Borders NHS Board

NHS BORDERS 2014/15 WINTER PERIOD REPORT

Aim

To update the Board on key activity relating to the 2014/15 winter period.

Background

NHS Borders, like all Scottish Health Boards, is required on an annual basis to produce a Winter Plan which outlines potential risks and contingency planning relevant to the winter season, with a particular focus on the festive period. The 2014/15 Winter Plan was discussed and subsequently approved at the 4th December 2014 NHS Borders Board meeting.

The Winter Plan is an overarching plan which signposts other relevant plans, which may be required over the winter period, for example severe weather plans, pandemic influenza plans and infection control policies and protocol. The overall aim of the planning process is to ensure that the Health Board prepares effectively for winter pressures so as to continue to deliver high quality care, as well as National and local targets.

After each winter period the Winter Planning Group convenes to assess what worked well and what did not over the previous period and key recommendations are made, which are taken forward in preparation for the next winter period. The key recommendations from 2013/14 can be found at Table 10 at the end of this report and a review meeting for understanding the lessons learned from 2014/15 is scheduled for April 2015.

Assessment

As in previous years the key elements of the 2014/15 winter plan were staffing resilience, unscheduled and elective capacity planning, including appropriate escalation and contingency or surge, infection control planning and procedures, and our communication strategy.

In 2014/15 there was a programme of vaccinating staff against influenza. As of 31st January 2015, 54% of staff had been vaccinated against a target set by the Scottish Government of 50%. This is an improvement in performance compared to 2013/14 when the uptake was only 38%.Planning for 2015/16 has already commenced and it is hoped that the excellent results reported in 2014/15 can be further built upon next year.

Additionally, there was a programme of vaccinating children within the Scottish Borders against influenza. A total of 6,901 Primary School children have been vaccinated out of a total of 8,300 eligible children. This resulted in an 83.14% uptake, which was the highest uptake in Scotland for this programme. The average uptake for Scotland based on the data received so far is 71.7% (range 62.6% to 83.1%).

November and December 2014

Table 1: Sickness absence for November/December 2013 and 2014

	November 2013	November 2014	December 2013	December 2014
Borders General Hospital (BGH)	3.81%	4.67%	3.68%	6.04%
Primary & Community Services (PACS)	3.74%	5.17%	3.49%	5.57%

Table 1 shows that sickness absence for the BGH and PACS during November and December 2014 has increased when compared to the same period for last year. This can be attributed to an increase in both BGH and PACS in long term and short term from November/December 2013 compared to November/December 2014 (see Table 2 below).

Table 2: Figures of Long Term and Short Term sickness for November/December 2013 and 2014

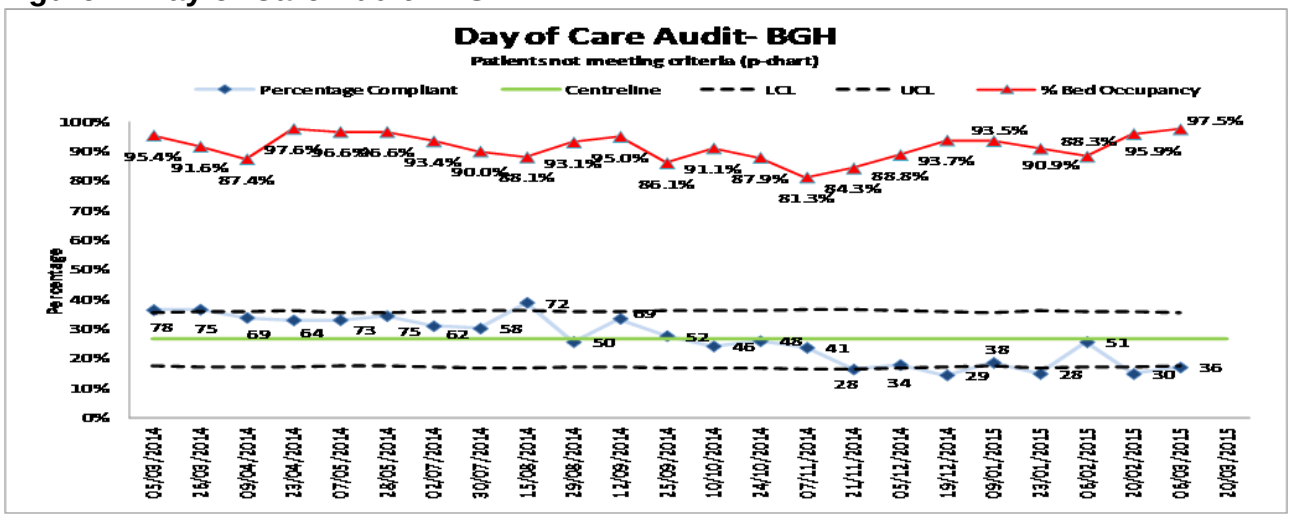
	November 2013	November 2014	December 2013	December 2014
BGH				
Long Term	2.13%	2.59%	1.7%	3.41%
Short Term	1.68%	2.08%	2.04%	2.63%
PACS				
Long Term	1.59%	2.92%	1.59%	3.10%
Short Term	2.09%	2.25%	1.9%	2.46%

