asked NHS England/Improvement for a very urgent risk assessment of all transfusion laboratories and for contingencies to be put in place. This is the service that could bring obstetric, trauma, cancer and many other acute services to a halt. The workforce was at a critical level even before the COVID-19 epidemic and this new requirement brings issues into acute focus.

Workforce concerns

Workforce shortages highlighted 'pre-COVID' remain. Especially urgent workforce shortages – those with the potential to impact on the functional capacity and performance of services – relate to transfusion and histopathology. Although recruitment into histopathology has increased, there remains a 25% shortfall in staff able to report results, with some regions having even higher shortages, as highlighted in the College document, COVID-19 testing: a national strategy. Much more needs to be done, particularly with regard to the rapid rollout of digital pathology and increases in scientific and medical specialist training.

Many district general hospitals have been unable to fill microbiology posts over recent years, and workforce pressures are keenly felt. The epidemic has highlighted the essential need for near-patient infection expertise. Microbiology and infection prevention and control input into primary care, including the residential care sector, is extremely patchy and requires urgent investment and support.

The skills and expertise across the virology, microbiology, infection prevention and control, molecular pathology and biochemistry communities have enabled the rapid expansion of testing to date. These skills must be preserved and expanded as a stable workforce is urgently developed for the vastly extended capacity demands going forward. Investment in the scientific and medical workforce across these specialties must happen as a matter of urgency.

There are concerns for histopathology nationally with regard to staffing and lack of budget to run labs optimally. Institutions have seen an additional impact of the pandemic as pathology staff are self-isolating or ill; being diverted to other activities such as running the increased mortuary service, and some biomedical staff have been redeployed to mortuary and microbiology labs. Therefore, capacity to respond to even normal levels of NHS cancer activity is further reduced, and any "surge" in cancer services will be difficult to cope with.

Pathology demand depends on samples sent by clinicians and as such directly reflects the need and throughput of clinical medicine. This has dramatically changed during the COVID-19 pandemic, and as such many cellular pathologists have been able to use the reduced histopathology and

cytopathology throughput to ensure any historic backlogs are reduced, or totally eliminated. As such most, if not all, departments are likely to be able to recommence post COVID-19 with zero backlogs. It has also allowed cellular pathology staff and departments, where workloads and staffing levels have allowed, to catch up on areas such as audit, Quality Assurance, Standard Operating Procedures and Continuing Professional Development. This drop of up to 30% of activity has returned us to sustainable working levels in staffing.

Cellular pathology departments would expect the current low levels of throughput to rise back to pre-COVID-19 levels once the pandemic restrictions are eased. This will include material (both histology and cytology) from cancer screening and treatment, as well as routine clinical practice such as endoscopies, elective non-urgent surgery, and GP derived minor surgery. It is predicted that cancer related material will start first, and if other areas of work are not recommenced at the same level initially, that cellular pathology departments would be able to cope and deliver good turnaround times. If all services commence at the same time, cellular pathology services, given that all reporting currently relies on human interpretation, will be swamped very quickly. Good clear liaison and communication between national decisions, clinical teams and pathology for plans on recommencement of work is vital to ensure good marrying up of resources. But there will remain a fundamental mismatch between workload and the people to do the work.

Given changes in the use of clinical pathways during COVID-19, it may be that some clinical pathways will alter long-term and this may have a direct impact on cellular pathology requirements, but we anticipate the fundamentals of molecular, cell and tissue diagnosis to remain key for the foreseeable future. Pathologists will work with our other clinical users and professional groups to establish what these new pathways are and look at the impact.

According to Cancer Research UK figures, there are around 2.1 million people waiting for breast, bowel or cervical screening.

For every week that screening is paused, 7,000 people aren't being referred for further tests and 380 cancers aren't being diagnosed through screening programmes.

But while the screening backlog is big, potentially the biggest impact on survival is being felt in cancer diagnosis and treatment.

There's been a significant drop in the number of urgent referrals for cancer, often reported as 'two-week wait figures', with 290,000 fewer people being referred for further tests than normal.

Urgent referrals dropped to around 25% of usual levels in England at the start of the pandemic but have since started to rebound, with figures at around 50% of usual levels in recent weeks. But for each week referrals stay below 100%, the number of cancer cases that are going undiagnosed will continue to stack up.

