# Twitter Thread by david oliver

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## A short thread about hospital bed pressures

## This may surprise some people outside the healthcare bubble but for a population of c 60 million, England (pre-pandemic) only had just over 100,000 General and Acute Hospital Beds and c 4,300 ICU beds and both running close to full

as an aside @HSJnews reported that we have perhaps 3,000 general and acute beds available than this time last year for various reasons, pandemic and "winter pressures" or not.

We struggle to staff many of those beds fully with 100,000 NHS post unfilled inc 1 in 8 in nursing

the pandemic response means we have to separate wards and admission streams into "hot" (proven or suspected covid) and "cold" (covid unlikely or excluded) areas and try to separate staff (though some have to work throughout hospital). This takes further beds out of availability

England is already right at the bottom of the OECD league of developed nations for hospital beds per 1000 population and ICU beds per 100,000 and well below European average on both and in similar place in "doctors and nurses per 1000 " league table (even if posts filled)

Because it is comparatively rare in England to have completely separate acute/urgent (with full A&E dep and acute admissions) hospital site and elective/planned/procedure/outpatient/cold surgery site . If there are pressures on acute and general beds it impacts that planned work

A proportion of Covid-19 cases are acquired or detected once people already in hospital beds and this can then lead to outbreaks in bays of wards or across whole wards and this means wards or bays get temporarily closed to admissions (or to discharges into community facilities)

once those beds & bays get closed it further reduces the available bed pool for admissions and make the *real* bed number lower than the notional number.

And then as we run into the "festive" period (although there has been fantastic work with "discharge to assess" and enhanced funding to help people leave hospital sooner) - delayed transfers will rise

this will also reduce the number of beds effectively available

Meanwhile, infection control measures mean hospitals taking beds out of bays to keep beds further apart and care activities can take longer with all the PPE and precautions meaning staff under further time pressure

meanwhile in A&E - overcrowding and waits were already issues - and contrary to what you might read, most of this is due to sick patients who need admission to beds deeper in the hospital and flow through those beds, not walk -in patients in minors/chairs who go home the same day

as you can imagine, with covid doing the rounds again the last thing we need is more overcrowding now as it is already bad for patient health and staff morale and risks cross infection of people at or in hospital.

many older A&E departments and AMUs were built for smaller numbers than they now handle and even the new build ones were often built in assumption about smaller numbers. They were not built with streaming into infected and non infected patient groups in mind (at this scale)

A&E activity and hospital admissions and delayed transfer bed days have risen steadily year on year even as bed numbers have fallen (we have lost c 25% of general and acute beds over past 3 decades when admissions and attendances have nearly doubled)

meanwhile, since 2010, social care cuts mean c 500,000 fewer people in receipt of home care (despite rapid population ageing and growing need) and no significant increase in total care home places (just over 400,000 in england)

and social care has suffered even worse staffing gaps than NHS (1 in 8 vacancies unfilled and immigration policy making things worse as are council cuts which affect terms and conditions when other jobs with living wage are less hard)

meanwhile, no increase in GP number for a decade even though GP workload up 15% in that time and district nursing numbers have nearly halved

then on top of that, we will now face seasonal surge of other respiratory and gastrointestinal viruses which can cause outbreaks all of their own and similar issues trying to admit to wards or discharge patients to community facilities or to home care/community rehab teams

with regard to ICU - yes they did pretty much double (more in some places) capacity at pandemic peak in the spring but on borrowed staff, borrowed space and reduced staffing ratios. It is not viable to keep on doing that long term and yes they have *non* covid patients too!

You put all that together and not only are chief operating officers, site/bed manager and operational managers in frontline services an underappreciated/unsung part of workforce - one of the hardest jobs in healthcare but...

but.....it is pretty enervating having armchair critics, keyboard wariors, covid-denialists talking like they actually *want* 95% or 100% midnight occupancy and rammed ICUs and that would be a great thing - "sweating the assets". 90% is hard enough as an operating model

"what about Nightingales?" you say

A hall in an exhibition centre with beds is NOT a hospital. They are not staffed for the volume of patients they could notionally take and only 3 of the 7/8 have taken any in patients (totalling less than 400 between them).

Easy soundbites and trite rhetoric and inexpert back of a fag packet ideas are not meaningful, risk assessed logistically sound solutions

Attacks on the NHS by anti lockdowners and conspiracy theorists are not helpful and don't stand scrutiny

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