Over the festive period the patient flow improvement initiatives continued. The Connected Care Programme has been focussed on no delays for patients and has been utilising the bi-weekly Day of Care audit tool to provide the system with the intelligence to inform improvement. Improvement opportunities, at different stages of their improvement cycles, include:

- MDTs goal setting and scripting MDT to reduce variation – currently at the compliance stage of testing.
- Immediate pick up of patients by Social Work when transferred to DME – now implemented as business as usual. There have been multiple tests of change in this area and the impact of these interventions has shown a system shift in the average length of stay in this area. Relating directly to the interventions we have seen a reduction in people waiting for MDT/Consultant Decision or Review to 0, and people waiting for Social Work allocation/assessment/completion reducing from 5 to 1. Work continues to test compliance and reduce variation in this area.
- Progressing criteria led discharge in two settings – downstream medicine and Stroke MDTs.
- Refocus of Discharge Support – implementation of a Discharge Hub. NHS Borders are currently reporting that 90% of patients referred to the Discharge Hub are being assessed within 4 hours, and 81.5% are being discharged within 72 hours. In development of the Hub NHS Borders reduced the number of lists from 4 to 1, releasing time within the system to progress patient care. In addition, there has been a reduction in time discussing the patients from 1.5 hours to 30 minutes, again this released time to progress patient care.

These improvements have contributed to the reduction of people not meeting the Day of Care criteria – reducing from an average of 31% to 19% (Figure 1).

Figure 1: Day of Care Audit - BGH



NHS Borders delivered the Emergency Access Standard (EAS) of 97.7% for November 2014 but this dropped significantly in December 2014 to just 90.7%, which is well below the National Emergency Access standard of 98%.

Table 3: ED attendances by Flow November/December 2013 and 2014

Patient Flow Description	November 2013	November 2014	December 2013	December 2014
Flow 1: Minor injury and illness	1023	1058	908	1107
Flow 2: Acute assessment – includes major injuries	233	221	353	263
Flow 3: Medical admissions	492	480	594	679
Flow 4: Surgical admissions	247	205	235	226
Total	**1995**	**1964**	**2090**	**2275**
Admissions through A&E	739	685	829	905

Table 3 shows that from November 2014 to December 2014 the Emergency Department (ED) attendances rates rose from 1,964 to 2,275 patients, an increase of 311. Over the festive period there was an increase in attendances at ED of 12.4% compared to 2013/14 period. ED attendance increased over the festive weekends by 8.2% and Public Holiday attendance increased by 4% compared to 2013/14. In December 2014 there was an increase in patient attendances in ED of 185 compared to the same time last year, with an increase of admissions into hospital through ED of 76 compared to December 2013.

Breach analysis for December 2014 suggests that the most significant contributory factor in reported performance were delays associated with bed availability. Reported performance, excluding those admitted to hospital, for December 2014 was 98%

suggesting that performance within ED for non-admitted pathways was maintained at the required standard.

Table 4: Operation cancellations for November/December 2013 and 2014

	Number of cancellations	No HTU/ITU beds	No ward beds	Cancelled by patient/patient did not attend	Patient unfit/Procedure no longer required	Other
November 2013	52	2	6	10	27	7
November 2014	59	8	0	15	23	13
December 2013	47	2	7	3	27	8
December 2014	73	2	7	16	33	15

Table 4 demonstrates that in November 2014 the two highest reasons related to the operations being cancelled by the patient/patient did not attend and the patient being unfit/the procedure was no longer required. For December 2014 the top reasons for cancellation was the patient unfit/procedure no longer required, cancelled by the patient/patient did not attend and other reasons (not specified, e.g. unavailability of surgeon).

