NHS CONFEDERATION

System under strain

Why demand pressures are more than a winter phenomenon

Contents

Preface

For some time, the NHS Confederation has been warning that annual reports of a winter crisis in hospital accident and emergency departments disguise more systemic problems caused by increasing demand for NHS and social care services and underfunding.

Last autumn, NHS Confederation chief executive Niall Dickson spoke of an "all year round crisis" in the NHS, stressing that both reform and significant new funding would be required to avoid unsustainable and unsafe levels of demand.

This report sets out the evidence for this view and highlights some of the ways NHS organisations have been working to mitigate the pressures they face. Finally, it proposes how forthcoming changes at NHS England and NHS Improvement could present an opportunity to support NHS and social care organisations in working better together locally to meet rising demand.

Introduction

In recent years, it has become routine for the media to highlight a crisis in the NHS each winter. Examples cited include postponed operations, patients diverted between hospitals, and ambulance crews providing care to patients outside emergency departments that are full to capacity.

The tendency has been to focus on what happens in one part of the NHS system at one point in the year. However, with demand for care outstripping funding growth, the pressures facing the NHS and social care are year-round. Moreover, these pressures extend beyond the struggling hospital accident and emergency departments that we see in news bulletins, and into every area of the NHS, as well as the social care system that supports it.

This report shows that increases in demand are not restricted to particular parts of the service and specific times of the year. It describes ways in which increasing demand in one part of the system can affect the performance of other NHS services elsewhere. It outlines how some NHS and social care providers have adapted their services to enable patients and service users to access care more efficiently.

Finally, it argues in support of a shift away from viewing performance solely as an organisational issue. It calls for regulators to support NHS and social care providers and commissioners in thinking more holistically about how the benefits of local provider and commissioner relationships can be maximised to meet soaring demand.

"With demand for care outstripping funding growth, the pressures facing the NHS and social care are year-round."

Rising demand is not restricted to winter

The most emblematic symbol of escalating demand for NHS services is the image of ambulances queueing at the acute trust accident and emergency department 'front door' in wintertime. But increasing demand for services across the NHS is occurring throughout the year and affecting all parts of the NHS.

Demographics of demand

The underpinning drivers of increasing demand relate to both demographics and expectations. As Figure 1 shows, the overarching trend is that the UK population is growing and ageing. The population grew by 15.9 per cent in the 31 years between 1985 and 2016. During the same period, the proportion of the population aged 65-84 increased by 1.7 percentage points and the number of people aged 85+ increased by 1.2 percentage points. In actual terms, the number of people in this category more than doubled.[1]

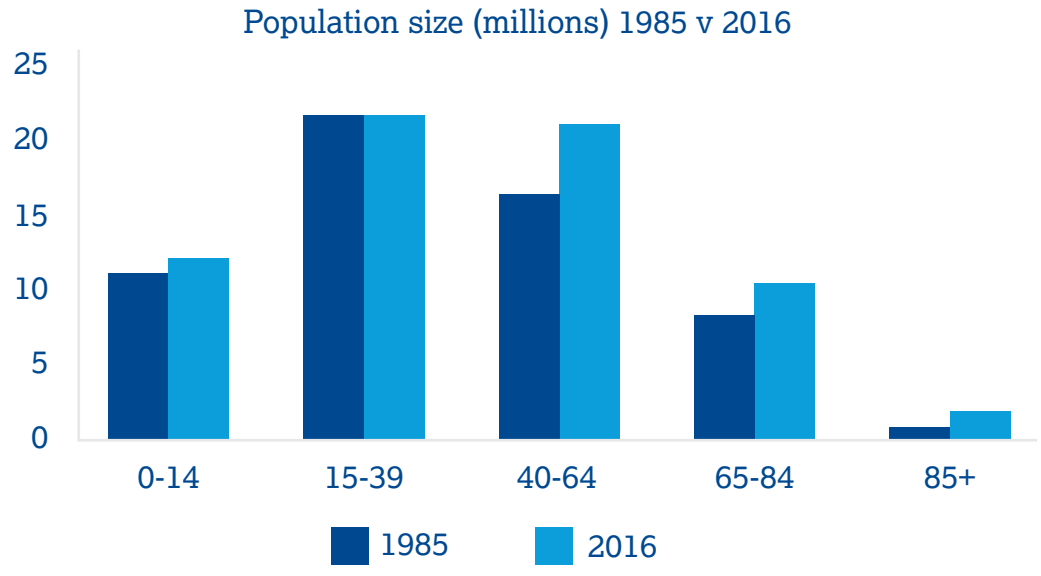
> "Increasing demand for services across the NHS is occurring throughout the year and affecting all parts of the NHS."

