Royal College of Physicians

NHS reality check
Delivering care under pressure

Mission: Health

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.[1] 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.[2] 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.

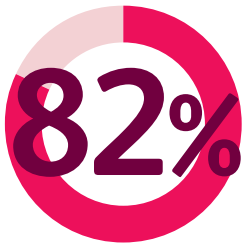
Gauging the pressure

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

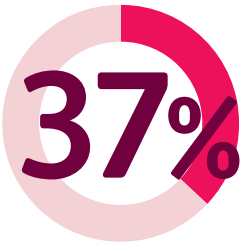
82% believe that the workforce is demoralised

Rising patient need

78% cite rising demand for their service in the past 12 months

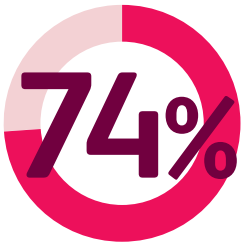
Delayed transfers of care

60% experienced delays in transfers of care from their service



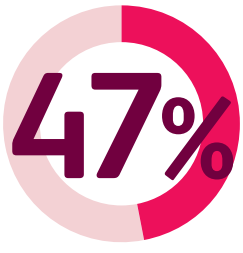
Reduced care quality

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:

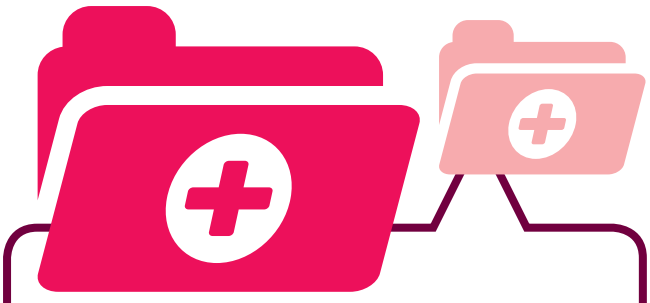
- ensure that overall training numbers are sufficient to deliver enough doctors across all parts of the medical workforce, from GPs to physicians
- realign the workload balance across the medical workforce, and create ways to incentivise work in acute and general medicine

- 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.



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.

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.[3]

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.

> '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.'

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.[5] Recent analysis shows that this equates to nine out of ten hospitals running over capacity.[6]

‘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.[7] 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[8] highlighted that almost half (49.7%) of junior doctors feel that poor morale has a serious or extremely serious impact on patient safety.

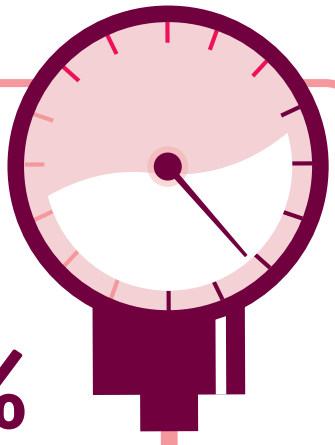
‘I feel like I am on the Titanic.’

‘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.

"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."

"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)."

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

'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.'

"The pressure to admit fewer patients is unbearable. As we have no beds, we are trying to do things as outpatients which we would never do ... if patients are not extremely frail, then we are trying to discharge them and manage. I feel I am so close to making mistakes, just luck that I have not made one yet."

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

"The pressure on beds has been resulting in patients being discharged sooner than ideal and being told that they will be booked into specialist clinic urgently for follow-up monitoring. At the same time, the specialist clinics are being cancelled at short notice to free up consultants to do additional ward rounds to discharge more patients. So, the patients who are being discharged early are not really getting into clinics, that were anyway overbooked and then cancelled."

"Our hospital has had a bed occupancy of over 99% for the past 12 months, which has severely limited elective work and delayed the management of serious chronic disease."

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.

"We have patients being managed in corridors. Some deaths occurring in corridors. The atmosphere in the ED is frantic, with evidence of low morale and burnout [and] high turnover of staff."

"Lack of junior medical doctors on the wards, almost every day. Too many patients under nominal care, patients admitted onto different medical wards under my name. Almost impossible to take clinical accountability for all these patients when they cannot even be reviewed on my ward round."

"There is no doubt that patient safety has hugely deteriorated. Many more mistakes made, much less willingness by management to investigate and prevent further ones (mainly because so much pressure on time)."

"Doctors have less time to assess patients accurately, due to time pressures."

"Increasing pressures to turn round patients lead to risk of missing details. Increased patient volume without more resource spreads the resource thin."

5 Patient experience and quality of care suffer

‘Even when care is safe, it is more often being provided in a way that damages patient dignity.’

‘…significant deterioration, aim is for early discharge, unsafe patient movement, no regard for continuity of care.’

‘Patients on trolleys in the corridor is now acceptable practice.’

Speaking out and raising concerns

There are inherent safety risks in a hospital running at full (or over) capacity – from an increase in hospital-acquired infections, to the impact of burnout from overworked staff. In challenging financial times, it is crucial that members of the NHS workforce are supported to raise and escalate safety concerns. However, only one in five (21%) doctors know who the freedom to speak up guardian is in their trust and, of those who do, fewer than one-third (30%) believe that the guardians have helped to improve the culture of transparency and raising concerns in their organisation.

We also asked, more broadly, whether doctors in their organisation feel confident in raising concerns and issues. We found that doctors are almost split down the middle on this – with fewer than half (47%) agreeing that this was the case, and a similar number (45%) stating that they did not feel doctors in their organisation were confident to speak up.

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.[9] 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.[10]

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.’

While some doctors are confident in raising concerns, many question whether those concerns will be acted on.

‘…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

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3 NHS England. *Monthly delayed transfers of care data, England, December 2016.* Leeds: NHS England, February 2017. www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/December-16-DTOC-SPN.pdf [Accessed 23 February 2017].

4 NHS England. *Combined performance summaries, 2015–16.* Leeds: NHS England, February 2017. www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/ [Accessed 28 February 2017].

5 NHS England. *Bed availability and occupancy – quarter ending 30th September 2016.* Leeds: NHS England, November 2016. www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/KH03-Q2-2016-17-Statistical-Press-Notice.pdf [Accessed 23 February 2017].

6 BBC News. *NHS health check: Nine in 10 hospitals ‘overcrowded’ this winter.* www.bbc.co.uk/news/health-38853707 [Accessed 23 February 2017].

7 Gordon H. The consultant census: rota gaps in 2017. RCP: *Commentary* 2017; April:p6.

8 Royal College of Physicians. *Being a junior doctor.* London: RCP, December 2016. www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor [Accessed 23 February 2017].

9 Francis R. *Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS.* February 2015. freedomtospeakup.org.uk/the-report/ [Accessed 23 February 2017].

10 Care Quality Commission. *National Guardian’s Office.* www.cqc.org.uk/content/national-guardians-office [Accessed 23 February 2017].

About this report

RCP members were invited to respond to an online survey between 9 January and 3 February 2017. In total, 2,101 doctors completed the survey.

About the RCP

The RCP aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Mission: Health

The RCP’s Mission: Health campaign calls for urgent action to address pressures on the health service. Throughout 2017, the RCP will be working with patients, professionals and policymakers to develop our vision for the future of the health service. Drawing on their experiences, expertise and evidence, we will explore the major issues facing the NHS, develop solutions and showcase good practice.

For more information, visit
www.rcplondon.ac.uk/missionhealth

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