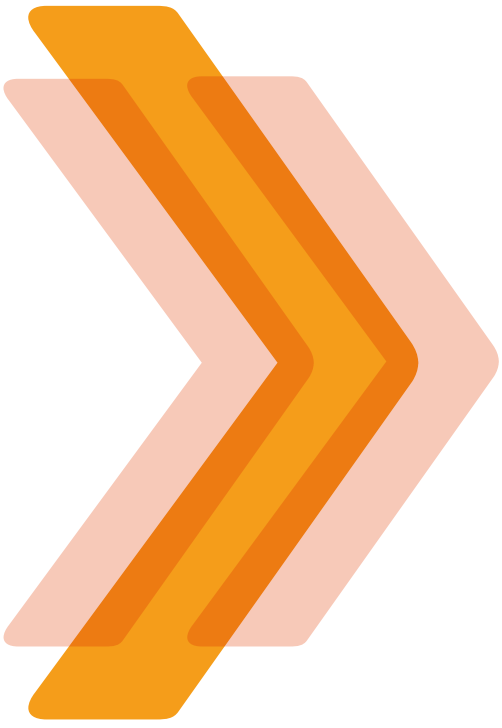
The King's Fund

Ideas that change health care

SUMMARY

Understanding NHS financial pressures

How are they affecting patient care?



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Overview

- Financial pressures on the NHS are severe and show no sign of easing. However, we know relatively little about their impact on patient care.
- This study sought to investigate the impact of financial pressures in four very different areas of the health service: genito-urinary medicine (GUM), district nursing, elective hip replacement and neonatal services. Our research used data analysis and interviews to explore different experiences across the system.
- We found that GUM and district nursing services were under particular strain. Both access to services and quality of patient care have been affected in ways that are difficult to detect with currently available metrics.
- Within elective hip replacement services, activity has increased in recent years and patients remain happy with the outcome of their operations, but the latest data shows that average waiting times for treatment are starting to rise. Neonatal services appear to have largely maintained quality and access despite a number of longstanding pressures, although there is variation between units.
- Our findings create a challenge to the direction of travel set out in the *NHS five year forward view* of strengthening community-based services and focusing on prevention.