Acute care

Acute trust activity data for the last five years show significant percentage increases across multiple measures of activity. In the five years between January-March 2013/14 and January-March 2017/18, total A&E attendances for the winter quarter increased by 8.6 per cent. Summer (July-September) A&E attendances also increased by 7.3 per cent over the same time period.[2]

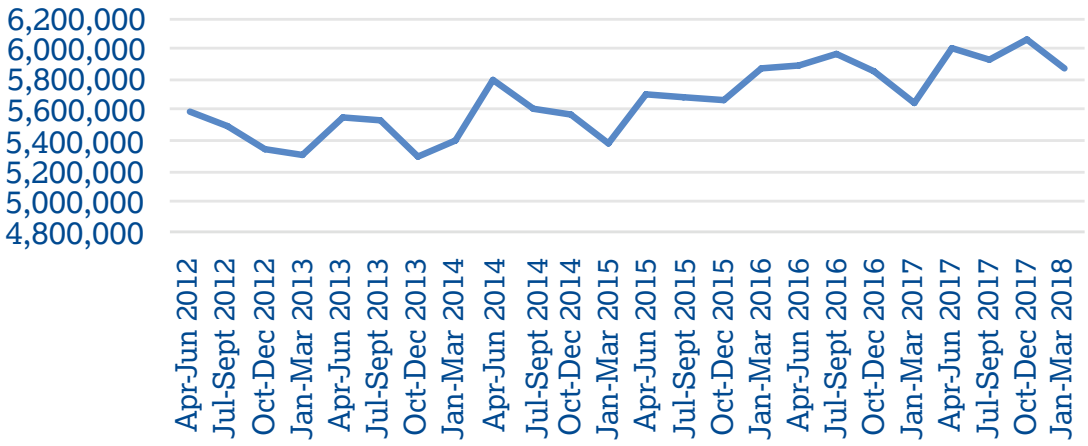
In the period between January-March 2013/14 and January-March 2017/18, the number of first consultant outpatient attendances for general and acute services increased by 8.1 per cent. The increase for July-September over the same time period was 10.6 per cent. Emergency admissions increased by 14.6 per cent between July-September 2013/14 and July-September 2017/18. They increased by 12.5 per cent between January-March 2013/14 and January-March 2017/18.[3]

Figure 1. UK population size and age composition in 1985 and 2016



Source: Securing the future: Funding health and social care to the 2030s

Figure 2. Total A&E attendances by quarter, 2012/13 – 2017/18



Source: NHS England quarterly attendances and emergency admissions monthly statistics, NHS and independent sector organisations in England

Mental health care

Because of recent changes in the way the data is recorded, it is difficult to provide reliable figures for changes in demand for mental health services. However, NHS Digital's Mental Health Bulletin for 2016/17[4] states that as a "best estimate", the number of people known to be in contact with adult mental health or learning disabilities and autism services has risen by 10 per cent between 2015/16 and 2016/17, although it warns that these figures may be revised as more information becomes available.

Care Quality Commission analysis shows that although the number of patients admitted to mental health inpatient facilities has remained stable, the total number of detentions under the Mental Health Act rose by 26 per cent between 2012/13 and 2015/16.[5]

This analysis also shows how demographic trends affect mental health – the oldest are proportionately much more likely to be users of mental health services, with 20 per cent of those aged 90 and above and 13 per cent of 80-89-year-olds using mental health services, compared with 2.5 per cent of 60-69-year-olds and 3.2 per cent of 50-59-year-olds.

