

Borders NHS Board**SCOTTISH BORDERS HEALTH AND SOCIAL CARE PARTNERHSIP**
2017/18 WINTER PERIOD EVALUATION REPORT**Aim**

To update the Board on key activity relating to the 2017/18 winter period and present the evaluation of the Winter Plan 2017/18

Background

The Scottish Borders Health and Social Care Partnership, like all Partnerships, 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 2017/18 Winter Plan was developed as a whole system Scottish Borders Joint Winter Plan between NHS Borders and Scottish Borders Council and was approved at the October 2017 NHS Borders Board and subsequently noted by the Integrated Joint Board in November 2017.

Summary

This winter has been one of the most challenging for the past 4 years. In addition to the normal winter pressures, there were 3 major challenges during the course of this winter;

- Norovirus outbreak. There was a major norovirus outbreak in October 2017, which continued into the early part of November, resulting in a loss of beds
- Flu outbreak. The flu outbreak this year was one of the most significant in recent years and this impacted on front door activity and admissions
- Snow. We experienced the worst snow weather for the past 8 years during February and into March with major disruption to health systems.

This winter, the normal provisions for additional winter activity were put in place. In addition, the following new measures were taken;

- A range of initiatives within social care to reduce delays to discharge
- A number of actions to better support patients within primary care
- An increase in assessment and ambulatory care capacity, including a test of a Surgical Assessment Unit and the expansion of the Acute Assessment Unit
- Additional surge capacity in Community Hospitals
- Planned reduction in inpatient elective operating during January 2018

Feedback from primary care suggests that GP practices were busy but made arrangements that allowed them to cope with additional demand. Activity data indicates that the front door of the BGH was much busier than in previous years. BECS activity increased by 9% and Emergency Department by 8%. Both departments saw 30% or greater increases in patients requiring urgent assessment. This suggests more patients presenting acutely unwell. Despite these challenges, both departments reported that the planning for additional activity had worked well.

Although admissions to the BGH reduced by 8% overall and by 10% for adults over the winter period, the length of stay increased by 6% from an average 4.3 days to 4.7 days, but with the greatest increase from 1st January onwards. As a result, there was a 10% increase in occupied beddays for medical patients during this period. This is likely to be due to two factors

- front-door services were very effective at managing patients to avoid admission, meaning patients who were admitted were sicker or more complex than previous years.
- There was a 30% increase in delayed discharge occupied beddays in the period up to beginning of January

This increase in length of stay outbalanced the reduction in admissions and resulted in very high demand for inpatient beds. In addition, there were a number of peaks in admissions which caused increased impact on patient flow.

The demand for acute medical beds exceeded capacity on a regular basis over this period. As a result, numbers of boarding patients increased by two-thirds. Operationally, there were major challenges in the ability to identify suitable patients to board to non-medical wards and the time and resource required to manage this resulted in delays and increased length of stay. This further exacerbated the challenges in managing patient flow.

An additional 44 surge beds were open over this period across the BGH, Community Hospitals and Social Care. However 10 of these beds were open before the winter period began. These were insufficient to accommodate demand from the New Year, resulting in the Planned Surgical Admissions Unit opening as inpatient beds for 28 days and the Acute Assessment Unit for 38 days. There were 16 days during this period when there were insufficient beds to accommodate all patients and some patients were cared for overnight in ED.

There was a consequent deterioration in performance against the Emergency Access Standard, with breaches increasing from 584 last year to 982 this winter. We experienced 109 eight-hour breaches during this period, of which 58 were overnight.

Elective operating was impacted with total number of procedures undertaken falling from 1457 last year to 1336 this year and numbers of patients exceeding their Treatment Time Guarantee as a result of cancellations rising from 63 at beginning of November to 254 at end of February.

On a positive note, uptake of staff flu vaccination was higher than last year at 54% and vaccination of over-65s in the community increased compared to last year.