Around 12,750 people are waiting for cancer surgery across the UK, as the number of operations has fallen to around 60% of expected levels. Chemotherapy has also taken a hit, with 6,000 fewer people than expected receiving chemotherapy since lockdown began.

Investment in infrastructure

Urgent changes are needed to support our return to core services. Rapid replacement of at risk outdated and at risk laboratory information management systems (LIMS - lab computers that handle all the results) is key to de-risking future function, and roll out of digital pathology is urgent.

We have a very narrow window of opportunity to make changes to our technological infrastructure to help reduce delays during the period of active epidemic and provide a more efficient system for the future.

As an exemplar of huge change at scale during the period of the epidemic, our laboratories, working with NHS Digital and NPex, have rolled out data connectivity between the vast majority of our laboratories to allow reporting and transfer of results for COVID-19 testing, a rapid and transformational change for the future, and one with much wider capabilities in allowing network working.

Rapid IT infrastructure transformation, hardware (to replace the nearly 30% of LIMS) that are virtually obsolete), connectivity to link systems, and, for histopathology and haematology, digital imaging will be key to making services more stable and efficient. There have been some good examples of single LIMS roll outs in Wales that have made patients' test results more accessible, and able to be reported across the country. Similarly, some regions have good systems that link many hospitals and indeed some acute and primary care systems. These models need to be widely adopted. LIMS are vital to effectively manage samples, and associated data and automate workflows.

Historically there has very poor investment in pathology IT systems, leading to most laboratories using very old systems on limited resources, often run by part time lab staff rather than informatics specialists. The companies who make these systems struggle to innovate, as they don't have resources to invest in improving systems and are locked into a business model of collecting recurring license fees for out of date systems.

Large scale failure of obsolete LIMS has happened recently, and had major incident level impact on clinical services. This must be prevented by rapid replacement.

Digital pathology

Digital pathology (whole slide imaging) is a technology that allows glass histopathology slides to be reviewed digitally on a computer screen, rather than with a microscope. As a result, it is a technology that can transform pathology services in the NHS and beyond.

Digital pathology is an enabling technology that allows cellular pathology laboratories to share work digitally, instead of a microscope and glass slides. The technology is relatively new and rolled out in a relative minority of labs1 and very few are using it for substantial amounts of diagnostic work.

It also facilitates remote working in several ways which are useful during the pandemic - home reporting, avoiding the need to be physically in the same space as a colleague giving a second opinion, and facilitating trainee pathologists in learning.

We expect that the uptake of this technology will be accelerated by the pandemic, as for example video conferencing has been.

If we invest further in digital pathology it would help with delivery of cellular pathology services by (a) making it easier to refer cases to specialist centres (b) making it possible for labs to make use of other pathologists to deliver the service (e.g. home workers, recently retired colleagues, outsourcing to other pathologists) and (c) working more flexibly (e.g. avoiding the need to commute at normal office hours into a crowded lab).

Any investment in informatics to help pathology must be long term and well spent. Implementing these systems requires significant laboratory and medical transformation. While a single scanner can be installed and connected in a matter of months, providing some short term benefit, most labs find that substantial digitisation projects require 2-3 years including the planning and workflow changes necessary to make a successful full digital transformation.

For any informatics investments it will be better and more cost effective to have single national systems, or co-ordinated standards based federated systems, rather than multiple small systems.

Any investment should also build on the initial investment of the NHS to develop centres of excellence in digital pathology nationally. These centres can help with any further expansion of the technology across the NHS, by sharing knowledge and standards.

Death investigation— systematic reviews

The College would like to see detailed investigations (systematic reviews) to establish the different causes of deaths during the COVID-19 pandemic, with a view of possibly starting this autumn. The College would also support systematic reviews into issues such as personal protective equipment supplies, body storage, outbreak planning, delaying elective surgery, and background screening for the virus.

COVID-19 post-mortem portal

The College has developed the post-mortem portal as a means to build a database of information to help inform the treatment of COVID-19 patients and research about the disease. This initiative has the support of the Coroners Society of England and Wales and the Chief Coroner. It is led by Professor Jo Martin, College President, and Dr Mike Osborn, Chair of the College's Death Investigations Committee.

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