Community services

Data for community services is less readily available, but recent work by the NHS Benchmarking Network using data drawn directly from NHS community providers shows that in 2015, bed occupancy levels reached 91 per cent, up 2 percentage points from the previous year.[6] This suggests a sector which is running at full capacity.

Primary care

As with community services, very limited data is available about the nature of demand in primary care. However, research by The King's Fund, published in 2016, using data provided by ResearchOne, the non-profit research arm of a primary care computer system provider, found that in a sample of 177 practices, total direct face-to-face and telephone contacts increased by 15.4 per cent across all clinical staff groups between 2010/11 and 2014/15. During this period, the number of face-to-face consultations increased by 13.3 per cent, and telephone contacts increased by 62.6 per cent.

Over the same period, average in real terms list size increased by 10 per cent and the overall number of consultations per patient per year rose

from 4.29 to 4.91. In other words, more patients were using these GP services, and patients were using the services more often.[7]

Ambulance services

According to figures from the Association of Ambulance Chief Executives (AACE), in 2016/17, 11.2 million 999 calls were made, including 1.46 million that were redirected from NHS 111. The number of 999 calls received increased by 21 per cent between 2013/14 and 2016/17, but the number of patients taken to hospital increased by a much lower proportion of 3.8 per cent, as ambulance staff treated more people in homes and in the community.[8]

Data analysed by the National Audit Office showed demand for ambulance services (measured as the number of ambulance calls and NHS 111 transfers to ambulance services) increased by an average of 5.2 per cent year on year in the period between 2009/10 and 2015/16.[9]

Social care

As social care is not universally provided free at the point of access, the care sector experiences increasing demand in a different way from the NHS. Although the same demographic pressures apply to social care as they do to health services, local authorities have tended to respond by tightening eligibility criteria for social care.

Researchers at the Health Foundation and The King's Fund reported findings that in 2010 only 25 per cent of councils said they planned to support people with "moderate" levels of need in future. This contrasts with 53 per cent of councils supporting people with "moderate" levels of need in 2006.[10]

Concerns about those who no longer receive care are reflected in Carers UK's *State of caring 2017* report. Thirty-four per cent of people responding to this research said they or the person they care for had experienced a change in the amount of care and support services they receive in the last year, with almost four in ten of these (39 per cent) saying the amount of care or support arranged by social services had been reduced. Thirteen per cent said the care or support service they used had been closed with no replacement offered. Seven per cent of those experiencing a change said the amount of care or support had reduced because the cost had increased.[11]

"As social care is not universally provided free at the point of access, the care sector experiences increasing demand in a different way from the NHS."

Health and care services face unprecedented financial pressure

The NHS is dealing with escalating demand at a time of unprecedented funding constraint. Although Prime Minister Theresa May has signalled a more generous long-term funding plan is under consideration, the National Audit Office (NAO) noted in a report published in January 2018 that the NHS England budget is at present projected to increase by an average of 1.9 per cent per year over the period between 2014/15 and 2020/21. The NAO adds that investment has been front-loaded over the earlier part of this period, meaning a bigger slowdown later. This compares with spending increases of 3.7 per cent per year on average since the health service was founded in 1948. The NAO states that funding per person, once adjusted for age, will fall by 0.3 per cent in 2019/20.[12]

Funding pressure on the NHS can manifest itself in different ways: as well as having fewer funds available in total, the NHS is seeing money intended for capital expenditure diverted into revenue spending. A Public Accounts Committee inquiry in March 2018 heard that the Department of Health had been repurposing money in this way since 2013/14, transferring 20 per cent of the initial £5.8bn capital budget into revenue budgets in 2016/17.[13]

This is particularly significant when efforts to respond to increasing demand are considered, as capital expenditure is what providers use to invest in new facilities and technologies. If funds are diverted away from these activities and used instead to cover day-to-day operating costs, the NHS has even less ability to expand provision by putting in place new infrastructure.