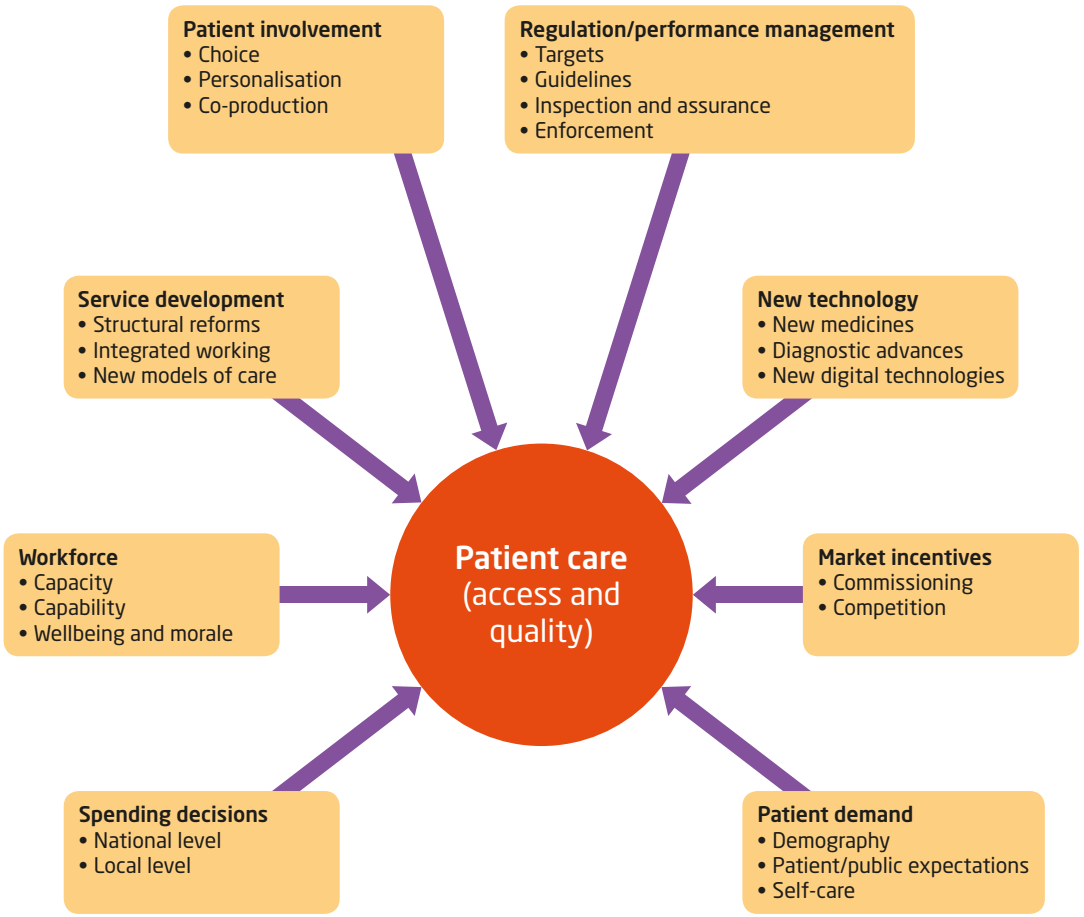
The issue

The NHS is under growing financial pressure. Between 2010/11 and 2014/15, health spending increased by an average of 1.2 per cent a year in real terms and increases are set to continue at a similar rate until the end of this parliament. This is far below the annual growth rate of 3.7 per cent in previous years, and is not sufficient to cover growing demand. As budgets tighten, NHS organisations have been struggling to live within their means – acute trusts ended 2015/16 with a deficit of £2.6 billion.

It is difficult to ascertain the impact these financial pressures are having on patient care. For one thing, national data on NHS performance mainly covers acute hospital services, with little known about community-based services. For another, while attention tends to focus on explicit restrictions to patients' access to care – such as longer waiting times or restrictions on access to treatments like in vitro fertilisation (IVF) – changes to the quality of care patients receive are less visible, but just as important.

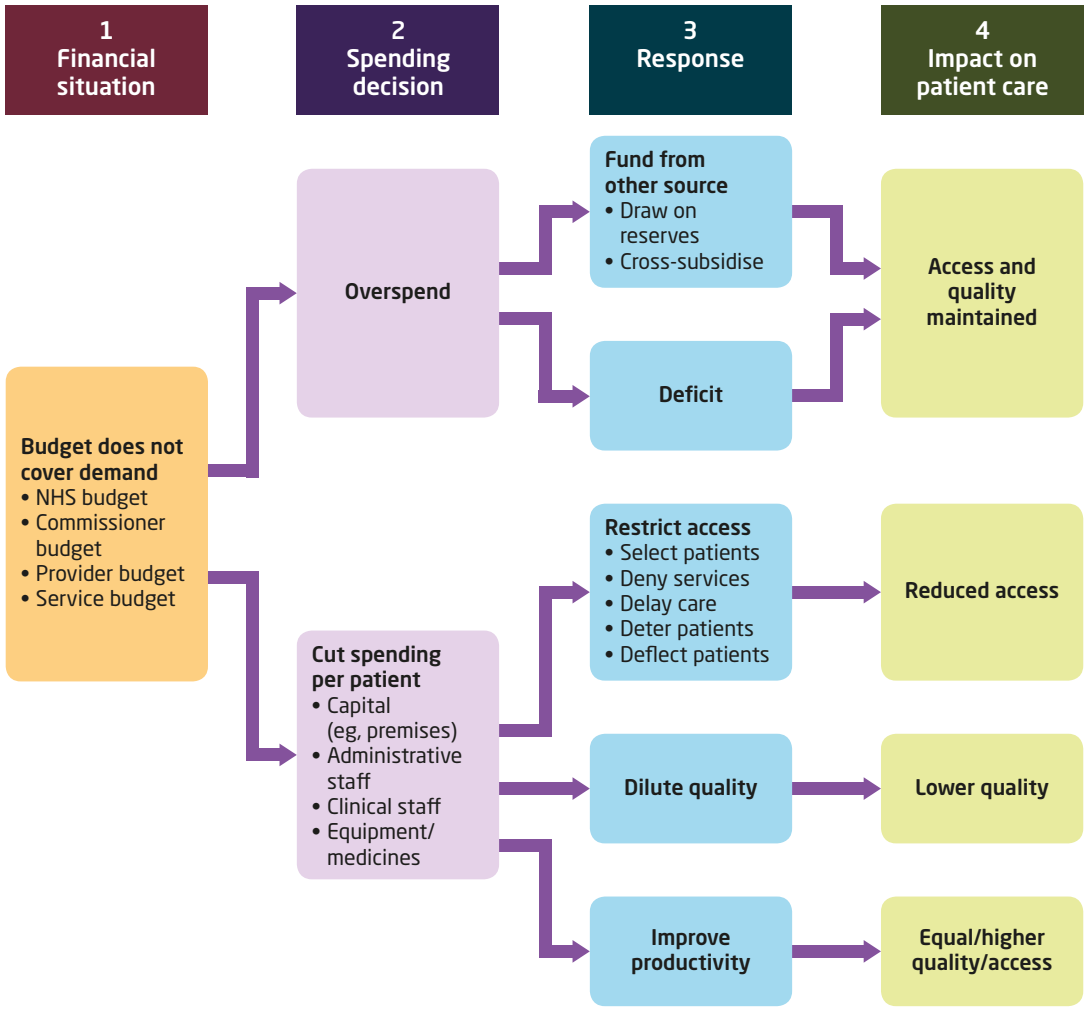
Lack of funding is by no means the only challenge facing the health system. A number of other factors affect the availability and quality of patient care; the impact of these factors may be intensified by the financial challenges.