It is a credit to staff across health and social care that delivery of care was maintained and patients were cared for appropriately and safely. Data and feedback suggests that the tried-and-tested operational provisions within the Winter Plan worked well to minimise the impact of additional activity. Although new initiatives to support the management of the increased demand, mainly additional social care capacity, had a positive impact, especially on delayed discharges, they did not have sufficient time to be established and did not address the demand for acute medical beds. As a result, there was a heavy reliance on short-term contingency arrangements, with a resulting impact on maintenance of routine services.

A range of recommendations for future winter planning are contained at the end of this report.

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 Board.

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 2018/19.
Consultation	Performance against the Winter Plan has been presented at numerous committees and groups within NHS Borders and Scottish Borders Council. Debriefs of both the Festive Plan and the Winter Plan have taken place. Feedback from these sessions has influenced this evaluation.
Consultation with Professional Committees	The Winter Plan has been reviewed by the Area Clinical Forum, the Clinical Executive and Clinical and operational groups throughout NHS Borders and SBC. The Plan was approved by the NHS Borders Board and noted by the Integrated Joint 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
Rob McCullough-Graham	Chief Officer		

Author(s)

Name	Designation	Name	Designation
Phillip Lunts	General Manager, Unscheduled Care		



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Assessment

As in previous years the key elements of the 2017/18 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. However, this year's Winter Plan was a driver for the establishment of social care alternatives to hospital, in particular initiatives to enable patients to be discharged from hospital earlier whilst assessment and social care planning took place.

Data within this evaluation relates to the period November 2017 to end February 2018, unless otherwise stated.

Executive Summary

This winter has been one of the most challenging for the past 4 years. In addition to the normal winter pressures, there were 3 major challenges during the course of this winter;

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It is a credit to staff across health and social care that delivery of care was maintained and patients were cared for appropriately and safely. Data and feedback suggests that the tried-and-tested operational provisions within the Winter Plan worked well to minimise the impact of additional activity. Although new initiatives to support the management of the increased demand, mainly additional social care capacity, had a positive impact, especially on delayed discharges, they did not have sufficient time to be established and did not address the demand for acute medical beds. As a result, there was a heavy reliance on short-term contingency arrangements, with a resulting impact on maintenance of routine services.

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Resilience Planning

The Winter Plan this year recommended assessment of NHS and SBC joint capacity for resilience. This confirmed that plans were in place for maintaining business continuity in both organisations. These plans were tested intensively as a result of the severe weather experienced in February. A separate review of this event is taking place. However, the fact that services were maintained without any serious adverse events, and the lessons learned from this event, will be invaluable in helping to further strengthen the resilience of the Partnership for future years.

Prevention of admissions

In 2017/18 there was an increased focus on vaccination of NHS staff against influenza. As at 23rd February, 56% of staff had been vaccinated against a target set by the Scottish Government of 50%. This was an improved performance against previous years.

Vaccination of essential SBC staff and carers within home care services was also offered. 85 members of Scottish Borders Council staff were vaccinated and a drop-in clinic for SBCares staff was available. However, formal monitoring of uptake was not undertaken, so the extent of vaccination of these groups is not clear.

There was a spike in staff off sick due to flu-related conditions in January this year, but this mirrored a similar increase last year.

The community vaccination programme vaccinated three-quarters of all primary school and over 65 age groups, representing an improvement for over-65s and a slight drop for primary school age.

Other at-risk groups' percentage vaccination increased. Borders overall performance was in the top half for Scotland in all categories.

Table 1 Flu Vaccination

Programme	2015		2016		2017		Position in Scotland
	Borders	Scotland	Borders	Scotland	Borders	Scotland	
Primary school flu vacc	79.3%	71.5%	78.11%	72.1%	77.1%	71% (provisional)	Not yet released
Over 65	75.8%	74.5%	74.8%	72.6%	75.9%	73.7%	2 nd highest
Pregnant and not in a clinical risk group	52.7%	49.9%	49.8%	46.6%	52.4%	47.8%	5 th highest
All at risk (exc. healthy pregnant women & carers)	50.7%	48.0%	49%	44.5%	51.0%	44.9%	2 nd highest

Communications activity was focused on supporting the national activity co-ordinated by NHS24 which aimed to highlight the appropriate services available for a wide range of ailments and conditions; including links to useful NHS Inform self-help guides. The other key message 'know who to turn to', fronted by the 'Meet Ed' campaign, aims to inform the public to only present at the Emergency Department in an emergency situation, and instead utilise support and advice available from GPs, Pharmacies and Minor Injury Units.

