Twitter Thread by Chris Hopson

Chris Hopson
@ChrisCEOHopson

1/21 Parliament votes on the new tiered restctions on Tuesday. A lot of comment in today's papers on what's happening in the hospital sector. Important questions on NHS capacity, demand, preparedness, Nightingales etc. Thread below sets out NHS hospital trust perspective.

2/21 Have deliberately concentrated in thread on hospitals as this is where current public debate ahead of Tuesday's vote is. But many of same issues apply to community, mental health and ambulance trusts, all of whom are under the same current level of pressure as hospitals.

3/21 Running a hospital at the moment is much more complex & difficult than normal due to COVID-19. That often doesn't show up in usual national data that some are currently quoting (e.g. NHS capacity levels below last year / not under real pressure so where's the problem?)

4/21 Remember pre-covid starting context. NHS already had large demand supply mismatch. Insufficient hospital beds. 100,000 staff vacancies. Despite frontline efforts, worst A&E/elective surgery performance in a decade. Huge overstretch in winter (late Dec-Feb) for last 5 yrs.

5/21 COVID-19 then made task massively more difficult in number of ways. Need to treat three sets of patients - COVID-19; planned care with urgent/important backlog cases from first phase of covid that simply can't wait any longer; and usual emergency patients needing treatment.

6/21 Infection control requirements and workforce impact of covid-19 mean juggling this workload complex and difficult. Brilliant new Hospital series – first three episodes here: https://t.co/UHHyQlRsIN - shows scale of challenge. Anyone commenting on hospitals should watch it.

7/21 Infection control mean hospitals have to create three separate areas: red for covid, amber for patients waiting for test results and green for non covid. Amount of lost capacity will vary by trust but all hospitals reporting capacity loss of somewhere between 5 and 20%.

8/21 Meanwhile, ensuring patient flow for elective surgery has become much more complicated. Myriad reasons. Need for patient testing/pre-isolation. Demand for theatre space hugely outstripping supply. Surgery slower due to need to don, doff and work in cumbersome PPE..

9/21 ..Then, as soon as number of covid patients rises, wards have to be turned from elective surgery recovery into covid wards. Despite massive efforts to use every single ounce of capacity available including private sector and working collaboratively with neighbouring trusts.

10/21 Then layer workforce issues on top. NHS staff reflect communities they serve. Trusts in areas of high infection rates lose large numbers of staff to covid/self isolation/looking after family. If key worker on pathway (e.g. anaesthetist) off, other staff's work at risk.

11/21 When covid cases increase, staff have to be transferred from other duties to look after covid patients. Some trusts in areas of high covid infection are therefore having to leave some beds unoccupied as they don't have sufficient people to safely staff them.

12/21 Much of this will not show up in national hospital demand/bed occupancy data. That data is of questionable use anyway in debate on social contact restrictions. It’s national data that takes no account of large regional variation in numbers of covid patients in hospitals.

13/21 In the words of one trust CEO last week “it’s so frustrating that people can’t see the reality that today's 85% bed occupancy is equivalent to normal 95% bed occupancy. We’re going absolutely full pelt with exhausted staff and haven’t even reached winter yet”.

14/21 Two other issues. ICU capacity by itself is not a good indicator of hospital pressures, as some are arguing. ICU beds account for a small proportion of a hospital’s total bed base. And many more covid patients are now being treated on general wards without mech ventilators.

15/21 Widespread misunderstanding about purpose of Nightingales. Always intended as last resort insurance policy to avoid overwhelm. Not purpose built hospitals & only staffed by taking staff from existing hospitals. NHS would always want to use existing hospital capacity first

16/21 …Patient experience in Nightingale inevitably worse. Diverting staff to Nightingales will inevitably reduce quality of care in existing hospitals. So, wrong to suggest that current position of not systematically using Nightingales is indicator NHS has sufficient capacity.

17/21 What does all this mean? Although current national level data on bed occupancy/hospital demand not dangerously high, this is not a good guide to how pressured hospitals are. And it’s certainly no indicator of how busy hospitals could be in peak winter – the key issue.

18/21 Hospital leaders clear their trusts already at full stretch. And they're unlikely to be able to cope if a third surge of covid patients in January coincides with surge in emergency demand (e.g. respiratory illness/broken bones from slipping over) normally seen in winter.

19/21 They're desperate to avoid reducing planned care – the usual response to demand overload in winter. They know how important it is to treat those whose care has been delayed from the first phase. They know that lives genuinely are at risk if they do delay that care.

20/21 Combination of vaccines, mass scale rapid turnaround testing and therapeutic drugs genuinely offer way out of current covid challenges in late Spring / early Summer. But, in meantime, particularly this winter, restricting social contact only way of cutting covid spread.

21/21 This is why trust leaders are clear that Govt & parliament should err on side of caution in setting restrictions on social contact. Trust leaders adamant that it's their job to treat all patients who need care and reducing number of covid patients only way to ensure this.