The Public Accounts Committee concluded that the national bodies charged with running the NHS "are too focused on propping up the system and balancing the books in the short term and have not paid enough attention to transforming and improving patient services".[14]

An independent review for the then Department of Health, conducted by former University College Hospital London NHS Foundation Trust chief executive Sir Robert Naylor found that the NHS required "a robust capital strategy" to determine the final investment requirements through sustainability and transformation partnership (STP) plans.[15] The review found that the NHS could potentially "release £2bn of assets and deliver 26,000 homes and with an effective programme of interventions in high-value propositions in London, this could significantly increase the property receipts to a figure exceeding £5bn in the longer term". However, the report warns: "...substantial capital investment is needed to deliver service transformation in well evidenced STP plans", adding that the total capital required by these plans is likely to be around £10bn in the medium term.

A further challenge is that NHS capital assets are not distributed evenly across the country – for instance, land in London is worth far more than land in some other parts of England, meaning that where NHS organisations are able to dispose of land assets, the impact can vary hugely from place to place.

Social care also faces grave funding pressures. According to analysis by the Health Foundation and The King's Fund, spending by local authorities on social care per adult resident fell by 11 per cent in real terms between 2009/10 and 2015/16. The authors add that "an increasing number" of local authorities report social care suppliers "handing back contracts".[16] Sustained pressure on NHS budgets means the amount of funding clinical commissioning groups receive is not keeping pace with inflation. NHS Clinical Commissioners has calculated the scale of this 'real terms reduction' as follows:

"From 2017/18 until 2019/20, clinical commissioning group (CCG) core allocations are due to increase on average by 2 per cent each year across England. But when inflation is applied the real terms increase is only 0.6 per cent per year. With adjustments for population growth, the value of the national CCG budget shrinks by 0.48 per cent – or £330m – by 2019/20 compared to 2016/17. So, while being expected to do more, on average CCGs will have £5.72 less to spend per person in 2019/20 than in 2016/17."[17] These cumulative pressures mean that commissioners are having to make difficult decisions in their local areas about how to allocate scarce NHS resources most efficiently. The most recent efforts to make more central funding available to NHS providers via the £2.45bn Provider Sustainability Fund have, for 2018/19, come with an expectation that providers should meet trust-specific financial targets, known as control totals, in order to access the money. Trusts that do not meet these targets, or that do not participate in the scheme, will receive only partial additional funds, or none at all.

Increasing demand and static funding can lead to deteriorating performance levels

The dual pressures of increasing demand and financial constraint help to create a climate in which it is more challenging for NHS organisations to ramp up activity in order to match the greater numbers of patients attempting to access services. One consequence of this is a deterioration in performance against activity targets.

Last year the NHS failed to meet the 18-week referral-to-treatment (RTT) target for the second year in a row. This target requires that 92 per cent of patients on incomplete referral-to-treatment pathways should have been waiting for 18 weeks or fewer. The target is measured at the end of March, and last year 90.3 per cent of patients met these criteria.[18] The NHS Mandate pledge that at least 95 per cent of patients attending A&E should be admitted, discharged or transferred within four hours has been put on hold as a target, not having been met in any month since July 2015.[19]

Recent analysis under the QualityWatch programme, which is jointly run by the Nuffield Trust and the Health Foundation, and which analyses the performance of the NHS across a series of quality metrics, has found a picture of deteriorating performance.