Our communications focussed on media messaging through print (primarily local press) and SB Connect (delivered to every household across the Borders), NHS Borders website and social media. There was no paid for activity by NHS Borders. Our 'Weekly Winter Update' (WWU) was used over the winter period which carried our key messages in a visual and easy to read format. Social media played a big part in how we communicated this year and was positively received with messages being widely shared. The key messages highlighted above were posted on our social media platforms daily. During the festive period when we experienced high demand for our services and also when we had periods of severe weather, we utilised social media more in order to get advice, service information and statements from senior management to both staff and the general public quickly which proved very effective.

Primary Care

Although GP practices report increased levels of activity over this winter period, arrangements enabled them to cope well with the demand. As in previous years, GP practices undertook a range of approaches to managing surge activity, especially after the Festive Period holidays;

- Arranging additional surgeries after the public holiday period
- Booking fewer routine patients over the festive period to increase the availability of 'on the day' appointments
- Increasing the number of Advanced Nurse Practitioners on duty
- Increasing the number of 'on the day' appointments on the Fridays immediately before the public holidays
- Having extra dispensing staff on duty immediately prior to Christmas
- Increasing the number of GPs available for emergency appointments and home visits

During a period of intense pressure at the BGH in January, 7 GP practices (out of 23) agreed to open on a voluntary basis on Saturday mornings for 4 weekends. This initiative was arranged at short notice as a test to see if it would reduce pressure on front door services at the BGH. However, data analysis and feedback suggests that it did not have a significant impact on levels of attendances at either BECS or ED. Part of the learning indicated that peak activity takes place after the practices closed (1-2 in afternoon).

The paramedic practitioners continued to operate in a number of areas within the Borders. There are now 4 qualified Paramedic Specialists and a further 2 undertaking training. The paramedic practitioners also worked closely with BECS, collaborating to support Home Visits.

Two small-scale initiatives were established to help support patients at home and avoid admissions;

- Development of anticipatory care plans for people in nursing homes
- Development of self-management plans for patients with COPD

Although both of these initiatives progressed, they were commenced too late in the year and require sufficient time to establish. They therefore did not impact significantly on activity over the winter period.

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

Data is for the period November 2017 to January 2018. There was a 9% increase in total BECS contacts over this winter compared to the previous winter. December saw the highest number of overall contacts. Over the festive period, BECS staffed to higher levels than normal based on NHS24 predictors, but saw an increase of 60% in activity above these predicted levels of activity. January saw a peak in patient demand for rapid contacts (1 hour attend and 1 hour visit). This indicates a significant increase in numbers of significantly unwell patients referred and is likely to be at least in part attributable to the impact of the Flu outbreak on elderly patients. The number of patients presenting with respiratory symptoms rose by 60% over the festive period compared to the previous year.

BECS performance against national standards deteriorated as a result.

In summary, although BECS saw a large increase in attendances, with the largest increase in patients with significant illness, requiring urgent attention, the service managed this extra demand within its resources. There were particular challenges on weekend afternoons and future planning should incorporate additional clinical staffing at these times.

Table 2 BECS Activity and Performance

		Nov-16	Dec-16	Jan-17		Nov-17	Dec-17	Jan-18
attend	1 hr	40	38	44		69	59	61
	2hr	92	103	96		69	130	89
	4hr	425	629	557		453	703	480
visit	1hr	27	36	34		22	37	49
	2hr	108	124	142		132	163	124
	4hr	229	327	353		232	402	370
phone	1 hr	65	95	92		90	86	100
	2hr	104	143	144		117	135	152
	4 hr	161	226	256		184	251	203
TOTAL		1251	1721	1718		1368	1966	1690

