Understanding NHS financial pressures – good news for neonatal services?

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The scale of the financial challenge facing the NHS has been well publicised. So too, in recent months, has been the deterioration in NHS performance against a number of key targets, such as A&E waits and ambulance response times. These missed targets undoubtedly point to a system struggling to cope, but how much do they tell us about the impact on patient care and are these pressures being felt in the same way across the system?

These questions were at the heart of some recent research by The King's Fund, set out in our report *Understanding NHS Financial Pressures.*[1] Against the background of a slowdown in NHS funding growth (beginning in 2010/11) we wanted to get underneath the top-level figures on finance and performance and explore how financial, and other, pressures are affecting patient care. Our research focused on four services, chosen to reflect the variety within the system in terms of commissioner, contracting approach, position on the patient pathway, and provider type. Alongside sexual health services (testing and treatment for sexually transmitted infections, or genitourinary medicine (GUM)), district nursing, and elective hip surgery, we looked at neonatal services – our example of a specialised service, commissioned by NHS England.

In one sense, our findings on neonatal services represent good news. Our research into GUM and district nursing identified clear evidence that, as a result of financial and other pressures, access to and quality of patient care in some parts of the country have suffered. In the case of hip replacement surgery, an area where activity has increased in recent years, we saw the first signs of care being affected, with waiting times beginning to increase. In neonatal services, however, the picture looked a bit different: 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. However, we identified a number of longstanding challenges and considerable variation between services.

The good news

In fact, there is some evidence that the quality of care in neonatal services is improving. Data collected through the National Neonatal Audit Programme (NNAP) show clear progress against a range of measures since the programme was introduced in 2006 (although further improvement is required before all targets are met).[2] Indeed, most of the people we interviewed as part of our research – national stakeholders, commissioners, and a range of provider staff – described neonatal services as being of a high quality, with many highlighting advances in clinical practice and improved neonatal survival rates. Those working in neonatal services spoke with pride about the care provided by themselves and their colleagues.

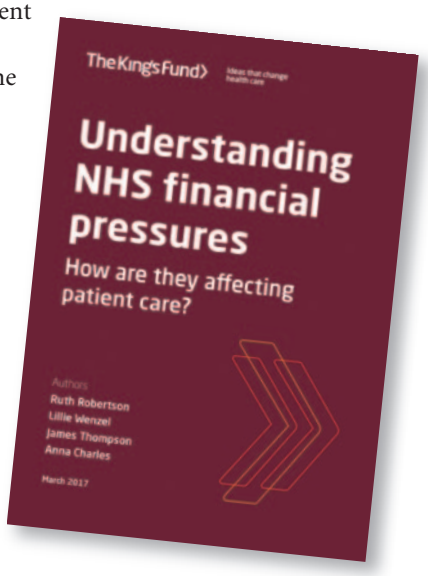
On the question of financial pressure, we could not find clear evidence that this had increased in recent years. Admittedly, building up a clear picture on funding for neonatal services and how this has changed was not easy; there is no publicly available data on national spend on these services and local payment arrangements vary widely. Many of the people we spoke to felt that funding for neonatal care had failed to grow in line with demand, and that services had experienced financial pressure for some time but we did not get a clear sense that this pressure had increased significantly in recent years.

But...

This is not to say that neonatal services aren't under pressure. Although we didn't detect a significant change in recent years, we did find evidence that these services have for a long time been experiencing a number of substantial challenges. We also identified considerable variation in performance between units, reflected in both the NNAP data, and the *NHS Atlas of Variation in Healthcare.*[3] A national service specification was introduced to help this issue, but in practice the extent to which its standards are met still varies. In short, our positive findings are checked by an important 'but'.

The most significant challenges facing neonatal services appear to relate to workforce. We found that shortages in staff of all types mean that many units are failing to meet recommended staffing levels. One neonatal consultant service lead told us: "For intensive care, 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% of the time." We identified a particular gap around specialist staff, and found that units increasingly have to recruit nurses with little or no prior experience of working with neonates. Those we spoke to attributed shortages to insufficient staffing establishments, or to difficulties with recruitment and retention.