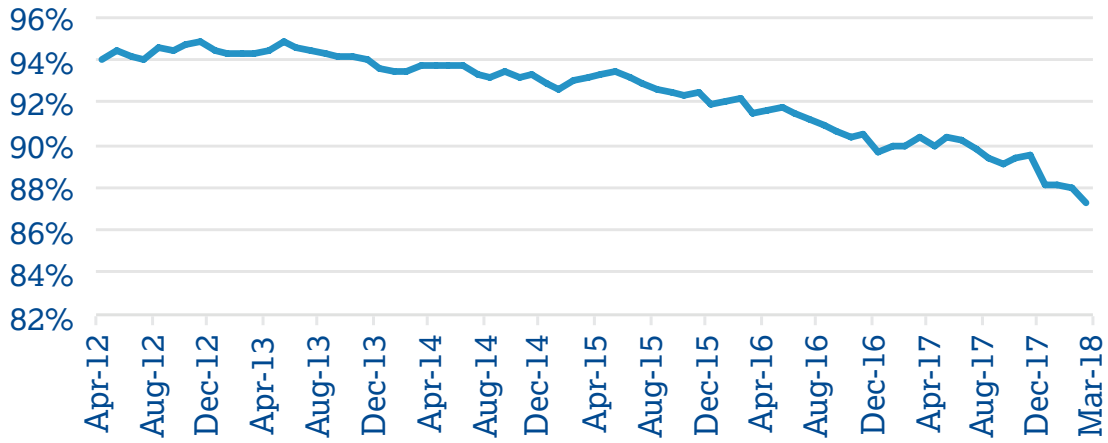
The QualityWatch analysis revealed that performance across a majority of quality metrics analysed under the programme began to deteriorate in 2013/14, three or four years into the period of slower NHS funding growth that began in 2010. [20]

In social care, where services are often provided by private contractors, market failure has become an increasingly common phenomenon. The Association of Directors of Adult Social Services (ADASS) budget survey for 2017 found provider failure had affected 69 per cent of councils within the six months prior to responding. Thirty-nine per cent of councils completing the ADASS survey reported that a home care provider they contracted with had closed or ceased trading in the last six months and the figure was 43.9 per cent of councils for residential/nursing homes.[21]

Mental health providers are seeing lengthy waits for some of their services, with more than a quarter of patients (27 per cent) waiting 11 weeks or longer to access NHS eating disorder services and more than four in ten (42 per cent) waiting 11 weeks or more for NHS memory services.[22]

In primary care, although the 2017 GP Patient Survey results showed patients were still attaining a good level of access to GP services, the proportion saying it was easy to get through to their GP on the telephone (68.0 per cent) had decreased by 1.9 percentage points compared with the previous year. The proportion of patients saying they had been able to get an appointment to see or speak to someone the last time they tried (84.9 per cent) had decreased by 0.7 percentage points year on year.[23]

Figure 3. Proportion of patients waiting 18 weeks or less to start treatment



Source: NHS Referral to Treatment (RTT) waiting times, England

Pressure in one service area can have knock-on effects in others

When one part of the health and care system comes under demand pressure, the consequences are rarely restricted to that service alone. For instance, congestion in the accident and emergency department can lead to hold-ups for ambulances that need their patients to be admitted to A&E before they can go to help other patients. According to NAO analysis, in 2015/16, 500,000 ambulance hours were lost because of delayed transfers of care at hospitals.[24]

If 'step-down' beds in social care or community care (where patients are discharged to when they are well enough to leave hospital but not well enough to go straight home) are full, hospitals are unable to discharge inpatients. This can then cause delays in admitting patients into inpatient care from accident and emergency departments, further exacerbating overcrowding in A&E. This is neither good for patients nor an efficient use of resources.

Delayed transfers of care

The impact on acute hospitals of lack of service availability elsewhere in the health and care system can be observed very clearly in data on delayed transfers of care. The number of delayed transfers of care has been increasing rapidly in recent years, with a total of 154,602 days of delay in March 2018, compared with 115,158 in March 2013, an increase of 34.3 per cent. Delayed transfers of care occur when a patient is judged ready for transfer by clinicians but remains in a bed at the hospital or provider where they have been treated.

Analysis of delayed transfer of care data from 2017/18 shows that the proportion of days of delay relating to patients awaiting a care package in their own home was 21.0 per cent, 16.6 per cent related to those awaiting further non-acute NHS care, 14.3 per cent for those awaiting a nursing home placement, and 14.2 per cent for completion of assessment, 12.0 per cent were as a result of patient or family choice and 11.5 per cent as a result of awaiting a residential home placement.[25]

Overall, in 2017/18, the NHS was responsible for 57.3 per cent of the delays, with social care being responsible for 35.2 per cent and 7.4 per cent being attributable to both the NHS and social care. Five years previously, in 2013/14, the NHS had been responsible for 68.0 per cent, with social care responsible for 25.8 per cent and both responsible for 6.2 per cent, suggesting that reductions in availability of social care services have had a significant impact on the ability of the NHS to move patients through its system efficiently.

