Acacium Group

Maximising NHS capacity – an insights bulletin from Acacium Group

Acacium Group is the NHS's largest partner offering staffing, managed services and innovative delivery models to local NHS and social care systems. We place around 21,000 staff each week, and deliver the NHS's largest diabetes prevention service. We are one of the NHS's largest digital IAPT mental health providers and deliver numerous staffing solutions – including the staff supporting the NHS Nightingale Hospital COVID-19 vaccination service in London. We are also the largest partner running hospital Trust staff banks, with 59,000 NHS staff under our responsibility and a track record of improving workforce efficiency and reducing agency spend.

Over the past year, **we have worked closely with the NHS** to help provide it with the **added flexibility** it needs to **grow capacity** at short notice to **meet surges in demand**. This experience has equipped us with a number of insights into how NHS capacity can be maximised in the future, on an ongoing basis – set out in this bulletin, which will be of interest to all those involved in planning the NHS's recovery.

The bulletin covers:

- Some facts and figures on the NHS's fixed capacity
- Ways in which we have supported the NHS increase capacity, flexibly, in response to demand
- Contact details for further information

Facts and figures

At the start of 2020, as a proportion of the population, the NHS had some of the lowest numbers of hospital beds, diagnostic equipment and healthcare workers amongst OECD countries:

- The UK's 2.5 **hospital beds per 1,000 population** is less than half the 5.9 in France, and under a third the 8.0 in Germany – the best equipped European country
- The UK has the **fewest CT and MRI scanners** per capita among comparable countries, and the **second smallest radiology workforce** within Europe, with 7 per 100,000 compared to a mean of 12 across Western Europe
- With 7.8 **nurses per 1,000 population**, the UK has just over half the number of nurses per 1,000 population as Germany (13.2), and less than half the highest (Norway – 18)

Whilst no health service could have been prepared for the extreme pressures of COVID-19, the NHS has had to go further than others in maximising the capacity it has to maintain patient care.

Maximising capacity

From our experience working with the NHS at the local level, we recommend decision-takers at the national level consider implementing and scaling three key concepts:

Concept 1:
'pop-up' step down services to address Delayed Transfers of Care (DTOCs)

DTOCs occur when patients are unable to be discharged from hospital. Delays are often caused when the patient's home or supported care facility is not ready to receive them or suitable transport cannot be arranged. DTOCs therefore measure the efficiency of the interface between hospital, community and residential social care – and if the latter two do not have enough support and capacity then hospital discharges will be delayed.

In the years leading up to the pandemic, DTOCs have been increasing. The latest NHS England data release from February 2020 (when the pandemic paused the release of DTOC official statistics), shows that:

- From February 2019 to February 2020 Delayed Days (bed days lost) in acute NHS organisation increased by a quarter, from 82,000 to 103,000
- Across acute and non-acute NHS organisations, over 5,300 beds were affected by a DTOC in February 2020 – an increase of 20% from the year before
- The impact of these increases have variable impacts in different areas of the country; for example, around 4% of the total delayed days in February 2020 occurred at one trust in the North of England

The pandemic has exposed further the need to tackle DTOCs, since every delayed transfer imposes an unnecessary constraint on NHS capacity, as well as causing considerable distress and unnecessary stays in hospitals for patients. The Government has implemented a number of steps over the last 12 months – including recommending the 'discharge to assess' policy, which calls for patients to be discharged from hospital before assessing their social care needs – but some of these steps have increased demand on the step-down care services which fit between hospital and community settings. Step-down services have also needed to provide facilities specifically for COVID-19 patients, to ensure the often-vulnerable patients discharged to them are not put at risk.

