

Winter sitreps: getting underneath the data

The winter sitreps use well established terms, like diverts, handover delays and escalation beds, which we and others talk about on a regular basis. But what do they mean and what do they tell us about winter pressures on the health sector?

A&E closures are temporary closures of A&E departments at times when patient safety is compromised; either due to overwhelming demand or an incident at the trust. No A&E closures were reported in 2016/17 and none have been reported so far in 2017/18.

A&E diverts are times when new arrivals (either ambulance arrivals, ambulatory arrivals or both) are diverted from one A&E department to another to enable a department to catch up with a peak in demand or respond to an incident. Diverts are usually for short periods of time so a trust may report multiple diverts on one day. Where possible diverts are avoided because whilst they reduce the pressure on one hospital they increase the pressure on the receiving hospital, and for that reason they are a good indicator of pressure on the system.

General and acute bed availability in the sitreps is made up of both 'core' bed stock which is part of the trust's usual capacity and 'escalation' beds, additional temporary beds opened to provide extra capacity. While trusts will look to open up additional beds as needed to respond to demand they are limited by needing enough physical space within the hospital, enough staff to run them safely, and sufficient funding to pay for them. High numbers of escalation beds are a good indicator of peaks in demand on the service; however the number is likely to plateau once space, staffing and funding limits are reached. It is worth remembering that trusts will also be investing in resources and working with partners to increase capacity in out of hospital care to reduce the number of patients requiring a hospital bed.

General and acute bed occupancy refers to the percentage of open beds (core plus escalation) that are currently occupied by a patient. NHS Improvement and NHS England **recommend** that once bed occupancy is over 92% trusts should implement escalation plans to ensure there is enough capacity to keep patients moving through the system.

The availability and occupancy of three types of **critical/intensive care beds** are also recorded: adult critical care, paediatric intensive care and neonatal intensive care. Typically occupancy of these beds is lower than for general and acute beds, however the number of available beds is much smaller meaning that peaks in demand can create patient safety concerns. For example, on five days in the first six weeks of winter only one paediatric intensive care bed was available in the whole of the London region.

The 2017/18 data includes the total number of **ambulance arrivals** at the reporting trusts; as well as the number of ambulances experiencing a **handover delay** of over 30 or over 60 minutes. The transfer of a patient from the care of the ambulance staff to the care of the A&E staff should take no more than **15**

minutes. A handover delay does not necessarily mean the patient waited in the ambulance, they may have been moved into the A&E department but staff have not been available to complete the handover. This is also regarded as one of the most significant indicators of a system under pressure because as well as illustrating how stretched A&E departments are it also means that the number of ambulances available to respond to other calls is reduced.

Winter often sees a peak in norovirus which, due to its highly infectious nature, leads to not only the closure of the bed occupied by a patient with norovirus but also other beds in the same ward to prevent it spreading. The winter sitrep records both all **beds closed to norovirus** and those which are **closed unoccupied**. Bed closures have an impact on trusts ability to manage flow within a hospital, restricting both the number of beds available for patients and where certain patients can go. Peaks in norovirus can also affect staff, so one of the indirect messages in this dataset is likely to be pressure on staffing, although we won't see this until the staff sickness data is published in a few months time.

A new measure introduced this year, **beds occupied by long stay patients**, captures the number of beds each day occupied by patients who have been in hospital for over seven days and over 21 days. It is important to note that this does not distinguish between long stay patients still requiring medical care and those who are ready for discharge but have been delayed. This dataset is likely to be influenced by the prevalence of norovirus, as patients with norovirus or on an infected ward can't be discharged back to anywhere with other vulnerable people, for example a care home, even if they no longer require hospital care.

Although not reported in the sitrep Public Health England also produce a weekly update on the **prevalence of flu** which is another significant indicator of pressure on the health system. As well as increasing the number of patients requiring hospitalization, and in severe cases even intensive care support, this is also an indicator of pressure on the primary care system with increased GP appointments. As with norovirus, flu can also affect the healthcare workforce, so whilst more staff have been vaccinated against flu this year than last a high prevalence in the population is also likely to affect staff sickness.

There is no 'one size fits all' answer to understanding the impact of winter pressures on the NHS. But understanding what the winter sitreps can tell us, and triangulating this with other data sources and insight from frontline staff, helps us build the best picture we can.

NHS Providers aims to do this each week in our *NHS Winter Watch* bringing together data and member insight to reflect on the week and sharing the data in our [winter sitrep dashboard](#).