



State of the health system

Beds in the NHS: England



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1

Introduction

Pressures on NHS hospital beds are well documented. Our members report substantial problems and strains within the bed system; recent media coverage has also raised similar concerns. Although not the only indicator, data on how beds are used within the NHS provide an excellent insight into the healthcare system.

This shortened paper presents NHS bed data from England. The full paper presents data from across the UK. The data demonstrates the increasing pressures on the system. It provides evidence of the underlying cracks within the NHS, such as funding constraints, changes and increases in demand, disjointed care and workforce pressures. The evidence will inform the debate and help build a sustainable future for the NHS.

The first section of this paper identifies core themes from a literature search on beds within healthcare systems. This section provides context for the data and should therefore be read alongside the data section to improve understanding of the evidence. The next section sets out our asks on how beds are used within the NHS. The main section of the paper sets out the bed data. A technical note on the data and a glossary of the definitions used can be found in the annex.

2

Bed pressures: causes and consequences

Bed numbers across advanced economies have fallen throughout the last three decades.¹ Improvements in healthcare have greatly reduced the length of hospital stays and increased the number of day-case patients.² However, even supported by well-funded, integrated primary and community care, and an appropriate mix of health care staff, hospital beds remain a fundamental resource that underpin all health systems.

The use of beds within healthcare systems is inherently complex, with multiple overlapping causes of pressure points. The discussion below summarises the main themes that arose from a literature search on beds within healthcare systems. It provides context for the data presented later in the paper, highlighting the mismatch in the supply and demand for beds. It explains the concept of bed occupancy and factors that impact this, such as variations in demand and length of stay, before describing current occupancy levels. The section concludes by outlining the major implications that bed pressures cause for doctors, patients and the quality of their care.

Bed pressures: causes

Demand for beds is rising, but the number of beds is falling across the UK.

Demand for beds peak at different times of the day, week and year.

To minimise the impact on occupancy, there must be sufficient beds to accommodate variation.

Faster turnover times can help hospitals use beds more efficiently.

Average length of stay has fallen.

In the UK, at a time when demand for NHS care is growing, the number of beds has continued to decline significantly.³ Overall, the number of people attending emergency departments, and from there being admitted into hospital, is increasing.⁴ Increased demand, which is closely linked to the rising prevalence of long-term conditions, is coupled with a growing number of older people – the highest users of beds – who often have multiple, complex conditions, including dementia.⁵

Bed occupancy – the percentage of beds in use – is a key consideration when thinking about hospital beds. Hospitals cannot operate at 100% occupancy, as some spare bed capacity is needed to accommodate natural variations in demand and ensure patients can ‘flow’ through the system. If hospitals only planned their bed requirements against the average demand level, then whenever demand increased above the average there would be a shortage of beds.⁶ Variations in staffing must also be taken into account, as beds cannot be safely filled without appropriate staffing levels.

Demand for beds peaks at different times of the day, week and year. To minimise the impact on occupancy, there must be sufficient beds to accommodate these peaks. In most hospitals there is a mismatch between peak arrival times (morning) and peak discharge times (late afternoon).⁷ This means there must be enough beds during the day for both new patients and those being discharged later that day. Very few patients will be discharged overnight, so there must also be sufficient beds to manage this. Across the week there is variation too, with the most arrivals on a Monday and fewer discharges at the weekend.⁸ Finally, there is seasonal variation, with the well-known challenges that winter presents resulting in higher numbers of emergency admissions.⁹

There is a time delay every time a bed is vacated, while the bed is cleaned, prepared for a new patient and transfer and admission processes are completed. This is known as the turnover interval time. Maximising the efficiency of the process is key. As occupancy on wards increases this becomes harder and harder for staff, but factors such as early discharge planning and early review by a senior clinician can help.¹⁰ Patients with the shortest length of stay (the majority of patients) are more resource intensive, as the same turnover interval occurs regardless of length of stay.¹¹ Minor changes to their length of stay or turnover interval can have a major effect on overall bed availability.¹²

Average length of stay has fallen considerably due to improvements in surgical procedures, technology and community-based care.¹³ However, it does vary significantly between patients, with older people experiencing notably longer stays.¹⁴

But, delayed discharge is a major issue, particularly for older people.

Long stays can also be exacerbated by delayed discharge (or transfer of care). This is where patients remain in hospital when they are medically fit to be discharged. It commonly affects older people.¹⁵ While delayed discharges only account for a relatively small percentage of beds overall, the number of days each hospital bed is unnecessarily occupied is one of the factors driving up bed occupancy rates.^{16,17,18} Unnecessary longer stays also lead to worse health outcomes for older people and can increase their care needs after leaving hospital.¹⁹ Delayed discharge is increasingly caused by delays in securing a residential or nursing home bed, or community care, including care to be delivered in a patient's own home.²⁰ These trends highlight the well-documented challenges facing social care, although awaiting access to other in-hospital services remains a considerable problem.

The optimum occupancy level varies between different healthcare settings.

Returning to bed occupancy, hospitals are commonly told to aim for a rate of 85%. This follows a study in the late nineties, which found that bed shortages and periodic crises were increasingly likely to put health services above this rate.²¹ Others have pointed out this research was based on a particular set of circumstances – an emergency bed pool of around 200 beds – and therefore generalising the findings to all acute hospitals must be done with care, as different sizes and types of bed pools have different optimum average occupancy levels.²² Smaller bed pools and more critical beds, such as those in intensive care, must operate with a lower average occupancy level to maintain availability.²³

However, occupancy levels are increasingly high across the UK.

However, regardless of the specific target, the key point is that hospitals are increasingly operating at very high levels of occupancy, particularly during the winter months.²⁴ Furthermore, the main measurement of occupancy is recorded at midnight – not the peak time for demand – so in reality many hospitals are frequently operating close to or above 100% occupancy during the day.²⁵

Bed pressures: consequences

Emergency departments are under huge pressure and operations are being cancelled.

The implications of this are widespread. A lack of available beds creates backlogs, contributing to the widely reported delays in emergency departments. This affects both patients waiting to be seen, and so-called trolley waits – patients who have been seen and need to be admitted, but have to wait for a bed to become available. Indeed, recent research shows that hospitals with the highest occupancy rates are furthest from the four hour waiting time target.²⁶ The demand for beds also leads to cancellation of elective operations; while this frees up beds, it delays the care that other patients need and have often been waiting for many weeks.^{27,28}

Patients are juggled between beds – this can be detrimental to their care.

Patients who do get a bed can still suffer adverse consequences from high occupancy rates. When there is excess demand for beds, patients are commonly placed on clinically inappropriate wards.²⁹ This can affect patients' experience and the quality of care they receive, while placing extra demands on healthcare staff. In order to juggle bed availability, patients can be moved to a number of different beds during their stay in hospital, which can be distressing, particularly for older people.³⁰ Each bed move adds an extra turnover interval and adds an extra day to patients' length of stay.³¹ The pressure that shortages create also has a damaging impact on staff morale, recruitment and retention, which in turn impacts negatively on patient care.³²

The risk of hospital acquired infections is a concern.

There is a range of evidence that high occupancy increases the rate of hospital acquired infections, which had in recent years reached a more stable level, and has been highlighted by doctors as a particular concern.^{33,34} Infections are not only a risk to patients, but inevitably lead to temporary bed or ward closures, furthering the occupancy problem.

Pressure on staff to free up beds can risk patient safety.

Finally, there is a concern among doctors and other healthcare professionals that staff may feel pressured to free up beds.^{35,36} In the worst case scenario this can lead to patients being discharged before it is safe or appropriate to do so.³⁷ Not only does this compromise patients' care at the time, but evidence suggests it leads to an increased chance of emergency readmission, which is something that has increased notably in recent years.^{38,39,40} Bed shortages are not just affecting patient care and experience; as doctors on the front line report, shortages are risking patient safety.^{41,42}

Pressures within mental health services are particularly acute

Service and bed availability is a substantial problem within mental health care, with substantial reductions in the number of beds over the last two decades.⁴³ Mental health bed occupancy is increasingly high.⁴⁴

Delayed discharge is a notable issue for patients with mental health problems, many of whom can have long stays in acute care settings.⁴⁵ The main reasons for delayed discharge are a lack of suitable community services or facilities to support patients at home, or the lack of an available bed within a community or specialist facility.⁴⁶

Bed shortages can result in mental health patients, including young people, being sent far away from their home and support network.⁴⁷ ‘Out-of-area’ placements are costly for the NHS and doctors are deeply concerned about the impact they can have on vulnerable patients.^{48,49} Indeed, the added distress can have profound, and unfortunately fatal, consequences.⁵⁰ Similarly distressing is the fact that in some cases young people are placed on adult wards.⁵¹

There is also an association between the reduction in mental health beds and the increase in the number of patients admitted following detention under the mental health act.⁵² Evidence suggests that some patients are being sectioned in order to secure a bed, which would be otherwise unavailable to them.⁵³

3 Our asks

The BMA has previously raised concerns about the impact of bed pressures on patient safety and care in the NHS across the UK. Our members remain deeply worried and their concerns are supported by the available data: the reduction in bed numbers needs to stop until clear bed plans are in place.^{54,55,56}

The BMA is calling for NHS bed plans that:

- account for future service demands and changes in the population health needs
- are sustainably funded and staffed, not driven by financial targets and ensure resource reflects the priorities of the NHS
- are focused on quality care, safety and the patient experience⁵⁷
- support health professionals by introducing measures to avoid premature discharge as a result of bed resource constraints^a
- take a holistic approach to care, where the health and social care systems work together to deliver a joined up service for the patient – for example, ensuring there is appropriate funding and support for community care so patients can leave hospital without delay^{58,59}
- prioritise providing mental health care close to patients’ home. Care close to home means patients have access to their local support network of friends and family

We also ask that clear consistent data is collected within the NHS. This project has identified significant gaps and inconsistencies in the data collected on beds within each nation. For example, the lack of data on cancelled operations because of bed shortages or the number of patients being placed in clinically inappropriate wards. Without data it can be difficult to fully understand how the NHS is functioning, where the pressure points are and what mitigating actions can be taken.