That said, the number of days of delay attributable to social care declined over the 2017/18 period, with the figure in April 2017 being 67,328 (38.1 per cent), reducing to 47,457 (30.7 per cent) by March 2018. For days of delay occurring within NHS acute provider organisations, the greatest proportion (21.8 per cent) was because of awaiting further non-acute NHS care. This can be contrasted with data for non-acute providers such as mental health and community providers, where the greatest proportion of days of delay (also 21.1 per cent) were because of awaiting a care package in the patient's own home.

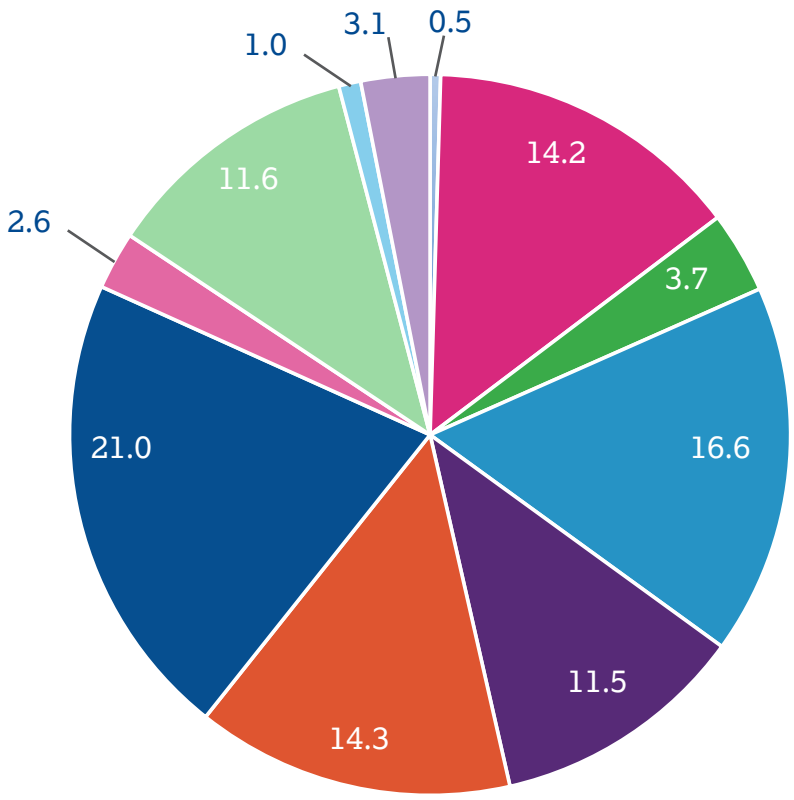
One explanation for the large proportion of delays in NHS acute providers relating to other non-acute NHS care is that community providers are increasingly taking on responsibility for caring for patients who have undergone hospital procedures at a much earlier stage in their recovery. This helps patients to return to their homes earlier, and supports hospitals in increasing the throughput of patients so that space can be made available to address increasing demand. But it increases pressure on the community service providers themselves, as they must offer much more intensive services in order to be able to look after these patients.

Analysis by the NHS Benchmarking Authority in 2017 found that despite the growing role of community services, there had been no significant shift in funding for either adults' or children's services into the community sector for the previous five years.[26] And if community services are unable to accept new patients for capacity reasons, this can mean longer delays for patients waiting to leave acute trusts.

Primary care providers are also broadening their role by taking on responsibility for managing many aspects of the ongoing care of people with long-term conditions. As a result, various blood tests and condition monitoring services are now routinely offered via GP practices. But this increases the demand for GP and nurse appointments at doctors' surgeries at a point when these services are already stretched.