Norovirus is regularly a specific winter time challenge and there were no Norovirus outbreaks noted during November and December 2014, however, a small number of bed days were lost in December 2014 due to suspected cases of Norovirus and prompted isolation in accordance with agreed protocol (63 bed days in total). This was not considered a significant factor in reported performance.

The BGH nursing vacancy Whole Time Equivalent (WTE) for November and December 2014 was 44.32 and 44.49 which was a slight increase from the previous month but still well below the vacancy levels carried into previous winter periods.

<u>January and February 2015</u>

Table 5: Sickness absence for January/February 2014 and 2015

	January 2014	January 2015	February 2014	February 2015
Borders General Hospital (BGH)	4.72%	5.92%	4.38%	4.95%
Primary & Community Services (PACS)	4.81%	6.09%	3.98%	5.36%

Table 5 shows that sickness absence levels during January and February 2015 increased for both BGH and PACS. Table 5 showed for January 2015 the increase in both short and long term sickness absence for both BGH and PACS. Figure 2 shows an increase in cold, cough and influenza illnesses from 7.65% in December 2014 to 12.62% in January 2015 which accounts for the significant increase in short term sickness absence levels. In December 2013 this figure was 5% for cold, cough and influenza illness.

Figure 2: Percentage of Short Term Sickness absence hours

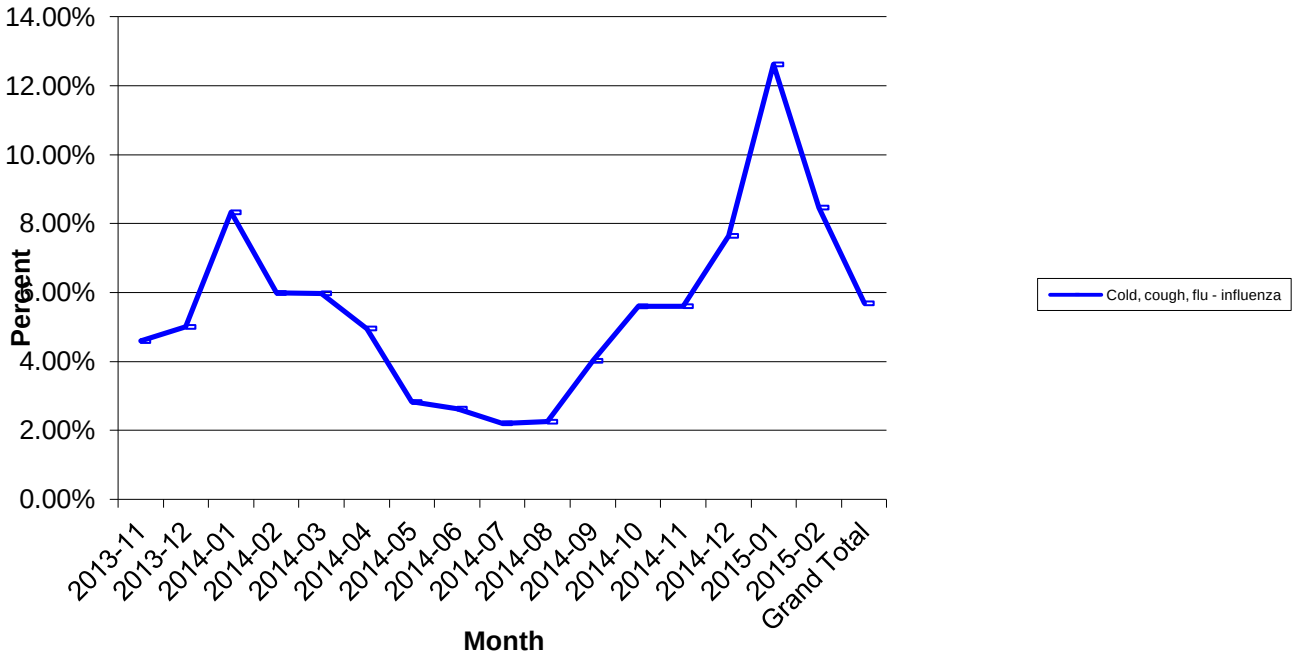


Table 6: Figures of Long Term and Short Term sickness for January/February 2014 and 2015

	January 2014	January 2015	February 2014	February 2015
BGH				
Long Term	2.28%	2.8%	2.04%	2.30%
Short Term	2.43%	3.12%	2.79%	2.43%
PACS				
Long Term	2.1%	2.77%	1.74%	1.62%
Short Term	2.7%	3.33%	2.24%	3.16%

All additional surge capacity was opened during December 2014 in accordance with plans to support admission and this has largely remained open since that point. This has been supplemented as required by converting our planned surgical admission unit (PSAU) to an inpatient ward in accordance with our bed escalation policy. PSAU was open a total of 32 days over the festive period. While this worked well as a contingent measure, it proved disruptive to elective flows and arrangements will be reviewed as part of planning for 2015/16 in order to improve planning as necessary ahead of next winter.

