Borders NHS Board

NHS BORDERS 2015/16 WINTER PERIOD REPORT

Aim

To update the Board on key activity relating to the 2015/16 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 2015/16 Winter Plan was discussed and subsequently approved at the October 2015 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 protocols. 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 2014/15 can be found at the end of this report and a review meeting for understanding the lessons learned from 2015/16 is scheduled for April 2016.

Assessment

As in previous years the key elements of the 2015/16 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.

Prevention of admissions

In 2015/16 there was a programme of vaccinating staff against influenza. As of end December 2015 (when monitoring ceased), 44% of staff had been vaccinated against a target set by the Scottish Government of 50%. This is a decrease in performance compared to 2014/15 when the uptake was 54%. Planning for 2016/17 has already commenced and it is hoped that the results reported in 2015/16 can be further built upon next year.

Additionally, there was a programme of vaccinating children within the Scottish Borders against influenza. A total of 4,961 Primary School children have been vaccinated out of a

total of 8,554 eligible children. This resulted in a 58% uptake, which is the second highest uptake in Scotland for this programme.

The communication strategy took a relatively low-profile approach compared to previous years, relying on national campaigns to get messages across to the public. There was a greater use of social media, particularly between Christmas and New Year to promote healthy New Year resolutions. A 'Meet Ed' leaflet, detailing alternatives to attending the Emergency Department (ED) and to access health services during holiday periods has been produced. This was available relatively late in the winter but is not date-specific and will be used during other times of peak activity as well.

Primary Care

There were a number of initiatives identified to be taken forward during the winter of 2015/16 that would reduce demand for health services. These included;

- Paramedic Support to Teviot locality GPs
- Eildon Locality Health and Care Team to avoid admission and support discharge
- Management of the 30 most frequently admitted patients to avoid readmission

It was recognised that these projects were unlikely to progress sufficiently to impact on winter pressures during 2015/16 and this has been the case. However, these and other initiatives will be further developed during 2016/17 to be in place as an active part of the winter plan for 2016/17.

Front door activity

The Winter Plan aimed to maintain performance in Borders Emergency Care Service (BECS) and to maintain the 4–hour Emergency Access Standard above 95% and at similar levels to the rest of the year.

Borders Emergency Care Service activity
There was a 6% reduction in activity in BECS over this winter compared to the previous winter. Capacity plans for BECS worked well and there were no significant challenges during the winter period.

Table 1: BECS Activity

	Nov- 14	Dec- 14	Jan-15		Nov- 15	Dec- 15	Jan 16
Activity(contacts)	1107	1341	1737		989	1271	1666

Activity in the Emergency Department (ED) reduced by 5% compared to last winter. This was directly related to the opening of the Acute Assessment Unit, which takes GP referrals to medicine that last year were seen in ED. Taking this into account, December was similar to last year, but both January and February had higher activity than last year.

Table 2: ED Activity

Patient Flow Description	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
Flow 1: Minor injury and illness	1058	1107	1194	1042		1229	1125	1190	1147
Flow 2: Acute assessment – includes major injuries	221	263	204	293		195	246	261	230
Flow 3: Medical admissions	480	679	647	626		561	354	408	456
Flow 4: Surgical admissions	205	226	210	167		174	207	190	196
Total	**1964**	**2275**	**2255**	**2128**		**2159**	**1932**	**2049**	**2029**

The Emergency Access Standard (EAS) of 95% was achieved each month over the winter period and showed that arrangements for managing emergency activity were effective. The major improvement from the previous winter was a reduction in breaches due to waiting for medical beds, down from 431 to 67 over the period with no increase in breaches due to other reasons, including delay to first assessment.

EAS reported performance did not include Acute Assessment Unit (AAU) in December and January, as attendances were recorded as admissions during this time. However, combined ED/AAU performance for December and January also exceeded 95%. Acute Assessment Unit performance is included in February data from 22nd February.

Table 3: EAS performance

Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
97.66 %	90.81 %	89.71 %	91.21 %	91.41 %	94.79 %	96.52 %	96.34 %	97.13 %	96.45 %	96.62 %	95.96 %	97.24 %	96.88 %	96.77 %	95.18 %

The Acute Assessment Unit (AAU) was established in December 2015 as a central plank of management of acutely ill patients. The AAU comprises an acute assessment area for patients requiring medical attention and diagnosis, and an ambulatory care area for patents who require urgent but not immediate investigation and planned treatment.