The social care sector also reports pressures stemming from demand issues affecting NHS services. According to the Association of Directors of Adult Social Services (ADASS)' 2017 survey of members, 61.3 per cent of councils responding reported increased demand from people with very high needs not being admitted to hospital, 54.7 per cent of councils reported increased demand for health care activity to be undertaken by social care staff, and 15.5 per cent said fines had been levied against their council for delayed transfers of care, whereas 7.7 per cent said an intention had been expressed to do so.[27]

Figure 4. Days of delay in 2017/18: causes



- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute NHS care
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or family choice
- Disputes
- Housing patients not covered by NHS and Community Care Act
- Other

Source: NHS England: delayed transfers of care, NHS organisations, England

Addressing the issue: initiatives to improve efficiency, productivity and demand

Faced with spiralling demand, and without the funding to expand capacity to match, NHS and social care organisations have been seeking different ways of working in order to mitigate the impact of system-wide pressures on services.

In recent years, acute care providers have undertaken significant work to optimise the journey of inpatients through their services. Some elements of this work generally go by the name of managing patient "flow". The logic of flow improvement is that the main driver of delays is "a mismatch between when capacity is available and when demand presents to a service".[28]

Providers can ensure the availability of sufficient surplus capacity to accommodate bulges in demand when they happen, before demand pressures spiral, causing greater challenges elsewhere in the system. But with average general and acute overnight bed occupancy rates increasing – standing at 92.6 per cent in the latest round of data[29] – it becomes more difficult to use in 'slack' in this way.

Some NHS organisations have looked to change how they provide services in order to increase efficiency. Examples from two trusts are provided below.

North East London Foundation Trust

Faced with growing demand pressures and operating in a tough financial climate, mental health provider North East London Foundation Trust (NELFT) has reconfigured aspects of its services in order to increase efficiency and reduce delays for patients.

Agile working

In July 2015, NELFT leaders decided to roll out agile working across the trust, enabling more than 4,000 of its 6,000 staff to work remotely, and freeing up nurses' time to see more patients.

The trust established ten "agile locations" across north east London, Essex and Kent for staff, and the trust headquarters in Rainham, Essex was set up with more than 70 agile workspaces, six training rooms, seven meeting rooms and a board room. As part of the changes, trust chief executive John Brouder gave up his own office, switching to using the trust's agile workspaces.

Staff visiting patients were able to reduce their travel time through better planning, freeing up more contact time with patients, and benefiting from instant access to all patient records and reference material. The trust calculates that the change has increased productivity, with nurses being able to see around 9 per cent more patients than previously as a result of the switch.

Redbridge Community Health and Social Care Services

Working with the London Borough of Redbridge, NELFT put in place Redbridge Community Health and Social Care Services (HASS), an integrated service for health and adult social care allowing patients to access community mental health and social care services in a more streamlined way.

The service operates via four multi-disciplinary community health teams in different locations in the borough, based on GP clusters. Each team comprises social workers, occupational therapists and nurses, as well as specialist teams with expertise in physiotherapy, speech and language therapy and rehabilitation. It focuses on early intervention and prevention, supporting adults with a learning disability or on the autistic spectrum, adults with physical and/or sensory disability, adults with a mental health issue and vulnerable older people.

Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside and Glossop Integrated Care NHS Foundation Trust has established a Digital Health Centre to support the care of residents within residential and nursing homes, as well as people who live in their own homes and use a local authority-provided community response service.

The aim of the scheme is to reduce attendances to and admissions from A&E for residents of care homes, nursing homes and the wider community in Tameside and Glossop.

Each care home and team has observation equipment such as blood pressure monitors, tympanic thermometers, oxygen saturation monitors and other simple diagnostic tools. The trust provides a standardised training programme on the use of these.

A team of nurses, based at the hospital, provides clinical advice to carers, residents and local authority community response service partners, meaning that where clinically appropriate, a patient can be treated remotely via Skype video link.