Table 3: BECS performance

	Activity compared to last year	Performance	Compared to last year
Attends			
4 hours	55%	95%	(+1.4%)
2 hours	-1%	71%	(-9.4%)
1 hour	2%	34%	(-16.7%)
Home visits			
4 hours	10%	92%	(-4.3%)
2 hours	12%	77%	(+1.8%)
1 hour	11%	59%	(-4.7%)

Emergency Department (ED) and Acute Assessment Unit

Activity in the Emergency Department increased by 8% compared to 16/17 (12% compared to 15/16). There was no increase in Flow 1 (minor) patients and an 8% decrease in Flow 4 (surgical admissions) patients attending ED. However, there was an increase of 29% in Flow 2 & 3 patients (patients presenting with major conditions, including medical admissions), with the largest increase (45%) in December. This reflects an increase in patients presenting with acute conditions.

The Acute Assessment Unit was occupied by surge beds and therefore closed to attendances for 38 days this period compared to 7 days last winter. As a result, there was a 21% reduction in AAU activity.

Combined ED and AAU activity increased by 6% this year compared to last year.

During November, a Gynaecology and Surgical Assessment Unit was established in Ward 16. This provided an assessment service for patients requiring surgical or gynaecology review who would otherwise have been seen either in ED or admitted to the ward. This service ended on 29th November, when the assessment area was bedded. This review does not include this data.

Table 4 Combined ED/AAU Activity

Flow	Nov-16	Dec-16	Jan-17	Feb-17		Nov-17	Dec-17	Jan-18	Feb-18
Flow 1: Minor Injury & Illness	1246	1259	1151	1074		1281	1309	1146	1076
Flow 2: Acute assessment - includes major injuries	210	224	307	255		379	433	409	358
Flow 3: Medical Admissions	581	631	614	559		560	673	636	525
Flow 4: Surgical Admissions	223	220	258	198		189	219	205	187
Grand Total	2260	2334	2330	2086		2409	2634	2396	2146

The Emergency Access Standard (EAS) of 95% was not achieved throughout this winter period. The highest monthly achievement was 93.5% in November 2017. Performance fell below 90% in both December and January. Flow 1 performance remained above 97% each month, but Flow 3 performance was particularly low, reflecting the demand for medical beds. This included 16 occasions when a total of 58 patients were cared for overnight in ED, due to a lack of beds within the hospital to admit them to.

Of all attendances in ED and AAU, 33.6% were admitted. This compares with 35% of attendances admitted in the previous winter period and 31% for the period immediately preceding this winter.

The highest numbers of breaches were for patients waiting beds, comprising 54% of all breaches. 90% were waits for medical beds. Next highest cause of breaches were waits for first ED assessment, averaging 9% of breaches.

A positive is that Flow 1 performance, for patients attending with minor conditions, remained above 97% throughout this period. This indicates that ED internal ability to manage patient flow was adequate and that the cause of the low EAS performance was related to hospital-wide systems, mainly access to beds.

Table 5 EAS performance

EAS	Nov-17	Dec-17	Jan-18	Feb-18
Flow 1: Minor Injury & Illness	98.9%	97.1%	97.8%	98.0%
Flow 2: Acute assessment - includes major injuries	91.6%	82.9%	83.9%	85.2%
Flow 3: Medical Admissions	83.9%	75.0%	67.5%	83.0%
Flow 4: Surgical Admissions	88.9%	88.6%	81.5%	88.8%
Total	93.5%	88.4%	86.0%	91.4%

Due to the demand for inpatient beds, the Acute Assessment Unit was used as an inpatient area for 38 days during this period or 32% of the time. As a result AAU attendances fell to 578 for this period, compared to 714 for the previous year (a fall of 19%).