^a For example, ensuring NICE guidelines are fully implemented to improve the transition between inpatient hospital setting to the community with social care needs.

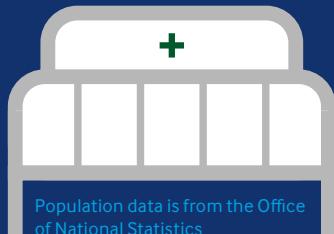
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Bed data

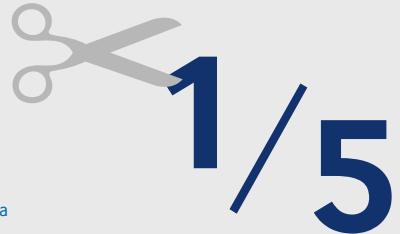
The following section presents the bed data available in England. The full version of this paper presents data from each nation across the UK. The data will be vital for informing discussions on how to build a sustainable future for the NHS. It is important however that the bed data is reviewed within context. The data therefore should be considered alongside the section on bed pressures, causes and consequences, so the context and implications can be fully understood.

England bed data

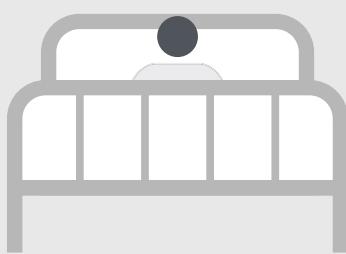
In 2000 there were an average of **3.8** beds per **1,000** people. This had dropped to **2.4** beds by **2015**.



Between **2006/07** and **2015/16** the number of overnight beds has decreased by **over a fifth**.



Unless stated otherwise, all data is published by NHS England



44% decrease in the number of mental health beds since **2000/01**.



In the first week of January 2017, almost **three quarters** of trusts had an **occupancy rate over 95%** on at least one day of that week.

Between **2000/01** and **2015/16** the number of **day beds** as a proportion of total general and acute beds has increased from 5% to 10%.

5% increase



Between **September 2010** and **September 2016** there has been a **12% increase** in hospital admissions, but a **41% increase** in the number of delayed bed days.



In November 2016, **14.8% of patients** spent more than **4 hours waiting** for a hospital bed, having been seen in A&E.



Average length of stay has **decreased**, from **7.1 days** in **2004/5** to **5 days** in **2015/2016**.

Source: NHS Digital

Between December 2014 and November 2015 mental health patients **under the age of 18** spent a total of **17,788 bed days** on an **adult ward**.



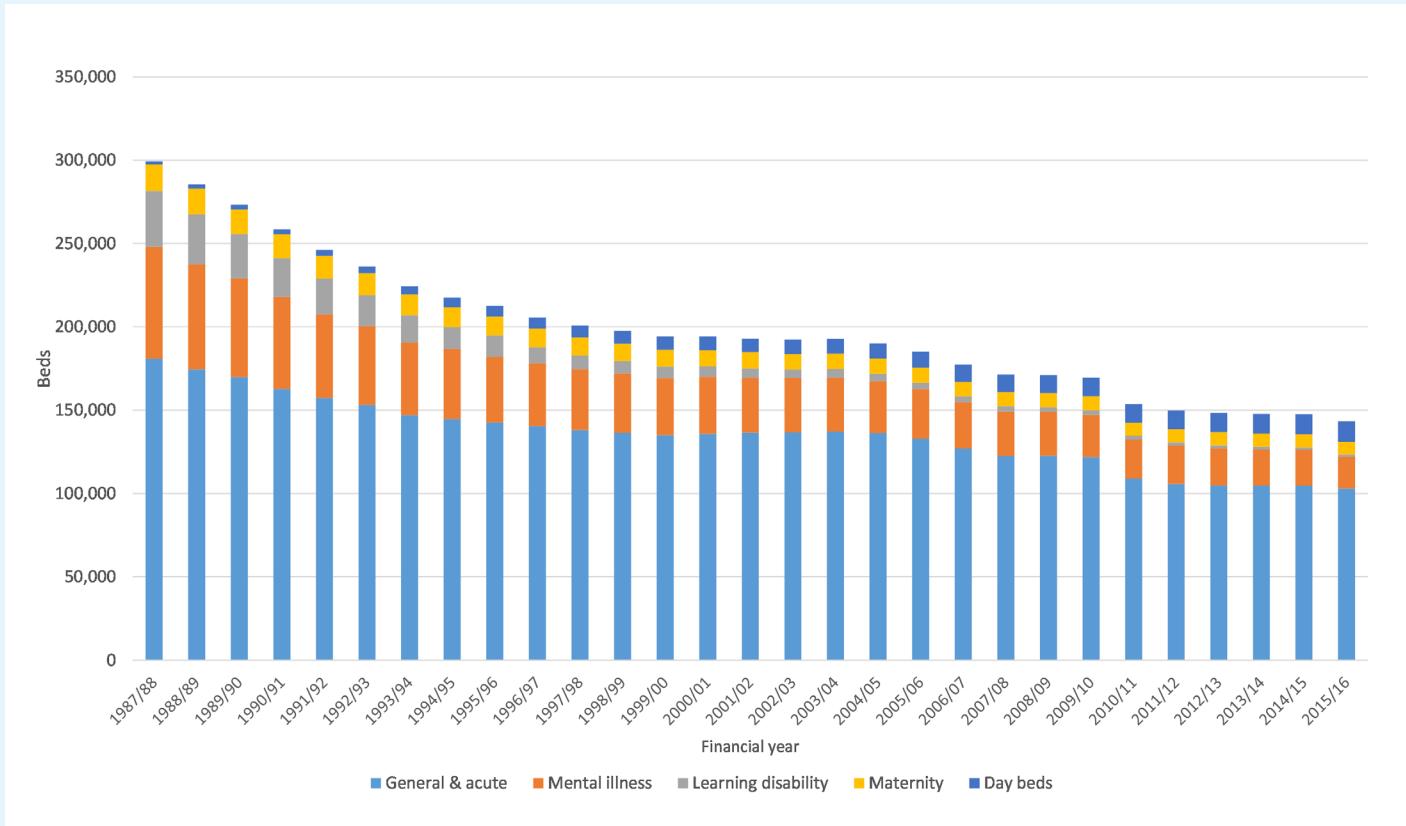
Source: NHS Digital

Between March and October 2016 an average of **726 mental health patients** had been given **out of area placements** each month.



