

Understanding NHS financial pressures

How are they affecting patient care?

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Key messages

- Financial pressures on the NHS are severe and show no sign of easing. Our research in four different parts of the health and care system – genito-urinary medicine (GUM) services, district nursing services, elective hip replacement services and neonatal services – found that financial and other pressures are affecting these service areas to different degrees.
- The greatest impact on patient care was found in GUM and district nursing services, where we found clear evidence that access to and quality of patient care has suffered in some parts of the country. Within hip replacement services, the first signs that patient care is being affected are emerging, with waiting times for treatment beginning to rise. Neonatal services appear to have largely maintained quality and access, although there is variation between units, and several longstanding pressures on services remain.
- Financial pressures are affecting patient care in ways that are difficult to detect with currently available metrics. For example, care provided by some district nursing and GUM services is becoming more episodic in nature, with staff forced to focus on the ‘nuts and bolts’ of diagnosis and treatment without time to address the full range of patients’ needs. Essential support and prevention services that provide care beyond the core service have in some cases been decommissioned or reduced. This highlights the importance of defining, measuring and monitoring quality at local and national levels in services where metrics are currently scarce.
- The growing gap between demand for services and available resources means that staff are acting as shock absorbers, working longer hours and more intensely to protect patient care. This was seen most clearly in district nursing services, where pressures on staff were reported to be leading to higher levels of stress and, in some cases, increasing absence due to sickness. This is particularly worrying given the well-established link between staff wellbeing and the quality of patient care.
- In the face of these challenges, NHS services are not standing still. Commissioner and provider staff in all four service areas were working hard to maintain service quality, innovate, and develop new models of care. However, there were also



instances where innovation was stifled because the funding, staff time or skills necessary to stimulate change were not available.

- Our research highlights the importance of collaboration between commissioners, providers and users at a service level to address the challenges facing services and to secure the future sustainability of the health and care system. It also shows that some of these relationships are not working effectively at the moment.
- In some (mainly acute) services, patients have so far been relatively protected from the impact of recent financial pressures. Factors that combine to provide some protection to these services include high-profile national targets (such as the 18-week referral-to-treatment target); near real-time monitoring (eg, monthly publication of cot occupancy data for neonatal care); activity-based funding that provides additional revenue as demand rises; and the fact that cuts in services like neonatal care would have a high profile among politicians and in the media. In the face of mounting pressures, many acute hospitals have also run deficits.
- Financial pressures have had a much greater impact on some other services. Factors that can combine to make some services particularly vulnerable include: a lack of data to monitor performance; block contract arrangements that have not adjusted to rising demand; services commissioned from the public health budget that has been cut in a way that NHS budgets have not; cuts having long-term implications that will not show up in outcome data for several years; and groups most affected by service changes not having a strong political voice. Many providers outside the acute sector have avoided running deficits, but have had to make changes to services to achieve this.
- Although NHS funding growth began to slow in 2010/11, it appears to have taken some time for financial constraints to impact on patient care, and our data suggests that these impacts will spread and intensify in the future. 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. With acute services such as hip replacement and neonatal care relatively protected so far, while some community-based and public health services like GUM and district nursing have been cut, the NHS appears to be moving further away from its goal of strengthening community-based services and focusing on prevention, rather than making progress towards it.



1 Introduction

Analysts of NHS financial data have painted a clear and stark picture of the severe funding pressures currently facing the health service ([Lafond et al 2016](#); [Murray et al 2016](#)). For those of us trying to understand what these financial figures mean for patients, the picture is far less clear.

The relationship between financial performance and quality is complex. Poor financial performance has traditionally been seen as a sign of poor leadership and management (and thus correlated with poor-quality care). However, it could be a good thing for patients if deficits indicate extra spending to secure the quality of care. Good financial performance could be a bad thing for patients if providers cut costs by changing their service model in a way that damages quality, or restricts access to care. We do know that organisations rated 'good' or 'outstanding' by the Care Quality Commission (CQC) report better financial performance on average than those with lower quality ratings ([National Audit Office 2016a](#)). However, there is variation, and it is difficult to attribute cause and effect.

This picture is further complicated by the fact that national data on NHS performance mainly covers acute hospital services, and thus only tells part of the story about the impact of financial pressures. For many services, particularly those based in the community, little is known about how access to care and the quality of care has changed over time at a national level.

Furthermore, while national 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 much less visible, even though they can be just as important, if not more so.



Purpose of the research

The purpose of our research was to get underneath the top-line figures on NHS spending and financial performance to examine what the current funding constraints mean for patient care.

Given the size and complexity of the NHS, it would be difficult (if not impossible) to summarise the impact of financial pressures on patients across the system. However, to provide some insights into this variation, we investigated the impact of financial pressures in four very different parts of the health and care system: genito-urinary medicine (GUM), district nursing, elective hip replacement, and neonatal services. By talking to national stakeholders, local commissioners and clinicians, other health care professionals, managers, and patient representative organisations, we sought to:

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

We undertook qualitative research interviews, which allowed us to explore the less visible impacts of financial pressures and provided insights not picked up in national datasets, and integrated national data and other published evidence where available.

Methodology

Our research comprised an in-depth study of four different services. Service areas were selected on the basis of scoping conversations with a range of stakeholders including policy-makers, provider and commissioner organisations, as well as a rapid literature review. Our objective was to identify four service areas that between them reflected the range within the NHS, in terms of:

- type of service/position on patient pathway, ranging from a public health to a specialised service
- commissioner, including clinical commissioning groups (CCGs), NHS England and local authorities
- contracting and payment arrangements, including block contracts and tariff-based payments



- provider type – for example, acute or community provider and, where relevant, NHS and independent sector organisations.

On the basis of our discussions and taking into consideration the above criteria, we selected the following four areas:

- genito-urinary medicine (GUM) services
- district nursing services
- elective hip replacement services
- neonatal services.

For each service area, in order to identify existing evidence on financial and other pressures and to inform the interviews with stakeholders, we reviewed the following:

- relevant research literature, policy documents and grey literature, dating back to 2005
- media stories relating to the specific or wider service area
- published data, including data on budgets, costs, activity and outcomes.

Semi-structured interviews

Interviews were carried out with a number of stakeholders in relation to each of the four service areas between April and July 2016. These included national bodies, patient representative organisations and staff from local commissioning and provider organisations, including managers, clinical leads and nursing staff (provider organisations) and commissioning leads and contract managers (commissioning organisations).

As far as possible, we selected interviewees from organisations that varied in terms of performance (clinical and financial) and geography. Where relevant, we also sought representatives from NHS and non-NHS provider organisations. In addition to the service-specific interviews, we carried out a small number of interviews with stakeholders who were likely to have a wider perspective – for example, representatives of local Healthwatch organisations.



The number of interviews conducted (99 in total) was broken down as follows: GUM (39); district nursing (19); elective hip replacement (18); neonatal (19); other/general (4).

The purpose of the interviews was to understand three key issues:

- the different perspectives on the financial and other pressures facing these services
- the way in which the system is responding
- whether and how patient care, and staff, are being affected.

Interviews with national stakeholders focused on the high-level themes in each of these areas, while interviews with local stakeholders included some discussion of the more detailed aspects of commissioning and service provision. We conducted all interviews on a confidential basis.

Interviews were audio-recorded and professionally transcribed. The content of the transcripts was analysed, and this analysis and the findings of the evidence review were used to develop detailed write-ups of the pressures facing each service area (set out in sections 4 to 7). These were each peer reviewed by two to three relevant experts, including a representative from a provider and a commissioning organisation.

Limitations of the research

Our research was limited by the lack of published data available to track changes in patient care over time. This was particularly the case for our district nursing and GUM case studies, which draw more heavily on evidence from our qualitative fieldwork.

The qualitative evidence in this report helps to fill in some of the gaps in published data, but is based on information collected from interviews with a relatively small group of people working in each service area. Although we sought views from a range of individuals (*see above*), there is a risk that our evidence does not capture the full range of experiences in each service area across England.

Table 1 outlines the key characteristics of the different service areas.



Table 1 Key characteristics of four case study service areas

GUM	District nursing	Hip replacements	Neonatal care
What type of service is it?			
Public health	Community health service	Routine elective	Specialised service
How much is spent on it annually?			
£366m in 2015/16 (Department for Communities and Local Government 2016b)	It is not possible to obtain an accurate figure for spending on district nursing services, or on community health services more generally	National data not publicly available Reference cost data suggests that the cost of delivering elective hip procedures was approx £344m in 2015/16 (Department of Health 2016a)	National data not publicly available Reference cost data suggests that the cost of delivering neonatal care services was approx £755m in 2015/16 (Department of Health 2016a)
Who is the commissioner?			
Local authority	CCG	CCG	NHS England
How is it commissioned?			
Block contract or locally agreed tariff usually based on NHS Improvement's Payment by Results (PbR) tariff or newly developed integrated sexual health tariff that covers GUM and contraceptive services	Most services are funded under block contracts	Majority paid for under national tariff, with some flexibility for locally agreed prices. Some block contracts also in place	Determined locally – block contract or locally agreed tariff
Who are the main providers?			
NHS acute trusts, increasing independent sector provision Some sexually transmitted infection (STI) testing is also provided by GPs and some pharmacies	Standalone community NHS trusts; combined community and acute or mental health trusts; charities, social enterprises or private sector providers	Majority acute NHS hospitals together with additional supply from other independent sector hospitals	NHS acute and specialist trusts and one private provider

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Table 1 Key characteristics of four case study service areas *continued*

GUM	District nursing	Hip replacements	Neonatal care
Who are the main users?			
Around three-quarters of users are aged 15–34 (Public Health England 2016a)	Adults of all ages, with a range of conditions and needs, who require nursing care at home. Most often required by older adults	The majority of patients are aged 50+	Premature babies and other babies with specialist care needs
How do they access the service?			
Open access – no referral needed	Referrals may come from: GPs, hospital doctors, other health and social care professionals, or self-referral	Referral from general practice	Inward referral from obstetric, maternity or fetal services, or referral from other neonatal providers
What type of care do they receive?			
STI testing, treatment and prevention, contraception	This may include long-term condition management, treatment of acute illness, post-operative care and end-of-life care	Surgical intervention	Special care, high dependency care and intensive care
How is the service delivered?			
In hospital and community settings. Often in 'one-stop shop' clinics that also provide contraception and/or HIV treatment	Care usually takes place in one-to-one interactions in patients' homes	In surgical theatres in NHS acute trusts or private provider sites	Providers work together in networks (known as operational delivery networks), which comprise three levels of unit: intensive care, local neonatal, and special care baby units



Structure of the report

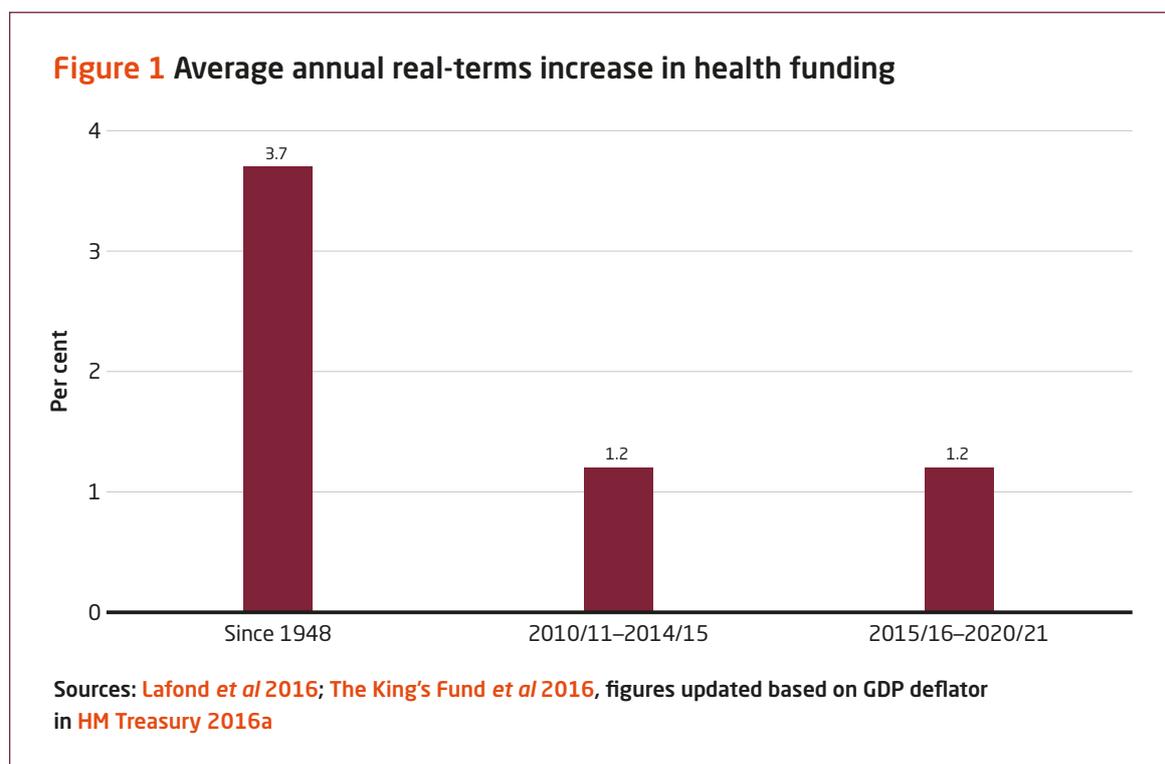
Section 2 sets the context for our research by outlining the extent of the financial and other pressures facing the NHS. Section 3 describes how spending decisions are taken in the NHS and outlines two frameworks that helped us to understand the range of ways in which providers and commissioners respond when funding does not cover demand. Sections 4 to 7 present the research findings in each of the four service areas: GUM services, district nursing services, elective hip replacement services and neonatal services. The report ends by discussing what the research findings tell us about how financial pressures are affecting patient care across the NHS.



2 Financial and operational pressures in the NHS

This section of the report describes the challenging context within which NHS organisations are currently operating. This is the starting point for our research in the four chosen service areas.

The level of financial pressure on the NHS is severe and shows no signs of easing (see Figure 1). This is primarily due to a significant slowdown in funding growth: 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 historic annual growth rate of 3.7 per cent.

This decline in funding growth has occurred at a time when the NHS is treating more patients than ever before (*see box*). The current rate of funding growth is not sufficient to cover growing demand, which is estimated to cost NHS providers an extra 4 per cent each year ([Lafond et al 2016](#)).

Recent increases in NHS activity

- More than 22.9 million **accident and emergency (A&E) attendances** in 2015/16: a **7 per cent increase from five years ago** and a 22 per cent increase from 10 years ago ([NHS England 2016a](#)).
- More than 4.1 million **emergency admissions via A&E** in 2015/16: a **16 per cent increase from five years ago** and a 40 per cent increase from 10 years ago ([NHS England 2016a](#)).
- More than 89.4 million **outpatient appointment attendances** in 2015/16: a **27 per cent increase from five years ago** and a 79 per cent increase from 10 years ago ([NHS Digital 2016c](#)).
- More than 8.46 million **elective admissions** in 2015/16: a **14 per cent increase from five years ago** and 41 per cent more than 10 years ago ([NHS Digital 2016b](#); [Health and Social Care Information Centre 2011, 2006](#)).
- Total **clinical contacts in general practice** are estimated to have **increased by more than 15 per cent** between 2010/11 and 2014/15 ([Baird et al 2016](#)).
- More than 1 billion **prescription items dispensed** in 2015: an **increase of 50 per cent from 10 years ago** ([Health and Social Care Information Centre 2016](#)).

Lack of funding and rising demand are by no means the only challenges facing the health service. There are a range of factors that affect the availability and quality of patient care (*see Figure 2*). While the impact of each of these factors is intensified by the financial challenges, some of them have an independent impact on patient care that does not relate to funding.

Figure 2 Factors affecting the quality of health care services patients receive



For example, capacity within the NHS workforce is key to the service’s ability to offer the care required and ensure that care is of high quality. However, there are workforce shortages across the health service that cannot be addressed in the short term by extra funding alone. Some providers have no staff available locally to fill vacancies, even where funding is available to cover their salaries. The National Audit Office (NAO) reported an NHS staffing shortfall of almost 6 per cent in 2014, equivalent to a gap of around 50,000 full-time equivalent staff ([National Audit Office 2016b](#); [The King’s Fund 2016](#)).



To address these pressures, the NHS has been set a series of productivity targets since 2010. Most recently, the Forward View challenged the health service to find £22 billion in savings by 2020/21, equivalent to 2–3 per cent each year (NHS England *et al* 2014). This is a significant challenge when compared to the average productivity growth over the past 35 years, of around 1 per cent a year (The King’s Fund *et al* 2016; Alderwick *et al* 2015; NHS England *et al* 2014). Although there are extensive opportunities for the NHS to improve productivity and provide higher-quality care at a lower cost, it can take years to realise significant savings (Alderwick *et al* 2015; Ham 2014).

Different parts of the health system have responded to the funding and productivity challenge in different ways. Until recently, deficits have effectively been tolerated in the acute sector, which overspent against budget in each of the past three years and posted a deficit of almost £2.6 billion in 2015/16 (*see* Table 2). At the same time, acute sector performance is worsening against key waiting time targets for accident and emergency (A&E) services and elective care (Murray *et al* 2016).

Table 2 Net financial position by provider sector, 2013/14 to 2015/16

	Acute	Mental health	Ambulance	Specialist	Community
2013/14	-£421m	+£163m	+£15m	+£112m	+£39m
2014/15	-£1,014m	+£87m	+£13m	+£56m	+£15m
2015/16	-£2,581m	+£55m	-£12m	+£73m	+£18m

Source: adapted from Dunn *et al* 2016; 2015/16 figures updated from audited accounts (NHS Improvement 2016a, 2016b)

Financial performance in other parts of the NHS looks more robust (Table 2). However, this raises two questions: how have providers outside of the acute sector managed to balance their budgets, and what impact has this had on patient care?

There is relatively little data on operational performance outside of the acute sector, which makes it difficult to answer these questions. For example, there is no national



data on access to community services or the quality of care they provide. However, there is evidence to suggest that the better financial performance in mental health and community services may have been partly delivered at the expense of patient care (Maybin *et al* 2016; Gilbert 2015). The King's Fund's work on pressures in general practice shows that it is also an area under significant strain (Baird *et al* 2016).

What does this mean for our research?

In sections 4 to 7 we look at the experiences of four services that have been seeking to maintain quality and access in this pressured and challenging environment. Although our research focuses on the impact of financial pressures, Figure 2 shows that untangling the impact of funding from other pressures on the system is a difficult task. Because of this, our research seeks to describe the range of pressures facing each of the four service areas and acknowledges that these pressures combine in different ways to affect the service delivered to patients. To explore further the different ways in which the financial challenges are experienced across the NHS, we have purposely selected services that are located in different parts of the health system, provided and commissioned by a range of organisations.

Before moving on to present our findings, we provide some context on the different ways in which the NHS can respond when funding does not cover demand.



3 How financial pressures can affect patient care

This section describes how spending decisions are taken in the NHS. It then sets out two frameworks that helped to shape our thinking about the range of ways in which providers and commissioners can respond when funding does not cover demand.

The hierarchy of decision-making

There is no agreed list of services or treatments to which NHS patients are automatically entitled ([Rumbold et al 2012](#)). Instead, patients have a series of broad rights that are outlined in the NHS Constitution, and the care they receive is the result of decisions that are taken at all levels of the system. This ‘hierarchy of decision-making’ ([Klein and Maybin 2012](#)) includes:

- **central government**, which determines how much of the overall public budget to allocate to the NHS, and sets overarching objectives for the service through the NHS mandate
- **NHS England and other NHS national bodies**, which identify priorities consistent with those objectives, and allocate resources between different commissioners
- **commissioners** (clinical commissioning groups (CCGs), NHS England and local authorities), which decide which services to fund (or not fund) in their local area in order to meet patients’ needs
- **providers**, which decide how to allocate the resources they receive from commissioners between departments, services or individual wards
- **clinicians**, who decide whether a patient needs treatment (within the parameters set by others in this hierarchy) and what care they should receive, in consultation with the patient
- **patients**, who increasingly take part in a shared process of decision-making about whether to receive treatment, what type of treatment to receive and what care they can provide for themselves through self-care.



In some cases, decisions about what care patients receive are explicit – published in policy documents and open to public debate; in others, they are implicit – for example, decisions taken by clinicians ‘at the bedside’.

Decisions at every level are influenced by a range of factors. These include professional judgement, local and national priorities, historic service provision, and guidance provided by the National Institute for Health and Care Excellence (NICE) and other professional bodies. These decisions are also influenced by the level of funding available; indeed, determining how to deliver high-quality services within finite budgets is a fundamental challenge for any publicly funded health care system.

Six ways in which financial pressures can affect patient care

Where funding does not cover demand, patient care can be affected in different ways. These changes can be the result of deliberate decisions to restrict access to a service or reduce its quality, but more often than not, they are the unintended by-product of decisions focused on other issues. For example, a commissioner’s decision to move to a cheaper service model might lead to a reduction in the quality of the service, even if this was not an explicit choice at the outset.

In this subsection, we outline a framework developed by Rudolf Klein and Jo Maybin in a previous report from The King’s Fund, *Thinking about rationing*, which describes six different ways in which patients’ access to high-quality care can be restricted (Robertson 2016; Klein and Maybin 2012). This framework introduces a broader way of thinking about the impact of financial pressures on patient care and shows that some impacts are easier to detect than others.

Our analysis of national media reporting of the words ‘NHS’ and ‘rationing’ found that it focuses on instances where restrictions are placed on patients’ access to care (*see box on media reporting on NHS rationing*). However, while the first five approaches in the framework below relate to access to care, the final one focuses on the equally if not more important instance where patients still receive care, but its quality is adversely affected by a lack of funding.

Below, we describe each of these six types of rationing in turn and provide an example of where it is happening in the NHS. A separate report provides more examples (Robertson 2016).



Although not relevant to the NHS, a further type of rationing not captured in the framework below is rationing by price. In the health systems of some other countries and in the English social care system, funding constraints may result in people being charged more for a service.

Rationing by deflection

What is it?

One part of the health (or care) system refuses to provide an individual with a service (even though it is clinically appropriate for that person to be treated) or to fund their care, and instead seeks to transfer this responsibility to another part of the system. This may involve deflecting a patient to another funder – for example, from a CCG to the local authority. It may also mean diverting a patient to another NHS provider.

Is this happening in the NHS?

Efforts by CCGs in one area of England to encourage referrals to the private sector for patients with private health care insurance provide a recent example of this happening in practice. One CCG has seen a 5.75 per cent increase in private sector referrals in the first six months of 2016 (compared with the same period in 2015) since writing to GPs encouraging them to remind patients to consider using their private health care insurance ([Price 2016](#)). In the NHS, we also often see examples of deflection *from* social care, when medically fit patients are delayed in hospital as they wait for social packages to be put in place in their homes ([Thompson 2015](#)).

Rationing by delay

What is it?

Patients are required to wait longer for a diagnosis or treatment. National maximum waiting time targets are in place to limit the extent to which the NHS can delay access to some services.

Is this happening in the NHS?

National data shows that performance against national waiting time targets is worsening. In the second quarter of 2016/17, performance against the target that patients spend no longer than four hours in accident and emergency (A&E) was at its worst level for this quarter for more than a decade, and waiting lists for elective treatment were at their highest level since 2007 ([Murray et al 2016](#)).



Rationing by denial

What is it?

Patients are not provided with a certain treatment because the relevant commissioner does not fund it, or because the provider does not consider it appropriate. This includes decisions not to provide ineffective or low-value treatments, but can also mean denying patients effective care on cost-effectiveness grounds. In practice, denial can overlap with selection (*see below*), as few treatments are denied to all patients in all cases. However, the two can be distinguished by the fact that denial relates to rationing of a particular treatment, whereas selection relates to rationing for particular patients.

Is this happening in the NHS?

In reality, there are very few (if any) treatments that are denied to all patients in all circumstances. Even where a service is not routinely available, GPs can submit individual funding requests to their CCG asking them to fund care in exceptional cases. Most CCGs publish lists on their websites of treatments that are not routinely funded – for example, because they are of low or no clinical value. Some areas use the list of 34 procedures developed some years ago by Croydon Primary Care Trust ('the Croydon list') as a starting point. This includes procedures that are considered to be relatively ineffective (eg, grommets) or largely cosmetic (eg, varicose vein removal), those that have a small benefit-to-risk ratio in mild cases (eg, wisdom tooth extraction), and those for which cost-effective alternatives should be tried first (eg, carpal tunnel release surgery) (**Audit Commission 2011**).

Rationing by selection

What is it?

Selection is the denial of treatment to certain patients who do not meet a set of eligibility criteria. These criteria are typically linked to evidence on effectiveness of different treatments for people with different characteristics.

Is this happening in the NHS?

Recent examples of selection include the introduction of body mass index (BMI) and other criteria to determine which patients are referred for surgery (**Bodkin 2016**; **Santry 2016**). As discussed in more detail in section 6, these actions have proved controversial, with some questioning their clinical basis.



Rationing by deterrence

What is it?

The NHS – either deliberately or inadvertently – can put up barriers that make it difficult for patients to find out about and book appointments with local services. If individuals are not given information about a service, they may not realise that their access to care has been restricted.

Is this happening in the NHS?

An example of deterrence is the increasing difficulty patients are experiencing in contacting their GP surgery. The national GP Patient Survey found that 26 per cent of people had experienced difficulties in getting through to their surgery on the phone in 2016, compared with 18 per cent in 2012 ([Ipsos MORI 2016](#)).

Rationing by dilution

What is it?

Unlike the other approaches, dilution relates to the quality of care patients receive, rather than their access to a particular service or treatment. Where dilution occurs, a service or treatment continues to be provided, but the quality of that service is reduced as a result of pressure on resources. This may be because there are fewer staff to deliver the service or a change is introduced to the way the service is delivered that has a detrimental effect on quality.

Is this happening in the NHS?

One example is in mental health services, where the pressure to reduce costs has been a major factor driving large-scale changes to services, which may have had a detrimental impact on patient care ([Mental Health Taskforce 2016](#); [Gilbert 2015](#)). There is evidence that while the number of patients using adult secondary mental health services in England has risen (by 5.1 per cent between 2011/12 and 2012/13), the number of contacts that each patient has with the service has fallen (by 4.3 per cent over the same period). This means that more patients are receiving treatment, but their treatment involves fewer appointments or contacts with the service ([Gilbert 2015](#)). However, we do not have metrics to define whether this has resulted in a dilution of quality, which highlights the difficulty identifying this type of rationing.



Media reporting on NHS rationing

We were interested to explore how the national media understand and report on NHS rationing, and how the nature and volume of reporting has changed over time. We therefore undertook a systematic, retrospective search of media coverage. Eight media sources* were searched for articles using the terms 'ration', 'rationed' or 'rationing' in relation to the NHS from January 2011 to December 2016.

Volume

NHS rationing was reported throughout the period, with reports increasing markedly towards the end of this search period. There were 225 stories in 2016 compared with 144 in 2015 and 86 in 2011. Our search indicates that media interest in NHS rationing is growing; this is reflected by publications that rarely covered stories about NHS rationing in the early years of the search period beginning to do so much more frequently in 2016.

In the latter half of 2016, there has been an increasing volume of stories about the severe financial difficulties facing the NHS, with warnings that this will 'force hospitals across the UK to shut down' ([Woodhouse 2016](#)) and that the NHS is 'in meltdown' ([Pickles 2016](#)) and 'on the brink of collapse' ([Campbell 2016](#)).

Content

NHS rationing is clearly an emotive topic, demonstrated by many of the headlines that appeared in our search. The results of the search provide an insight into the sorts of things that are reported as 'rationing', suggesting that this term is usually understood to relate to access restrictions. Much of the reporting focused on:

- restricted access to drug treatments, particularly cancer drugs. Decisions by NICE were frequently reported throughout the search period, and some media sources refer to NICE as the 'NHS rationing body'
- restricted access to procedures including in vitro fertilisation (IVF), cataract surgery and vasectomies
- restricted access to equipment such as hearing aids
- restricted access to surgery for certain groups of people, such as smokers or those with a high BMI
- rising waiting times for surgery or other procedures.

* Sources: BBC News, the *Daily Mail*, *The Guardian*, the *Metro*, *The Mirror*, *The Sun*, *The Times* and *The Telegraph*

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Media reporting on NHS rationing *continued*

Variations in access to NHS care in different areas are another common subject of reports about NHS rationing. This variation is commonly described in the press as the 'postcode lottery', and is often reported in relation to individual cases.

By comparison, only a handful of the stories that appeared in our search reported on quality dilution. These stories related to reductions in nurse numbers, with headlines such as: 'Nurses forced to ration care on wards due to lack of time after 5000 posts cut' ([Press Association 2013](#)) and 'NHS patients suffering falls at night due to nurses looking after 18 people each' ([Gregory 2016](#)).

This does not tell us about overall reporting on quality dilution, but does suggest that the media tend to associate the term 'rationing' with access rather than quality issues.

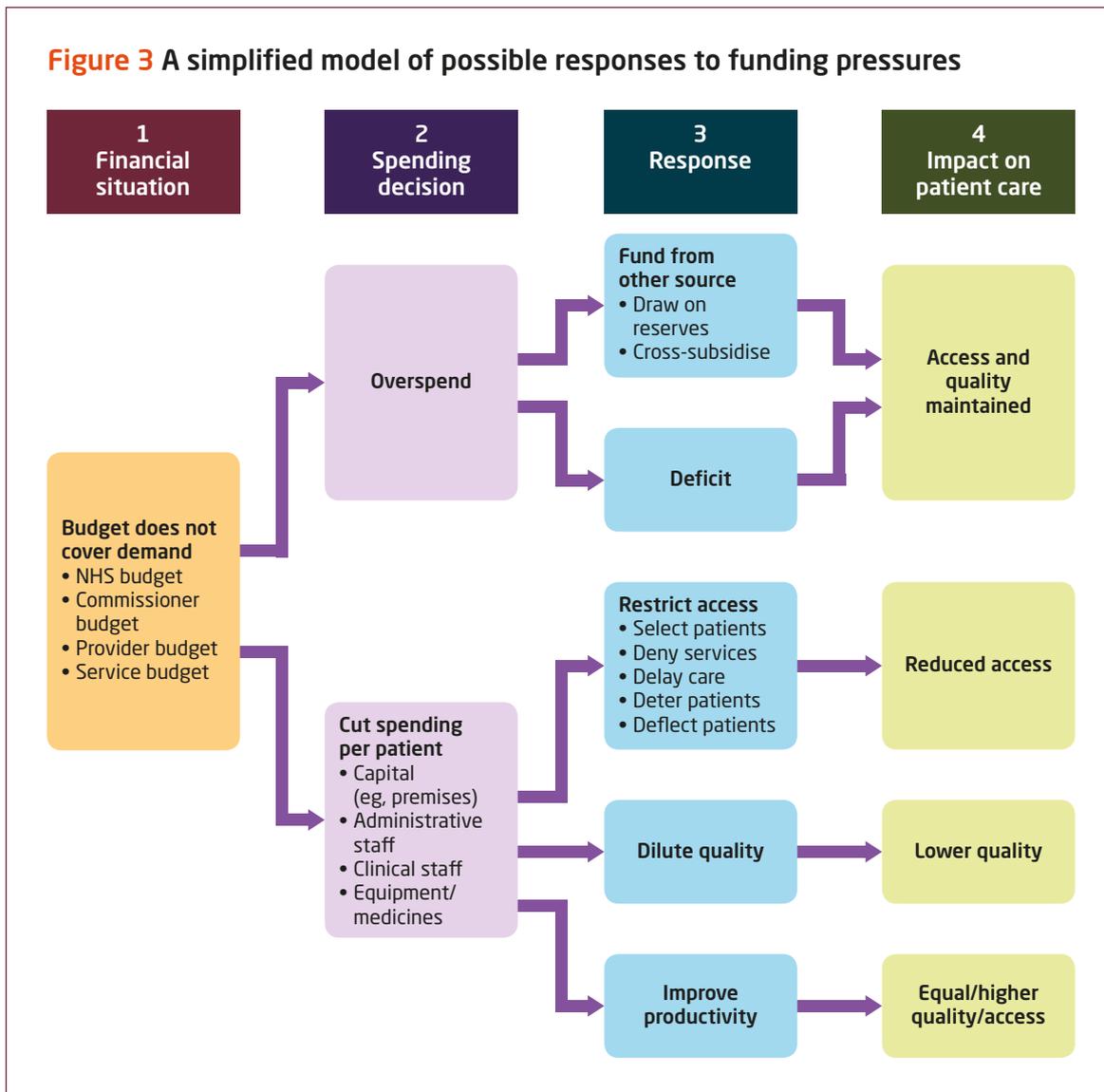
A model for understanding the impact of financial pressures

Although the NHS has always had to take difficult decisions about how to allocate resources, increasing financial pressures mean that these decisions are becoming more challenging.

Drawing on the discussion above, we developed a simplified framework for understanding the way in which NHS organisations can respond to increased financial pressure (*see* Figure 3). The figure shows that in addition to the six types of rationing discussed earlier, an organisation may also be stimulated to improve productivity or – as has, until recently, been the case in the acute sector – they may go into deficit.

In reality, an organisation will employ multiple strategies. For example, it may be in deficit while also improving productivity and putting restrictions on access to care. Legal requirements, national regulations and the nature of different services also close off some of these routes for certain services and open up others. As already discussed, the responses outlined in Figure 3 are not always the result of conscious decisions to restrict access or reduce quality; rather, they are often the unintended consequences of decisions about other issues.

Figure 3 A simplified model of possible responses to funding pressures



What does this mean for our research?

The research described in sections 4–7 looks at four services that have taken different paths through the diagram outlined in Figure 3. By talking to those who plan and deliver care in four service areas, our research investigated whether each of the responses outlined above, including some of the less visible impacts of financial pressures (described on pages 20–2), are occurring in the NHS and affecting patient care.



4 Genito-urinary medicine (GUM) services

Key messages

Our research found clear evidence that pressure on GUM services has increased and 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.

- National data suggests that financial pressures really began to bite in 2015/16 when local authority spending on GUM services fell by 3.5 per cent compared to 2014/15, as commissioners implemented cuts to public health budgets.
- There is significant variation at a local level. 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.
- Demand for GUM services is increasing rapidly. The number of new attendances at GUM clinics increased by nearly a third between 2011 and 2015, and diagnosis rates for sexually transmitted infections (STIs) such as syphilis and gonorrhoea are increasing.
- We found evidence of services being tendered with significantly lower budgets. In some areas, this has resulted in clinics being closed, moved to less convenient locations or operating with reduced opening hours.
- There have also been cuts to health adviser posts and to prevention, sexual health promotion and outreach services targeted at high-risk groups. This is very worrying given that the incidence of some STIs is increasing rapidly.



- In contrast, some commissioners and providers have developed new models of care and new contracting approaches to maintain the quality of services. Financial pressures have also stimulated innovations such as the introduction of home sampling kits, which can be ordered online.
- Changes introduced in 2013 have resulted in a stronger focus on value for money but have fragmented commissioning, leading to disjointed services for some patients and lack of clarity over accountability at local and national levels.
- Alongside reductions in staff in some organisations, we found evidence that these pressures are having a negative impact on staff morale and leading some to consider alternative careers.
- GUM is protected 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.

What are genito-urinary medicine services?

GUM services provide testing, treatment and prevention interventions for STIs such as chlamydia, genital warts and gonorrhoea. They also provide testing (but not treatment) for HIV. GUM is an important clinical service, as it protects patients from the long-term consequences of untreated STIs, which can include infertility and chronic pelvic pain. It also performs a key public health function, in that it stems the onward transmission of infections and reduces the risk of epidemic.

Local authorities have commissioned GUM services since 2013, when public health functions were transferred to them from primary care trusts (PCTs) as part of the Health and Social Care Act 2012 reforms. GUM is one of three sexual health services commissioned by local authorities from their public health budget (the other two being contraception, and sexual health advice, promotion and prevention). Regulations dating back to 1916 place a legal requirement on local authorities to provide an open access confidential STI testing and treatment service (**Department of Health 2013a**).



GUM services are mainly provided in consultant-led clinics that are usually run by NHS acute trusts in both acute and community locations. The service is configured in different ways across the country – sometimes alongside HIV treatment services, and increasingly integrated into community-based ‘one-stop shops’ with sexual and reproductive health services ([Department of Health 2013b](#)). Recent tendering exercises have accelerated the pace of reconfiguration and have increased the number of private sector providers.

Although GUM is a mandated service, it is left to local authorities to decide how they commission it – for example, deciding the number of clinics, what hours they open, and the staffing model used. Recommended service standards with quality measures have been developed by the British Association for Sexual Health and HIV ([2014](#)) and the performance of GUM services is monitored at a national level via two indicators in the public health outcomes framework: HIV late diagnoses and chlamydia diagnoses among 15–24-year-olds ([Public Health England 2016c](#)).

Although this case study focuses on GUM, many of the clinical and managerial staff that we spoke to during our research worked across GUM, sexual and reproductive health and HIV services. As these are very closely connected, it is difficult to isolate the impact of financial pressures on GUM services alone. We picked up issues relating to these other service areas, and have included these below where they impact on GUM patients.

Is this service under financial pressure?

What the data tells us

Forecasts for 2016/17 show that local authority funding has shrunk by 26 per cent in real terms since 2009/10 (after removing the effect of changes to local authority commissioning responsibilities over that period) ([Smith et al 2016](#)). However, since moving to local authorities, public health spending has been somewhat protected from this level of cuts by a ring-fenced budget (although the protection does not extend to specific services).

In stark contrast to other areas of local government spending, the public health grant actually increased after it was transferred from PCTs, although this trend was short-lived. More than a quarter of local authorities saw their public health



budgets increase by around 20 per cent over the two years to 2014/15 ([Department of Health 2013d](#)). However, in 2015/16, public health budgets were cut by £200 million (6.7 per cent) during the year ([House of Commons Health Select Committee 2016](#)) and local authorities have been asked to find further real-terms savings equivalent to at least £600 million by 2020/21 (equivalent to average real-terms savings of 3.9 per cent a year) ([The King’s Fund et al 2016](#)). Local authorities are legally required to balance their books each year, making it inevitable that commissioners will pass these cuts on to providers.

STI testing and treatment accounts for a significant proportion of local authority public health spend (around 12 per cent on average, with some local authorities spending up to 32 per cent of their public health budget on GUM ([Department for Communities and Local Government 2016b](#))), so it has been identified as a particular area to contribute to these savings. Between 2013/14 and 2015/16, reported local authority expenditure on STI testing and treatment decreased by around 4 per cent in cash terms, with the majority of that reduction occurring in 2015/16 (see Figure 4). However, the picture varies considerably across the country.

Figure 4 Local authority expenditure on STI testing and treatment services 2013/14 to 2015/16



Source: [Department for Communities and Local Government 2016a, 2016b, 2015](#)

Note: changes are in cash terms



Between 2013/14 and 2015/16, around one in four (36) local authorities reported cuts to their spending of more than 20 per cent in cash terms, while around one in seven (20) reported increases of this amount ([Department for Communities and Local Government 2016b, 2015](#)). Budgets for 2016/17 show that cuts are set to deepen: planned national spend on STI testing and treatment is 7 per cent less than planned spending in 2015/16 ([Buck 2016](#)).

Other areas of public health spend that are not protected by a legal mandate have seen much bigger reductions. This includes spending on sexual health advice, promotion and prevention, which decreased by 14.6 per cent between 2013/14 and 2015/16 ([Department for Communities and Local Government 2016b, 2015](#)).

What the interviews tell us

Although the mandate means that GUM services are somewhat protected from cuts, and national data suggests that significant spending cuts did not start until 2015/16, interviewees told us that some services had experienced large budget cuts before this time. This reflects the variation in spending data at local level and the time lag between agreeing a contract and implementing it.

The starkest accounts came from providers and commissioners who had been through tendering exercises over the past three years. They told us about GUM services being put out to tender with budgets that were up to 40 per cent lower than in their previous contract. Those whose service had not yet experienced a budget cut were anticipating reductions over the next few years.

We also heard that the ring fence around the public health budget was quite 'leaky'; interviewees told us that some local authorities were defining spending on other services (such as parks and non-health services) as falling within public health.

Looking to the future, there were also worries about the removal of the ring fence in 2018/19. Commissioners and providers both told us that they were worried about public health money being channelled to other local authority services to compensate for cuts to council budgets. Uncertainty about budgets beyond 2018 is making it difficult for some to plan services properly and to contract services for more than two or three years. The impact of the proposed shift to funding via retained business rates from 2018/19 is adding to the uncertainty.



Funding pressures on GUM services date back well before the current financial squeeze; indeed, before 2010, there were reports of sexual health monies being diverted elsewhere in the NHS ([White 2008](#); [Mooney 2007](#)). However, many interviewees told us that the current situation felt more intense and was having a bigger impact on service provision than anything they had experienced in the past.

What other challenges is the service facing?

Funding pressures are not the only challenge facing GUM. The service is struggling to cope with rising demand, the fragmentation of sexual health commissioning since 2013, and workforce and accountability issues. Although these issues have an effect independent of the financial challenge, in each case their impact is intensified by it.

Patient demand

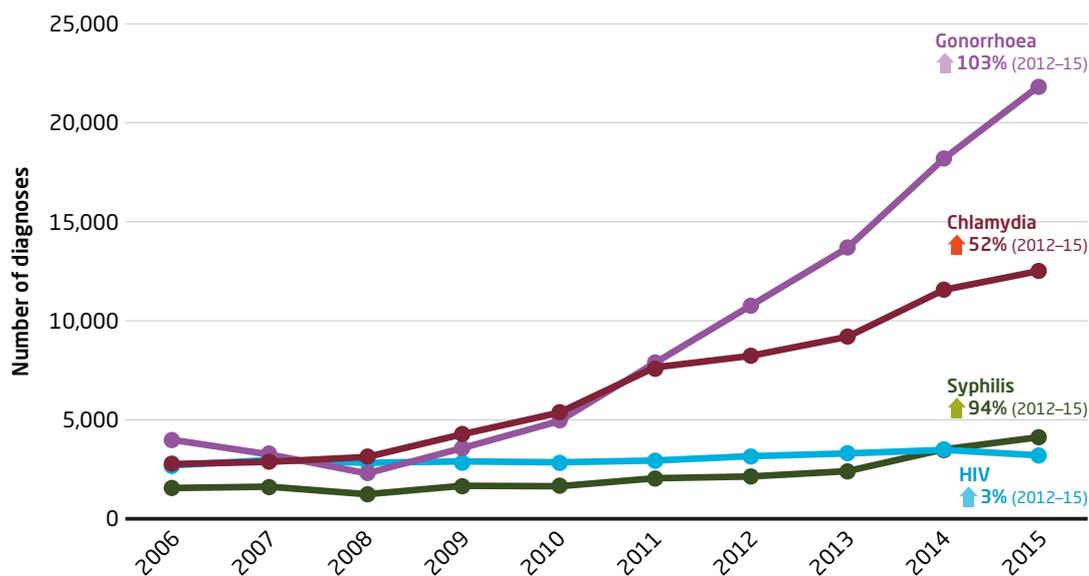
Demand for GUM services is growing: the number of new attendances at GUM clinics increased from 1.6 million in 2011 to more than 2.1 million in 2015 ([Public Health England 2016a](#)). For GUM services, increased demand can be a positive development, as increased testing is the first step to decreasing the prevalence of STIs among the general population.

However, diagnosis rates for many STIs are increasing at a faster rate than attendances, which suggests an increase in the incidence of STIs. Although there was a small decrease in the overall number of new STIs diagnosed in England between 2014 and 2015 (mainly due to a decrease in chlamydia diagnoses), diagnoses of gonorrhoea (up by 11 per cent) and syphilis (up by 20 per cent) continue to rise ([Public Health England 2016b](#)).

Increases in STIs are most marked among men who have sex with men ([Mohammed et al 2016](#)). Figure 5 shows the sharp upward trend in gonorrhoea, syphilis and, to a lesser extent, chlamydia diagnoses since 2010 among this group. Public Health England believes that this is due to an increase in condomless sex ([Public Health England 2016b](#)).



Figure 5 The number of STI diagnoses among men who have sex with men in England, 2006 to 2015



Source: Public Health England 2015b

Commissioning and contracting arrangements

Changes to commissioning arrangements for sexual health, reproductive health and HIV services

Since 2013, the commissioning of sexual health, reproductive health and HIV services has been split between local authorities, CCGs and NHS England. This has created a confusing patchwork of responsibilities, which, for some patients, has resulted in three different commissioners planning and paying for different aspects of their care (see Table 3).

When we asked commissioners, providers and national stakeholders what one message they would like us to send back to government about GUM services, they most frequently cited the challenges created by these changes to commissioning arrangements. Both the Health Select Committee and the All-Party Parliamentary Group on Sexual and Reproductive Health have highlighted this as a major issue (House of Commons Health Select Committee 2016; All-Party Parliamentary Group on Sexual and Reproductive Health in the UK 2015).



Table 3 Commissioner responsibilities for sexual health, reproductive health and HIV services in England

	Local authorities	NHS England	CCGs
Sexual health	<ul style="list-style-type: none"> • STI testing and treatment • Chlamydia screening • Young people’s sexual health services • Services in schools • Sexual health aspects of psychosexual counselling • Sexual health advice, promotion and prevention 	<ul style="list-style-type: none"> • STI testing and treatment provided under the GP contract 	
Reproductive health	<ul style="list-style-type: none"> • Contraception, primarily delivered in community clinics 	<ul style="list-style-type: none"> • Contraceptive services provided under the GP contract • Cervical screening • HPV immunisation programme 	<ul style="list-style-type: none"> • Termination of pregnancy services • Contraception for gynaecological purposes • Non-sexual health elements of psychosexual health services • Sterilisation
HIV	<ul style="list-style-type: none"> • HIV testing, prevention, and social care 	<ul style="list-style-type: none"> • HIV treatment and care • HIV testing when required in other NHS England-commissioned services 	<ul style="list-style-type: none"> • HIV testing when required in other CCG-commissioned services • Community-based HIV clinical nurse specialists

Source: adapted from **All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015)**

The changes have fragmented commissioning arrangements and, in some areas, resulted in a lack of collaboration between commissioners that has created disjointed pathways for patients (*see* ‘What does this mean for patients?’ on page 40). The fragmentation has also created perverse incentives for commissioners. One interviewee told us that the split in commissioning responsibilities made it easier for local authorities to cut services because they are not financially liable



for the consequences of those service changes. It also means the savings from some of their investments accrue elsewhere. For example, while local authorities pay for STI testing, CCGs pay for the treatment of long-term consequences of untreated chlamydia or gonorrhoea (such as infertility or ectopic pregnancy) and NHS England pays for HIV treatment.

A new approach to commissioning by local authorities

Many of the commissioners we interviewed told us that local authorities have a very different approach to commissioning and procurement than their PCT predecessors – one that is more rigorous and more focused on getting value for money. They told us that in the past, many providers were left alone to develop their services, whereas the new commissioning arrangements involve more specification, more scrutiny and more ongoing monitoring. This cultural divide between the commissioning approach of local authorities and NHS commissioners is influenced by numerous factors, including local authorities' legal requirement to balance their budgets each year, their long experience of procurement, and the fact that GUM is a major component of the local authority's public health budget, when it was just a small part of a PCT's acute services contract.

They [GUM service contracts] didn't have specifications, they didn't have performance indicators, and they've moved from that position to somebody saying 'this is our money, you'll not spend it on anything else. What are you spending it on? Let's have a look at it, tell me what your staffing is? Tell me what you're spending this money on and what's your performance?' So it's been a massive culture shock – 'and oh, by the way, you weren't successful so we're taking business off you'. It's been horrific for them really, if you look at it from where they're sitting.

Commissioner

Some providers criticised the new commissioning approach, telling us that it creates extra work for them (for example, requests for information that they felt were unnecessary). Linked to this, most of the providers we interviewed said that commissioners do not understand their service and that this has contributed to ill-informed service specifications and poor commissioning decisions.



Workforce

Across the country, there are difficulties recruiting doctors into GUM-specialty training programmes. One interviewee told us that 50 per cent of training places in their service were unfilled. Suggested reasons include the increasingly less-medical nature of the specialty (HIV treatment and care has changed significantly and many GUM services have integrated with contraception services and moved into community settings). They also include the uncertainty created by tendering: when services move to non-NHS providers, they frequently stop providing specialist training places ([British Association for Sexual Health and HIV 2013](#)) and the prospect of ongoing tendering exercises throughout their careers puts some clinicians off applying for these posts. Providers also told us that they had experienced difficulties recruiting to band 6 (more experienced) nursing roles.

National policy and oversight

Local authorities are democratically accountable to their local population for the services they provide, but national accountability for the quality and outcomes of their public health commissioning work is unclear. The All-Party Parliamentary Group on Sexual and Reproductive Health has highlighted the urgent need to clarify accountability arrangements for sexual health, reproductive health and HIV services at both local and national levels following the 2013 changes to commissioning structures ([All-Party Parliamentary Group on Sexual and Reproductive Health in the UK 2015](#)).

The controversy over whether NHS England or local authorities are responsible for funding PrEP – a medication that can prevent the transmission of HIV – is a recent example of the confusion over commissioning responsibilities and accountability created by the 2012 reforms ([Baylis 2016](#)). Because this is a ‘pre-exposure’ medication taken before sex, NHS England argued that it does not have the power to commission PrEP as it should be considered as ‘preventive care’ (funded by local authorities) rather than ‘treatment’ (funded by NHS England). However, a High Court ruling has now confirmed that NHS England does have the power to commission the drug ([Dearden 2016](#)).



What are the responses to these challenges?

Commissioning and contracting

Faced with shrinking budgets and increasing demand, commissioners have started to look for new ways to make savings in their GUM budget. When local authorities took over responsibility for commissioning GUM services in 2013, they initially rolled over previous PCT contracts. Over the past three years, though, these contracts have started to be put out to tender, providing an opportunity for local authorities to make ‘big bang’ changes to the GUM service model and to reduce budgets significantly (*see above*). We also heard examples of tendering exercises where incumbent providers had not submitted bids for a contract, or had submitted bids for more than the contract amount, because they felt it was impossible to provide a safe and effective service within the given budget envelope.

Interviewees also told us about other developments, including the following.

- Some services are moving from tariff-based to block contracts in order to control commissioner costs (shifting the financial risk of increased activity on to providers).
- A new integrated tariff for GUM and contraceptive services has been introduced in some areas, which commissioners consider better reflects the true cost of providing these services (a number of commissioners described GUM as being historically overfunded, while contraceptive services were underfunded).
- One commissioner told us that their neighbouring local authority was refusing to pay when their patients attended clinics outside of the local area, and another commissioner told us they were considering adopting this policy from next year. Local authorities are responsible for the cost of their local population’s care wherever they access it across England, and the government has recommended that a consistent cross-charging process is set up for circumstances where local residents seek care elsewhere ([Department of Health 2013c](#)).
- Some commissioners have added incentives to contracts to encourage providers to repatriate out-of-area patients.



- Other local authorities are addressing the issue of residents seeking care outside their area by taking collaborative approaches to commissioning across regions. This was one of the motivations behind the London Sexual Health Transformation Programme, which is developing a collaborative approach to sexual health commissioning across 29 London boroughs and plans to implement the integrated sexual health tariff in most London boroughs from April 2017 ([London Councils 2016](#)).
- Some commissioners were seeking legal advice on the definition of a 'comprehensive open access service' to enable them to identify what further changes can be made to services within the law.

Productivity improvements and innovation

Some interviewees acknowledged that funding pressures motivated them to think creatively and challenge their service model. Others felt that services were being forced to focus on managing demand, rather than innovations that provide a better service for patients:

... that's the tragedy about this, is you give a blank sheet of paper to local government to do something really exciting, and then you take the money away. However innovative you are, you need a little bit of money to be innovative, often. And so, the innovation we're seeing, is trying to work out how to do the same for less, or more for less, rather than saying, 'oh, wouldn't it be exciting to try this', or 'now we could join things up'. What have we got in local government? We've got schools, we've got parents, we've got gyms, we've got drugs. Come on, let's put GUM in with that.

Consultant

Despite this, interviewees did talk about innovations and new ways of working that are helping GUM services improve their productivity and operate within their funding constraints. Some of the most striking of these involve the introduction of digital services. Innovations include the following.

- **New staffing models and staff training** that enable services to work with less specialist input. These include nurse-led services and initiatives to develop more pharmacy and GP provision to ease pressure on GUM clinics and provide



different access routes for patients. These models are seen as positive by some, but others expressed safety concerns over the reduction in specialist clinician input (*see below*).

- **Innovative approaches to commissioning** sexual health, reproductive health and HIV services in order to address fragmentation in patient pathways. For example, in Norfolk, the local authority and NHS England used a Section 75 agreement and a competitive dialogue procurement approach to jointly commission their GUM, contraceptive and HIV services as a ‘one-stop shop’ (**Local Government Association and Medical Foundation for HIV and Sexual Health 2015**).
- **Online access to self-sampling kits for use at home.** These allow people to order home sampling kits online, send off samples to be tested and receive results via text message. This improves patient choice and access for people who cannot easily get to a GUM clinic, or who would feel embarrassed to attend a clinic in person. Interviewees recognised that this could bring great improvements in access but some also emphasised that online testing should be ‘in addition to’ rather than ‘instead of’ GUM clinics, as online sampling does not provide the face-to-face contact needed to deliver a service that addresses the full range of some patients’ needs and would not be the right approach for all patients.
- **Patient triage in the waiting room, sometimes using digital triage systems** so that symptomatic patients are identified and seen by medical staff or advanced nurse practitioners, while asymptomatic patients are given self-testing kits that they can use themselves at the clinic and receive the results via text message.

One large-scale example of the implementation of digital or ‘e’ services is the London Sexual Health Transformation Programme. It will introduce: an online portal that provides information about sexual health; online triage that directs people to the most appropriate service for their needs; and access to self-testing kits. The programme aims to use digital services to make better use of resources by providing self-sampling for low-risk asymptomatic clients, freeing up GUM clinic time to deliver targeted services for high-risk clients (**London Councils 2016**).



Priorities for future investment

We asked interviewees about their priorities for future investment in GUM services. The most popular response among those from provider, commissioner and national stakeholder organisations was to invest in outreach services and prevention. These are community-based education and testing initiatives that target at-risk groups such as men who have sex with men, young people and sex workers. Most interviewees felt that although the core GUM service was under pressure, the best way to manage demand in the long term was to target investment on these upstream services, many of which have lost funding in recent years.

Other suggested areas for investment included digital technology, extending clinic opening hours, and increasing the number of GUM clinics.

What does this mean for patients?

Access to care

Financial pressures have had a significant impact on patient access to GUM services in parts of England. We heard examples of tendered services that reduced the number of GUM clinics, moved clinics to less convenient locations, or reduced clinic opening hours to cut costs. All of these changes had been made over the past three years. In one instance, a tender that integrated GUM and contraceptive services resulted in a reduction in the number of clinics from 13 to 5. Reducing the number of clinics is not always a bad thing for patients as it may result in the remaining clinics staying open for longer hours, but we heard of instances where access was made more difficult – for example, towns that no longer had their own GUM clinic.

This adds to evidence collected by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015), which shows that tendered GUM services have changed both clinic locations and opening times in order to cut overheads. The group also found evidence that access to STI testing has been restricted based on age.

While many clinics provide walk-in appointments, we heard examples of services that have moved to appointment-only clinics because of high demand. There is also some evidence that it is getting more difficult for patients to access GUM services quickly.



A national 48-hour waiting time target for GUM services introduced in 2004 improved access to GUM services significantly (Mercer *et al* 2012; **Department of Health 2008**). However, the target was discontinued in 2010 and waiting times are no longer measured at a national level (although some local authorities still monitor performance). A survey of 236 GUM clinics conducted by Public Health England found that between 2013 and 2014, the proportion of patients offered an appointment within 48 hours had decreased from 95 per cent to 88 per cent (Prescott *et al* 2015). A follow-up survey found that 48-hour access for symptomatic patients declined between 2014 and 2015, and was below the recommended standard for both years (Foley *et al* in press). One provider told us that they had ‘unofficially given up the ghost’ on providing patients with appointments within 48 hours.

Restrictions on access are by no means universal and access to services varies significantly across England. We heard some cases of tenders resulting in improvements to access such as new weekend clinics or extended opening hours.

Interviewees singled out prevention, sexual health promotion and outreach services as the areas subjected to the biggest cuts. These were also the areas that interviewees most frequently identified as a priority for additional investment (*see* box above). They are not part of the core GUM service, so are not protected by the legal mandate. One interviewee felt that because these are often provided by voluntary sector providers who work to shorter-term contracts, they are the first services to be cut. Another interviewee told us that the budget for their sex worker service, which worked in brothels and on the streets, had been cut by 50 per cent. National data on sexual health advice and prevention spend confirms that this has been an area subject to significant cuts (*see* ‘Is this service under financial pressure?’, page 28).

Although outreach activity is not monitored nationally, data on chlamydia testing for 15–24-year-olds suggests that cuts to outreach services are having an impact on testing rates. Data from Public Health England shows that in 2015 there was a 20 per cent reduction in the number of chlamydia tests performed in ‘other’ settings compared to 2014 (ie, not clinics, pharmacy or internet) (**Public Health England 2016b**). Although part of this reduction is explained by a change in the way internet tests are coded, the scale of the reduction suggests there has been a reduction in the outreach activity that brings young people in for chlamydia testing, which has not been counterbalanced through investment in other service provision.



Quality of care

Once patients attend a GUM clinic, many interviewees felt they still receive the same high-quality service as in the past. However, we also heard numerous examples of cuts to health adviser posts within GUM clinics. Health advisers are specially trained in partner notification – a key way of halting the spread of STIs among the general population by identifying, testing and treating current and past sexual partners of patients with diagnosed infections. They also provide advice and counselling to newly diagnosed patients and play an important role in prevention.

Interviewees also gave examples of GUM clinics having to significantly reduce the amount of consultant input into the service due to budget cuts. In some cases, no consultant was available on site at certain times of the week, meaning patients with complex STIs had to seek treatment elsewhere. The clinicians we interviewed were concerned that this inhibited their ability to provide a clinically safe service. In contrast, some of the commissioners we interviewed felt that new staffing models were improving productivity without affecting patient care; as most patients presenting at GUM clinics are asymptomatic, they felt services could be run with little consultant input. Although national workforce data showing the number of GUM doctors does exist, the short period for which it is available, changes in the way it has been reported over that period and the absence of doctors working for independent sector organisations mean we cannot draw meaningful conclusions from it about changes in clinical staffing over time ([NHS Digital 2016d](#)).

A number of interviewees said their service had become less holistic because of a lack of funding and staff. One interviewee felt that their commissioner saw GUM as a diagnosis and treatment service only, whereas they themselves saw a GUM clinic visit as a window into someone's (often chaotic) life, which presented an opportunity to address health problems along with other issues the person may be facing, such as drug addiction and sex trafficking. This highlights the difference between the service the local authorities are mandated to commission and the role of GUM as perceived by many who work in the clinics.

Cuts to some of the support services that help people diagnosed with STIs were adding to the feeling that the service was providing less support beyond core diagnosis and treatment than in the past, and less education and preventive care. We heard



examples of psychosexual health services for GUM patients and HIV support services being cut – both of which are key services for people recently diagnosed with STIs as well as those with recurrent infections.

Many interviewees also raised concerns that the fragmentation of commissioning since 2013 has resulted in patients receiving a more disjointed service. Examples where a lack of co-ordination between commissioners has had a detrimental effect on people using services include the following.

- Patients who attend hospital for their HIV treatment have to travel across town for routine STI testing because the GUM service was put out to tender and is no longer co-located with the HIV clinic.
- One HIV service closed and another was taken over by a neighbouring trust because they were not viable or safe to run as a standalone service once the GUM clinic had moved elsewhere.
- Some patients were unable to have long-acting reversible contraception (LARC) fitted for heavy menstrual bleeding in a combined GUM and contraceptive clinic because it was not for contraceptive purposes.

What does this mean for staff?

All interviewees from provider organisations who had been through a tendering process said it created a lot of uncertainty for staff and had a significant negative impact on morale. There were also concerns that the time and investment put into the process were disproportionate to the benefits that resulted from it. One interviewee said that with staff cuts on the horizon, the best and most experienced staff often leave first, causing operational challenges for the remaining staff and contributing to high stress levels.

We heard examples of administrative staff numbers being reduced, which meant that clinicians were spending a significant amount of time typing letters and doing other administrative tasks. Senior staff also highlighted the large amount of effort they put into developing tender submissions – time they felt could have been more constructively directed towards patient care.



The challenges of operating a GUM clinic with less funding, fewer staff and growing incidences of STIs, together with the uncertainty created by tendering and the upheaval of new providers taking over a service, had left some consultants considering alternative careers:

This is a time that all of us, for the first time, have talked about leaving sexual health. This is different. All of us have considered leaving... if I say that to my sister, she says, oh yeah, but you... this is what you like doing, you ride the storm. And so I do ride the storm. But I kind of think, yes, for the first time, you talk to anyone, they've thought about alternative careers.

Consultant

Local authority commissioning staff were also affected by these pressures. Although not universal, some of the commissioners we interviewed described very low morale because they were finding it very difficult to accept the cuts to services they were having to implement and the impact these cuts were having on patients.

But I suppose the cuts that I'm seeing now, the splintering of the commissioning, are probably the most drastic changes that I've seen working in nearly 20 years of sexual health. And, like I say, if I've got my line in the sand, I've got one foot on it now. And it's getting close to the point where I think we can't continue to ask our providers to give any more when they're overstretched, because otherwise we're going to have a service collapse somewhere. And at the end of the day, that's not just going to hurt that service and hurt those professionals, but it's really, really going to hurt our patients.

Commissioner



Conclusion

The need for local authorities to balance their budgets means that many have taken decisive action in response to financial pressures. While this has stimulated innovation in some areas, it has also led to clinics being closed or moved, changes in staffing models and – of particular concern – cuts to prevention and outreach services. These changes not only affect individual patients, but put the general population at greater risk of infection.

The pressures identified in GUM services, an area afforded some protection by a legal mandate to provide open access, are a warning for what may be happening in other public health services. They also raise concerns about what may happen after 2018/19 when the (albeit not watertight) ring fence is removed from the public health budget, and should the legal definition of a ‘comprehensive open access service’ prove weaker than it already is.



5 District nursing services

Key messages

Our research 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 regarding demand for district nursing and the level of activity currently taking place, but our own work and other research indicates significant growth stretching back over many years. This trend looks set to continue.
- There is also a lack of information on spending, but our research found that the budgets of many services have been static or reducing, despite a significant rise in activity. This is often difficult to evidence due to the nature of block contracting.
- Consequently, there is a significant gap between demand for district nursing and the available resources in terms of funding and staff numbers.
- It is difficult for providers to limit demand for district nursing; however, we heard some examples of providers attempting to do this by tightening access criteria. We also came across evidence of increasing delays for non-urgent referrals.
- Pressures in district nursing are affecting the quality of patient care. We heard 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.
- In order to protect patient care, many staff are working intensely over long hours without breaks. This is having a negative impact on staff wellbeing, often leading to low morale and high levels of stress.



- The impact of these pressures is spreading beyond patients and staff. Our research indicates that the effects are being felt by 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 (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.

What are district nursing services?

District nursing is a community health service that provides a wide range of nursing interventions and support to enable people to have their health and care needs met at home. District nurses often play a central role in the management of long-term conditions and the prevention and treatment of acute illness in the community. This care is usually reserved for ‘housebound’ individuals; it is most often required by older people living with frailty and long-term conditions, people recently discharged from hospital, adults with disabilities, and those who are near the end of their life (Maybin *et al* 2016; The Queen’s Nursing Institute 2009). Many services are organised as standalone district nursing teams, while some are part of integrated or multidisciplinary teams.

District nursing interfaces with many services; the closest links are with GPs, primary care nurses and other community health service professionals such as community matrons and specialist nurses. District nursing teams also work closely with social care workers, hospices, voluntary sector organisations, care homes and hospital teams (particularly surrounding discharge). Patients receiving this care often have multiple, complex health needs and depend on many health and social care services.

Community health services have been subject to frequent structural reorganisation and reform (*see* Foot *et al* 2014), most recently under the Transforming Community Services programme (Department of Health 2009b). Provider organisations include:



standalone NHS community trusts; combined community and acute or mental health trusts; social enterprises; and private sector providers (Spilsbury and Pender 2015). Taking community health services as a whole, non-NHS providers accounted for almost a third of spending in 2012/13 (Lafond *et al* 2014).

Since 2013, responsibility for commissioning these services has fallen to CCGs. Most services are commissioned under block contracts, featuring a fixed-sum annual payment that generally does not vary according to activity or quality of care, except for Commissioning for Quality and Innovation (CQUIN) measures, which make a proportion of the contract value conditional on the provider meeting certain quality goals. A single provider is usually commissioned to provide most or all of the community services in a geographical area under a single block contract (Monitor 2015).

Is this service under financial pressure?

What the data tells us

There is no comprehensive national data showing spending on district nursing or on community health services. Therefore, it is not possible to build an accurate picture of NHS spending in this area. The last aggregated information from commissioners dates back to 2012/13, before commissioning responsibilities were transferred to CCGs, when total PCT spending on community health services was £9.7 billion (11 per cent of the NHS budget) (Lafond *et al* 2014).

What the interviews tell us

There was a consensus among our interviewees that services are under significant financial pressure. Many commissioners and providers described funding in their area as static or reducing, despite rising demand. This is not a completely uniform picture, and we heard examples from national stakeholders of local areas that have seen recent funding growth; however, these were felt to be exceptions to the norm. Many interviewees, including senior managers of provider organisations and some commissioners, felt that activity is not appropriately remunerated under current payment mechanisms.



What other challenges is the service facing?

The difficulties facing district nursing services are by no means limited to financial pressures. Most interviewees reported that financial issues were not the only problem – nor indeed the most pressing one – facing the service. Rising demand and workforce issues were commonly cited as the most significant challenges. However, in many instances it was clear that these problems were intensified by financial constraints.

Patient demand

All interviewees highlighted a significant rise in demand for district nursing over time. They frequently linked this to increasing numbers of people living into old age with frailty and multiple long-term conditions, and a push to deliver more care in community settings and release hospital capacity, particularly through efforts to avoid hospital admission and promote early discharge. Interviewees described that district nurses are now commonly managing acutely unwell patients and performing procedures that would previously have been undertaken in hospital, adding significantly to both the volume and complexity of caseloads. End-of-life care was highlighted as a particular area of growth. A number of interviewees also highlighted that, at a local level, care homes can significantly increase demand as they often require intensive support from the local district nursing service.

Many interviewees described that the ability of district nursing services to manage demand is limited:

If a ward is full, a ward is full, but within district nursing caseloads there's no way of doing that. The referrals keep coming, and providing they are appropriate in terms of clinical requirements, then those patients will be accepted... The demands increase exponentially and it's not easy to control.

National stakeholder

There is no national data available to measure activity or demand for district nursing services, or to track how this has changed over time. However, previous research indicates significant growth in demand stretching back over many years (Department of Health 2004). In a survey of community nurses conducted in 2012, almost 90 per cent of respondents reported an increase in their caseload over the past 12 months, and more than 60 per cent described this increase as significant (Maybin *et al* 2016; Royal College of Nursing 2012).



Commissioning and contracting arrangements

During our interviews, commissioners and providers alike spoke at length about the problems associated with services being commissioned under block contracts, and attributed much of the current mismatch between demand and resourcing to this blunt contracting approach.

The most common concern among providers was the failure of block contract arrangements to appropriately remunerate them for the activity they are undertaking. Most described the value of contracts remaining unchanged, or even reducing, despite activity increasing significantly. There was a feeling that block contracting arrangements mask changes to activity and complexity, and make it difficult to make a case for extra funding. One provider described the block contract as ‘an absolute millstone around the service’s neck’.

From the commissioner perspective, the principal issue with block contract arrangements was their lack of knowledge of the service due to limited data and information. This includes information on the cost breakdown for different service lines within the block, and data reflecting the activity taking place and the quality and outcomes of care.

Some interviewees described taking steps towards a greater focus on outcomes in their contracting approach, with the aim of linking funding to outcomes and incentivising quality rather than simply providing a specified service for a defined period. However, most interviewees were currently still operating under traditional block contracting arrangements.

Workforce

Interviewees frequently raised workforce shortages as one of the most pressing challenges facing district nursing. There are limitations to national workforce statistics due to a lack of data from independent providers, transfers of staff from NHS to independent providers over time, and a lack of detail in the way the data is presented (Maybin *et al* 2016). However, available data indicates that the total number of nurses working in community health services has declined over recent years, and the number working in ‘district nurse’ posts has fallen dramatically (dropping by almost half between 2000 and 2014) (Maybin *et al* 2016). Monthly workforce data



releases suggest that this decline is continuing: the number of full-time equivalent district nurses fell by a further 14.8 per cent between September 2014 and September 2016 ([NHS Digital 2016f](#)). This was often reflected in the local experiences of commissioners, providers and frontline staff, who reported vacancy rates of up to 20 per cent.

We heard that some of these changes are a result of deliberate strategies by providers to reduce costs by holding back from filling vacancies or recruiting less senior staff. But we also heard that even where posts are available, services are often unable to recruit due to a lack of suitably qualified applicants. As one interviewee noted, ‘It’s not just that there isn’t the money, there actually aren’t the nursing staff’ (hospice manager). One provider had been allocated additional funding by their CCG after collecting data to demonstrate activity growth, but had not been able to use this funding as they were unable to fill vacant posts in their existing staff base, let alone the additional posts. Interviewees also highlighted significant retention problems, with nurses moving into other roles or leaving the service altogether. We heard that problems recruiting and retaining highly qualified nurses mean that senior roles often remain vacant or are filled with less experienced staff.

These workforce issues are well documented ([Addicott et al 2015](#); [Ball et al 2014](#); [The Queen’s Nursing Institute 2014](#); [Royal College of Nursing 2012](#)) and are described in detail in a recent report by The King’s Fund, which outlines how this has contributed to ‘a profound and growing gap between capacity and demand’ ([Maybin et al 2016](#), p 3). Many of our interviewees predicted that these issues were set to worsen over the coming months and years, due to the relatively older age profile of the district nursing workforce. A previous survey by The Queen’s Nursing Institute ([2014](#)) found that half of all district nurses planned to retire within 10 years.

Although the reasons for the decline in nurse numbers are multifaceted ([Maybin et al 2016](#)), a number of interviewees felt that the current shortage is partly due to a lack of investment in the workforce over time. When interviewees were asked what they would spend additional money on, the vast majority felt that this should be invested in strengthening the workforce by increasing the number of staff and upskilling the existing workforce through training (*see* box on ‘Priorities for future investment’ on page 54).



Pressures elsewhere in the system

Many interviewees described the impact of cuts or financial pressures in other services on district nursing workloads. District nursing was felt to be particularly sensitive to pressures elsewhere in the system, as it interfaces with many different services, as one interviewee explained:

It is a service that is highly networked and highly interdependent with the rest of the health and care system, and therefore how other services are operating or not operating has a major impact.

Provider and national stakeholder

- We heard examples of hospitals releasing bed capacity by discharging people earlier following admission for acute illness or surgery. District nurses often pick up the ongoing care that would have been carried out in hospital, such as managing surgical wounds or administering antibiotics.
- We also heard examples of pressures in general practice impacting on district nursing workloads; in one example, shortages in a GP out-of-hours service meant that district nurses were completing tasks traditionally undertaken by the GP, such as certifying deaths.
- Variation in the availability of social care was also frequently raised, and many interviewees felt that cuts to publicly funded social care put pressure on district nursing caseloads as they are providing additional support.

A number of recent reports from The King's Fund have highlighted that pressures on district nursing are affecting other services across the health and social care system, particularly general practice and social care (Baird *et al* 2016; Humphries *et al* 2016; Maybin *et al* 2016).

Linked to this, we also heard that there is often a lack of integration between district nursing and other services, including primary care, other community health services, social care and hospitals. Some interviewees reported that their local areas were working to develop closer integration.



National policy and oversight

A number of interviewees highlighted pressures placed on district nursing by the policy focus on moving care out of hospitals. Numerous policy documents have stressed the objective to offer care closer to home, most recently the Forward View, which pledged that ‘the future will see far more care delivered locally’ (NHS England *et al* 2014). We heard that work has often moved into the community without any accompanying resource in terms of extra staff or funding.

In addition, oversight of these services remains limited, particularly at national level. There is a paucity of data on demand for services, the level and type of care provided, and capacity within the workforce. Information on the quality and outcomes of care is also extremely limited, with very few national quality metrics in use. This means that pressures in this area are relatively invisible (Foot *et al* 2014). Some interviewees felt that acute hospitals have, to some extent, been protected from cuts so they can meet performance targets and safe-staffing levels, at the expense of community health services.

What are the responses to these challenges?

Commissioning and contracting approach

We heard of a small number of instances where providers had been able to obtain increased funding by collecting data to demonstrate activity levels to their CCG. However, as already mentioned, in one instance the provider had not been able to use the extra funding secured as they were unable to recruit to additional staffing posts; in another instance, the provider described that the additional funding had not kept pace with demand, and had only served to maintain safety.

Many interviewees described contracting approaches being changed to address the issues of block contract arrangements. Due to the time elapsed since the Transforming Community Services programme, many commissioners had recently extended or re-tendered contracts or were in the process of doing so, and a number of interviewees described moving towards outcomes-based contracting. Expectations appeared mixed; one commissioner predicted that their new contract would increase funding, with a large element of this being dependent on the outcomes achieved, while another described that they were ‘expecting more for [their] money’ and ‘looking for greater efficiency’.



Productivity and innovation

Interviewees described a number of approaches being taken to achieve greater productivity or efficiencies in response to current pressures, as follows.

- **Using digital technologies:** the most common example was of services providing staff with tablets, allowing remote access to patient lists and notes and enabling staff to go straight to patient visits at the start of their shift. There is significant variation in the extent to which services are using technologies, but there was evidence of some striking efficiencies where implementation has been successful; one national stakeholder gave an example of a service that had saved an average of one hour per nurse per day by introducing tablets.
- **Upgrading clinical equipment:** we heard about services using innovative wound dressings that allow less frequent visits and promote more rapid healing.
- **Reducing equipment costs:** some services are changing the way they order equipment – for example, ordering a supply to keep in stock rather than prescribing and ordering it for individual patients, where it would be wasted if it were not used by that individual. One frontline staff member reported that their service had reduced the number of different dressings used so that cheaper, larger-volume orders could be made.
- **Reducing variation:** a national stakeholder highlighted work being undertaken to reduce unwarranted variation in areas such as wound care, outlined in the framework *Leading change, adding value* (NHS England 2016i).
- **Improving co-ordination and integration with other services:** this was discussed in relation to other community-based services, including social care and primary care, and in relation to closer working with secondary care. A number of interviewees also spoke of seeking to collaborate with the voluntary sector. This was seen as a way of improving patient experience and outcomes as well as achieving potential efficiencies.

Although these measures were often described as responses to pressures, some interviewees also highlighted that opportunities to make efficiencies can be more difficult to identify and implement in the context of current pressures. Many of these measures require initial investment of time and/or financial resource, and are therefore limited by constraints on finances and workforce capacity. Some



interviewees expressed a sense of frustration that long-term benefits were not being realised due to an inability to make short-term investments.

Another approach that some services are taking is to maximise the proportion of staff time that is spent on patient-facing work. Interviewees for this research – and for another recent study by The King's Fund ([Maybin et al 2016](#)) – described how this was often being achieved by cutting back on valuable, quality-supporting activities such as teaching, training and clinical supervision.

Priorities for future investment

We asked interviewees about their priorities for future investment in district nursing services. The overwhelming majority felt that additional investment should be spent on strengthening the workforce. This included increasing the number of staff (particularly qualified nursing staff), and upskilling the existing workforce through training and development (including a programme to develop team leaders, additional training for nurses without a district nursing qualification, and development programmes for health care assistants and other support staff). Some also suggested investing in additional administrative support within teams.

Other suggestions for additional investment were:

- technology, including tools for monitoring capacity and demand and mobile working
- improving office space
- developing closer integration, particularly with primary and secondary care.

What does this mean for patients?

Access to care

Although interviewees reported that it is generally difficult to manage demand for district nursing, we heard some examples of providers attempting to limit access. This was mainly through tightening referral criteria, particularly in relation to patients being 'housebound'. Increasingly, if patients are able to visit their general practice (even if doing so is challenging), they will not be eligible to receive care from district nurses. A number of interviewees indicated that more work is being deflected to primary care nurses, hospices and carers. We heard that this was



resulting in some patients becoming caught in disagreements between different parts of the system:

Patients get lost between what primary care say they are funded to do from the practice nurse point of view and what the district nursing service say they are commissioned to deliver; phlebotomy services is one that's been really challenging and the other one is Dopplers for leg ulcers.

Commissioner

One commissioner also described how their local provider was refusing work that was not explicitly included in their contract, such as nursing home visits, despite having previously undertaken this work. This meant that residents were attending hospital for procedures such as catheter changes and complex wound dressings, which people living at home could receive from district nurses.

However, we also heard from numerous interviewees that it is generally very difficult for services to make any significant changes to access as there are no limits to caseload size. Therefore, in many cases, the main change in access has been how quickly people are seen. We heard that there is often a delay for non-urgent referrals, and that 'it is becoming more and more challenging to ensure that everyone is having the timely response that they need' (frontline staff and national stakeholder).

The district nurses working at night are not able to give effective response times; you can wait up to eight hours... for patients experiencing pain and discomfort in the last two to three days of their life, it has a massive impact. It's a frightening time for patients and we are seeing an increasing volume of calls coming through to our advice line where people are in genuine distress.

Hospice manager

Some interviewees were concerned that unmet need is increasing due to changes in access; 'it's the services that they don't deliver and the impact on patients that concerns me' (commissioner). Levels of unmet need are extremely difficult to assess or quantify, but these concerns are worrying, particularly as services that might otherwise have filled the gap (such as social care and voluntary sector services) are also undergoing significant cuts (Humphries *et al* 2016). Some interviewees also raised concerns that informal carers are expected to provide an increasing amount of care as services fall away.



Quality of care

Most interviewees reported that people still receive good-quality district nursing care, highlighting staff dedication to maintaining standards and high patient satisfaction levels. However, we also heard that current pressures are affecting the way that care is delivered.

The issues raised most frequently by our interviewees were: staff being rushed and unable to take time to speak with patients; visits becoming increasingly task-focused; and less opportunity for thorough assessments. Recent research by The King's Fund – which included interviews with people receiving district nursing care, unpaid carers and staff – revealed a similar picture, identifying evidence of an increasingly task-focused approach, staff being rushed and abrupt, reductions in preventive care, visits being postponed, and a lack of continuity ([Maybin et al 2016](#)).

Many of the aspects of care that are being challenged by current pressures (such as the holistic nature of care) are precisely those that are most valued by patients and contribute to positive patient experience ([Maybin et al 2016](#)). Furthermore, a number of interviewees were concerned that this results in poorer outcomes: a task-focused and rushed approach can prevent nurses gaining a thorough understanding of the person's needs and concerns, and may lead to issues such as undiagnosed health problems or safeguarding concerns going unnoticed. Less opportunity for thorough assessments means that problems may not be detected early and opportunities for preventive care or early treatment may be missed. These findings all suggest that the pressures facing district nursing pose a substantial risk to the quality of patient care.

What does this mean for staff?

Many interviewees reported that pressures in district nursing are having a significant impact on staff experience and wellbeing. We heard that staff are making up much of the shortfall in service capacity by working significantly over their contracted hours, and working very intensely. The service seems to be depending on goodwill to a large extent, but one interviewee reported that 'more and more, the staff goodwill is running out' (frontline staff). We heard that staff are 'committed but absolutely stretched to the limit' (hospice manager) and 'under incredible pressure' (commissioner). We heard that this is resulting in high levels of stress, sickness and absence; some providers reported high sickness rates and concerning results from



their most recent staff surveys. Interviewees frequently reported low staff morale and ‘a lot of frustrations about not being able to deliver the kind of service that they actually want to deliver’ (national stakeholder).

The growing gap between demand and capacity in district nursing, and the impact on staff wellbeing, has been recognised for many years (Santry 2009; Stuart *et al* 2008; Evans 2002). Interviewees told us that these pressures are particularly acute at present as the demand–capacity gap has continued to grow. This was also a prominent feature in staff interviews conducted by Maybin *et al* (2016), where nurses were described as being ‘broken’, ‘exhausted’ and ‘on their knees’, with some leaving the service as a result.

Finally, we also heard that pressures in district nursing are affecting staff beyond those working directly in the service. For example, a hospice manager described that ‘sparse’ end-of-life care provision by the local district nursing service had had a ‘tsunami’ effect for their organisation, as they stepped in to perform basic palliative care tasks that would typically be done by district nurses.

Conclusion

A range of factors make district nursing (and other community-based services) particularly vulnerable to financial pressures. Challenges associated with demand, workforce and block contracting are compounded by the relatively limited oversight of community services compared with hospitals. Unlike acute service providers, community health services have not responded by running deficits. Instead our research indicates they have reduced staffing establishments (a result of workforce shortages as well as funding constraints).

We found clear evidence that pressures are having a significant impact on patients and staff, as well as on carers and other services. While changes may lead to short-term savings, there is a real risk that the reduction in preventive care and early intervention will lead to patients needing more intensive and expensive care in future.



6 Elective hip replacement services

Key messages

Our research found that 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 various ways to manage demand for this high-volume procedure. There are early signs in the latest data that these factors may be starting to affect patients' access to care.

- Hip replacement services are affected by growing pressures on hospital finances, which left the NHS acute sector almost £2.6 billion in deficit at the end of 2015/16. These include annual reductions to the national tariff, pressure on A&E departments, and difficulties discharging patients from hospital due to a lack of social care support for patients at home.
- Despite these pressures, activity has increased over the past six years. Between 2010/11 and 2015/16, the number of hip operations conducted grew at a faster rate than the population, while the average waiting time remained around 11 weeks.
- Hip operations continue to be highly valued by patients; following elective hip replacement, the average reported health gain is very high (96 per cent of patients report improvements), and year-on-year this has remained largely unchanged.
- Commissioners are seeking to manage demand for hip replacements and other elective procedures in a range of ways that include introducing new service models for musculoskeletal services and, in some cases, tightening referral criteria. Some of the people we spoke to questioned the clinical basis for the criteria being used.



- Although not conclusive, there are early signs that wider hospital pressures and efforts by commissioners to reduce referrals may be starting to affect access to care. The number of hip replacements recorded in 2015/16 was slightly lower than the previous year.
- Furthermore, average waiting times for trauma and orthopaedic patients (for which more recent data is available than for hip replacements specifically) shows that in October 2016, the average patient was waiting around a week longer for treatment than a year earlier. It also shows that 45 per cent more patients are waiting longer than 18 weeks to begin treatment than was the case in October 2015.
- Patients are also being affected by the wider pressures on hospitals. In particular, high levels of bed occupancy across hospitals – primarily a result of increased emergency admissions and difficulties discharging patients – have led to an increasing (albeit relatively small) number of operations being cancelled.
- The extent to which access to hip replacement services can be restricted in response to financial pressures is limited for a number of reasons: unlike many other NHS services, 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 efforts is in the public domain; national waiting time targets apply to the service; and the payment system creates incentives for providers to do more of such procedures to increase income. This means that hip replacement services are less vulnerable to financial pressures than some other services.



What are elective hip replacement services?

Elective hip replacements are one of the most common surgical procedures in England (**National Audit Office 2003**). Generally, elective hip surgeries are performed on patients suffering pain from osteoarthritis or rheumatoid arthritis (**National Joint Registry for England, Wales, Northern Ireland and the Isle of Man 2016**). Hips are replaced through an orthopaedic surgical procedure that can require several days' stay in hospital. Patients access this procedure through referral from their GP. Under the NHS Constitution, they should wait no longer than 18 weeks to begin their treatment following referral.

Elective hip replacement operations are commissioned by CCGs that contract with acute or specialist NHS and eligible non-NHS providers to perform each operation. In the main, services are commissioned under an activity-based contract paid for by a national tariff, whereby providers receive a set price for each procedure. Since 2011/12, best practice tariffs have also been used for hip replacements as a way to improve outcomes. Where these have been adopted, commissioners pay a premium for operations that meet a minimum number of defined markers of quality.

Is this service under financial pressure?

What the data tells us

National data shows that NHS acute providers – the main providers of elective hip replacement services – are experiencing significant financial pressure. As outlined in section 2, the NHS acute provider sector ended 2015/16 with an aggregate deficit of almost £2.6 billion, with a majority of providers reporting deficits.

The primary cause of these deficits is the fact that NHS funding has not kept pace with the growth in demand (**Dunn et al 2016**). One of the ways the NHS has tried to minimise spending and promote efficiency is by paying hospitals less for the activity they deliver.

National tariffs have been cut by an average of 1.6 per cent each year since 2010/11, while NHS-specific inflation has risen, resulting in a real-terms cut in the cash amount hospitals receive per patient of 3.8 per cent each year (**Gainsbury 2016**). Though tariffs in 2016/17 will increase by 1 per cent, this is still below the current level of NHS inflation (**Gainsbury 2016**).



However, while there is clear evidence that NHS acute trusts are under financial pressure, it is difficult to determine how this is affecting individual services within hospitals. Although commissioners pay for many services on the basis of a national tariff, in practice, decisions about how this income (and income for other services) is allocated are determined at an organisational level by individual trusts.

What the interviews tell us

We heard different views as to whether hip replacement services are under financial pressure. One interviewee mentioned that their income was covering their costs but by a shrinking amount, and they were not sure for how much longer that would remain the case. Some described their current balance between costs and income as ‘break even’, while others reported that costs were higher than their income. One manager from a provider organisation explained:

All our services have moved from being profitable five years ago to being loss-making now, because our costs have gone up so much and... the tariffs have reduced’.

However, for the most part, pressure on hip replacement surgery was discussed in the context of wider pressures on the hospital – for example, in terms of overall trust deficits and pressure on services to improve productivity. There is strong evidence that financial pressure on hospitals has increased in recent years ([Lafond et al 2016](#); [Murray et al 2016](#); [National Audit Office 2016a](#)).

What other challenges is the service facing?

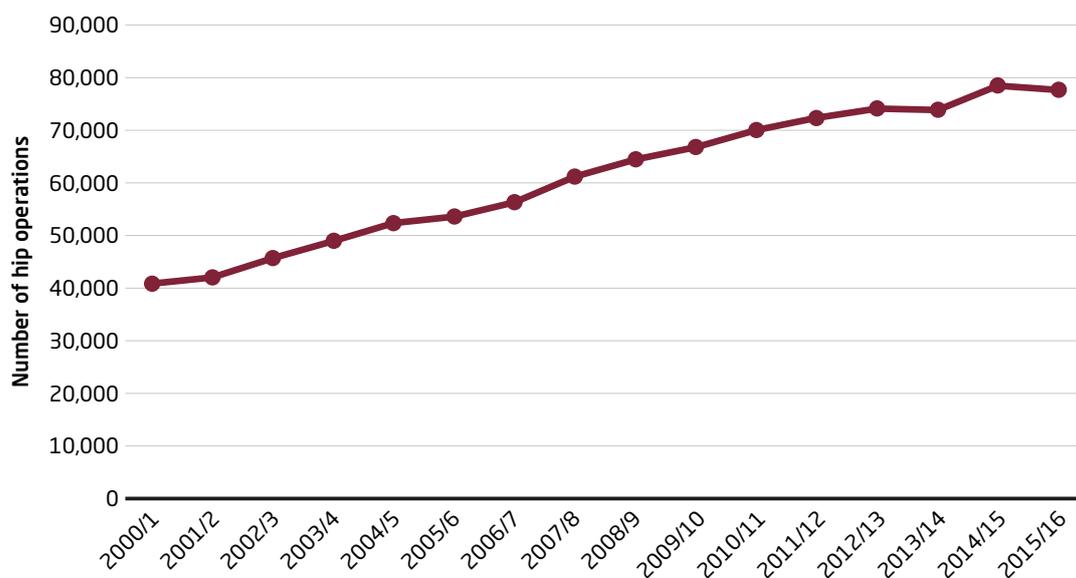
There are a range of other pressures affecting elective hip replacement services.

Patient demand

National data shows that in recent years, the number of elective hip replacement procedures has been growing. Hospital Episode Statistics, which record all NHS-funded activity (whether delivered by NHS or non-NHS providers), show that between 2000/1 and 2015/16, the number of procedures increased by 90 per cent (see Figure 6). It should be noted, though, that some of this increase is due to better recording of data ([NHS Digital 2016b](#)).



Figure 6 Number of NHS-funded elective hip replacements recorded in Hospital Episode Statistics, England, 2000/1 to 2015/16



Sources: NHS Digital 2016b; Health and Social Care Information Service 2015a, 2015b, 2013, 2012, 2011, 2010, 2009a, 2009b, 2007, 2006, 2005, 2004, 2003, 2002, 2001

The number of hip replacement operations has been increasing at a faster rate than the population, suggesting that access to this service is expanding (see Table 4). Between 2010/11 and 2015/16, the number of hip operations increased by 11 per cent, while the total population in England grew by 4 per cent and the population of over 50s (who are more likely to require a hip operation) grew by 9 per cent (Office for National Statistics 2016c). Since 2000/1, NHS waiting times for all elective procedures have fallen dramatically (Thorlby and Maybin 2010).

In interviews, we heard that the increase in demand for elective hip procedures was in part because of younger patients asking to have surgery earlier than previous generations did. As one surgeon explained:

We have the younger folks, who, basically, you know, don't want to wait until they're 60 to have hip replacements, they actually want them because they're presenting to their general practitioners, you know, early 50s, under 60s, and want to get on with it, and want a quality of life back.



Table 4 Growth in NHS-funded elective hip replacements recorded in Hospital Episode Statistics compared to the growth in selected population numbers, England

Time period	Increase in hip replacements	Total population growth	Growth in population aged 50+	Growth in population aged 60+
2000/1–2015/16	+90%	+11%	+21%	+24%
2005/6–2015/16	+45%	+8%	+16%	+19%
2010/11–2015/16	+11%	+4%	+9%	+8%

Sources: NHS Digital 2016b; Health and Social Care Information Centre 2011, 2006, 2001; Office for National Statistics 2016c

Demand is also growing among older patients. One interviewee explained that, due to general increases in population health, alongside successful and long-lasting surgical interventions, patients are also receiving surgery in later life; this may be for a first or subsequent hip replacement, or to replace previous implants they had outlived.

However, there are signs that the upward trend in activity may be reversing (see Figure 6). National data for 2015/16 shows a 1 per cent decrease in activity compared to the previous year (NHS Digital 2016b). This is only the second time since 2000/1 that activity has decreased (it also decreased by 0.4 per cent in 2013/14) and although one year does not constitute a trend, it may be the start of one (Health and Social Care Information Centre 2015b). This decrease may be linked to wider hospital pressures and efforts by commissioners to reduce referrals for surgery, as discussed below.

Commissioning and contracting arrangements

A number of the commissioners we spoke to highlighted challenges with the activity-based approach to contracting hip replacement services. They told us that this approach incentivises providers to maximise their volume of activity (and thus their income) rather than encouraging them to consider whether surgery is the right approach for every patient:



... there's no incentive for our secondary care organisations to do anything other than operate on patients; and I would say that sometimes there's probably alternatives which aren't explored... Often, when they get in to see an orthopaedic consultant, it's kind of 'job over' really, isn't it? You expect to be operated on rather than go and wait 18 weeks to be seen and then be told, 'actually, you should have gone to physio in the first place'.

Commissioner

Tariff-based payments also shift the risk of increased activity on to commissioners, who have to pay for each unit of activity completed.

Workforce

Most of the providers we spoke to told us they had a full complement of orthopaedic surgeons, but that they were having difficulties recruiting other operating theatre staff such as nurses and anaesthetists:

The other thing that affects productivity figures is the number of operating theatre staff you've got. So, basically, at the moment, we've got 10 vacancies... and we can't fill them... The other big challenge is, to fill those vacancies, our theatre managers are having to go and use agency staff.

Orthopaedic surgical care practitioner

As is common in other parts of the NHS, temporary or bank and agency staff were being used to help fill these gaps ([Addicott et al 2015](#)) but this was proving expensive in the short term. Respondents had concerns about whether the future workforce required to meet demand would be available over the long term.

Pressures elsewhere in the system

Hip replacements are one of many services provided by acute hospitals and, in our interviews, we heard of the difficulties elective orthopaedics are facing with competing demand for beds from other services.

The biggest issue for the providers we spoke to was the balance between using beds for elective patients and non-elective patients (those admitted in an emergency or who are otherwise not planned for). As one surgeon explained:



... while [elective] patients are often in pain, their situation often isn't life-threatening, so where we have to prioritise our capacity according to how many patients we can get in, then quite often it's orthopaedics that takes a big proportion and brunt of that, and more of the activity gets cancelled.

National data supports the picture described by interviewees of increasing pressure on the availability of beds in hospital; while combined elective and non-elective activity has grown by around 12 per cent since 2010 (NHS England 2016j), the number of hospital beds (for general and acute specialties) has decreased by 7 per cent over the same period (NHS England 2016b).

There have also been large increases in the number of patients delayed in hospital when ready to be discharged. The number of days that hospital beds were occupied with a patient ready to leave but unable to do so has increased by 77 per cent – from around 113,245 in October 2010 to more than 200,000 in October 2016 (NHS England 2016h).

All of this has an effect on bed occupancy, and national data shows that in the second quarter of 2016/17 (July to September), hospitals regularly had around 89 per cent of their general and acute beds occupied at any one time – up from 86 per cent in the same quarter of 2010/11 (NHS England 2016b). High bed occupancy levels have been shown to lead to bed shortages, which affect a hospital's ability to admit elective patients (National Audit Office 2000). High bed occupancy has also contributed to a small increase in the proportion of elective operations that are cancelled and a much bigger increase in the proportion that are not rebooked within 28 days (see below).

National policy and oversight

Elective hip surgery is subject to national waiting time targets. Where providers are unable to treat NHS patients within the maximum waiting time, they must make arrangements for patients to be treated elsewhere. In the past, providers were also fined approximately £300 for every patient whose treatment they were unable to begin within 18 weeks, although these fines were replaced in July 2016 with hospital-specific 'financial incentives' to enable hospitals to focus on meeting other financial and performance targets (NHS England 2016l). These targets limit the ways



in which local commissioners and providers can respond to rising demand and cost pressures.

The clinicians and hospital managers we spoke to told us that to date, they had made decisions to prioritise quality over performance, but there was concern as to how much this could still happen if operational and financial pressures continue into the future:

... and that comes back to the choice between finance and quality. So that's been a very clear choice I think people have made over the last year, 18 months... 90 per cent of acute trusts have overspent... As an executive, you're not going to get hanged for the finances because everyone's stuffed on the finances. They can't sack them all. Whereas on the quality side, obviously you can be, because not everyone is achieving the quality indicators.

Hospital manager

What are the responses to these challenges?

Commissioning and contracting

Local areas have been seeking to address the challenges described above by looking at their contracting approach for elective hip operations and wider musculoskeletal conditions, and by reviewing their approach to managing referrals. There is also evidence of increased use of private sector capacity to meet growing demand.

Contracting approaches

We heard examples of commissioners who have moved from tariff-based to block contracts (sometimes covering multiple years) for planned elective procedures. One interviewee from a provider organisation explained that:

... this last couple of years you might have had a CCG raise [block contracts] in passing... This year, the level of financial constraints are so high, and [with] the implementation of success regimes, [the CCG] has basically said, everything is on the table, we want to actively talk to you about this, and if you don't do a block there are going to be consequences for you.

Provider



This picture is supported by a recent report from the NHS Confederation based on Freedom of Information Act responses from 89 CCGs. It found that the number of CCG block contracts for planned elective care increased by 53 per cent between 2013/14 and 2015/16 ([NHS Partners Network 2016](#)).

Other CCGs have started contracting their musculoskeletal service using a prime provider contracting approach. This is similar to the integrated model of delivering these services, which was set out by the Department of Health ([2006](#)). This involves a single contract being established between the CCG and one provider that covers multiple musculoskeletal services for the local population (often over multiple years). The prime provider can then implement their own pathway to meet demand for musculoskeletal services. The pathway typically involves the main provider administering and delivering community and primary care alternatives for referrals before sub-contracting with secondary care providers (either NHS or independent sector) to carry out the operations. As the provider is liable for the costs of operations, this creates an incentive to treat patients in the community rather than always referring on to secondary care. This should mean a lower cost to the commissioner.

Referral management

Referral management is used as a way of determining which patients would benefit from receiving treatment. CCGs (and primary care trusts (PCTs) before them) have had policies in place for many years governing which patients are eligible for referral for particular treatments.

In recent years, there have been high-profile examples of commissioners introducing new referral criteria to help manage growing demand. For example, the Vale of York CCG has now introduced a referral policy for elective surgery whereby patients with a body mass index (BMI) of 30 or above will have to either reduce their BMI to below 30 or lose 10 per cent of their body weight, otherwise their surgery could be postponed for up to a year ([Vale of York CCG 2016a](#)). Patients who smoke will have to quit smoking for two months or wait up to six months for surgery. In this example (and others), there has been some debate over the extent to which these criteria are clinically based ([Royal College of Surgeons of England 2016, 2014](#)).



NICE has produced a set of quality standards for the treatment of osteoarthritis that are clinically led statements about how to deliver high-quality, clinically effective care. The recommended core treatments for osteoarthritis are ‘physical activity and exercise, weight loss if the person is overweight or obese, and providing verbal and written information to increase the person’s understanding of the condition’; however, there is no discussion of or recommendation about what the patient’s BMI or smoking status should be at the time of referral (NICE 2015).

Some interviewees expressed scepticism about whether thresholds based on things like BMI and smoking status were clinically appropriate, and how long they helped to prevent the requirement for surgery:

From our perspective, these aren’t valid ways of determining who should or should not [access surgery]; those decisions need to be made by clinicians looking at the bigger picture for that patient. There are patients with a BMI of 35 that are previous rugby players who certainly should have the hip replacement, and there are patients with a BMI of 35 or more who probably should have bariatric surgery or other interventions, and I think a clinician needs to be making that decision based on an assessment of the whole patient, not just one metric.

Surgeon

In practice, the criteria which determine when a patient is referred for surgery are determined locally. The implementation of NICE guidance is not mandatory and an analysis of the commissioning policies of 52 CCGs conducted by the Royal College of Surgeons of England (2014) found that 73 per cent did not follow the NICE clinical guidance.

However, CCGs that have introduced such thresholds say they have a responsibility to promote healthy lifestyles and they also highlight evidence that shows adverse outcomes post-surgery for patients who smoke or are obese (ie, BMI >30) (Harrogate and Rural District CCG 2016; Vale of York CCG 2016b).

We do not know how many CCGs have introduced new criteria for hip replacement referrals or what impact they are having on patients’ access to care. However, the controversy provoked by this explicit approach to restricting access to care puts some limitations on the extent to which CCGs can manage demand in this way.



Independent sector capacity

In response to high demand for hip replacements and other elective procedures, and limited capacity within the NHS, commissioners have been utilising spare capacity among independent sector providers. Spending on health care from non-NHS bodies has increased from £548 million in 2012/13 to £945 million in 2015/16 ([Health Foundation 2016](#)), and NHS England data shows that the proportion of NHS trauma and orthopaedic activity carried out by independent providers has grown from 12.9 per cent in August 2011 to 22.9 per cent in August 2016 ([NHS England 2016e, 2012](#)).

Productivity and innovation

Although providers of NHS care have always been looking to improve productivity and efficiency, the reduction in the amount hospitals are paid per patient of around 4 per cent a year since 2010/11 has added recent impetus to these efforts. There are two key areas in which recent reviews show opportunities for productivity improvements in elective hip replacement services, as follows.

- **Reducing variations in clinical practice.** A major review of opportunities to improve the quality of orthopaedic care in England highlighted wide variations in clinical practice in areas such as the number of prostheses used and readmission rates ([Briggs 2012](#)). For example, in 2012/13, the rate of elective hip replacement per 100,000 population varied from 55 to 208 ([Public Health England 2015a](#)). It estimated that it is possible to make a minimum efficiency saving of 4 per cent of the total spent on musculoskeletal conditions – or around £400 million (out of a total spend of £10 billion) – by reducing these variations ([Briggs 2012](#)).
- **More efficient procurement practices.** The Lord Carter review on productivity and performance in English acute hospitals shows that the hospitals buying in the highest volume of hip prostheses were not paying the cheapest price ([Department of Health 2016b](#)). The average price paid for hip prostheses varied from £788 to £1,590, and moving all hospitals to the best available price would result in savings of £40 million ([Department of Health 2016b](#)).

All our interviewees agreed that opportunities for productivity improvements were possible. They gave examples of projects they had either implemented or were working on, which included: the use of home-based virtual wards and virtual



follow-ups to deliver care in the community to save patients unnecessary visits to hospital; implementing specialist input at the point of receiving a referral to ensure that patients are directed to the correct consultant for their treatment; and enhanced recovery programmes that enable patients to reduce their length of stay post-surgery. Innovations that provide support to patients at home and in the community were identified by some interviewees as priorities for future investment (*see* box below).

Priorities for future investment

When asked about their priorities for future investment in hip replacement services, interviewees gave a range of responses, including:

- support for preventive services to help patients manage their osteoarthritis through healthy behaviours at home or in the community
- better information and decision aids for patients contemplating surgery while in primary care
- more intermediary/interface services for patients to access specialists before they are referred to secondary care
- investment to tackle the long waiting lists
- higher pay for theatre staff as an incentive for retention and to reduce reliance on expensive agency staff.

What does this mean for patients?

Access to care

More patients are currently getting hip replacements than was the case in 2010 when finances first started to tighten (*see* Figure 6 on page 62). At the same time, the average (median) time to treatment has remained around 11 weeks ([Health and Social Care Information Centre 2015a, 2011](#)). With waiting times relatively stable and the number of hip operations increasing faster than the rate of population growth, this suggests that access to this procedure has expanded in recent years.

However, there are signs that wider hospital pressures and efforts by commissioners to reduce referrals for surgery (discussed earlier) may be starting to have an impact



on access: in 2015/16, the number of hip operations reduced for only the second time in the past 16 years (*see* Figure 6).

Furthermore, waiting list data for trauma and orthopaedics – which is available for a more recent period than the procedure-level waiting time data for hip replacements – shows that in October 2016, the average (median) waiting time from referral to treatment was a week longer than the same month a year earlier (**NHS England 2016e**).

This data also shows that more patients are experiencing long waits for treatment. Data for October 2016 shows that the waiting list for trauma and orthopaedics has grown by 12 per cent compared to the same month in the previous year, and the number of patients waiting more than 18 weeks to begin treatment has grown by 45 per cent. Both of these increases are the highest reported in recent years (*see* Table 5).

Table 5 NHS-funded trauma and orthopaedics total waiting list and number of patients waiting more than 18 weeks to begin treatment, England, October 2011 to October 2016

Date	Total number of patients on waiting list	% change on previous year	Total waiting more than 18 weeks	% change on previous year
October 2011	383,971		46,142	
October 2012	375,784	-2	29,947	-35
October 2013	401,451	+7	30,820	+3
October 2014	413,545	+3	34,108	+11
October 2015	450,291	+9	43,289	+27
October 2016	503,957	+12	62,577	+45

Source: **NHS England 2016e, 2016f, 2015, 2014, 2013b, 2012**



For some patients, this extra time spent waiting can mean being in pain for longer, with decreased mobility.

... the impact on that individual patient and their quality of life while they're having to wait for that treatment... because they're continuing in pain, continuing in discomfort, can't continue with their normal working life because of pain and discomfort from the condition they're suffering.

Surgeon

Quality of care

Hip replacement surgery is a highly effective procedure, which meets with high levels of patient satisfaction. Patient reported outcome measures (PROMs) data for 2014/15 shows that the average health gain reported by patients following a hip replacement is very high (96 per cent report improvements), and year-on-year this remains largely unchanged ([NHS Digital 2016a](#)). Patients have also seen the median length of stay for this procedure reduce from five to four days between 2011 and 2015 ([Health and Social Care Information Centre 2015a, 2011](#)).

However, some patients may have their elective operation cancelled on the day or day after admission due to a variety of non-clinical factors such as ward beds being unavailable, emergency cases needing the theatre, theatre lists over-running, or unavailable staff ([NHS England 2016c](#)). National data shows that in the first quarter of 2016/17 (April to June), a total of 18,730 elective operations were cancelled (all specialties). Though this was the highest number in this quarter since 2001/2, cancelled elective operations continue to account for a small proportion of the total number of elective admissions. The proportion has remained largely unchanged over the past decade, although there are signs it may be starting to rise slowly: the proportion of operations cancelled in the first quarter of 2016/17 (0.9 per cent) was slightly higher than in the same quarter a year earlier (0.8 per cent) ([NHS England 2016c](#)). Patients are unlikely to have noticed this change; however, they will have been more affected by a sharp rise in the proportion of cancelled operations that are not rebooked within 28 days – up from 3 per cent in the first quarter of 2010/11 to 8.4 per cent in the first quarter of 2016/17 ([NHS England 2016c](#)).

Hip replacement patients may also have been affected by NHS Improvement's recent recommendation that most inpatient elective activity be suspended over the Christmas period ([Donnelly 2016](#)).



What does this mean for staff?

The pressures on staff working in elective hip replacement services reflect pressures on staff across acute hospitals. The clinicians and theatre staff we spoke to said they felt that the pressure they were under was great and unrelenting, though staff who had been in post for longer reflected that they had felt under similar pressures throughout their careers. This may in part be due to the continual national and political focus to bring down waiting times, as mentioned previously.

Theatre staff told us they are dealing with workforce shortages, competing operational priorities within hospitals, long waiting lists of patients who need treatment, pressure to meet waiting list targets, and the need to make productivity and efficiency improvements. They told us of being busy each day all year round rather than experiencing seasonal peaks in demand.

Conclusion

Elective hip replacement services are being affected by wider pressures on acute hospitals, such as increases in admissions from A&E departments and reductions in the national tariff. In recent years hip replacement activity has grown and average waiting times have been maintained in spite of these pressures. However, the most recent data suggests that this trend may be reversing, with the number of hip operations decreasing and average waiting times beginning to increase.

Compared to some other services, the extent to which access to hip replacement services can be restricted in response to financial pressures is limited: there is extensive data available enabling changes in access and quality to be scrutinised and monitored; information on CCG demand management efforts is in the public domain; national waiting times targets apply to the service, and the payment system incentivises providers to do more of such procedures to increase income. This means that elective hip replacement services are less vulnerable to financial pressures than some other NHS services.



7 Neonatal services

Key messages

On a number of indicators, the quality of neonatal services is improving. However, our research found evidence that neonatal services are also experiencing a range of longstanding pressures, and that there is considerable variation between local neonatal services in terms of how they are funded and how well they perform. This variation, along with the absence of information on overall spend on neonatal services, makes it difficult to build up 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.

- Overall, the quality of neonatal services is considered to be high. National data shows continuing improvement against a number of quality indicators, although further progress is required before all standards are met.
- 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.
- The absence of published data means it is not possible to track changes in national spending on neonatal services over time. In addition, funding for local neonatal services varies as a result of locally agreed payment arrangements and the different approaches taken by trusts to allocating resources between services.
- Some interviewees told us that financial pressure has increased noticeably in the past five to six years, but others considered this to be a longstanding issue. Demand has increased, partly as a result of an increase in the number of high-risk births.



- The greatest challenge facing neonatal services relates to workforce, with staff shortages leaving many units unable to meet recommended levels for both nursing and medical staff. This is a longstanding issue, although there is some evidence that the recruitment of specialist nursing staff in particular is becoming more difficult.
- Another longstanding issue is that many neonatal units are operating above the recommended occupancy levels. Although national data shows that overall occupancy levels have been broadly stable since 2010/11, these vary significantly between units. Pressure on capacity can lead to the transfer of babies between units, sometimes a long way from home, placing significant stress on families.
- Access to a range of allied health professionals who provide care to neonates 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. Ensuring access to these services is a longstanding challenge. These services appear to be particularly vulnerable when budgets are squeezed.

What are neonatal services?

Neonatal services provide specialist care for babies born preterm (at less than 37 weeks' gestation), and for babies born at full term that require ongoing specialist care. Approximately one in eight babies born in England, Scotland and Wales each year require admission to a neonatal unit ([Royal College of Paediatrics and Child Health 2016](#)).

Neonatal services have been delivered through formal networks since 2004. Since 2013, these have taken the form of operational delivery networks (ODNs), of which there are currently 20 across the United Kingdom (UK) ([British Association of Perinatal Medicine 2016](#)). Working together through ODNs, acute and specialist providers deliver different levels of care through three types of unit: neonatal intensive care units, local neonatal units, and special care baby units ([Department of Health 2009a](#)). Networks are supported by dedicated neonatal transport services, which transfer babies between units to ensure that they are treated in the appropriate level of unit. This activity is co-ordinated by ODN managers.



Neonatal services (and many other specialised services) have been commissioned by NHS England since 2013. NHS England delivers its commissioning responsibility through local hubs that commission services from individual providers within ODNs. Neonatal services are one of several services included in an overall specialised service contract.

The standards that neonatal service providers are expected to meet are set out in a national service specification ([NHS England 2013a](#)), developed by NHS England's Clinical Reference Group for neonatal services. The specification is intended to reflect best clinical and practice evidence, and brings together standards set out in a range of pre-existing guidance such as the *Toolkit for high quality neonatal services* (developed by a Department of Health-commissioned taskforce in 2009 ([Department of Health 2009a](#))) and the British Association of Perinatal Medicine's (2011) categories of care.

Is this service under financial pressure?

What the data tells us

Information on how much commissioners spend across all neonatal services is not publicly available. National reference cost data suggests that in 2015/16, the total cost of delivering care in neonatal units (the amount providers spent on these services) was nearly £755 million, representing an increase of 17 per cent since 2010/11 ([Department of Health 2016a, 2011](#)). (NB, here and throughout this section costs and activity have been calculated from the unbundled neonatal critical care health resource groups (HRGs), and exclude transportation.)

A recent report by the National Audit Office indicated that in 2014/15, neonatal intensive care services represented the fifth largest area of spend (4.9 per cent) within the total budget for specialised services ([National Audit Office 2016c](#)). In recent years, overall funding for specialised services has increased more quickly than funding in other parts of the NHS: the average annual rate of increase between 2013/14 and 2015/16 was 6.3 per cent, compared with an average of 3.5 per cent across the NHS as a whole ([National Audit Office 2016c](#)). However, because the specialised service budget covers a large number of services (149 in total ([NHS England 2016d](#))), which differ widely in nature, it is not possible to tell what this change means for neonatal services specifically.



One of the ways NHS England has attempted to manage the overall cost of specialised services – and other NHS services – is through reductions in the tariff. Although there is no national tariff for neonatal services, the National Audit Office report on specialised services (2016c) concluded that tariff reductions for other services may be having an impact on providers’ overall financial sustainability. Indeed, as discussed in sections 2 and 6, NHS acute providers are experiencing significant financial pressure and many organisations are now in deficit (Dunn *et al* 2016).

What the interviews tell us

Many of the people we spoke to from provider organisations felt that neonatal budgets were experiencing increasing pressure as they failed to keep pace with growing demand and rising costs. As one interviewee explained:

... the commissioners will give, you know, money to trusts and say, ‘this is what you’ve contracted for, now deliver it’. But, you know, the bottom line is, demand always outstrips supply.

Consultant

There were different views on how funding pressures had changed over time; although many interviewees felt that neonatal services had a history of underfunding, there was some suggestion that this had been felt particularly acutely in the past five or six years. One interviewee commented:

... it’s been pretty constant for the last five years, that feeling of ‘there’s no money for anything’ – that’s been a fairly constant theme.

Consultant

Two interviewees commented that funding for the management of neonatal networks had declined since this responsibility had been transferred to ODNs.

Other interviewees did not consider pressures on neonatal services to be any different from those being experienced elsewhere in the system, or in the past. One commissioner pointed to the growth in overall spending on specialised services as evidence that, in general, these services were under less pressure than some other parts of the NHS.



Many interviewees highlighted the issue of local variation. Because payment for neonatal services is agreed locally (some areas have developed a local tariff while others have adopted a block contract), the level of payment – as well as what is included within the neonatal budget – can differ significantly both between and within ODNs. As one commissioner explained,

[the] variation is relatively considerable; there is not necessarily a connection between a better service, or indeed, even a better staffed or whatever service and the price it is.

Interviewees suggested that neonatal services were also being affected by the approach to allocating funding within trusts, and that this was a further cause of variation in the level of income reaching individual neonatal services. We heard that trusts frequently take a proportion of ('top-slice') neonatal budgets, and consequently these services often do not receive the full amount agreed with commissioners. One senior nurse linked this to the growing pressure on provider budgets:

... because trusts are really challenged... when the monies come in through whatever means, you know, they will try their hardest to fill gaps in other departments that they don't have enough money coming into.

Nurse

Staff within neonatal services and commissioners both felt there was very little transparency in how this was done, or about how much of the neonatal budget was reallocated as a result. Some people suggested that neonatal services had historically been seen as a 'cash cow' and therefore were particularly vulnerable to losing out from this process, but others felt that the extent to which neonatal services were profitable varied between units.

The prospect of changing the payment system was raised in some interviews, with some making the case for a national tariff as a means of providing transparency around payment for neonatal services. However, despite the possibility having been raised by the government in recent years – for example, in relation to a future neonatal review ([Cumberlege 2016](#)) – none of the people we spoke to felt that the introduction of a tariff was imminent.



What other challenges is the service facing?

In our interviews we heard about a range of challenges facing neonatal services, in addition to financial pressures, many of which appear to be longstanding. These included increases in demand, significant pressures on the workforce, and some challenges relating to commissioning.

Patient demand

Demand for neonatal services is increasing. National data shows that between 2011/12 and 2015/16, neonatal critical care activity increased by 10 per cent (this excludes transportation activity) ([Department of Health 2011, 2016a](#)). This compares with an overall decline in the number of births in England over the same period ([Office for National Statistics 2016a](#)).

Reasons for this growth in demand include an increase in the number of high-risk births (for example, women having babies at a later age, or through in vitro fertilisation (IVF)) and babies surviving earlier and for longer. Some of these factors reflect improvements in clinical practice, but others are largely beyond the control of neonatal providers or commissioners. These include significant public health issues such as smoking and obesity, each of which were highlighted in the National Maternity Review as factors increasing the risk of complications during pregnancy and of poor birth outcomes ([Cumberlege 2016](#)).

There is also an issue in relation to inappropriate or avoidable admissions to neonatal units. This is partly reflected in the proportion of neonatal admissions which are at term, which (in English neonatal units) has increased from 56.6 per cent in 2011 to 58.3 per cent in 2013 ([NHS England 2016k](#)), although the level varies between networks (*see below*). Those we spoke to suggested this may be linked to pressures in other areas – particularly maternity services, where, for example, overstretched staff in postnatal wards are referring higher-risk babies to neonatal units to ensure appropriate monitoring. However, it was also suggested that these admissions may be linked to the payment system; we heard that the maternity tariff does not adequately cover the cost of care for higher-risk babies with more complex needs, and therefore trusts are incentivised to refer babies on to neonatal services.



Commissioning and contracting arrangements

In interviews we heard about several challenges associated with arrangements for commissioning neonatal services. These included problems resulting from the separate commissioning of neonatal and maternity services (the latter being commissioned by CCGs), such as the inability of neonatal service commissioners to drive changes in maternity services that could improve outcomes for neonates. One commissioner suggested that this system placed incentives on CCGs to shift activity to other parts of the system:

Where the pathway crosses between CCGs and NHS England, it's very difficult not to have the various incentives for pushing activity one way or the other. And our CCGs are so stretched financially. I'm sure it's driving some of the growth in specialised services.

Commissioner

Interviewees from provider organisations also questioned the quality of commissioning for neonatal services. We heard that these commissioners – responsible for a large number of specialised services – did not always ‘understand’ neonatal services or have a clear vision for how they should be operating. We also heard that commissioners did not always make effective use of the expertise (and data) available through ODNs, and that those working within neonatal services found it difficult to influence the commissioning process. These factors were often cited by those in provider organisations to explain why the funding allocated by commissioners did not meet their requirements for delivering the service.

A further criticism relates to the ability of commissioning teams to bring about changes in neonatal services. One interviewee told us that commissioners do not ‘have any teeth or enthusiasm for looking for evidence of variation in health care and doing anything about it’. One of the commissioners we spoke to told us that they did have some leverage over standards through the service specification for neonatal services, but also acknowledged that it was difficult to determine whether or not providers were investing in these areas in practice.

A number of these messages resonate with the findings of the National Audit Office’s recent review of specialised commissioning, and a subsequent report by the



Public Accounts Committee. For example, the National Audit Office review (2016c) highlighted the problems associated with the separate commissioning of specialised and other services. In its response to the Public Accounts Committee, the government outlined a number of steps, some already taken and others planned, to address the issues identified – for example, the development of a more collaborative approach to commissioning, and a programme of service reviews (including for neonatal services) (HM Treasury 2016b).

Workforce

A strong message from our interviews was that neonatal services are experiencing numerous and significant challenges around staffing. Many of these are longstanding, although some appear to have become worse in recent years. Workforce was the area most commonly identified during interviews as the biggest priority for investment in neonatal services (see box on page 84).

Interviewees told us that there are shortages of all types of staff, with particular pressures on nursing staff (especially in intensive care units) and junior doctors. National data suggests that the number of neonatal nurses has increased in recent years (NHS Digital 2016f), however the significant shift in the data over time suggests there have been changes in the way the numbers are reported and therefore it is difficult to tell what this means in practice, or whether nursing numbers have grown in line with activity.

Without exception, the provider staff we spoke to indicated that they did not have enough staff to meet staffing ratios recommended in the *Toolkit for high quality neonatal services* and by the British Association of Perinatal Medicine. The issue of staffing shortages was also reflected in conversations with commissioners, who explained that services' inability to achieve these ratios was the primary cause of non-compliance with the national service specification (see page 76). One neonatal consultant service lead commented:

We have never been in the position of having to cut our service but we are making clinical decisions all the time around delivering more service than we should because of demand with inadequate resource... So, for example, for intensive care



patients, we are meant to provide one-to-one nursing cover; for high dependency, one-to-two; and special care, one-to-four. We hit those targets about 70 per cent of the time.

Consultant

We heard that in some cases, staff shortages are leading to the closure of cots. The Royal College of Paediatrics and Child Health's (RCPCH) *medical workforce census 2013* found that the number of neonatal units reporting closures to new admissions as a result of staff shortages in the past 12 months was quite low, and the average number of times units were closed was also low. However, it also noted that there were some outliers (one unit closed 68 times), highlighting the variation in experience between units ([Royal College of Paediatrics and Child Health 2014b](#)).

In addition to the issue of overall staff shortages, interviewees told us that insufficient specialist staff numbers were causing a 'de-skilling' of the neonatal workforce overall, and that nurses are often taking on increasingly advanced roles in response to shortages of junior doctors (suggesting 'up-skilling' of other staff). However, we also heard that this model could work well. The changing skill-mix of the neonatal workforce was reflected in the RCPCH's 2013 *medical workforce census*, which identified a reduction in the number of doctors and an increase in the number of nurses on some neonatal rotas. It also highlighted an increase in the number of consultant vacancies on some rotas, despite a growth in the overall number of consultant neonatologists, which is likely to be linked to efforts to adapt rotas in light of junior doctor shortages. It is also worth noting that some of those we interviewed felt that if there were changes to how services are configured (as discussed below), and staff were used differently, some of these pressures might be alleviated.

Staff shortages were sometimes linked to staff vacancies, but they were also attributed to insufficient staffing establishments, which failed to increase in line with growing demand. Vacancies were attributed primarily to problems with recruitment, which in some areas is part of a wider issue. Interviewees also told us about pressures on staff training opportunities (which one interviewee linked to problems with recruitment) – a product of cuts to training budgets and trusts' reluctance to release staff working in highly pressured units. They also described



difficulties recruiting experienced neonatal staff, with trusts increasingly having to recruit nurses from other specialties, an increasing number of which do not have any experience of working with neonates. Some suggested vacancies were due to poor workforce planning, particularly in terms of specialist staff.

Many of these messages are supported by a 2015 report by Bliss, a charity that advocates for the interests of premature and sick babies and their families (Cleland 2015). Based on a survey of neonatal units in England, the report highlighted a range of staffing pressures, including the difficulty many units have in meeting recommended staffing levels. It further suggests some deterioration in the position over time: in the case of neonatal intensive care units, it identified a 10 percentage point increase in the number that were unable to meet recommended nurse staffing levels since 2010. It also found a 19 percentage point decrease in the proportion of nurses with specialist qualifications since 2010.

A few of the people we spoke to felt that the issues with recruitment, particularly of the most skilled staff, had become more acute in recent years. One study involving 43 intensive care neonatal units found that the provision of one-to-one nursing fell between 2008 and 2012 (Watson *et al* 2016). However, for the most part, we heard that neonatal services had been experiencing workforce pressures for many years, and that the inability to meet recommended staffing levels – particularly in terms of nursing staff – was a longstanding issue.

Pressures elsewhere in the system

The configuration of neonatal services was frequently raised, with many interviewees questioning the sustainability of existing arrangements. There were different views as to how best to organise services, but most of the people who raised this issue argued for greater centralisation of some services, with fewer units providing intensive care. Some suggested that this was necessary to address some of the problems around workforce by making more efficient use of the limited number of specialist staff. However, others noted that this would increase the likelihood of babies being treated a long way from home.



What are the responses to these challenges?

Priorities for future investment

We asked interviewees about their priorities for future investment in neonatal services. Their overwhelming response was that any additional funding should be spent on addressing workforce issues. Many of those we interviewed said they would use any budget increase to ensure that the recommended staffing ratios – for all types of staff but particularly nursing – were met at all times. However, as already noted, a number of people explained that funding was not the only problem linked to workforce, and that finding staff to recruit was likely to be difficult even if more money were available.

A number of the other areas identified for additional funding related to developments in the wider patient pathway that could help reduce pressure on neonatal services. This includes changes in maternity care, transitional care (care provided to babies who require additional care or observation but do not need to be admitted to a neonatal unit, and therefore the mother remains the primary carer) and outreach services. Further areas mentioned included:

- improving the physical environment in units, including providing accommodation for parents
- better psychological support for parents
- development of data on neonatal services to support more innovative changes and help tackle variation in performance.

Productivity improvements and innovation

We heard that neonatal services, along with other services in the trust, are being put under significant pressure to reduce costs and increase efficiency. Some suggested this pressure had increased within the past few years. One interviewee said that processes for seeking spending approval had become more laborious, while another explained that in the past few years, equipment purchases were ‘permanently put on hold’.

There were examples of services having reduced costs – for instance, through changes in procurement and cutting back on administrative staff. We also heard, particularly from commissioners, that the variation in performance across neonatal



units suggested opportunities for improving efficiency. One commissioner highlighted the use of CQUIN schemes in this context as a means of helping to ensure compliance with good practice and driving efficiency.

Required staffing levels and the use of high-cost equipment mean that neonatal services are inherently expensive to deliver, and interviewees told us that cutting costs (staff being the primary cost driver) or becoming more efficient is therefore more difficult than in other services. In the context of efficiency, this was linked to the nature of outcomes measures in neonatal services, many of which are considered to be quite blunt (for example, mortality rates) and poor indicators of wider service quality. However, one ODN manager commented that the fact that neonatal services were responding to an increase in demand without a commensurate increase in income suggested that they were necessarily becoming more efficient. The absence of information on spending on neonatal services means it is not possible to determine whether efficiency has increased in this way.

We heard about more innovative approaches to alleviating pressures on neonatal services, although there were few examples of these having been adopted in practice. Suggestions included better management of care pathways and better use of both transitional and community care in order to support discharge and improve capacity within units. As suggested above, some of the people we spoke to felt that the use of staff could be optimised through a different reconfiguration of neonatal services, with specialist staff concentrated in fewer centres.

Commissioning and contracting approaches

Although the national specification for neonatal services sets out admission criteria, there remains considerable variation in how these are interpreted within networks (*see below*). This is reflected by a wide variation in the number of babies admitted to neonatal networks at term: the 2015 *NHS Atlas of Variation* found that of babies admitted to specialist neonatal care, the percentage who were born at full term ranged from 47.9 per cent to 74.8 per cent across networks ([Public Health England and NHS England 2016](#)). NHS England has initiated work at a national level to help address the issue of inappropriate or avoidable admissions, focusing on the five most common clinical reasons for admission ([NHS England 2016k](#)).



What does this mean for patients?

There is some evidence that the quality of neonatal services is improving: neonatal mortality rates are declining ([Office for National Statistics 2016b](#)), and data from the National Neonatal Audit Programme (NNAP), which monitors standards in 10 areas of care, shows a clear improvement in several areas since the programme was established in 2006. For example, the proportion of babies that are screened for retinopathy of prematurity has increased from 57 per cent in 2008 to 98 per cent in 2015 ([Royal College of Paediatrics and Child Health 2016](#)). However, the NNAP reports also show that further progress is required; for example, although the proportion of babies that have their temperature recorded within an hour of birth had increased to 93 per cent in 2015, this remains short of the 98–100 per cent standard. Also, of those babies whose temperature was recorded in 2015, 28 per cent had a temperature that was below the recommended level ([Royal College of Paediatrics and Child Health 2016](#)). There is also evidence from a study of 43 intensive care units (observed between 2008 and 2012) that a reduction in one-to-one nursing is associated with an increased in-hospital mortality rate (Watson *et al* 2016).

Data collected by the NNAP also highlights the considerable variation in performance between and within networks ([Royal College of Paediatrics and Child Health 2016](#)). The national specification for neonatal services was introduced by NHS England to help address this longstanding issue, but in practice, the extent to which its standards are being met varies. As a consequence, commissioners have been required to agree ‘derogations’ (a temporary delay in meeting standards) with a number of providers. Although this is the case in many specialised service areas ([National Audit Office 2016c](#)), it was suggested in our interviews that neonatal services had one of the larger elements of derogation – overwhelmingly a result of failures to meet recommended staffing levels (as already discussed). One commissioner suggested that this put into question the standards set out in the specification:

... in essence, we've got a specification that doesn't match with providers' ability to deliver it; and that is a huge financial pressure, but also it's a challenge to the credibility of what we're specifying; because if no one can do that... but we're not shutting them all down. How does that stack up?



Most of those we spoke to felt that, in spite of the pressures described above, patients were continuing to receive a high-quality service. We heard that in many respects, neonatal services had improved in recent years, particularly as a result of developments in clinical practice. Some interviewees suggested that patients are continuing to receive a high-quality service primarily because of efforts made by staff to ensure that workforce pressures and financial considerations do not influence day-to-day care. As one interviewee explained, ‘on a day-to-day basis, money is not something that we do or should allow to influence decisions.’ However, some felt that parents did notice the pressures on staff, and that this was a cause for concern.

Two specific issues relating to the impact of pressures on patients are discussed below.

Transfers

One issue raised by many of the people we spoke to was the high levels of occupancy in neonatal units, and – linked to this – the transfer of babies between units for capacity rather than clinical reasons. However, it is important to note that national data does not suggest that this pressure has increased in recent years, although, as in other areas, there is significant variation between units.

National data shows that, on average, occupancy levels for neonatal critical care cots in England are approximately 70 per cent (the average in the first half of 2016/17 was 72 per cent), and that these have been broadly stable since 2010/11, the earliest date for which data is available ([NHS England 2016g](#)). There is also data to show that the number of neonatal cots increased by approximately 9 per cent between 2011/12 and 2015/16 ([NHS England 2016g](#)), broadly in line with the 10 per cent increase in activity set out above ([Department of Health 2016a](#)).

However, occupancy levels can vary significantly between individual units; in interviews, we heard that many units are frequently at 100 per cent occupancy, far exceeding the level recommended by the British Association of Perinatal Medicine. Intensive care units appear to be under particular pressure. This picture is supported by research carried out by Bliss, which found that over a third of the 90 units they surveyed were running above recommended levels, with the proportion rising



to over two-thirds among neonatal intensive care units ([Cleland 2015](#)). In some interviews, we heard that this issue had gradually worsened in recent years, although the relative stability in the national-level data suggests that the trend varies locally.

Data available through the NNAP suggests that 10 per cent of babies admitted to neonatal units in 2015 experienced at least one transfer during their time in neonatal care. There has been little change in this proportion since 2010 ([Royal College of Paediatrics and Child Health 2016, 2015, 2014a, 2013, 2012, 2011](#)). However, it is not possible to tell from this data what proportion of transfers are attributable to problems with capacity, and how this has changed over time.

Interviewees also told us that, when babies are transferred, they are frequently being taken to units in other networks, often a long way from home. The national specification for neonatal services requires that networks have capacity to provide all neonatal care to at least 95 per cent of babies born to women booked for delivery within the network ([NHS England 2013a](#)). However, NNAP data shows that in 2015, 18 per cent of transfers were to units outside of the mother's own network. This proportion has remained broadly the same since 2011 ([Royal College of Paediatrics and Child Health 2016, 2015, 2014a, 2013, 2012, 2011](#)).

In addition to the inherent risks of transfer, moving babies (for non-medical reasons) long distances can limit the extent to which parents are involved in their care – despite parental involvement having been linked with better outcomes. Interviewees also highlighted the impact that long-distance transfers can have on families: not only can this be a cause of significant stress, but parents and families can also end up incurring (sometimes very high) costs associated with travel, accommodation, and care for other children. Linked to this, many interviewees emphasised the problem of limited or poor-quality accommodation for parents in units.

This picture is supported by the findings of a report by Bliss, which found wide variation in the facilities and financial support available to the parents of neonates. It found that more than one in three hospitals lack dedicated accommodation for families of critically ill babies ([Anderson 2016](#)).



Access to the wider multidisciplinary team

Another issue raised by many of those we spoke to was difficulty gaining access to the range of professionals that care for neonates, other than doctors and nurses. This includes allied health professionals (AHPs) such as physiotherapists, dieticians, and speech and language therapists, as well as psychologists and pharmacists. Provision of these services depends partly on the level of neonatal unit, but many are cited within the Department of Health's *Toolkit for high quality neonatal services* (2009a) and British Association of Perinatal Medicine guidelines (2011), and in principle should be funded from the neonatal budget. These guidelines also require that psychological support is made available to parents.

In our interviews we heard that access to these professionals is extremely patchy, and securing investment of these services – compared with the 'core service' – was particularly difficult, with units having to 'fight' to secure them. However, while this suggests that AHPs and others may be first to feel the effects of tightening budgets, we also heard that gaining consistent access to these services had always been difficult.

These professionals play an important role in supporting the longer-term development of babies; speech and language therapists, for example, help neonates with oral development and feeding. As one interviewee commented:

In some ways parents might feel the lack of allied health professionals less [than nurse shortages] because they don't necessarily know they're entitled to it, they don't necessarily know their baby needs it. But the baby's development over time will be significantly hampered by not having had access to it early on.

National stakeholder

There are also cost implications of cutting these services to neonates. A few interviewees made the point that while this could generate savings in the short term, it also risked increasing the number of babies requiring ongoing, expensive care as children or adults.



What does this mean for staff?

As described above, we heard that staff in neonatal units are often working hard to ensure that service quality is maintained. Interviewees told us that the service is often being run on ‘goodwill’, with staff working ‘absolutely flat out’ and ‘running on full cylinders’. We also heard about the inherently challenging nature of delivering care to neonates, as well as the greater scope for extreme peaks in activity compared with some other services. In one case, this pressure had resulted in cot closures:

... the staff get stressed and burnt out much sooner than you would expect them to. That was a situation we did find ourselves in last year and that was a conscious decision to close some cots, to lift the morale of staff in the unit. The workload had been phenomenal. You can imagine working at 110 per cent all the time.

Matron

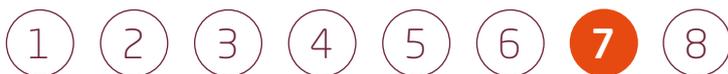
Pressures on staff were particularly associated with the inability of some units to meet recommended staffing levels given high levels of occupancy. One interviewee commented that cuts to ‘non-core’ staff had a negative impact on those within neonatal units:

... provider trusts are quick to cut out what they see as the non-essentials – so the ward clerks, the data clerks, the clinical support worker roles – to make some quick efficiency cuts in funding, but actually it doesn't really. It's not really helpful because that just means that the people that are left have to do those things as well as everything else that they were doing already.

Lead nurse for an operational delivery network

Those we spoke to also highlighted the reduction in staff training opportunities as a factor affecting overall staff experience. The issue of psychological support was also raised in the context of the neonatal workforce, with interviewees highlighting the impact poor access to these services could have on staff working in a very challenging environment.

Although some suggested that pressures on staff were an increasing problem, in general we heard that this was another longstanding issue.



Conclusion

National data does not point to increasing pressure on neonatal services, and on a number of indicators the quality of these services is improving. However, at a local level, there is a significant and longstanding variation in the level of funding that neonatal services receive, and how well they perform. This makes it difficult to build up a clear picture of how patients are being affected by financial and other pressures.

Our research found that neonatal services are experiencing a range of longstanding challenges including staff shortages and high levels of occupancy. It also highlighted the highly variable access to a range of allied health professionals that provide care to neonates, as well as support (including accommodation) provided to parents. Although these are longstanding issues, securing investment for these areas appears to be particularly difficult, suggesting that they may be most vulnerable when budgets are squeezed.



8 Overview

Our research explored the impact of funding pressures in four very different parts of the health and care system. Although the experience of every service area is unique, these case studies provide a window into the challenges faced by other services with similar characteristics. They also highlight the variation within each service area and between them in terms of the challenges they face, the responses to those challenges, and their impact on patient care.

In this section of the report we take a view across our work on GUM, district nursing, elective hip replacement and neonatal services to discuss what they tell us about how financial pressures are affecting patient care. While there is no single narrative that can sum up the experience of a system as diverse and complex as the NHS, some clear themes emerge from our analysis.

Pressures are affecting services across the NHS to varying degrees

We found evidence that a combination of financial and other pressures is affecting the four service areas that we looked at, to different degrees. This reflects widespread evidence of the extensive pressures currently facing NHS services ([Lafond et al 2016](#); [Murray et al 2016](#); [National Audit Office 2016a](#); [The King's Fund et al 2016](#)).

Our research suggests that financial pressures are having the biggest impact on patient care in district nursing and GUM services. Although there is significant geographical variation in the size of service budgets and how they have changed over time in both of these service areas, we found evidence that static or reducing budgets are combining with other pressures to affect access to and quality of care in some parts of the country. The latest performance data on hip replacements contains what may be the first signs of patient care being widely affected. Although activity has grown in recent years and patient reported outcomes continue to be excellent, waiting times for the average patient are creeping up, more patients are waiting beyond 18 weeks for treatment, and activity levels are lower this year than last. In contrast, available data on neonatal services shows that performance at a national



level has improved against a number of quality indicators in recent years. However, longstanding issues remain, such as staff shortages, peaks in demand that require babies to be transferred to distant units, and considerable variation in performance between units.

Access and quality are affected under the radar

We found examples of care being affected in each of the six ways described earlier in this report (see Table 6). In some instances, the impact is clearly visible in local and national data and is scrutinised by commissioners, national bodies and the media. For example, the number of patients waiting more than 18 weeks for a hip replacement is tracked nationally and subject to waiting time targets.

In other instances, patient care has been affected in ways that are more difficult to detect and receive less local or national scrutiny. These include restrictions on access to care that are not picked up in national datasets, such as longer waits for district nursing services and changes to the number, location and opening hours of GUM clinics.

Table 6 Examples of six types of rationing in the four case study service areas

Type of rationing	Example from our four service areas
Delay	There has been an increase in the number of symptomatic patients waiting longer than 48 hours for an appointment at a GUM clinic.
Selection	Some CCGs have introduced new referral criteria for hip replacement surgery based on whether a patient smokes or is overweight.
Denial	We heard one example of denial, where a district nursing service was refusing referrals of nursing home residents.
Deterrence	The closure of some GUM clinics, moves to less convenient locations, changes to opening hours, and cuts to outreach and health promotion services may deter some patients from seeking STI testing and treatment.
Deflection	Some neonates are being transferred to distant units as a result of high occupancy levels locally – a longstanding issue for this service.
Dilution	District nursing care is becoming more rushed and task-focused, with less opportunity for thorough assessments and preventive care.



These also include instances where the quality of patient care has been affected in ways that are difficult to measure with currently available metrics. For example, we found evidence that care provided by some district nursing and GUM services is becoming more episodic in nature, with staff forced to focus on the ‘nuts and bolts’ of diagnosis and treatment without time to provide a service that addresses the full range of patients’ needs. District nurses told us they had less time to provide thorough assessments, which meant problems could be missed that might require more intensive treatment later on.

There were also instances where wraparound services that provide essential support to patients beyond the core service were being decommissioned or reduced. For example, some GUM services had cut the number of health advisers available, whose role is to support people newly diagnosed with an STI and notify their sexual partners to help prevent onward transmission. Across our four service areas, interviewees identified upstream and preventive services as a priority for future investment, yet we found that preventive care is often the first part of a service to be cut when budgets tighten.

Even where national data is available to monitor access and quality, this can hide variation at local level. For example, there is considerable variation between neonatal units in how they perform and the extent to which they are meeting agreed standards.

Although some of the impacts we have identified are the result of explicit decisions to restrict access – such as new service models for GUM that include fewer clinics – in many cases they are the by product of decisions that focus on other issues.

It can be difficult to determine whether a service change (such as a new process that requires fewer staff) represents an efficiency improvement or a dilution of quality. In most of the services we looked at, quality measures were either not available (eg, in district nursing), could not be directly linked to changes to the service (eg, STI rates and GUM services) or did not show any negative effect from these pressures (eg, national neonatal audit data). This may be because patient care is unaffected; however, there is also a real risk that service changes affect aspects of care that are not captured by currently available metrics or have longer-term implications that will not show up in the data for several years. This points to a danger that financial pressures (often inadvertently) lead to a dilution in quality that goes unseen at both



local and national levels, and further highlights the importance of oversight and accountability for quality in the current climate. It also underlines the importance of defining and measuring quality in areas like community services where metrics are currently scarce.

District nursing and GUM services are under particular strain

Looking across our case study service areas, we have identified a range of factors that combine to make some services particularly vulnerable to financial pressures (*see box*).

Factors that can combine to make a service vulnerable to financial pressure

- Use of block contracts that have not adjusted to rising demand
- Provider or commissioners avoid running deficits and make service changes to achieve this
- Budget for the service or relevant sector is not ring-fenced: organisations can top-slice funding to subsidise other services
- Perverse incentives exist: costs resulting from cuts to the service are paid for by a different commissioner
- Consequences of poor care are long-term or not immediately visible
- The service is affected by financial pressures elsewhere in the health and care system
- The service is not a priority area or not subject to high-profile local/national targets
- Limited oversight and scrutiny
- Lack of data available to monitor access and quality
- Patients are from hard-to-reach groups or those with little political voice
- Access and quality issues receive little attention from politicians or the media

District nursing services have been particularly vulnerable because they combine both block contracts, which have not been adjusted to reflect rising demand, and community service providers, who have largely not run deficits to fund staff. This service is also vulnerable because of a lack of available data to track funding,



activity or quality, either at local or national level. Pressures are compounded by the interdependency and close links of district nursing with other parts of the system such as general practice and social care, which are also under strain.

GUM services have been particularly vulnerable because public health budgets have been cut in a way NHS budgets have not. A lack of local and national scrutiny (GUM is no longer covered by national waiting time targets) means patient care is being affected under the radar. In addition, accountability arrangements have been unclear since the 2013 reorganisation of commissioning functions. This is compounded by the fact that the consequences of making cuts to this service are felt over the long term, may take some time to show up in local or national data, and in some cases are paid for by a different commissioner. The service is, however, less vulnerable than some other areas of public health because of a legal mandate that requires local authorities to provide open access.

Elective hip replacement services have been relatively well protected from recent financial pressures by high-profile waiting time targets against which performance is regularly monitored and by hospital providers with the ability to run deficits. There is also extensive data available on patient reported outcomes and quality (eg, PROMs).

Neonatal services have also been relatively well protected from recent financial pressures by hospitals going into deficit as well as national scrutiny of performance. There is near real-time oversight and monitoring of performance data via monthly reports on the number of beds, occupancy and transfers, alongside tight regulation via the CQC. The fact that the consequences of poor care are immediate and life-threatening, and likely to receive close attention from politicians and the media, also affords this service some protection from cuts.

However, both neonatal and elective hip replacement services are affected by wider hospital pressures such as staffing shortages, pressure on beds due to an increase in emergency admissions and delays discharging patients, and reductions in the national tariff (along with decisions made within the hospital about how to allocate income between services).



The impact spreads beyond patients

The value of health care interventions spreads beyond each patient that receives treatment, and it follows that NHS financial and other pressures have an impact beyond those who have direct contact with health services. Interviewees told us about the impact spreading to the following groups.

- **Families:** For example, we heard that longstanding pressures on neonatal services can have an impact on parents and guardians. Transfer of babies to units a long way from home can be both stressful and expensive for families.
- **Carers:** In district nursing, carers are likely to receive less support from district nursing in regards to their own needs. We heard that carers may also end up having to deliver more care to make up for a reduction in nursing provision.
- **The general population:** Restrictions on access to STI testing and cuts to outreach and education services have implications for public health. If a patient is not diagnosed and treated for an STI they may unknowingly infect others, spreading the infection further among the population.

Although we were not able to measure this in our research, it is likely that pressure on services is also increasing unmet demand – that is, that people who need treatment do not receive it. This is particularly concerning where related services that might otherwise have picked up unmet need (such as social care and voluntary sector services) are also undergoing significant cuts ([Humphries et al 2016](#); [National Council for Voluntary Organisations 2016](#)).

Staff often act as shock absorbers

Although we initially set out to understand the impact of financial pressures on patients, during our research we were struck by the profound effect that financial and other pressures are having on staff.

Data from the national NHS Staff Survey shows that overall levels of staff engagement have actually increased in recent years, and the percentage of staff reporting feeling unwell as a result of work-related stress decreased slightly between 2014 and 2015 ([NHS Staff Surveys 2016a](#)). However, the survey results also show



that an increasing proportion of staff in NHS trusts are working additional hours (73 per cent in 2015), and that an increasing proportion are working unpaid overtime ([NHS Staff Surveys 2016b](#), [2015](#), [2014](#), [2013](#), [2012](#), [2011](#)). This may explain why national data on reasons given by staff for leaving NHS organisations shows that the number of voluntary resignations associated with ‘work–life balance’ increased from 3,233 in the first two quarters of 2011/12 to 8,657 in the first two quarters of 2016/17 ([NHS Digital 2016e](#)).

A strong finding across all four service areas was that staff are often absorbing the impact of financial pressures in order to protect patients, with services relying on discretionary extra effort in order to maintain quality. This was most clearly seen in our district nursing case study, where staff were working longer hours and more intensely, leading to higher levels of stress and, in some cases, increasing absence due to sickness. Although the NHS Staff Survey does not report data for district nurses specifically, it does show that a larger proportion of staff in community trusts than in acute trusts are working unpaid overtime and are experiencing illness due to work-related stress ([NHS Staff Surveys 2016b](#)).

This pressure on staff appears to be linked to financial pressures as well as to other factors. For example, for GUM services, the tendering process can be extremely stressful for staff due to the uncertainty it creates. Although this pressure is separate from funding issues, where services are tendered with lower cost envelopes, the impact of the process on staff is heightened.

In some cases, the extent of the pressure put on staff does not seem sustainable. In our GUM and district nursing case studies in particular, we heard about services operating on goodwill, but also heard that goodwill is running out. Maintaining a healthy workforce as the NHS goes through this period of intense pressure is particularly important given the well-established link between staff wellbeing and the quality of patient care ([Maben et al 2012](#)).



NHS services are under pressure financially, but money is not the only problem

While services are clearly under pressure financially, funding is by no means the only challenge. The services we looked at were under pressure from a combination of factors, and different challenges dominate in each. For example, the most critical challenge for district nursing services is a shortfall in the nursing workforce. There are instances where extra money has been found to recruit additional staff, but suitably qualified nurses could not be found to fill the vacancies. The new commissioning arrangements introduced in 2013 are a particular challenge for GUM services, with three different organisations now responsible for commissioning different aspects of some patients' care. This has fragmented patient pathways, created perverse incentives, and left lines of accountability unclear. Elective hip replacement and neonatal services are both affected by wider pressures on hospital services – including nurse shortages, increasing pressure from rising emergency admissions, and the annual reduction in the national tariff. The challenge of rising patient demand was having a major impact across all four services, highlighting the fact that the financial challenge facing the NHS is not simply about the level of funding available, it is about the mismatch between funding and rising demand.

Although money will not solve all of these challenges, in each case the ability of the system to respond is made more difficult by the current financial constraints.

Innovation has been both sparked and stifled

In the face of these challenges, NHS services are not standing still. Commissioner and provider staff in all four service areas were working hard to maintain service quality, innovate, and develop new models of care. There were several examples of services introducing new and innovative ways to manage activity and demand and streamline their services, which were generating efficiencies and improving care for patients. These include new online access routes for GUM services that allow patients to self-test at home and receive results via text message, and the use of tablets by district nurses, which gave them direct access to patient records and, in one service, saved each nurse an average of one hour per day. This adds to evidence of NHS teams across the country implementing innovations that improve quality and also reduce cost ([Alderwick et al 2015](#)).



However, there were also instances where innovation was stifled because either the funding, staff time or skills necessary to stimulate change were not available. In GUM services, one interviewee pointed out that although innovation is happening, the financial challenge is channelling staff energy towards initiatives that manage demand (helping to manage costs) at the expense of developing new and innovative partnerships with other community services that would bring more high-risk patients into the service (but might also increase cost).

System responses vary depending on who is commissioning the service and how it is commissioned

At the beginning of this report we mapped out different ways in which commissioners and providers can respond when demand outstrips funding (*see* section 3). In our four service areas, we saw different responses depending on *who* was commissioning the service (NHS England, CCGs or local authorities) and *how* the service was commissioned (by block contract or tariff).

For example, because local authorities are required to balance their budgets each year and these budgets are falling, they have had to take decisive action to find savings following on from cuts to public health budgets. To meet this financial challenge, the use of tendering allows ‘big bang’ changes to be implemented swiftly. While this can help accelerate the implementation of recommended service models (like integrating GUM and contraceptive services into a single clinic), it also facilitates the implementation of significant cuts to budgets by allowing major changes to be made to the model of provision.

Financial pressures are also leading commissioners to change how they commission services. We heard examples of commissioners of GUM and hip replacement services moving from tariff to block contracts in order to control their costs. By doing this they shift the risk of increased demand to providers. This reflects a national trend for planned elective services to move to block contracts (**NHS Partners Network 2016**). While it is easier to control commissioner costs when paying by block contract, there are risks that quality suffers as patient demand increases (if the block budget does not) and resources are spread more thinly. This is what is happening in district nursing services, where we have seen quality of care diluted in this way.



In GUM, district nursing and neonatal services, providers voiced frustration that commissioners' lack of understanding of their service was leading to ill-thought-through commissioning decisions. We heard some dissonance between what commissioners were asking services to deliver and what people working in those services thought was within the realms of possibility for them to provide. The current environment requires providers and commissioners to think in new ways, and effective collaboration between commissioners, providers, patients and carers will be necessary to address the major challenges they face. The sustainability and transformation planning process brings local system leaders together to address these challenges. Our research highlights the importance of collaboration between commissioner and provider staff and service users at service level to secure the future sustainability of the NHS. It also shows that some of these relationships are not working effectively at the moment in many parts of the NHS.

Pressures in one part of the system have knock-on effects elsewhere

The health and care system is highly networked and pressures in one service inevitably have knock-on effects elsewhere. This applies within hospitals, as shown in our hip replacement case study, where interviewees told us that pressure on A&E and the resultant increase in emergency admissions was contributing to an increase in the number of cancelled operations.

There are also examples of pressures in one part of the system having knock-on effects for those in other parts. For example, we heard about district nursing services being put under extra strain because some GPs were having to limit the work they could do for housebound patients. Conversely, other work by The King's Fund has found that GPs are put under extra pressure because of cuts to district nursing services ([Baird et al 2016](#)).

Pressures also affect health and care services outside of the NHS. For example, interviewees from a hospice reported undertaking increasing amounts of basic end-of-life care that would previously have been undertaken by district nurses. They described pressures in the district nursing service as having a 'tsunami' effect for them. Pressures on the social care system are also affecting hospital services (by making it more difficult for patients to be discharged) and community-based services like district nursing (who treat patients that are also receiving social care).



These pressures also work in the opposite direction – for example, through district nursing cutbacks increasing the social care workload.

This myriad of connections emphasises the need to take a whole system approach to addressing the current challenges facing the health and care system.

The NHS is storing up problems for the future

The NHS has been described as ‘an institution with a built in incentive to dramatise its own difficulties, to exaggerate short-comings and to shock its audience: the theatre of inadequacy’ (Klein 1983, p 201). A key challenge with our analysis was understanding whether pressures had deepened and whether the challenges of maintaining access to high-quality patient care were more intense now than in the past.

Although NHS funding growth began to slow in 2010/11, our research indicates that it has taken some time for financial constraints to impact on patient care. Interviewees told us that current pressures were more intense than in the past and that these issues have been building up over recent years. Staff across the NHS have been working hard to absorb a certain amount of pressure and protect patients, but are increasingly struggling to do so. Cuts to GUM budgets are growing and major changes to those services are being implemented as a result. District nursing services are also already under considerable strain. However, there are now also signs that services like elective hip replacements that have been relatively well protected in the past are starting to be affected.

This is in line with the findings from a recent analysis of 300 quality indicators, which show that quality has increased in many parts of the NHS in recent years but also highlight concerns about areas like public health and general practice, where performance against some key quality indicators is deteriorating, and warns about the future (Fisher *et al* 2016).

We spoke to provider staff and commissioners, keen to protect patient care during difficult times, who were facing tough choices about how to balance flat or reducing funding and increasing demand. When considering how to respond to the funding challenge, a key question is ‘what constitutes a good enough service?’



What sacrifices to quality, access and staff wellbeing are we willing to accept in more austere times? Many of the examples we heard concerning restrictions on access to services and initiatives that potentially diluted the quality of services may have been the right decision to make given the constraints within which the decision-maker was operating; tightening referral criteria, cutting non-core services and closing clinics may have been the least bad of a set of bad options.

However, many of the cuts to services that we heard about are not only affecting current provision, they also risk storing up problems for the future. The extra strain on staff is not sustainable and is already leading to low morale and increased sickness absence in some areas. Other research by The King's Fund on general practice and district nursing also shows that pressures are having an unsustainable impact on staff ([Baird et al 2016](#); [Maybin et al 2016](#)). This not only affects staff now but will add to difficulties with recruitment and retention of staff in future. Cuts to preventive services such as sexual health outreach and education put the population at greater risk of infection as they leave more people unaware that they have an STI. When under pressure, the system naturally focuses on more immediate concerns, but these long-term issues will be costlier further down the line.

Our research suggests that core acute services such as hip replacement and neonatal care have been relatively well protected so far while some community-based and public health services like GUM and district nursing have been cut. This creates a fundamental challenge to the direction of travel set out in the Forward View, of 'out-of-hospital care becoming a much larger part of what the NHS does' and the NHS 'getting serious about prevention' ([NHS England et al 2014](#)). The widespread implementation of new models of care that join up local services, focus on prevention and keep patients out of hospital will not be possible if the pressures we saw on district nursing services – a core community service that links with so many other parts of the NHS – continue. Similarly, the issues we have seen in GUM services raise questions about whether the NHS can focus on prevention when public health budgets are reducing and even those services that have some protection from a legal mandate are being cut back significantly.

This adds to evidence from other work by the Fund that despite pockets of innovation and areas where real progress is being made, the health and care system as a whole is moving further away from the model of care set out in the



Forward View. Our broader research shows that pressures across the health and care system have put the quality of care at risk in mental health, general practice, community, public health and social care services ([Baird et al 2016](#); [Humphries et al 2016](#); [Maybin et al 2016](#); [Gilburt 2015](#)). A renewed focus on maintaining the quality of services based outside of hospital is needed to reverse the current direction of travel. This not only relates to the way these services are funded, it also relates to the development of systems to monitor and assure quality at both local and national levels in areas where problems can be difficult to detect and where there is currently little data available.



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Before joining the Fund Lillie worked in the health team within PricewaterhouseCoopers' advisory practice, where she supported NHS organisations on a range of assignments including public procurement projects, organisational and commercial change and strategy development projects. While at PwC, Lillie spent 18 months on a secondment to the Department of Health's NHS Group where she worked on provider policy.

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The severe financial pressures on the NHS show no signs of easing, but how are they affecting patient care?

Understanding NHS financial pressures gets behind the top-line figures to find out how financial and other pressures are affecting patient care in four different parts of the health system: genito-urinary medicine (GUM), district nursing, elective hip replacement and neonatal services. In each area, research involved analysis of available data and interviews with national stakeholders, local commissioners and clinicians, other health care professionals, managers, and patient representative organisations.

Our research found that:

- although the current financial pressures began in 2010/11 they have taken some time to have an impact on patient care
- GUM and district nursing services are under particular strain
- hip replacement services are showing the first signs that patient care is being affected, with waiting times beginning to rise
- neonatal services appear to have maintained quality and access though other longstanding pressures remain and there is variation between units
- the growing gap between demand for services and available resources is affecting staff as well as patients
- commissioners and providers are taking innovative approaches to maintain the quality of care; however, in some areas financial pressures are stifling innovation.

Our findings create a challenge to the direction of travel set out in the *NHS five year forward view*. There needs to be a renewed focus on maintaining the quality of community-based services and on prevention. As many of the issues we identified are not picked up in current performance metrics, there also needs to be a focus on defining and measuring quality where data is currently scarce.

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