Table 6: AAU Performance

	Nov-17	Dec-17	Jan-18	Feb-18
Attendances	214	162	48	154
Breaches	26	29	16	28
EAs Performance	87.9%	82.1%	66.7%	81.8%

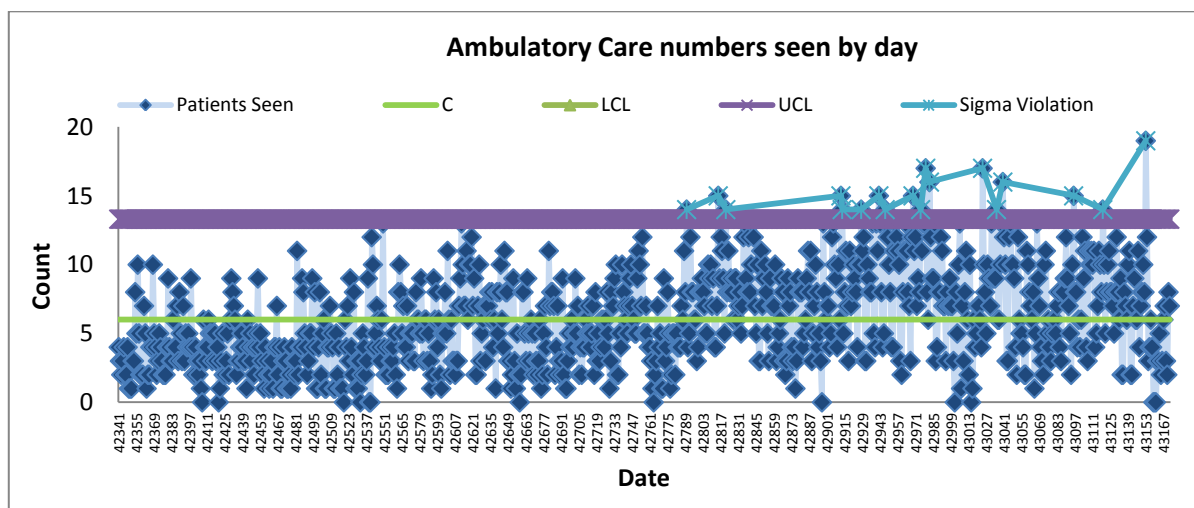
Ambulatory Care

Attendances in Ambulatory Care rose from 641 to 878 compared to last winter, an increase of 37%. Admissions from Ambulatory Care remained at 7%, unchanged from the previous year, demonstrating that selection of patients was appropriate.

Table 7 Ambulatory Care

	Nov-16	Dec-16	Jan-17	Feb-17	Total		Nov-17	Dec-17	Jan-18	Feb-18	Total
Attendees	146	155	186	154	641		224	203	260	191	878
Admissions	7	11	4	14	36		14	16	10	24	64
% admissions	5%	7%	2%	9%	6%		6%	8%	4%	13%	7%

Chart 1: Ambulatory Care (ACU) attendances by week



The Rapid Assessment and Discharge (RAD) team continued to operate on 6 days/week during the winter period and increased to 7 days/week during the January peak in activity, providing rapid AHP assessment for patients, whose condition might enable immediate discharge this was arranged at short notice, impacting on the sustainability and appropriateness of the rota. Nevertheless, the service was considered invaluable by clinicians within the BGH.

Admissions

Adult Admissions to the BGH over the winter period fell from 3935 to 3532 between Nov-Feb this winter compared to last winter, a fall of 10%. There was a 5% fall in medical admissions, a 7% fall in Orthopaedic admissions, a 20% fall in General Surgical admissions and a 33% fall in Gynaecology admissions (from 249 to 167). There was a 9% increase in ITU admissions, but this only represented an increase in admissions of 4 over the period.

General Medical admissions represented 56% of all admissions in this period compared to 50% of all admissions the previous year.

The highest period for admissions were the 7 weeks from week commencing 4th December to week commencing 15th January, representing 42% of total admissions compared to 39% of total admissions for the previous year. The week commencing 25th December had the highest number of admissions overall and for General Medicine admissions this year. Last year, the week commencing 31st December had the highest number of admissions. ITU admissions were higher this year than last year during the period from 18th December to 28th January. These periods reflect the peak of flu prevalence within the community. Orthopaedic admissions were variable across the period.