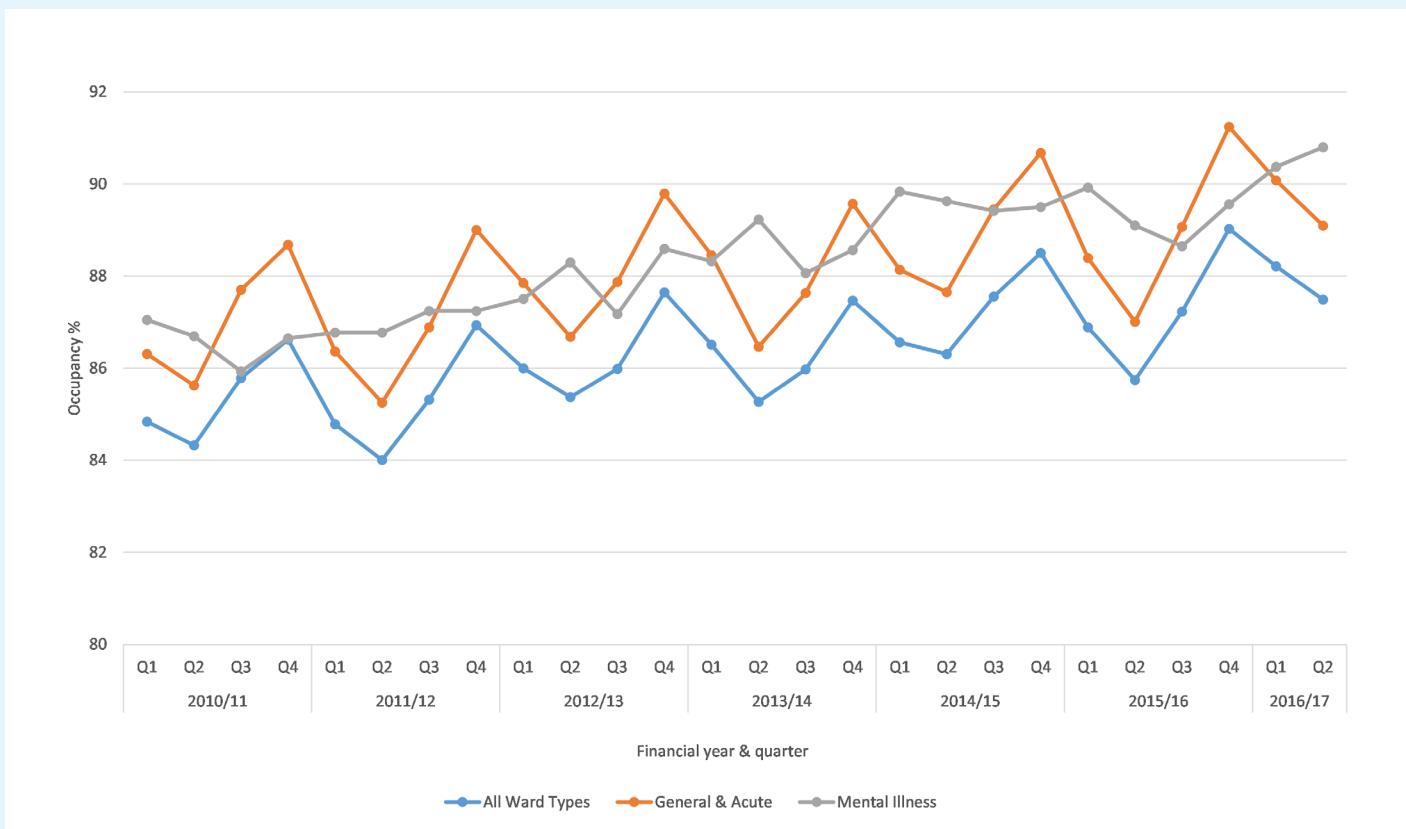
Source: NHS Digital

Graph 1 – The number of hospital beds



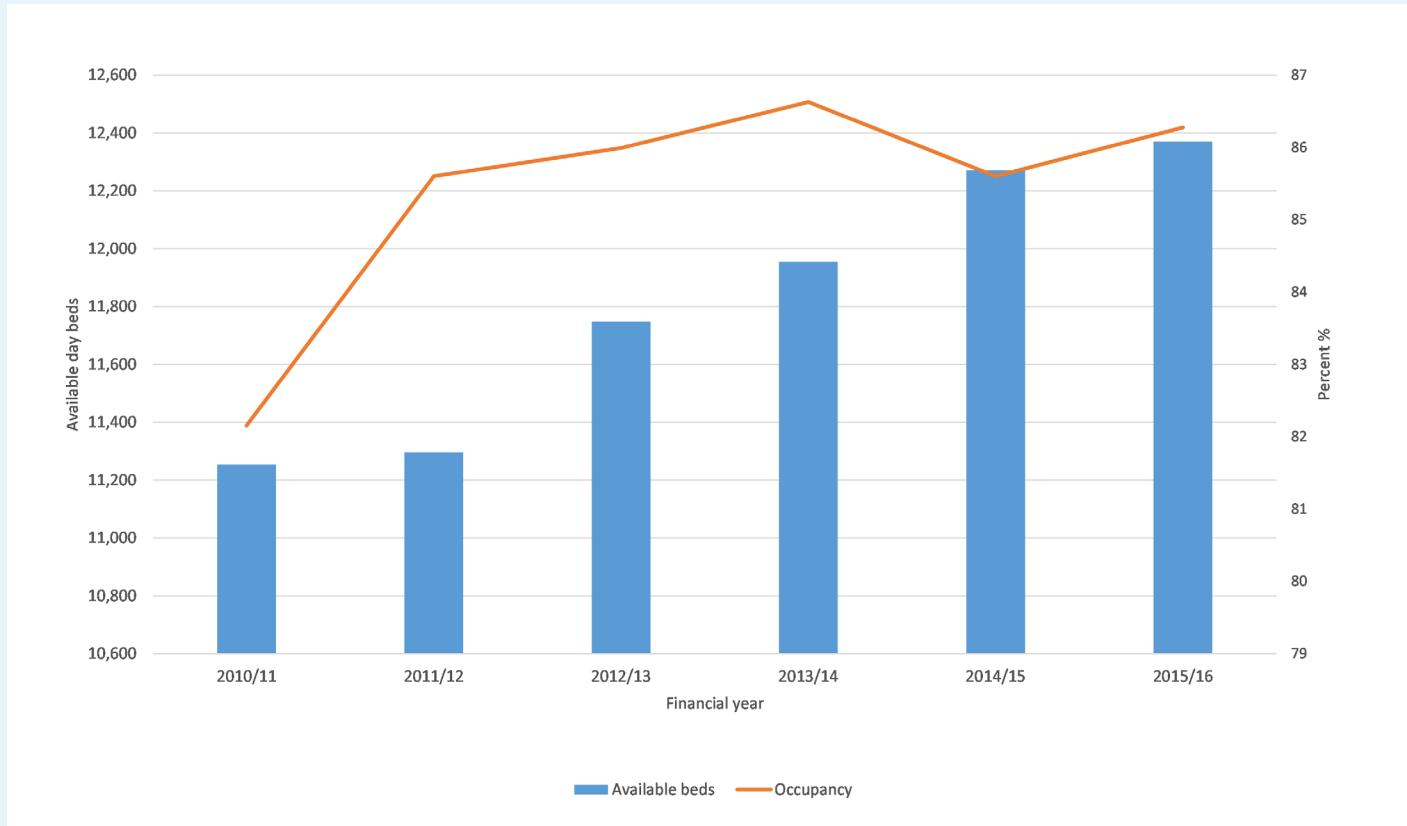
The average number of hospital beds in England has decreased significantly over time. Mental health beds have seen a particularly large decline. Source: NHS England; published 24/11/16.

Graph 2 – Bed occupancy



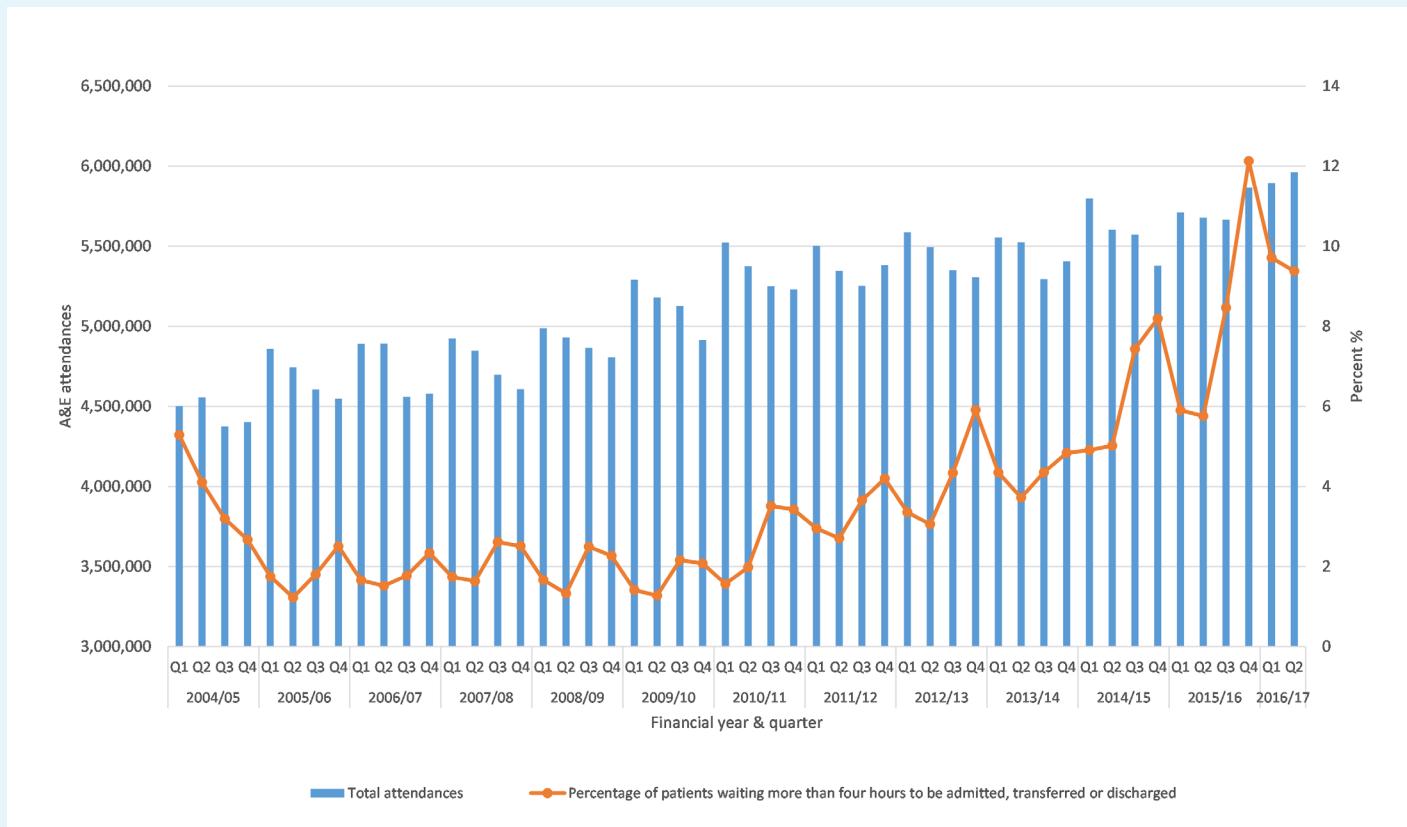
Average bed occupancy rates have increased over time, with rates for general and acute wards, and mental health, now peaking at over 90%. Source: NHS England; published 24/11/16.