Graph 1: AAU performance

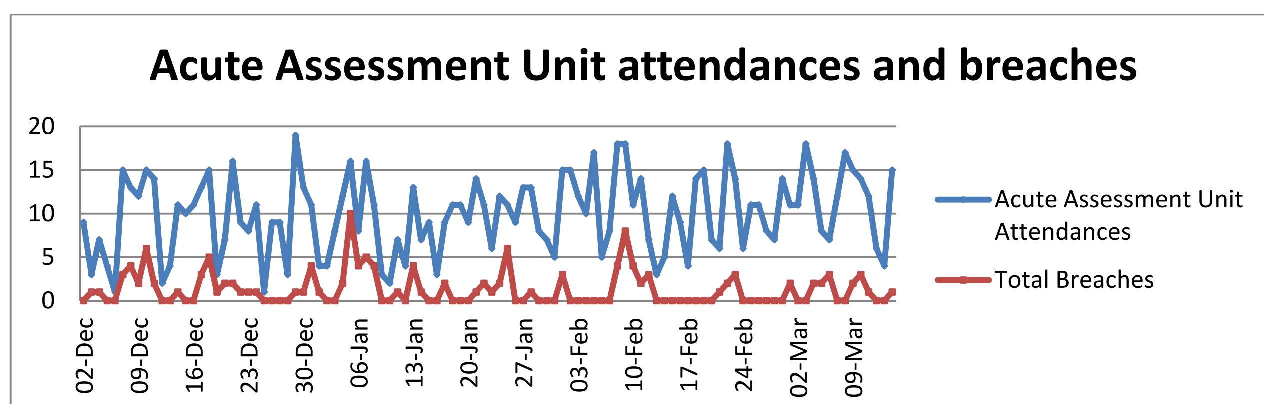


Table 4: AAU Performance

	Dec- 15	Jan- 16	Feb- 16
Attendances	278	276	314
Breaches	42	47	30

30% of all patients seen in AAU were discharged home.

The Rapid Assessment and Discharge (RAD) team pilot was extended through the winter period, providing rapid assessment for patients whose condition might enable immediate discharge with additional social or AHP support. During the month of January, the RAD team saw 47 patients, of these, 55% were able to be discharged the same day discharge (or avoidance of admission) in 55% of cases.

Admissions

Admission data is difficult to interpret because, between December and the 22nd February, attendances in the Acute Assessment Unit were recorded as admissions. Some of these attendances would previously have been seen and discharged from ED. However, the data would suggest that there has been a slight reduction in admissions compared to last winter.

Table 5: Monthly admissions to Borders General Hospital

	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
General Medicine	664	705	741	814		688	899	925	708
BGH (Excluding General Medicine)	640	675	480	526		617	584	443	450
Total BGH	1304	1380	1221	1340		1305	1483	1368	1158

Bed capacity

Planning for surge bed capacity was integral to ensuring effective patient flow this winter. The Winter Plan set out the following;

- Open MAU annexe (8 beds) from November to March
- Open Ward 16 surge beds (4 beds) from November to March
- Planning for ability to open beds in Planned Surgical Assessment Unit (PSAU) for one month (Ward 8) (6 beds)

The plan set out not to use additional beds in the stroke unit, Knoll and Hawick Community Hospitals based on experience in the previous year of the high cost and effectiveness of supporting these beds.

In practice;

- The MAU annex and Ward 16 beds were opened and fully utilised.
- In addition, Ward 8 was utilised for most of the period from early January to 17th March, 6 weeks more than predicted.
- The additional 2 beds in the stroke unit were also used on a regular basis.
- Additional beds in Hawick Community Hospital and Knoll Community Hospital were opened for periods of approximately 4 weeks each.

The use of these beds required additional medical cover and some additional nursing cover and again proved challenging to both arrange and maintain.