Again, for January and February 2015 there has been no Norovirus outbreaks and no beds were closed due to suspected cases. This is a reduction from this time last year where 249 bed days were lost due to Norovirus over the same period.

Delivery against the Emergency Access standard reduced in January 2015 to 89.7% and in February 2015 improved slightly to 91.2%. This is still below the National Emergency Access Standard of 98%.

Table 7: ED attendances by Flow January/February 2014 and 2015

Patient Flow Description	January 2014	January 2015	February 2014	February 2015
Flow 1: Minor injury and illness	959	1194	936	1042
Flow 2: Acute assessment – includes major injuries	382	204	306	293
Flow 3: Medical admissions	589	647	470	626
Flow 4: Surgical admissions	209	210	190	167
Total	**2139**	**2255**	**1902**	**2128**
Admissions through A&E	798	857	660	793

Table 7 shows an increase in ED attendances for minor injuries and illnesses for both January and February 2015 compared to the same time last year. For January 2015, there was an increase of 116 of total ED patient attendances compared to January 2014 and an increase in admissions through ED for January 2015 of 59 compared to the same time last year. For February 2015, the total number of patient attendances to ED rose by 226 compared to February 2014 and an increase in admission through A&E for February 2015 of 133 compared to February last year.

Table 8: Operation cancellations for January/February 2014 and 2015

	Number of cancellations	No HTU/ITU beds	No ward beds	Cancelled by patient/patient did not attend	Patient unfit/Procedure no longer required	Other
January 2014	84	3	12	7	38	24
January 2015	108	7	59	12	22	8
February 2014	60	0	22	13	16	9
February 2015	74	5	13	16	15	25

Table 8 denotes that for January 2015 over half the cancellations were due to no ward beds being available, despite all identified surge capacity within the hospital being open. In February 2015 the main reasons for cancelling were due to other (non-specified reasons), cancelled by the patient/patient did not attend, patient unfit/procedure no longer required and no ward beds available.

The average length of stay data for the BGH has slightly increased from November 2014 and December 2014 (3.23 and 3.31 respectively) to 3.86 and 3.70 for January 2015 and February 2015.

During January 2015 and February 2015 Delayed Discharges has been a targeted area and there has been a decreased within the BGH of 8 cases or 5 beds in January 2015 to 4 cases or 2 beds in February 2015. This has been significantly reduced from the figures in

November and December 2014, which were 12 cases or 5 beds in November 2014 and 13 cases or 4 beds in December. 2015

Table 9: BGH nursing vacancy WTE January/February 2014 and 2015

January 2014	January 2015	February 2014	February 2015
66.37	41.88	58.93	38.14

Table 9 shows a significant decrease from last year's figures which reflects the additional focus staffing resilience has received within the planning cycle.

Overall Assessment

The increased level of activity coming through ED and the availability of timeous and appropriate beds within the system has resulted in poor Emergency Access Standard (EAS) performance. The EAS Standard remains a proxy for good quality care across the whole system, including social care, and the poor reported performance is extremely disappointing.

It is evident that our ED continues to perform despite significant and unprecedented activity pressures, and while NHS Borders continues to work to improve this aspect of performance it is apparent that we need to focus on managing the systems and creating bed availability at key points within the working day and during the week.

NHS Borders currently has a Gastrointestinal Outbreak Policy which includes action cards for key staff. This is one of NHS Borders most tested plans as there are outbreaks of Norovirus most years. Out with Norovirus Season, a Norovirus Preparedness Group is convened to review learning from the previous season and oversee the implementation of actions to improve resilience. Health Protection Scotland collates learning from all Boards after each Norovirus Season and update National guidance accordingly. During Norovirus season, cleaning regimes across NHS Borders are enhanced together with proactive communications to raise awareness of precautions for staff and public to help prevent the spread of infection.

The Borders Emergency Care Services (BECS) showed an increase in activity across all areas compared to the previous year: telephone advice rose by 33.6%, attendances by 16.3%, visits by 31.3% and overall activity was up by 24.9%. GP surgeries being closed for two periods of four consecutive days over the festive period, both incorporating weekends, is thought to have been a contributing factor. However, despite increased activity levels the excellent reported performance for GP out of hour's service were maintained during this period.