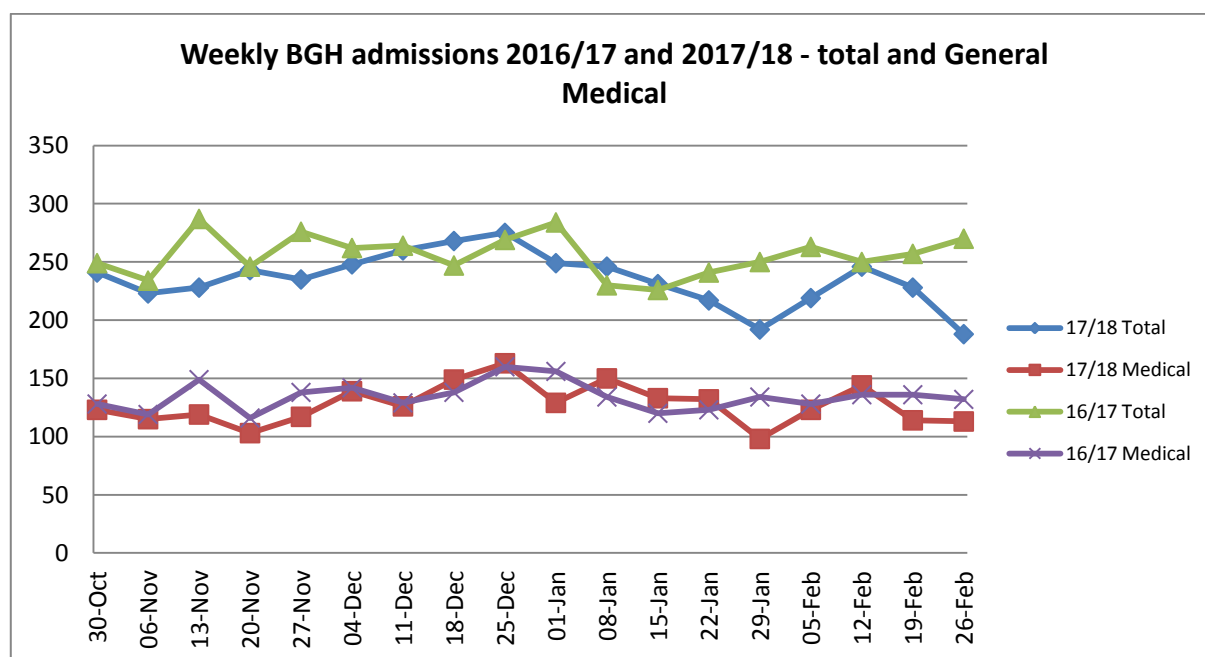
There was a 5% increase in Medical Paediatric admissions (35 extra admissions). The peak additional admissions were in December.