Our solution

In response, **we have helped the NHS to create 'pop-up' step-down services** – where we have supported partners to establish the site, rapidly mobilise trained staff for it, operate and manage it – in areas where pressure on the acute sector is greatest. **The speed of our solution gives the NHS the flexibility to respond to NHS need.**

Concept 2:
primary and community staff banks

Before and during COVID-19, primary and community care services have been undergoing a rapid transition. The new Primary Care Networks (PCNs), which bring together groups of GP practices to work at scale to deliver some services to bigger populations of 30-50,000 people, blur some of the traditional boundaries between primary and community care services. PCNs, by pooling the resources of multiple GP practices, can aim to employ more and varied staff – physiotherapists, specialist nurses and pharmacists, for example – that traditionally may not have been considered part of community care.

However, as with other areas of the NHS, even if the funding and will exist, finding the workforce to fill these new and varied roles, as well as the GP time to support PCNs themselves, has proved challenging:

- Up to November 2020, **the number of GPs** has increased by a little over 1,000 since 2015, less than a fifth of **the Government's target**
- The **Royal College of Physiotherapists** estimates physiotherapy vacancy rates across the country of between 6% - 20%
- The number of **nurses and health visitors working in community health services** has continued a long term decline in recent years: the number of community nurses is lower now than it was in 2010

Despite the staffing challenges, the success of PCNs and wider community services is crucial to the NHS's planned recovery from COVID-19 – as well as its ability to deliver on the ongoing extra pressures of COVID-19-related services.

Our solution

In response, we have begun considering an innovative solution. Hospital staff banks have been a feature of the NHS for decades. A bank flexibly provides temporary staff when an NHS organisation needs them. Unlike an agency, banks are often run directly by the NHS organisation, or on their behalf by third parties, and provide staff to a single or limited number of NHS organisations. When run efficiently, the cost to NHS organisations of using **staff from banks** is also often lower than from using agency staff.

Banks are much less well developed in primary and community care, which leave these services more vulnerable to having to access agency staff whilst piling even further pressure on the clinical teams. However, some ICSs are now beginning to explore implementing this solution at scale: indeed, **in one typical ICS region, we estimate such a solution could provide access to over 1,000 additional GPs, pharmacists, phlebotomists and associate nurse practitioners** to supplement the primary and community care workforce. With the need to rapidly stand up COVID-19 vaccination services in primary care putting ever great strain on practices, **banks provide one possible answer for maintaining routine services.**

Concept 3:
remote healthcare services

The COVID-19 pandemic has driven the rapid uptake of remote health services. The numbers of GP consultations, outpatient appointments, and even community diagnostic interventions have all increased dramatically over the last 12 months.

Even before the pandemic, remote services were seen as one solution to helping the NHS to deliver services more efficiently; in 2018, 25% of doctors thought that 10-20% of their new patients didn't need to come to an outpatient clinic at all. With the NHS's need to maximise capacity greater than ever, the smarter and more effective use of remote services will be critical to the NHS's recovery.

To take mental health as an example:

- The rise in the number of people needing to access services is outstripping the available workforce. Although the number of consultant psychiatrists increased by 4.3% between 2015 – 2020, referrals increased by 8% in 2018/19 alone
- Before the pandemic, waiting times varied dramatically with some areas seeing waits as short as four days for first treatment whilst others had waits of over 60 days
- The pressures of COVID-19 are expected to worsen the mismatch between demand and capacity, with the need for social distancing measures sometimes reducing capacity for some mental health providers by an estimated 10-30% whist demand increases by up to 20%

Our solution

For a sector that was stretched before COVID-19, this is clearly unsustainable. **Technology, and virtual delivery of services can provide part of the answer.** We are one of the NHS's largest digital IAPT providers, with 2,700 patients currently in treatment. **Our service both allows patients to access services out-of-hours and our registered clinicians to work when they want** – unlocking more clinical time by saving the need to travel between clinics, whilst delivering better recovery rates than the average across NHS IAPT services. **Digital IAPT services** – and other digital health services – can **play an important part in supplementing the physical capacity of NHS services.**

Further information

We hope this bulletin is helpful. If you would like further information, please get in touch with **info@acaciumgroup.com**.