Boarding

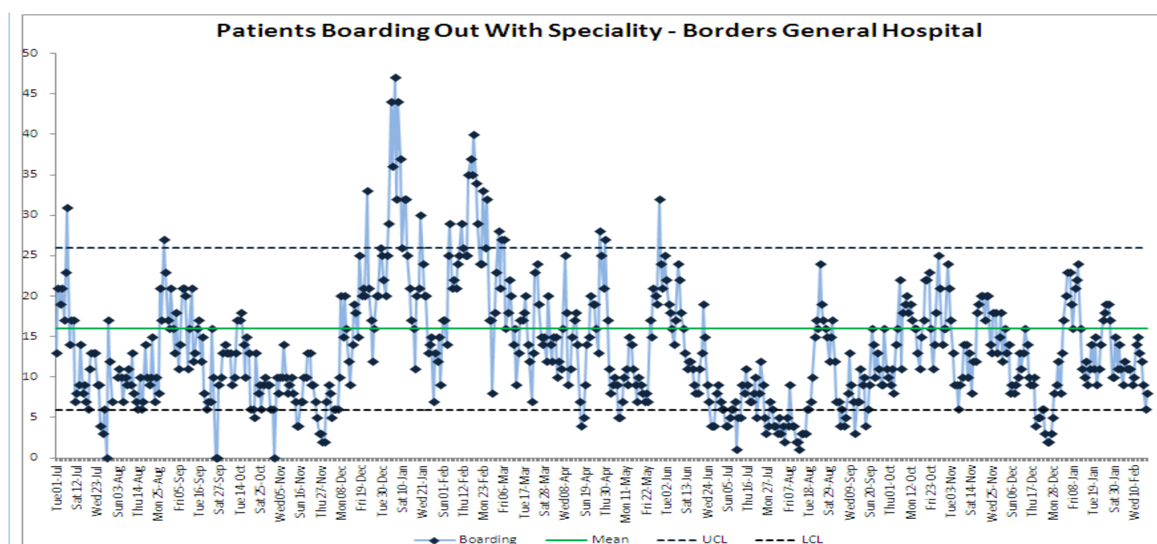
The winter plan set out to minimise the number of patients boarding into wards out with their specialty, especially medical patients. It estimated that we required the establishment of a 14-bedded extra medical facility within the surgical floor footprint to avoid boarding. This would be established using existing staffing and would be in addition to the surge bed arrangement for Ward 8.

The establishment of the additional medical beds within surgery was not achieved. This was because it was difficult to identify and agree which ward would host this facility and which group of patients could be relocated to release the beds. Once this was agreed, the operational arrangements to transfer patients and operate as a medical facility proved impractical in the timescales.

However, the use of Ward 8 as an additional medical facility did provide 6 more medical beds and feedback about this arrangement was that having a single geographical location for these patients helped medical staff to manage them more effectively. An additional junior doctor dedicated to reviewing ward patients and boarders assisted with this.

Boarding was substantially reduced from the previous winter, running at an average 12.6 patients/day, compared to 21.2 patients/day last winter.

Graph 2: Patient Boarding



Average length of stay for the BGH was lower than last winter. Some of this reduction is related to due to patients admitted to and discharged from the Acute Assessment Unit on the same day. In previous years, these patients would have attended ED and not been admitted. These additional 0-day stay admissions have resulted in a fall in overall length of stay. However, accounting for this change in data, there is still a reduction in length of stay of approximately 0.5 days.

Table 6: BGH Length of Stay

	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
BGH average length of stay	3.23	3.31	3.86	3.70		3.27	3.05	3.36	3.26

(days)									

Discharges

The Winter Plan set out to;

- Increase number of morning discharges to 40%
- Increase the number of weekend discharges by 25%
- Reduce delayed discharges to zero

Morning discharges

There was little change in the number of patients discharged by 12 midday each day.

Table 7: Daily Discharges

	Nov- 14	Dec-14	Jan -15		Nov- 15	Dec-15	Jan-16	Feb-16
Discharges by 11am	115	102	99		106	113	68	79
Discharges by 12noon	222	210	183		227	196	184	124

A detailed action plan for increasing morning discharges has now been produced and will be progressed over the next 4 months to ensure that morning discharge rates are improved for winter 16/17.

Weekend discharges:

The winter plan included additional Allied Health Professionals (AHP) cover, an additional discharge doctor and weekend admin and duty manager support and proposed the establishment of a weekend discharge team to support an increase in discharges. Although additional staff were in place, a coordinated weekend discharge team was not established.

However, there was no significant change in number of patients discharged at the weekend compared to the previous winter.

Trials of a coordinated weekend discharge team will be tested through the next 6 months to identify whether this model will improve weekend discharges for the winter.

Community Hospitals:

A key plank of the winter plan was the reduction in length of stay in community hospitals to an average 18 days per patient. Care managers were located within the community hospitals to support this.

However, length of stay stayed roughly the same as last winter.

Table 8: Community Hospital LOS

	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
Hawick	21.5	15.2	20.3	11.8		21.1	15.5	19.4	20.0

Haylodge	51.2	37.4	35.0	37.5		28.5	30.7	31.5	54.8
Kelso	23.0	16.2	27.2	26.5		24.9	32.1	33.6	26.9
Knoll	32.7	26.0	25.1	33.0		27.9	27.3	50.1	27.5

Delayed Discharges:

The winter plan aimed to achieve zero delayed discharges during the winter period. A focus on intensively managing both formal delayed discharges, through the Delayed Discharge operational group, and the discharge of patients with complex needs, through the daily Discharge Hub, was included in the Winter Plan.