We also learnt that some neonatal units are experiencing very high levels of occupancy. Although national data show that overall occupancy levels in neonatal units are approximately 70%



Research by The King's Fund set out in the report *Understanding NHS Financial Pressures.*[1]

(and have been broadly stable since 2010/11),[4] we heard that this varies significantly; many units frequently operate at 100% occupancy, far above the level recommended by the British Association of Perinatal Medicine. For babies cared for by neonatal services, this pressure on capacity can have significant consequences. In our interviews, we heard that high levels of occupancy can result in babies being transferred for non-clinical reasons, sometimes to units a long way from home. Not only can this limit parents' involvement in their baby's care, it can also lead to significant stress for families and often significant costs, for example for travel, accommodation and care of other children.

A further issue highlighted by our research related to the patchy access to allied health professionals and others working alongside neonatal doctors and nurses, such as specialist pharmacists. Our interviewees highlighted the significant role these services play in babies' long-term development; speech and language therapists, for example, provide critical support in relation to babies' feeding and oral development. While these services appear to sit outside of the 'core' neonatal service, they can have a significant impact on the long-term development of babies and consequently on their future care needs (and costs). Though this is a longstanding issue, there was some suggestion from the people we spoke to that these areas are particularly vulnerable when budgets are squeezed.

Unsurprisingly we found that the pressures facing neonatal services are having an impact on staff. In several interviews, we heard that service quality was being maintained primarily because staff went to great efforts to ensure pressures on resources did not affect day-to-day care. Although, as in other areas, we did not find that this strain had increased significantly in recent years, we learnt that it could be severe; one matron told us: "Last year [we took] 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% all the time."

The big picture

Looking at these issues in the context of our broader research, we identified some common themes. For one thing, it was clear that each of the services we looked at are facing a range of pressures, aside from financial ones – such as growing demand, or workforce challenges. Though these are often closely linked with financial pressure, they have an independent impact too. For example, in neonatal services as elsewhere we found that staff shortages were explained not only by pressure on budgets, but often by the poor availability of suitably qualified staff to recruit. Growing demand was linked to a range of factors including women having babies later or through *in vitro* fertilisation (IVF) leading to more high risk births, and medical improvements that are enabling premature and very ill babies to survive earlier and for longer.

The pressures on neonatal staff were also far from unique. We found signs that, to some degree, staff are acting as 'shock absorbers' in each of the services covered by our research, with many professionals working more intensively and for longer to protect patient care. Given the well-established link between staff and patient experience, this is a worrying finding. The likely impact on staff morale, recruitment and retention over time also raises an important question as to how sustainable this position is.

Similarly, the suggestion that the 'non-core' support provided to neonates is particularly vulnerable when budgets are squeezed resonated with our findings elsewhere. In district nursing and GUM services in particular we found that services were increasingly focused on the 'nuts and bolts' of diagnosis and treatment, with wider support and preventative elements of care being reduced. Like the increasing strain on staff, these findings suggest that financial and other pressures across the system are not only affecting patient care now, they are storing up problems for the future.

Of course, evidence that our services were experiencing some common challenges does not change our overall conclusion: recent financial and other pressures appear to be having the greatest impact on care in GUM and district nursing services, while neonatal services and, to a lesser extent, hip replacement surgery, appear to have been relatively well protected so far. Looking across the four service areas, we drew some tentative conclusions as to why this might be. Despite there being no public data on national spend, in contrast to areas such as GUM and district nursing, there is some data to support near real-time monitoring of neonatal services – for example on cot occupancy levels – making significant changes in performance hard to miss. Neonatal services also provide care to very ill babies and the consequences of a significant cut in resources could include immediate loss of life; this is different from GUM and district nursing, where the impact of cuts are likely to have an impact over the longer term. Linked to this, we noted that neonatal services have a high profile among politicians and in the media and consequently are afforded some protection from spending cuts in a way that lower profile services are not. In addition, while we have seen acute providers run significant deficits, those in other sectors have tended to avoid doing so, but have often made changes to services in order to achieve this.

These factors probably help explain the 'good news' for neonatal services. But the fact that these services appear to have, so far, been relatively well protected from recent financial pressures does not mean we can sit back and relax. The ongoing variation in clinical practice locally is striking and, as the pressures facing the NHS continue, developing an understanding of what lies behind these differences should be a key priority. It is also important not to ignore the longer term pressures facing neonatal services and, more importantly, what they may mean for the future.

References

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