A local media campaign 'keep our emergency department at the BGH for emergencies only' was launched at the beginning of December, to encourage patients to get their care from the most appropriate provider and only use the ED in a real accident or emergency. The radio campaign ran on a Thursday and Friday so there was a focus on the weekend periods. The campaign ran until 23rd February 2015. Additional air time was added in the period between Christmas and New Year as an additional reminder. Social media played a large part in this year's campaign with one 'know where to turn to' Facebook posts receiving a reach of 5,528 and 58 shares.

Summary

Table 10: 2013/14 recommendations

2013/14 recommendations	Progress
Availability of Home Care must continue to be improved and linked to the Delayed Discharges Group to establish an early response mechanism.	Difficulties remain with home care provision. Different models of care and support are being trialled to help improve the issue including: • Commissioning a second Fast Reaction Team to respond and facilitate discharge; • Use of care home beds in flexible ways to ensure a person does not have to remain in hospital; • Working closely with all providers; and • Consideration was given to purchasing block hours in anticipation.
Finalise the proposal; for the emergency bed store and how it will be managed.	The Major Incident Store is now stocked with 24 beds (10 for a major emergency, 8 for surge and 6 for broken bed rotation/repair). There is also a stock of 14-16 mattresses in the acute store for use in a major emergency, as surge and as repair stock. There were previously only between four and six beds for all of the purposes mentioned above. General Services have a SOP and risk assessment in place.
Update escalation policy adding in Standard Operating Procedures (SOP's) to activate surge capacity.	The NHS Borders Escalation policy has been updated and now includes a surge decision-making flow which will guide staff when surge capacity is required. The Board Executive Team (BET) agreed that the policy should remain under constant review and added to as appropriate. A table top exercise to test the policy was held on 4th November 2014. A table top exercise to test how Pre-Surgery Assessment Unit (PSAU) would stand up if required is being planned.
Improve planning around staffing to flex	Permission has been given to recruit staff

capacity to respond to demand.	so as the following surge beds could be stood up if required throughout the winter period: • Ward 16 x 4 beds weekdays; • Ward 16 x 14 beds at weekends; • Border Stroke Unit x 2 beds • Medical Assessment Unit (MAU) x 8 beds. This should take the pressure off the bank and reduce our resilience on agency when surge capacity is required. The recruitment process is underway and that the majority of staff was in place by the beginning of December.
Improve planning in order to optimise elective activity.	A plan has been developed which will support NHS Borders manage elective activity over the winter period and reduce the risks of waiting times.
Ensure there is a presence throughout the festive period of experience of coordinating community hospital transfers.	The Discharge Liaison Team will be in the hospital every day over the festive period and as part of their remit to coordinate Community Hospital Transfers.
Earlier planning of Hospital Senior Management annual leave and on-call rota throughout the festive period.	Management rotas for the festive were finalised. There will be at least one manage from each service (Unscheduled Care, DME, Planned Care and Woman and Children's) in the hospital over the normal working days and an enhanced out of hours cover on the bank holidays and weekends.

Recommendations for Future Winter Planning:

1. Proactive Discharge Planning, this is not a problem specific to the festive period or winter period but needs to be addressed;
2. Delayed Discharges and achieving the two-week target;
3. Avoiding attendances;
4. Capacity management; and
5. Managing flow through ED.

Recommendation

The Board is asked to **note** the learning and improvement opportunities for next year which will now be taken forward by the Winter Planning Group.

Policy/Strategy Implications	Request from the Scottish Government that all Health Boards produce a Winter Plan

	signed off by their Board. This report will inform the Winter Planning Process 2015/16.
Consultation	Feedback was provided by the Winter Planning Group, Clinical Services and Managers.
Consultation with Professional Committees	The original Winter Plan was approved by the NHS Borders Board.
Risk Assessment	The Winter Plan is designed to mitigate the risks associated with the winter and festive periods.
Compliance with Board Policy requirements on Equality and Diversity	Planning for all activity for all Groups across the Winter Period.
Resource/Staffing Implications	Resource and staffing implications were addressed within the Winter Plan.

Approved by

Name	Designation	Name	Designation
Evelyn Rodger	Director of Nursing & Midwifery, Interim Director of Acute Services		

Author(s)

Name	Designation	Name	Designation
Zoë Brydon	Interim Project Support	Kirk Lakie	Service Manager