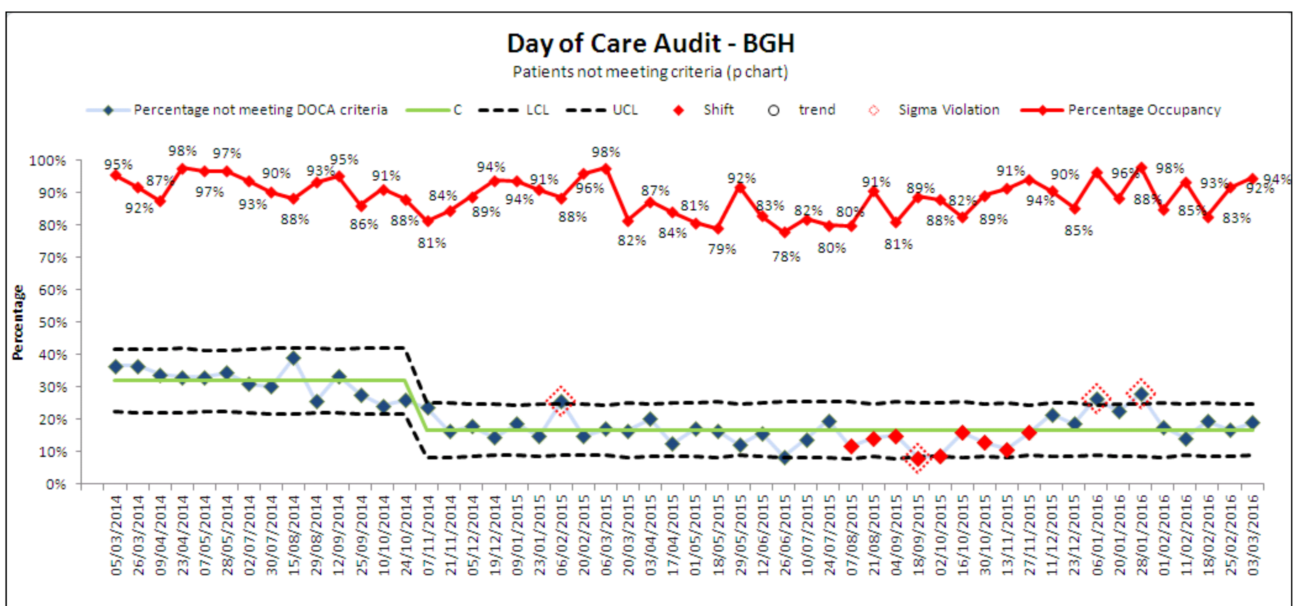
In practice, formal delayed discharges numbers were similar and days delayed increased by one third.

Table 9: Delayed Discharges

	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
No of patients - BGH	12	13	8	4		14	8	14	10
No of patients – Comm. Hosps	32	47	41	42		40	42	38	26
Total days delayed - BGH	122	98	116	17		171	124	150	65
Total days delayed – Comm. Hosps	264	421	460	469		381	607	552	423

The percentage of patients in the BGH who did not require to be in hospital, based on day of care audit criteria, did not reduce compared to the previous winter;

Table 10: Day of Care Audit



Elective operating:

A key feature of the Winter Plan was to maintain elective operating without disruption due to unscheduled pressures. A decision was taken to combine all day case activity through

Day Procedure Unit and procedure numbers were balanced accordingly. This released PSAU to function as an inpatient area (Ward 8 – see above)

During December and January, cancellations due to bed availability did not increase from previous months. The position worsened in February, when 35 procedures were cancelled due to lack of bed availability. Patients exceeding Treatment Time Guarantee also increased from zero to 11 patients at one point. Overall numbers of cancellations was however significantly less than the previous year.

Table 11: Cancellations of Elective Procedures

	Number of cancellations	No HTU/ITU beds	No ward beds	Cancelled by patient/patient did not attend	Patient unfit/Procedure no longer required	Other
Nov- 2014	59	8	0	15	23	13
Dec- 2014	73	2	7	16	33	15
Jan- 2015	108	7	59	12	22	8
Feb- 2015	74	5	13	16	15	25
Nov- 2015	51	1	10	13	10	17
Dec- 2015	36	2	6	7	7	14
Jan- 2016	59	3	19	11	13	13
Feb- 2016	49	2	21	6	8	12

Staffing:

The Winter Plan set out to proactively recruit to fill vacancies and future predicted vacancies in nurse staffing, as well as to cover the additional staffing required for surge beds.