Graph 3 – The number of beds for day cases



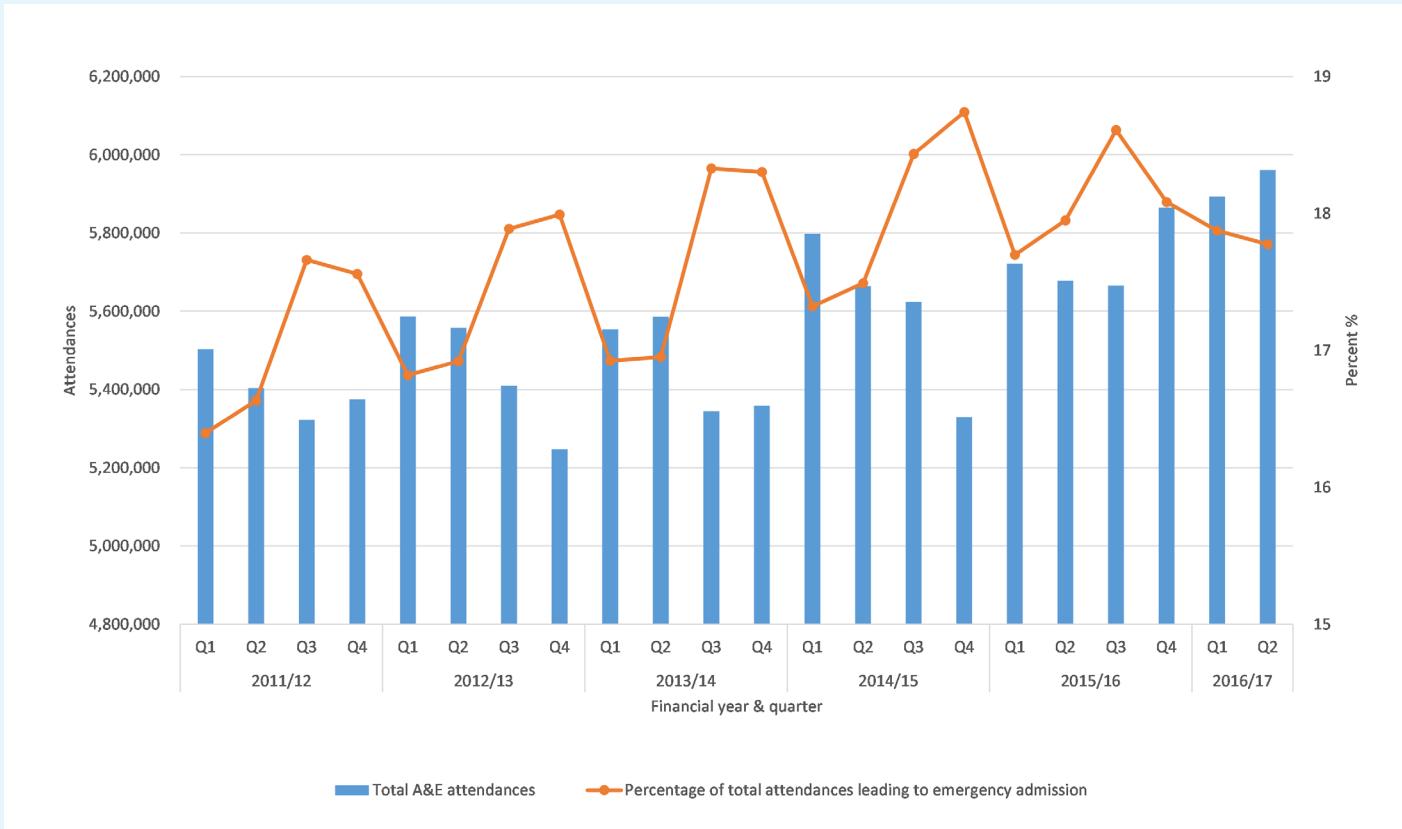
The number of day beds is increasing (as is the number of day case admissions). However, the occupancy rate for day beds has still increased. Source: NHS England; published 24/11/16.

Graph 4 – The wait in A&E



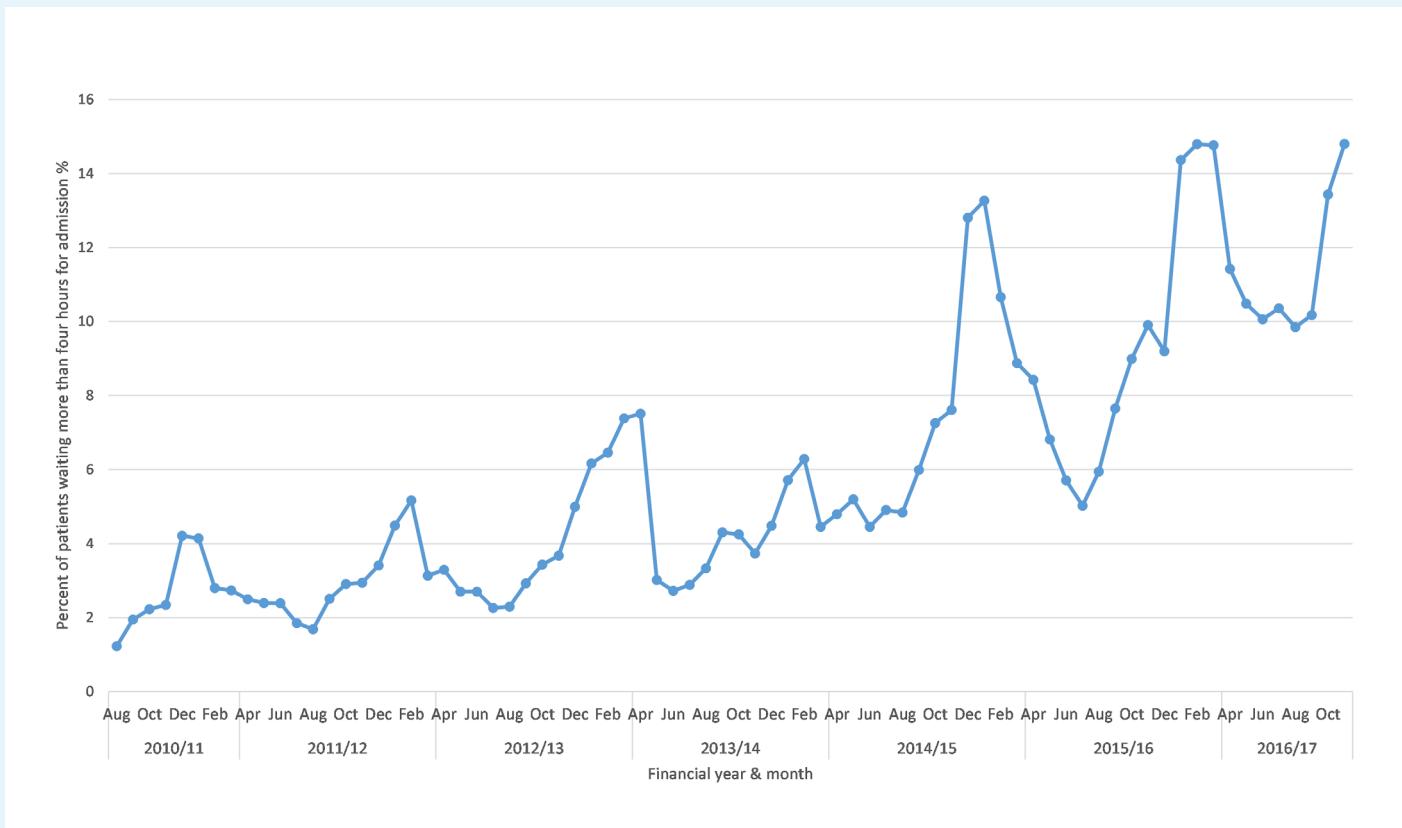
The percentage of people waiting more than four hours in A&E has increased over the last five years following an earlier period of stability. Source: NHS England; published 12/01/17.

Graph 5 – Admissions from A&E



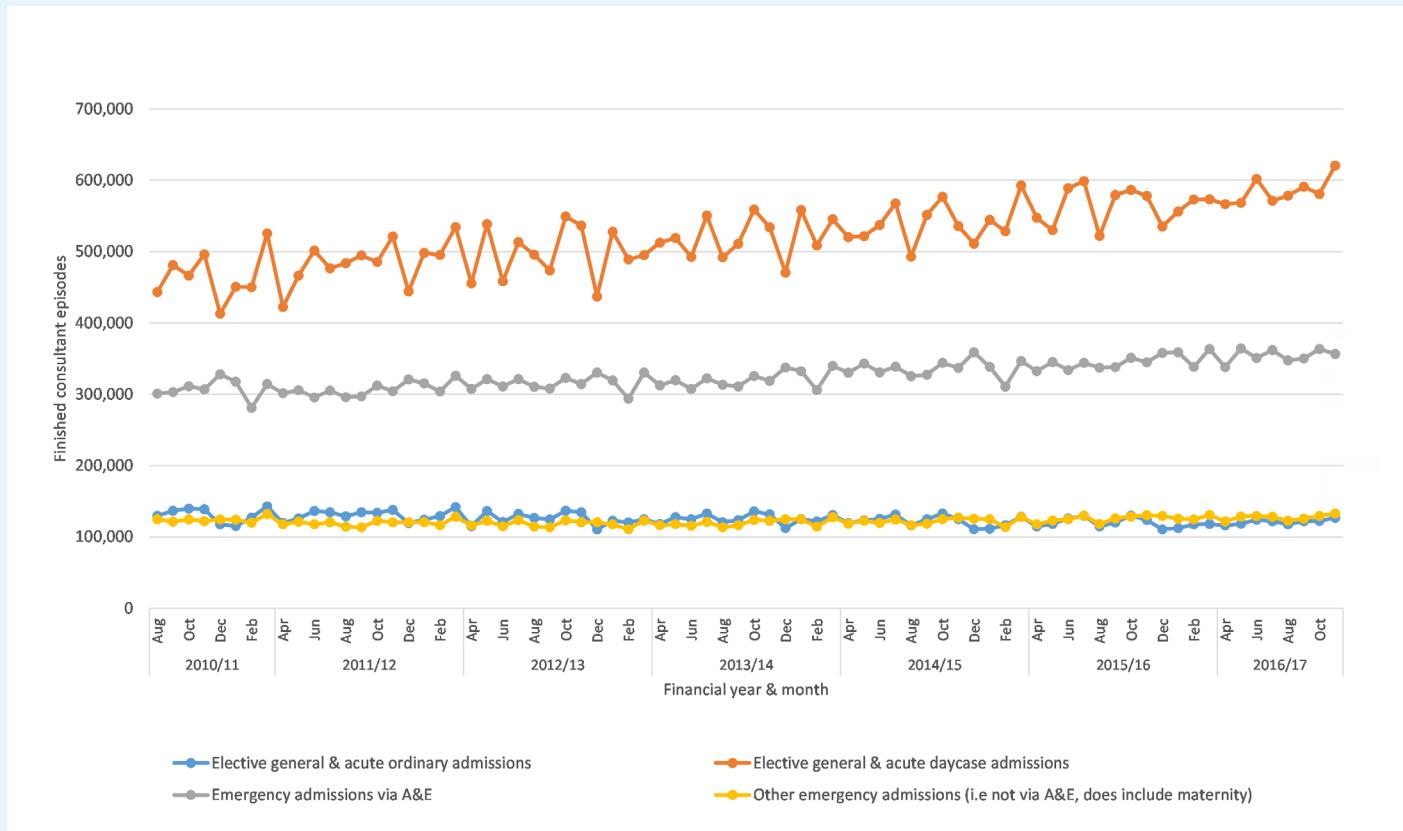
Not only has the number of people attending A&E increased over the last five years, but so too has the proportion of those people being admitted. Source: NHS England; published 12/01/17