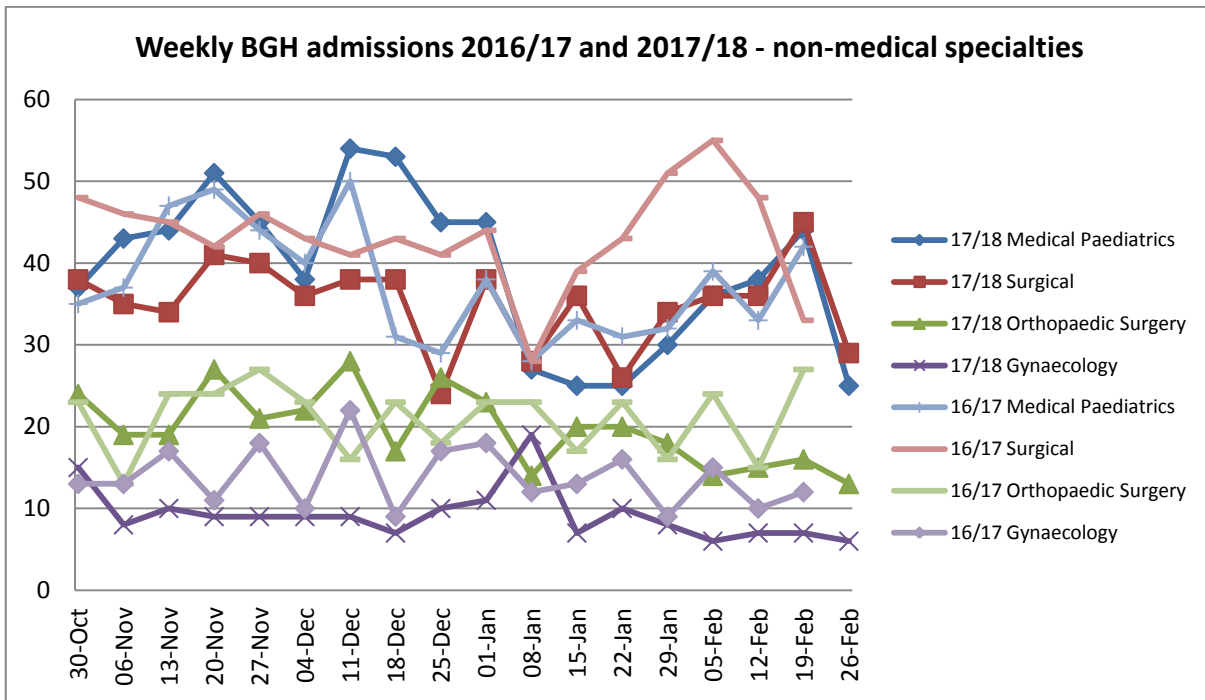
The top 50% of reasons for admission indicate that there was an increase in respiratory conditions. Data is not robust as 25% of all admissions were coded with non-specific indication of disease (codes Z0). Admissions for respiratory related conditions – J codes plus R0 (Symptoms and signs involving the circulatory and respiratory systems) – represented 18.2% of admissions in 2016/17 and 16.4% of admissions in 2017/18. However, there were a higher number of admissions related to respiratory conditions in the three weeks from 10th December to 19th January this winter compared to last winter. This matches the data on hospital-confirmed cases of Flu which increased by 118% between weeks commencing 16th December and 19th January inclusive.

Table 8 Confirmed hospital flu cases from week commencing 16th December 2017 to week commencing 19th January 2018

	Week 51 – Week 4 (2016/17)	Week 51 – Week 4 (2017/18)
Flu A	68	134
Flu B	3	21
Total	71	155

Chart 2: Weekly admissions to Borders General Hospital





Length of Stay

Average length of stay for the BGH rose over the period Nov – Feb compared to last winter, with an overall average length of stay of 4.7 days, compared to 4.3 days last year. The average LoS for General Medicine was 4.2 days compared to 4.15 days the previous winter (and 3.48 days for the period June-Oct 2017). There was a peak in increase in length of stay during January of both years.