The service was launched in March 2017 and by May 2018, 46 out of 47 care and nursing homes in the area had signed up. As of 1 May 2018, the service had achieved the following results:

- 1,263 emergency department attendances prevented, validated against an agreed true avoidance criterion
- 400 GP interactions avoided, meaning patients have been managed with advice/guidance or directed to another community team or service
- 725 prescriptions issued by GPs based on clinical information provided by Digital Health Centre documented assessments, without the need for a face-to-face GP visit.

NHS Confederation viewpoint

The NHS and social care have been operating under a prolonged period of constraint, with funding for services increasing at a much slower rate than would be necessary to keep pace with escalating demand.

For the NHS, recent drop-offs in performance against quality standards and targets mandated in the NHS Constitution add to a mounting and increasingly undeniable body of evidence that a combination of increasing demand and insufficient funding is leading to poorer quality NHS care and longer waits for patients.

In the past, we were managing to meet these targets and a whole array of others; the fact that we are now not doing so reflects the intolerable pressure facing those who are delivering front line services. In our view, things would be a lot worse, had the service not been able to make significant strides in productivity, thanks to better planning and the dedication of NHS staff.

Missed targets and raised thresholds affect individual patients every day. They have to wait longer to access the care they need, they find their procedure has been cancelled because there is no capacity in the system, and individuals in need of social care – and their carers – are not able to receive the publicly funded support they would have been able to take for granted a decade ago.

Our work with the Institute for Fiscal Studies and the Health Foundation[30] shows that tough choices are necessary if health and social care services are to receive the funding they require. According to that research, if waiting time targets are to be met, and underprovision in mental health services addressed, annual funding increases of 4 per cent will be necessary over the next 15 years. We believe this funding increase should be implemented now.

But as well as these long-term funding challenges, there are shorter-term changes that must be made in order to give health and social care services the best chance of meeting the demand pressures described here.

As demonstrated by the case studies featured in this report, health and social care providers can achieve much when they work across traditional organisational boundaries to mitigate demand pressures. Sustainability and transformation partnerships and new models like integrated care systems can enable such innovations across health economies, while individual providers are redesigning pathways at a local level to better respond to demand.

But in order to implement these ways of working at scale, NHS and social care organisations will need the support of NHS England and NHS Improvement.

Recent announcements have signalled a determination to bring the two organisations much closer together with shared management and a greater regional focus. If this creates a more coherent approach, and supports providers and systems to develop local solutions, it is to be welcomed. However, there are further steps the centre could take to support this agenda.

First, there is a clear need for better activity data to support providers outside the acute sector in improving efficiency. Although there have been moves to gather more information about demand for mental health services, community services and primary care do not have access to the same level of information. This data would enable providers to make better informed decisions about their own provision, as well as supporting more joined-up decision-making across care pathways.

Secondly, the regulatory system is still too focused on organsations. Although the Care Quality Commission has started to conduct inspections across a 'place', the whole accountability framework remains targeted at the organisational level. This makes it much more difficult for trusts to consider the wider benefits of the system as a whole as opposed to what may be in their own narrower organisational interests and it can mean that they can face penalties for performance issues the cause of which may not be within their control.

A good example of this is how trusts' success in meeting control total targets is linked to extra funding from the Provider Sustainability Fund. Some of this was earmarked specifically to provide increased capacity in accident and emergency departments over winter.

While we welcome the increased investment that the Provider Sustainability Fund has brought, linking access directly to individual organisational performance mitigates against the collaborative action that is needed and in effect penalises patients in areas where arguably the need is greatest. That said, there is limited appetite among providers at present for system-wide financial targets where there is a risk that a failure in one area could result in even less money entering struggling health economies.

As a first step, we would therefore urge the arm's-length bodies to exercise discretion on whether to withhold access to additional funds on financial performance grounds. When a provider does not meet a financial target, regulators should consider whether this represents a corporate failure, or points to a set of issues at least in part outside the control of the organisation in question. In the latter situation, given the demand and financial pressures outlined above, denying access to funds will only harm patients and increase the size of the eventual funding increase required to stabilise the service.

The NHS Confederation will be working with finance directors at provider and commissioner organisations in the coming months to explore some of these ideas in more detail.

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