Figure 1 Factors affecting the quality of health care services patients receive



Health care organisations can respond to financial pressures in a range of ways. Some of these can have positive effects on patient care, others can have negative effects even though this may not be the intention.

Figure 2 A simplified model of possible responses to funding pressures



Our research

We investigated the impact of financial pressures in four services: genito-urinary medicine (GUM), district nursing, elective hip replacement, and neonatal services. These services were selected to reflect differences in how patients accessed the service, who commissioned and provided it and how it was delivered. In each service area, we undertook research interviews with national stakeholders, local commissioners, health care professionals, managers and patient representative organisations, and analysed national data and other published evidence where available.

The aim was to understand whether and how the slowdown in NHS funding since 2010/11 has affected patients' access to high-quality care and to explore whether financial pressures are felt differently in different parts of the health system.

Our findings

Genito-urinary medicine (GUM) services

We found clear evidence that pressure on GUM services has increased over the past few years and that patient care in some parts of the country has suffered as a result. This is due to a range of factors, including budget cuts, rising demand, new commissioning arrangements, and workforce challenges. Total local authority spending on GUM services fell by 3.5 per cent between 2014/15 and 2015/16, but at the same time demand was increasing rapidly, with new attendances at GUM clinics increasing by nearly a third between 2011 and 2015.

However, there is significant variation at a local level; for example, around one in four local authorities reduced GUM spending by more than 20 per cent between 2013/14 and 2015/16, while around one in seven increased spending by this amount.

In some areas GUM services had been put out to tender with budgets that were up to 40 per cent lower than in previous contracts, resulting in fewer clinics. There have also been cuts to health adviser posts and to prevention and outreach services, which not only affect individual patients but also put the general population at greater risk of infection. However, some commissioners and providers have been motivated to develop innovative approaches to maintain the quality of services.

Since 2013, the commissioning of sexual health, reproductive health and HIV services has been split between local authorities, clinical commissioning groups (CCGs) and NHS England. This has resulted in a stronger focus on value for money in some areas, but has also led to disjointed services for some patients and lack of clarity over accountability at local and national levels.

A combination of financial and other pressures has had a negative impact on staff morale in some areas, leading some to consider alternative careers.

GUM services have some protection compared to other public health services due to a legal mandate that requires councils to provide comprehensive open access services, though this is not precisely defined. The problems we have identified are a warning about what may be happening in other services that are not protected in this way.

District nursing services

We found strong evidence that district nursing services are under pressure and that this is negatively affecting the quality of patient care. Demand is growing, while services are facing funding constraints and a critical shortfall in the workforce.

There is very little data on either demand or funding, but our research found evidence of significant growth in activity and that, despite this, many budgets are

static or falling. This has led to a gap between demand and the available resources in terms of both funding and staff numbers.

These pressures are having an impact on patient care. We heard examples of providers tightening the criteria for access to district nursing services and also of increasing delays for non-urgent referrals. The quality of care is affected by the fact that staff are increasingly rushed, visits have become more task-focused, and there is less opportunity for thorough assessments. This dilution of quality may damage patient experience and outcomes.

To minimise the impact on patients, many staff are working intensely over long hours. This is having a negative impact on staff wellbeing, often leading to low morale and high levels of stress, which in some cases seems unsustainable. Our research also indicates that these pressures are having an impact on other NHS services, social care providers, informal carers, and voluntary sector organisations such as hospices.