Recruitment events were undertaken to proactively fill the staffing requirements for surge beds and known vacancies. The BGH nursing vacancy Whole Time Equivalent (WTE) for November and December 2015 was 31.12 and 23.11 which was well below the vacancy levels carried into previous winter periods.

Table 12: Nursing Vacancies

Borders General Hospital nursing vacancies (whole time equivalent)	Nov-14	Dec-14		Nov-15	Dec-15	Jan-16
	44.32	44.49		31.12	23.11	28.6

However, staffing continued to be a challenge over the winter period, due to the inability to fully recruit to vacancies, the reliance on nurse bank to support the opening of additional unplanned beds and an increased sickness rate during January and February (see below). As a result there was an increased reliance on agency nursing over February and March in particular.

Sickness:

There were lower levels of sickness in November and December 2015 compared to the equivalent period the previous year.

Sickness related to flu and respiratory conditions was reduced compared to the previous year.

Table 13 shows that sickness absence for the BGH and PACS during November and December 2015 has decreased when compared to the same period for last year.

However, nursing and midwifery sickness was significantly higher than the overall rate.

Table 13: Sickness Absence

	Nov-14	Dec-14	Jan-15	Feb-15		Nov-15	Dec-15	Jan-16	Feb-16
Borders General Hospital	4.67%	6.04%	5.92%	4.95%		4.06%	4.06%	4.76%	4.6%
BGH Nursing and Midwifery						5.18%	6.6%	5.9%	5.88%
Primary & Community Services (PACS)	5.17%	5.57%	6.09%	5.36%		4.84%	5.52%	6.01%	5.55%
PCS Nursing and Midwifery						6.27%	7.37%	7.04%	6.9%

Outbreaks:

There were no significant outbreaks of infectious diseases over the winter period. Although numbers of beds blocked due to Norovirus and other gastrointestinal infections during this time period increased from the previous year, the numbers remain low compared to earlier years.

Table 14: Blocked Bed Days

NOV 2013 - FEB 2014					
Flu		D&V		Total	
Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds
Not collected		1492	246	N/A	
NOV 2014 - FEB 2015					
Flu		D&V		Total	
Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds
135	39	60	12	195	51

NOV 2015 - FEB 2016					
Flu		D&V		Total	
Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds	Blocked Beds	Blocked Empty Beds
30	2	342	67	372	69

Overall Assessment

NHS Borders performance in delivering health services during the winter period 2015-16 has improved, based on performance measures, compared to the previous winter.

This was predominantly because patient flow through the BGH was effective and measures to ensure appropriate staffing in key areas – Border Emergency Care Service (BECS), ED, surge beds – allowed us to manage activity in a timely fashion.

A number of areas of focus within the winter plan appear to have supported this good performance, including the planning for activity increases at the front door of the hospital, the establishment of the Acute Assessment Unit and the opening of surge beds, including the formal creation of additional medical beds in Ward 8.

A number of areas did not deliver on the aims outlined in the Winter Plan, including morning and weekend discharges, Community Hospital length of stay and reduction in delayed discharges, and in particular the number of bed days lost due to delayed discharges. As a result, our reliance on surge beds was greater than predicted in the Winter Plan.

Despite an improvement in arrangements for recruitment of additional staff, staffing remained a challenge, partly due to the need to open additional surge beds.

Infection control measures to manage potential outbreaks were tested on a number of occasions and worked well, but we did not experience any significant challenges due to outbreaks of infectious diseases, which also helped the winter performance.

Recommendations for Future Winter Planning:

1. Build on front door work to prevent admission, including Acute Assessment Unit to reduce admissions and length of stay and reduce requirement for additional bed capacity.
2. Remodel inpatient footprint to ensure appropriate allocation of specialty beds, including ensuring the correct allocation and staffing of medical beds. This will minimise boarding patients.
3. Develop community-based prevention strategies to avoid patients requiring admission.
4. Focus on proactive Discharge Planning at an individual patient level to reduce delayed discharges and patients waiting inappropriately in hospital beds.
5. Resolve the issues preventing patients being discharged in the morning.
6. Develop more effective discharge planning and a coordinated weekend discharge team.
7. Build on the proactive recruitment strategies to minimise staffing vacancies going into winter.
8. Earlier preparation and implementation of Winter Plan for 2016/17.

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 2016/17.
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**
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