Graph 6 – Trolley waits



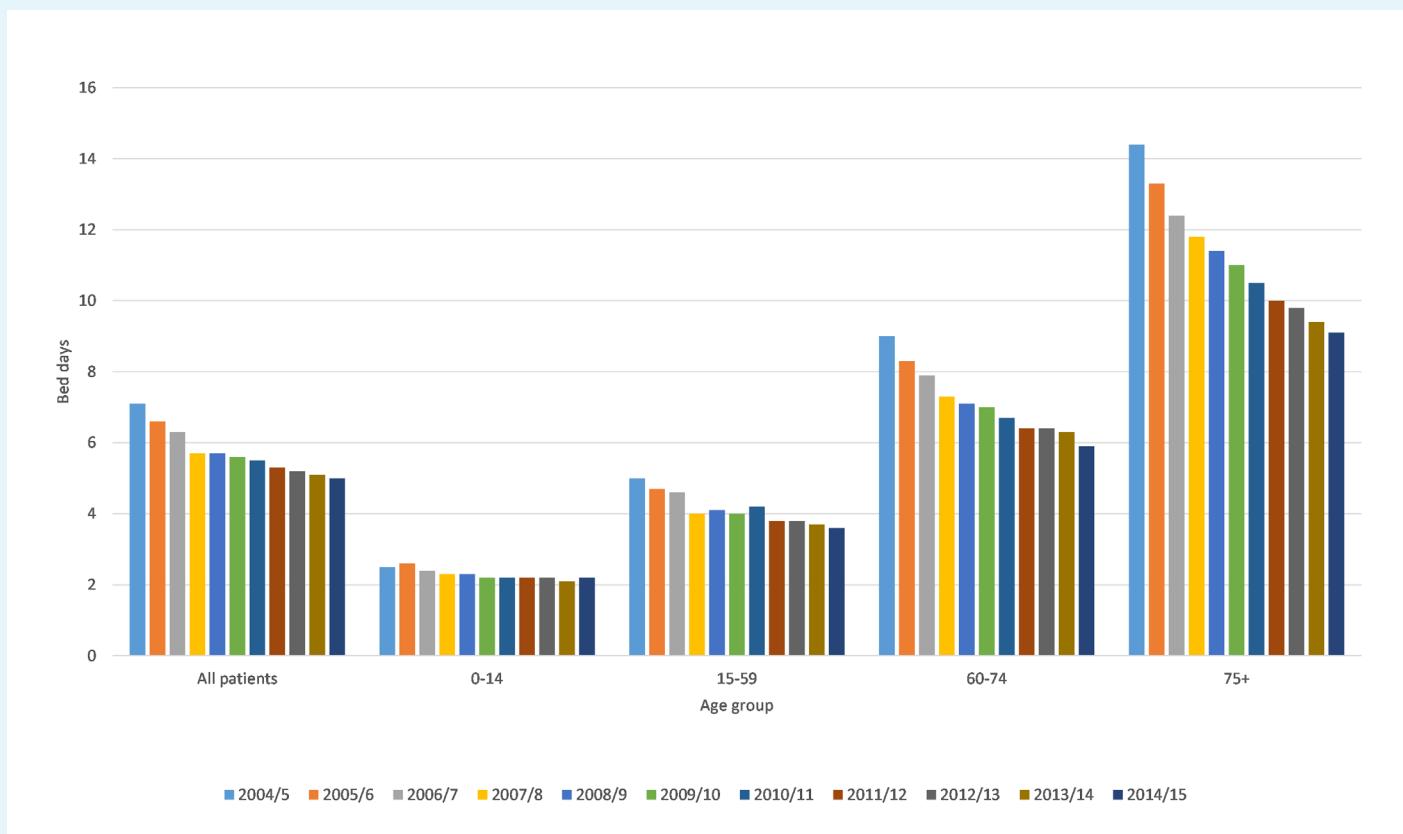
The number of patients waiting more than four hours for a bed having been assessed in A&E – so called 'trolley waits' – has increased notably over the last five years. It reached the highest level to date in November 2016. Source: NHS England; published 12/01/17

Graph 7 – Hospital admissions



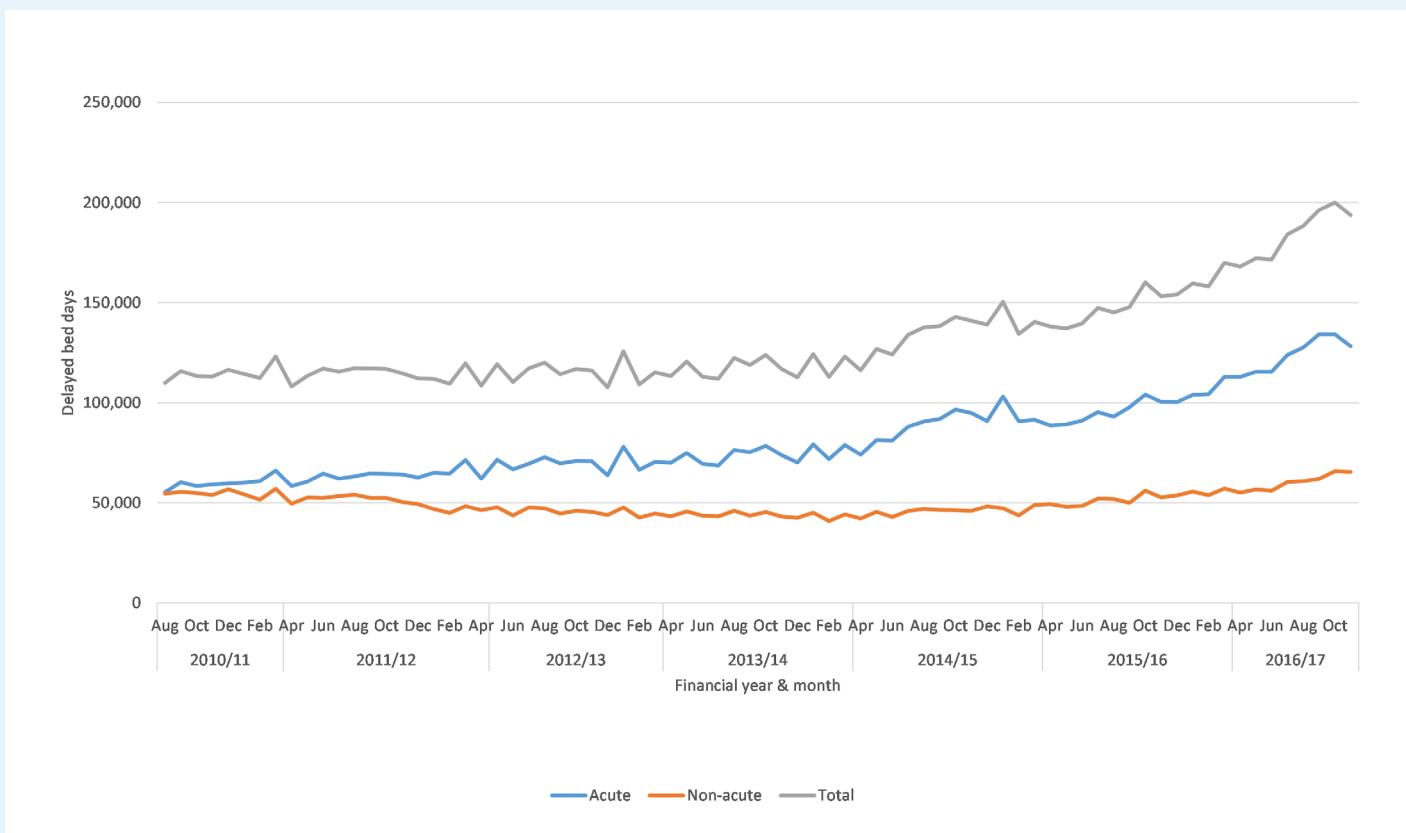
Over the last five years there have been increases in the number of admissions via A&E and the number of elective admissions not involving an overnight stay (elective day cases). The number of ordinary elective admissions (where patients do stay in overnight) and emergency admissions not via A&E has remained stable. Source: NHS England; published 12/01/17