Community health services are particularly vulnerable to financial pressures, as funding (usually via block contracts) is not directly linked to the activity taking place. Care is less visible than in other settings, and quality is more difficult to monitor due to a lack of quality metrics and national data collection. This makes it easier to squeeze funding, but more difficult to see the consequences of doing so.

Elective hip replacement services

The number of elective hip replacements conducted in the NHS has increased in recent years and patients are overwhelmingly happy with the outcome of their operations. However, the service is affected by the wider pressures on hospitals, and CCGs are looking at ways to manage demand for this high-volume procedure, for example, by introducing new service models for musculoskeletal services and, in some cases, tightening referral criteria. Although not conclusive, there are early signs that these initiatives may be starting to affect access to care: the number of hip replacements recorded in 2015/16 was slightly lower than in the previous year.

Furthermore, average waiting times for trauma and orthopaedic patients (for which more recent data is available than for hip replacements specifically) are increasing, with the average patient in October 2016 waiting around a week longer for treatment than they were a year earlier.

Patients are also being affected by the wider pressures on hospitals. In particular, high levels of bed occupancy– primarily a result of increased emergency admissions and difficulties discharging patients – have led to bed shortages and an increasing (albeit relatively small) number of operations being cancelled.

The extent to which access to elective hip replacement services can be restricted in response to financial pressures is limited for a number of reasons: there is extensive data available on hip replacements, which allows changes in access and quality to be scrutinised and monitored; information on CCG demand management initiatives is in the public domain; national waiting time targets apply to the service; and the current payment system creates incentives for providers to do more procedures to increase income.

Neonatal services

On a number of indicators, the quality of neonatal services is improving. However, our research found evidence that neonatal services are also experiencing longstanding pressures, particularly in relation to staff shortages, which leave many units unable to meet recommended levels of nursing and medical staff. They are also experiencing growing demand, with many operating above the recommended occupancy levels – although this varies between units.

There is also considerable variation between local neonatal services in terms of how they are funded. This variation is a result of locally agreed payment arrangements and the different approaches taken by trusts to allocating resources between services. Taken together with the absence of published data on overall spend on neonatal services, this makes it difficult to build a clear picture of how funding for these services has changed. However, our research found that there is not – yet – clear evidence of financial pressures having increased significantly in recent years, or of a significant impact on patient care.

There continues to be considerable variation between units and networks in terms of how well they perform and the extent to which they are meeting agreed standards. Pressure on capacity can lead to the transfer of babies to units that are sometimes a long way from home, placing significant stress on families. This is a longstanding issue. There is also some evidence that the recruitment of specialist nursing staff is becoming more difficult.

Access to allied health professionals who provide care to neonates – eg, physiotherapists and speech and language therapists – is highly variable. Although parents and families are often unaware of the role played by this wider team, the absence of these professionals can have a significant impact on babies' long-term development. These services appear to be particularly vulnerable when budgets are squeezed.

Our conclusions

Financial and other pressures are affecting the four services areas we looked at to different degrees.

They are having an impact in ways that are difficult to detect with currently available metrics. For example, care provided by some district nursing and GUM services

is having to focus on the 'nuts and bolts' of diagnosis and treatment without time to address the full range of patients' needs. This highlights the importance of improving the definition and measurement of quality in areas like community services where metrics are currently scarce.

The growing gap between demand for services and available resources is clearly increasing the pressure on staff. This is particularly worrying given the well-established link between staff wellbeing and the quality of patient care.

Commissioners and providers in all four service areas are working hard to maintain service quality, innovate, and develop new models of care. However, there are also instances of innovation being stifled because of limits in the availability of funding, staff time or relevant skills.

Commissioners, providers and users will need to collaborate at a service level in order to address the challenges facing services and to secure the future sustainability of the health and care system. Some of these relationships are not working effectively at the moment.

The slowdown in NHS funding growth that began in 2010/11 has taken some time to affect patient care. Many of the cuts that have been made – such as cuts to staff and preventive services – are storing up problems for the future.

Our findings create a fundamental challenge to the direction of travel set out in the *NHS five year forward view* and the implementation of new models of care. Acute services such as hip replacement and neonatal care have been relatively protected from financial pressures so far, while some community-based and public health services like GUM and district nursing have been cut significantly. This suggests the NHS is moving further away from its goal of strengthening community-based services and focusing on prevention, rather than making progress towards it.

To read the full report *Understanding NHS financial pressures: how are they affecting patient care?* please visit: **www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures**