NHS reality check
Delivering care under pressure

March 2017
Introduction

In recent months, it has become a truism to report on an NHS in the midst of an ‘eternal winter’ crisis, with well-rehearsed statistics on rising patient need and a service buckling under pressure.

By the end of the 2015/16 financial year, NHS providers logged a record deficit of £2.45 billion, with funding having slowed to an annual growth of just 1.2% a year. Put simply, while the NHS budget has been protected relative to other government spend in the past 5 years, patient need has continued to outpace resources. Years of rhetoric about transforming services to care for people better in their homes and communities have yet to deliver tangible results. Preventative and mental health services are often the first to face disinvestment in difficult financial times, compounding the crisis.

At the Royal College of Physicians (RCP), we asked our members to tell us about their experiences on the front line of care delivery. This report gives voice to over 2,100 doctors and NHS teams who are overwhelmed by rising levels of need in hospitals that operate with no slack – doctors who describe themselves as continuously ‘firefighting’, ‘papering over the cracks’ and ‘hanging on by their claws’ – and lays out in stark terms what this means for patient care. Shining through their stories is the dedication of a profession deeply concerned about the future of the NHS, but determined to keep the ship afloat. Attention is often focused on the pressures on hospital emergency services, but our evidence shows that doctors providing care across the medical spectrum – in services that are the backbone of hospital care – are struggling to cope.

The RCP is clear that the NHS is currently underfunded, underdoctored and overstretched. Patients and NHS staff deserve better. We need a new plan for health and social care: a plan designed to meet the UK’s health and care needs in the long term, and to value, support and motivate NHS staff.

Gauging the pressure

- **Patient safety**: 55% of doctors believe that patient safety has deteriorated over the past 12 months.
- **Understaffing**: 84% experienced staffing shortages across the team.
- **Poor staff morale**: 82% believe that the workforce is demoralised.
- **Rising patient need**: 78% cite rising demand for their service in the past 12 months.
- **Delayed transfers of care**: 60% experienced delays in transfers of care from their service.
- **Reduced care quality**: Over one-third (37%) cite lower-quality care in the past 12 months.
- **Confidence in the future**: Nearly three-quarters (74%) of doctors are worried about the ability of their service to deliver safe patient care in the next 12 months.
- **Speaking up**: Fewer than half (47%) believe that doctors in their trust are confident about speaking up.
- **Freedom to speak up guardian**: Nearly four in five (79%) doctors don’t know who their freedom to speak up guardian is.
Time for action

NHS and social care funding
NHS and social care budgets have not kept pace with rising demand for services. We need a new financial settlement that:

> sets realistic targets for efficiency savings
> invests in the long-term sustainability of the NHS and social care, putting an end to a cycle of short-term planning.

Service transformation
Investment in community and social care provision will ensure that people get the right care, in the right place, reducing avoidable hospital admissions and delayed transfers of care. We need:

> a significant increase in investment in social care, specifically better step-down provision to facilitate patients’ transition out of hospital into community or other care settings
> to allow time in job plans for physicians to build links across teams and settings, and to collaborate and innovate
> to ensure that sustainability and transformation plans (STPs) reflect current need as well as future aspirations, with doctors contributing to future planning through their local STP.

Prioritise public health and prevention
Supporting people to live healthier lives will reduce avoidable illness and help to keep people out of hospitals. We need to:

> adopt progressive public health policies, including upstream measures designed to promote healthier lifestyles – for example, using tax mechanisms as a means to reduce overconsumption of alcohol, unhealthy food and drinks, and cigarettes
> invest in prevention by reversing the cuts to the local authority public health allocation.

Invest in, support and value the NHS workforce
The UK does not train enough doctors, and hospital teams are under increasing pressure from staffing gaps. We need to:

> ensure that overall training numbers are sufficient to deliver enough doctors across all parts of the medical workforce, from GPs to physicians
> realign the workload balance across the medical workforce, and create ways to incentivise work in acute and general medicine.
> address nurse shortages and promote innovative staffing models, eg physician associates working with doctors
> take cross-governmental action to relieve immediate pressure on the NHS workforce, and to deliver a sustainable NHS staffing model in the long term.

Prioritise patient safety

Patient safety should be a fundamental organising principle of every health service provider. We need to:
> empower all members of the clinical team to raise concerns without fear of repercussion
> monitor engagement of physicians and managers within trusts regularly, and share results with all staff.

Why are hospitals under so much pressure?

Hospital services are under acute strain. Greater attendance and admissions, driven by a rising older population as well as increasing numbers of people living with complex, multiple comorbidities, have not been met with a corresponding increase in resources.

Analysis by the King’s Fund\(^1\) has shown that attendance at accident and emergency (A&E) departments increased by 17% between 2003/4 and 2015/16. Nearly one-third of the overall increase occurred in the past 2 years (ie from 2014/15), indicating a sharp rise in demand within a relatively static overall budget. Subsequent hospital admission rates are also rising, with 27% of patients admitted in 2015/16 compared with 19% in 2003/04.

The increasing number of clinical contacts taking place in hospital confirms the strain. In December 2016, a total of 1,173,505 patients started consultant-led treatment, a 4.5% increase compared with December 2015.\(^6\)

At the same time, community health and social care services do not have the capacity to deliver all the care that is needed, meaning that high admission rates have coincided with record levels of delayed transfers of care. In December 2016, there were 128,000 delayed days in acute care, an increase from 100,300 the previous December.\(^4\)

The result is hospitals squeezed from both sides – unable to control underlying causes of demand for their services, and unable to safely transfer the care of some patients who no longer need to be there.

\(^1\) Bed occupancy has got out of hand. The emergency department can’t admit patients, the hospital can’t discharge patients. The destruction of social care has inevitable consequences.\(^7\)

Bed occupancy rates are an indicator of the robustness and relative safety of a hospital, and the NHS is currently experiencing record levels of dangerously high bed occupancy (over 85%). The average occupancy rate for general and acute beds in quarter 2 of the 2016/17 financial year (July–September 2016) was 89.1%, down slightly from 90.2% in quarter 1.\(^8\) Recent analysis shows that this equates to nine out of ten hospitals running over capacity.\(^9\)
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Increasing number of admissions, bed occupancy, shortage of medical and nursing staff, 40–80 medical outliers on surgical wards on a daily basis, 25–35 patients allocated to a consultant team with limited number of juniors as a routine, clinics cancelled frequently to allow consultant cover on wards…

Staffing levels below establishment are also prevalent, with 84% of doctors experiencing staffing shortages across their team in the past year. In January this year, the RCP surveyed consultant physicians about consultant and trainee staffing levels in their departments. Of respondents, 52% reported at least one vacant consultant post in their department. Of those reporting vacancies, 43% had one vacancy, 31% two vacancies, and 25% three or more. The problem of inadequate staffing is exacerbated when hospitals are running at or over capacity.

‘55 escalation beds in operation today with no extra medical or nursing staff. Completely unsafe.’

We know also that, in spite of these immense challenges, NHS staff are the health service’s greatest asset, and they continue to work tirelessly to provide the best patient care.

‘Staff will work as hard as they can to deliver the best patient care possible. It is just getting harder.’

‘The fact that it [safety] hasn’t worsened is purely due to the dedication and hard work of all staff – from admin and cleaners through to nurses, support services and all grades of doctor. We are all covering rota gaps, working long hours, checking things get done. It isn’t sustainable and I worry that things will soon become unsafe.’

Despite this dedication, it is clear that morale in some organisations trusts is at breaking point, with 82% of doctors experiencing a demoralised workforce in the past year. This is bad for doctors and bad for patients – the RCP’s Being a junior doctor report highlighted that almost half (69.7%) of junior doctors feel that poor morale has a serious or extremely serious impact on patient safety.

‘I feel like I am on the Titanic.’

‘I’m worried that a swathe of junior doctors will walk away from UK medical careers, either temporarily or permanently…’

‘…I can see a tranche of senior consultants/GPs just opting to retire early…’

‘My biggest concern is that the answer to safer patient care seems to be to work the doctors harder. This is intrinsically unsafe; we already work at full pelt, and every rank experiences rota gaps…’

Safe management of patients is impossible due to inadequate staffing levels, especially at nights and weekends. Patients are at risk, and junior and senior staff are very stressed and near breaking point.

4.5% increase in patients starting consultant-led treatment between December 2015 and December 2016
What does this mean for patients?

When hospitals are full, patients are directly affected, because the continuity, quality and safety of their care all suffer.

1 People aren’t always admitted to the right place for the right care – from medical outliers in surgical or even non-medical wards, to people being “cared” for and waiting in corridors. This can represent a direct risk to safety.

2 To cut down on A&E waiting times and 12-hour breaches, patients are being shifted to the first available ward bed without consideration of specialty needs, and complex patients with specific specialty needs are ending up in inappropriate wards, which is not only leading to delay in specialty input but also adding to length of stay times.

3 ‘Caring for patients in corridors is difficult and puts strain on the caring staff trying to do their best. Patients are also outlying on non-medical wards and even in radiology departments. The strain on the system is palpable.’

‘Currently the hospital is overfull, with patients on trolleys in corridors and in the middle of the bay (with no curtains, access to electricity, oxygen etc). We have no extra resources to cope with this. We also have lots of outliers and elective surgery has been cancelled (including cancer surgery).’

4 ‘The hospital is operating at full capacity all of the time. We are asked (almost) daily to “lower our thresholds” for what we consider to be a safe discharge.’

Lack of capacity means that some people are discharged from hospital too soon, often to overstretched primary, community and social care services.

3 Elective surgeries and clinics are cancelled to focus resources on the most immediate need, directly impacting on quality and continuity of care.

4 Doctors, nurses and all staff are spread too thinly, risking unsafe or poor care – increasing the risk of errors and missing details by clinicians who have less time to spend with each patient.
Speaking out and raising concerns

What are freedom to speak up guardians?

In 2015, Sir Robert Francis’ Freedom to speak up review recommended that every trust appoint someone to the role of freedom to speak up guardian. The guardians are intended to work with trust leaders to ensure that effective local processes are in place to help and support staff to raise concerns about patient safety. When the review was published, Sir Robert Francis summed up the concerns around speaking out on patient safety: ‘in recent years there have been exposures of substandard, and sometimes unsafe, patient care and treatment. Common to many of them has been a lack of awareness by an organisation’s leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did.’

All NHS trusts and NHS foundation trusts are required by the NHS contract (2016/17) to have nominated a freedom to speak up guardian by 1 October 2016. While it is likely that the many freedom to speak up guardians are still bedding down into their organisations, it is concerning that the majority of doctors don’t know who their guardian is, and that, of those who do, the vast majority feel that they have made no improvement to the culture of transparency and raising concerns. It has never been more important that doctors, and all staff working within the NHS, are confident in raising concerns over patient safety. It feels like the conversation around safety is completely contradictory to the ones around funding.

‘...everyone can speak up, but there are few who can actually make the changes needed in the NHS.’
Opportunity costs

The resource crunch is undermining the huge potential for transformation, quality improvement and research within the NHS, as well as progress already made in improving patient safety.

‘Although we have made continuous improvement to systems and processes to keep patients safe, this is constantly undermined by high occupancy, crowding in ED and delayed transfers of care.’

‘Basic standard will likely be delivered [but] services are unlikely to develop and excel.’

‘There’s really not the time to step away from the bed and contribute to improving things, to do things differently.’

‘Some aspects, eg infection control measures, have improved but I feel increasing lack of capacity in the system is a much greater and increasing risk.’

References