Graph 8 – Length of stay



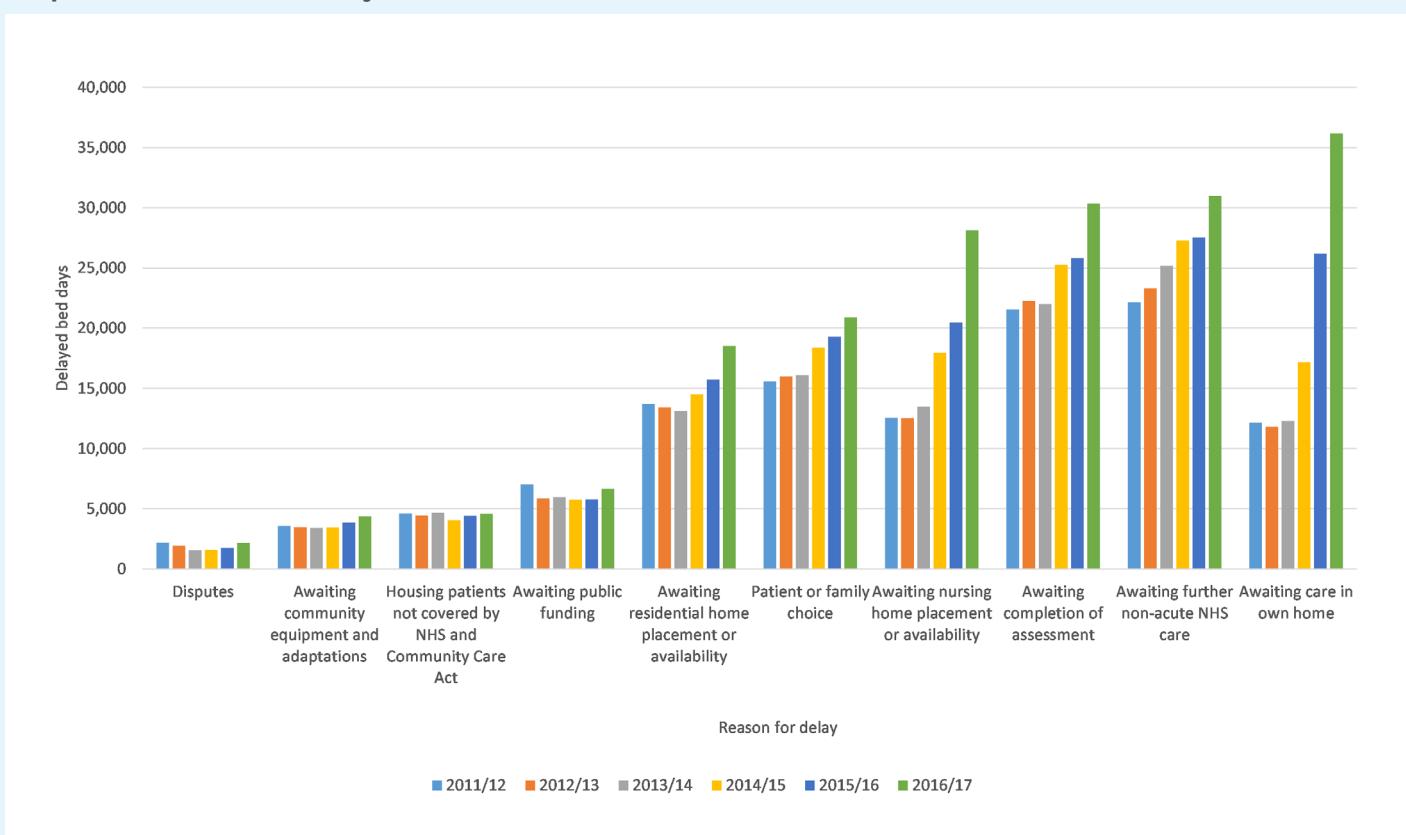
Length of stay has decreased for all patients, to an average of five days. Patients aged over 75 have seen the biggest change. Source: NHS Digital; published 25/11/2015

Graph 9 – Delayed transfers of care



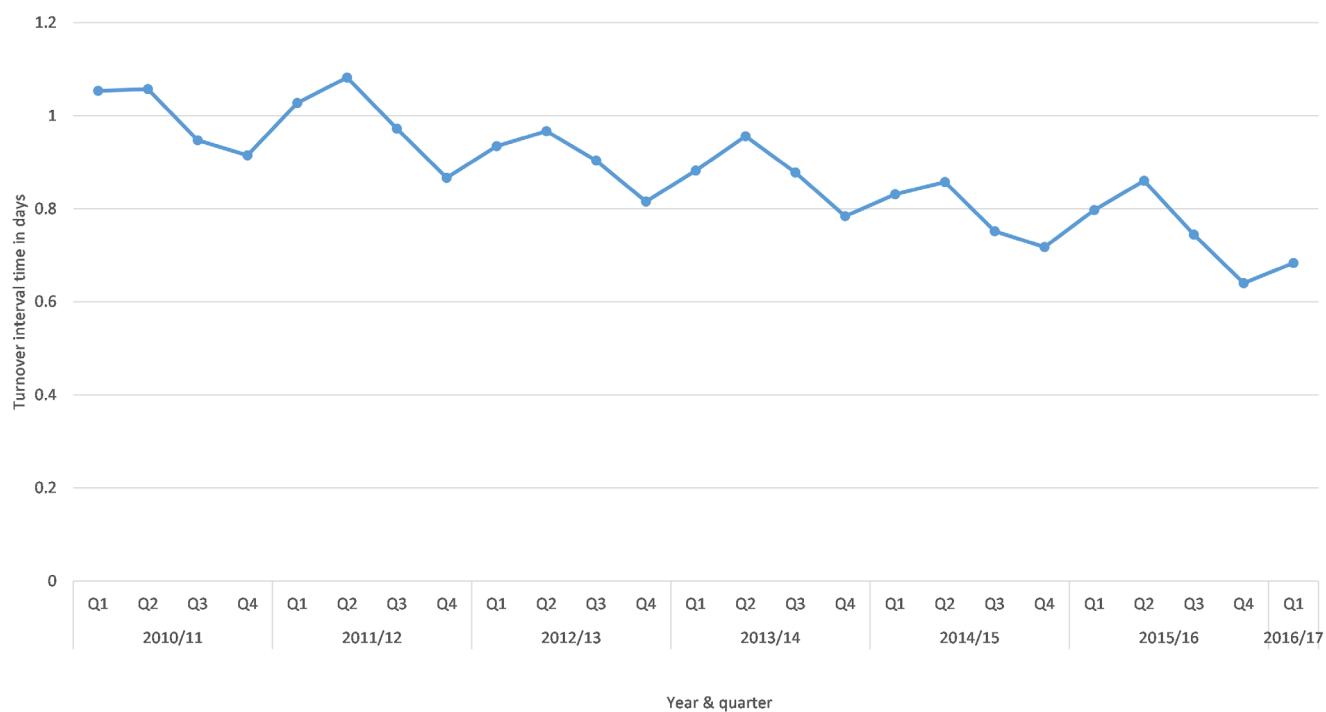
The number of days beds are occupied by patients who are experiencing a delayed discharge or transfer of care is increasing.
Source: NHS England; published 08/12/16

Graph 10 – Reasons for delayed transfers



Over the last three years, 'awaiting care in a patient's own home' has been responsible for the largest percentage increase in delayed days. It is now the single biggest reason for delays. Source: NHS England; published 08/12/16

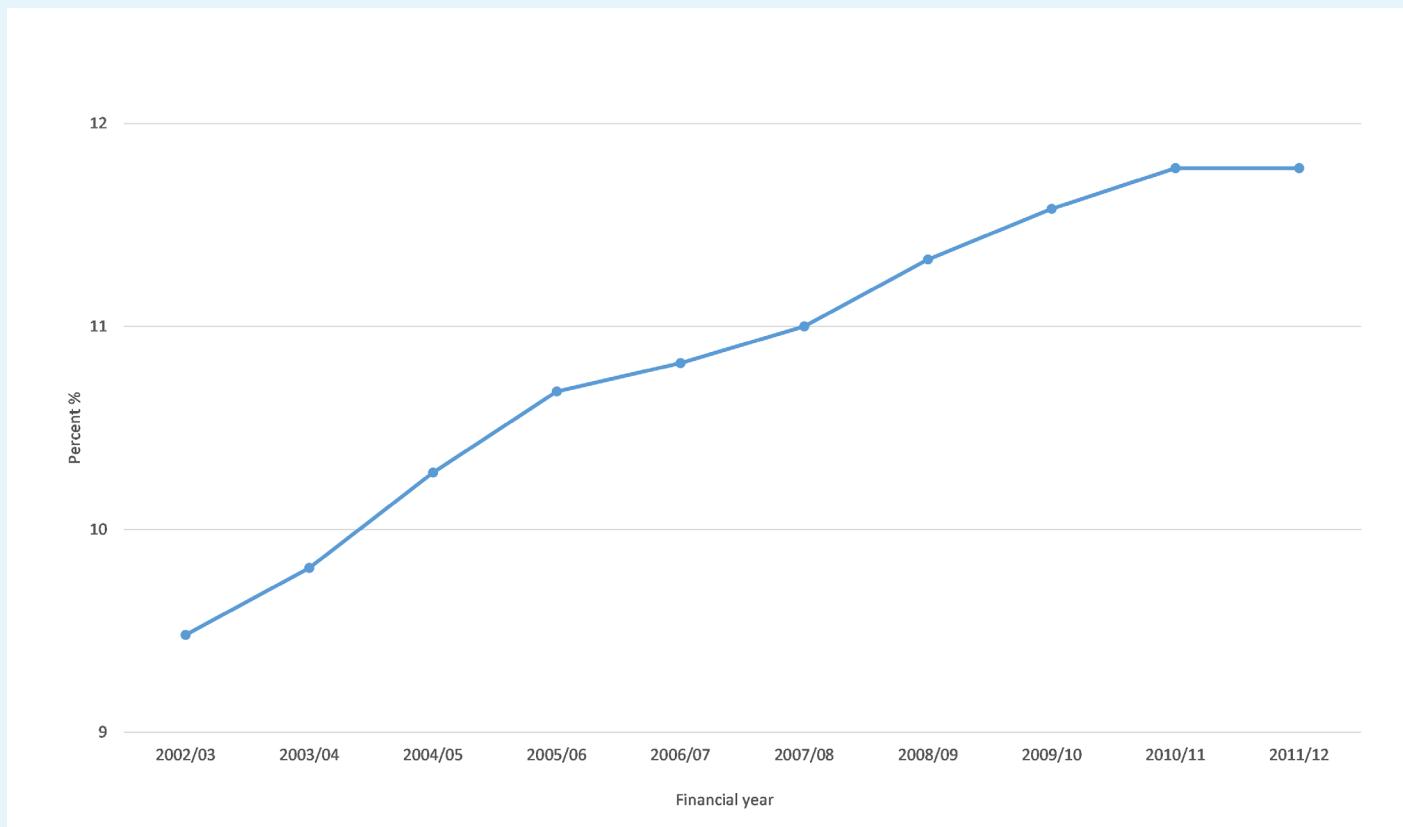
Graph 11 – Turnover interval



N.B. NHS England do not publish these figures so they have been calculated internally.

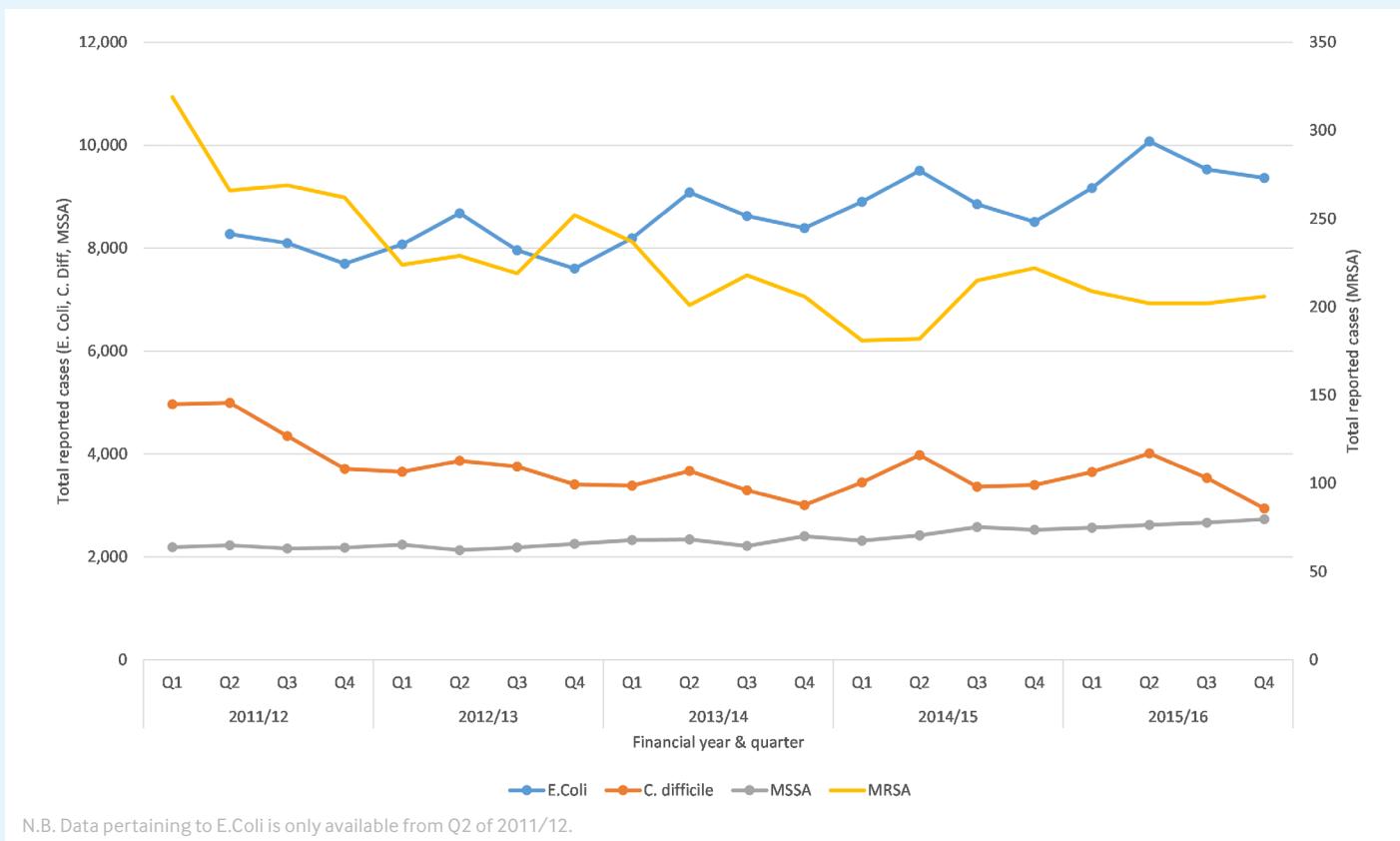
The turnover interval between the discharge of one patient and the admission of the next patient to the same bed is reducing.
Source: NHS England; published 24/11/16

Graph 12 – Emergency readmissions



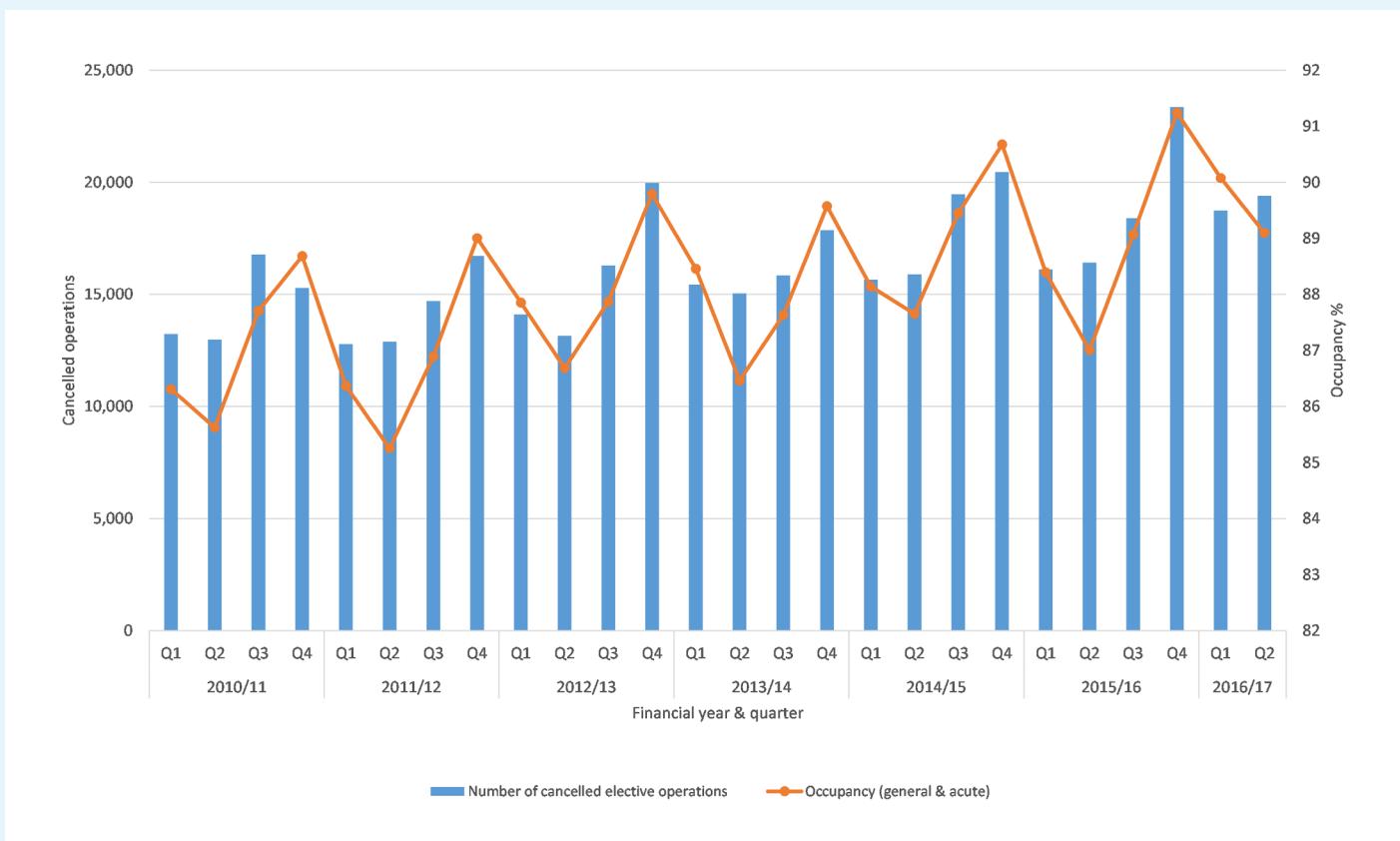
The percentage of emergency readmissions, occurring within 30 days of the patient's last, previous discharge increased between 2005/06 and 2011/2012. Data is still collected, but has not been published since 2012. Publication should restart, as it is a potentially important indicator that may be associated with premature discharge. Source: data.gov.uk; published 02/2014

Graph 13 – Hospital acquired infections



The rates of hospital acquired infections vary in England. Rates of MRSA and C.Difficile have decreased, but rates of E.Coli and MSSA are increasing. Source: Public Health England; published 07/07/16

Graph 14 – Cancelled elective operations



The number of cancelled elective operations has increased over the last five years. As expected, the peaks in cancellations match the peaks in occupancy levels. Source: NHS England; published 11/11/16

Annex A – Definitions

The purpose of this annex is to define a number of key terms which appear in the paper. Some definitions are consistent within all four nations, while some are nation-specific. Included within the latter category are a number of terms that appear broadly similar for every nation; however, small but crucial differences mean that they must be treated differently. The annex has been organised to reflect this fact.

The following definitions are consistent across all four nations:

Day case

A patient admitted electively to hospital with the intention of discharging them on the same day.

Elective admission

Patients admitted electively are those patients for whom treatment or care has been organised in advance. They are admitted to a hospital at an appointed time, as opposed to unscheduled admissions (eg emergencies or maternity patients). Subdivided into elective ordinary admissions (patients who occupy beds overnight) and elective day case admissions.

Emergency readmission

The number of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay as a percentage of all admissions. Admissions for cancer and obstetrics are typically excluded as they may be part of the patient's care plan.

FCE (finished consultant episode)

A finished episode of care under a consultant for either an inpatient or a day case, after which the patient is either transferred to another consultant or discharged.

Length of stay

The amount of time between the admission of patient and their discharge.

Occupied bed day

For wards open overnight an occupied bed day is defined as a bed which is occupied at midnight on the day in question. For wards open day only an occupied bed-day is defined as a bed in which at least one day case has taken place during the day. Occupied bed days are used to quantify the availability and use of beds over time. They are calculated by counting the number of days between the date of admission associated with the beginning of a patient's spell of treatment and the date of discharge associated with the end of the same spell of treatment.

Turnover interval

The time between the discharge or transfer of a patient from a bed and the admission of a different patient to the same bed.

The following definitions are specific to England:

Available hospital beds

The average number of beds which are available for patients to have treatment or care. Subdivided into overnight beds (counted at midnight) and day beds. It must only include beds in units managed by the provider, not beds commissioned from other providers.

Delayed transfer of care

A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when: (a) A clinical decision has been made that patient is ready for transfer and (b) A multi-disciplinary team decision has been made that patient is ready for transfer and (c) The patient is safe to discharge/transfer.

Escalation beds

These are additional beds brought into service by a trust in order to accommodate extra patients in periods of high demand. They are included within the total number of available hospital beds and the rate of occupancy. Trusts often have an escalation plan for introducing these types of beds to ensure there is adequate staffing and facilities available.

Occupancy

The percentage of time that beds are occupied. Calculated by multiplying 'average daily occupied beds' by 100 and dividing by 'average daily available beds'. For wards open overnight an occupied bed day is defined as one which is occupied at midnight on the day in question. For wards open day only an occupied bed day is defined as a bed in which at least one day case has taken place during the day. For issues arising from the way in which occupancy is measured, please consult the technical annex.

Ordinary admission

A patient not admitted electively, or any patient admitted electively in the expectation that they will remain in hospital for at least one night. Also included are patients expected to be discharged on the same day as their admission, but who then stay overnight. Measured by FCEs (defined in the first section of this annex).

Non-elective admission

Any emergency admission (ie one in which admission is unpredictable or short notice because of clinical need) or maternity admission. Measured by FCEs.

Annex B – Technical note

The purpose of this annex is to highlight various issues and limitations that exist in relation to the data that has been used to compile this paper, as well as to try to pre-empt questions or observations that readers might have. All issues known to the authors of this paper are addressed in the following pages.

The variation in the quality of the data typically stems from changes in methodology and collection, significant restructures to the geographical makeup of services, or alterations to definitions or terms. As in the definitions annex, some of these points affects data across the UK, while the rest are specific to particular nations.

UK data issues

Comparability

Though there has been some work to improve comparability of data between nations (for example, episode based data in Northern Ireland can be compared with the equivalent hospital episode statistics data published annually in England), substantial differences in methodologies and data collection still remain; consequently it is inadvisable to attempt comparison between datasets from the four UK nations. Though in some instances an indicator might be defined in very similar terms, there are still likely to be fundamental differences underlying the way in which the data has been collected and presented (for example delayed transfers of care in England and Scotland: the English data concentrates on transfers and discharges, and thus includes patients delayed while awaiting further acute care; the Scottish data is limited to patients awaiting discharge, a fundamental difference in scope and focus).

Midnight census

National data on bed occupancy is based on whether the beds are occupied at midnight. Trusts and boards across the UK use the same measure, although some address this issue by counting patients at other times as well. Nonetheless, this raises the question to what extent the occupancy data is truly representative. At least one study argues that peak occupancy usually occurs at around 8am⁶⁰, and thus a midnight census is misleading, and does not account for an occupancy level that ebbs and flows throughout the day with the rise and fall of demand – hospitals can therefore approach and indeed exceed 100% occupancy during the day.

Population data

National population data is published by the Office for National Statistics, and mid-year estimates of the calendar year. Bed data, however, covers the financial year (April to March). In this report we have combined data covering two slightly different periods (January to December and April to March) – the figures of bed numbers per thousand population included in the report are therefore intended as guidelines to give a general sense of the figures only.

England-specific data issues

Annual/quarterly data

Following the last annual publication of overnight and day bed availability and occupancy data in 2009/10, subsequent publications occurred on a quarterly basis. Care should be taken, therefore, when comparing figures from before and after 2009/10. It should also be noted that any figures included in this report relating to bed availability and occupancy for whole years as opposed to quarters after 2009/10 are averages, which are taken from the four quarterly datasets released over the course of that year.

Delayed transfers of care

There are several notable issues regarding the quality of the data on delayed transfers of care. The Nuffield Trust has flagged the fact that there is a lack of clarity about the use of definitions, which could lead to providers defining delayed transfers (or the reasons for those delays) differently; in turn this could adversely affect the accuracy of the data. The data is also sub-divided into acute and non-acute, which is unique amongst the comparable datasets that measure key indicators in England – it is based on the nature of the care a patient receives, as opposed to the organisation at which it is delivered. No reason is provided as to why the data is organised in this way. As a result it has the potential to contribute to misinterpretation of the figures. Moreover, the data does not cover patients aged under 18, nor does it include transfers from one acute service to another. Following conversations with a number of NHS professionals, the King's Fund also felt that there were variations in how local areas report delays.^{62,63}

Emergency medicine departments

There are three types of emergency departments in England; major emergency departments, single specialty units and minor injury units. All three are included in the data in the report. For a department to be classified within any of those three categories of emergency departments it must average over 200 attendances per month (though the number of departments treating fewer than 200 emergency patients a month is not published, we presume that it statistically insignificant).

Emergency readmission data

The publication of data relating to emergency readmissions ceased after the financial year ending in March 2012. Though the underlying data is still being collected, it has not been made available. The data has still been included in the report, as readmission is often cited as a considerable issue⁶⁴, and the fact the figures are no longer published is noteworthy in and of itself.

Geriatric medicine beds

Prior to 2010/11, the 'general and acute' category of beds were subdivided into two separate sectors: acute and geriatric. Following the changes to the publication of bed data implemented after 2009/10, the figures were only published for general and acute beds, and no distinction was made for geriatric beds. For the sake of consistency, the geriatric category has been excluded from any graphs in the report.

Mental health data

There are a number of issues with the quality and consistency of mental health data in England. Consequently there are substantial problems in terms of relating bed occupancy and availability to the treatment of patients with mental health illnesses. Notably there have been several significant changes to the available datasets which have created issues of comparability, which in turn precluded analysis of long term trends. In this report, we have used snapshots from periods in which there were no methodological changes instead where possible.

Regional restructure

Due to the restructures that took place within the NHS in 2006 and 2013, consistent regional data is largely restricted to data published between those two years. Previously the data had been organised by the 10 strategic health authorities, but following their abolition (and the creation of clinical commissioning groups) in 2013, the data was instead divided according to the 25 regional area teams. This presented problems with regard to how best to represent substantial amounts of data in an accessible way. Coupled with the fact that the regional data revealed very little of interest, we consequently decided not to use any regional data within the paper.

Turnover interval

Turnover interval is not presently published in England. Consequently figures were calculated internally using NHS England's monthly hospital activity data and the widely agreed upon formula: (available bed days – occupied bed days)/inpatient discharges. The figures should therefore be used as a guideline to illustrate how turnover interval has changed in the past six years (and how it follows seasonal trends). In terms of understanding the data, a figure of 0.5 would indicate that half a day (12 hours) was the average amount of time between one patient being discharged from a particular bed and the admission of another patient to that same bed. Discharge can include a transfer to a separate bed in another ward, transfer to a different facility or the death of a patient.

Bed data is collected and published by NHS England. Guidance on using the data can be found in the link in the endnote.⁶⁵

Endnotes

- 1 Nuffield Trust (2016) *Understanding patient flow in hospitals*. London: Nuffield Trust.
- 2 BMA (2016) *State of the health system – Beds in the NHS: UK*. London: BMA (See England graphs 3, 8; Northern Ireland graph 3; Scotland graph 8; Wales graph 6).
- 3 BMA (2016) *State of the health system – Beds in the NHS: UK*. London: BMA (See England graph 1; Northern Ireland graph 1; Scotland graph 1; Wales graph 1).
- 4 BMA (2016) *State of the health system – Beds in the NHS: UK*. London: BMA (See England graph 5; Northern Ireland graph 7; Scotland graph 5; Wales graphs 4, 5).
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- harm. We urge the BMA to ask the DoH and any other relevant authorities to halt any further reduction in bed numbers and put measures in place to avoid any premature discharges. (Staff and associate specialists 2016).
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- 54 That this meeting believes that trends in reducing hospital beds have gone too far and need to be urgently re-evaluated (ARM 2016)
- 55 That this conference is concerned about the continued reduction in the number of in-patient hospital beds and the enormous pressure to discharge patients too early which may lead to patient harm. We urge the BMA to ask the DoH and any other relevant authorities to halt any further reduction in bed numbers and put measures in place to avoid any premature discharges. (Staff and associate specialist conference 2016)
- 56 That this conference insists that the Government tackles the bed crisis with more hospital beds and proper funding for care in the community.(Policy group, consultants 2016)
- 57 That this meeting believes that further reduction in NHS bed numbers will be counterproductive in providing optimal healthcare and lead to staff and patient dissatisfaction and or adverse outcomes (ARM 2010).
- 58 That this conference insists that the Government tackles the bed crisis with more hospital beds and proper funding for care in the community (Consultants conference 2016).
- 59 That this conference is concerned about the continued reduction in the number of in-patient hospital beds and the enormous pressure to discharge patients too early which may lead to patient harm. (staff and associate specialists 2016).
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