Chart 3: BGH Length of Stay

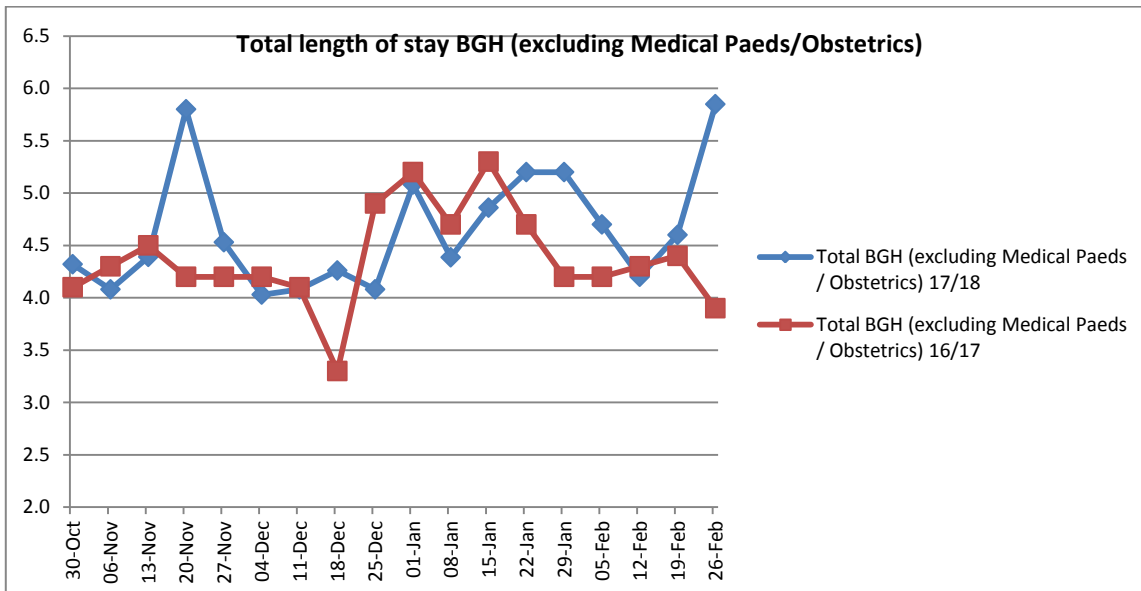


Table 9: BGH Length of Stay

Week Beginning	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb	
2017/18																			
General Medicine	4.1	3.4	3.8	6.2	5.0	3.6	3.7	3.9	3.7	4.3	3.8	5.0	4.6	4.1	4.2	2.4	4.4	5.5	
Elderly Medicine	18.1	20.1	25.6	34.7	13.9	21.6	14.7	22.2	14.7	18.0	12.7	15.6	14.0	23.3	15.7	29.5	18.7	23.6	
General Surgery	2.3	2.6	2.6	2.7	2.1	2.3	2.4	2.6	2.4	2.9	2.7	2.0	3.0	3.9	2.6	2.4	3.1	3.7	
Ortho	3.3	2.6	3.6	4.0	3.2	3.5	3.2	3.8	3.2	5.5	8.4	3.6	8.4	6.8	5.8	3.8	3.3	5.0	
AllSpecialties	4.3	4.1	4.4	5.8	4.5	4.0	4.1	4.3	4.1	5.1	4.4	4.9	5.2	5.2	4.7	4.2	4.6	5.8	
2016/17																			
General Medicine	4.1	5.2	5.3	4.3	3.9	4.9	4.6	3.5	5.5	5.4	4.4	4.5	4.3	3.8	4.1	3.6	4.1	3.5	
Elderly Medicine	17.5	16.6	22.4	20.7	15.7	15.3	18.3	9.6	26.3	16.2	13.3	30.8	20.8	14.3	17.6	14.5	26.3	18.6	
General Surgery	2.3	2.2	2.5	2.6	2.4	2	3	1.6	2.2	2.6	3	2.5	2.9	2.5	2.1	2.7	2.3	2.3	
Orthopaedics	4.2	4	3.3	2.8	4.3	2.9	2.8	2.7	3.1	4.8	8.1	7.5	4	4.8	5.1	3.6	2.9	3	
AllSpecialties	4.1	4.3	4.5	4.2	4.2	4.2	4.1	3.3	4.9	5.2	4.7	5.3	4.7	4.2	4.2	4.3	4.4	3.9	

Bed capacity

The Winter Plan aimed to establish 14 surge beds within the BGH, together with 13-18 surge beds in Community Hospitals. It also planned to establish a total of 18 social care step down beds. This was a total of 54 beds.

In fact, 44 additional beds were opened as surge capacity in the following configuration;

- 10 of the surge beds within BGH were already open at the commencement of the Winter period. The remaining beds in Ward 16 were opened at the end of November when the Surgical Assessment Unit closed.
- 9 additional community hospital beds were opened – 1 in Hawick, 2 in Knoll and 6 in Haylodge, although only 2 of these were available before the end of January.
- 21 social care step-down beds, including the 6 additional beds in Waverley, Transitional Care facility and 17 beds within Craw Wood Discharge to Assess facility, with 7 of these beds opening in early January. A further 8 beds were identified within Craw Wood but had not opened by the end of February.

Due to demand on beds, additional beds were opened in interim accommodation:

- The Planned Surgical Assessment Unit was used for inpatients on 28 days during this period. This compares to 17 days in 16/17 but 56 days in 15/16.
- the Acute Assessment Unit was used for inpatients on 38 days during this period compared to 7 days the previous year

As a result, these areas ceased to provide their core function, resulting in elective cancellations and the diversion of acute medical attendances to the Emergency Department.

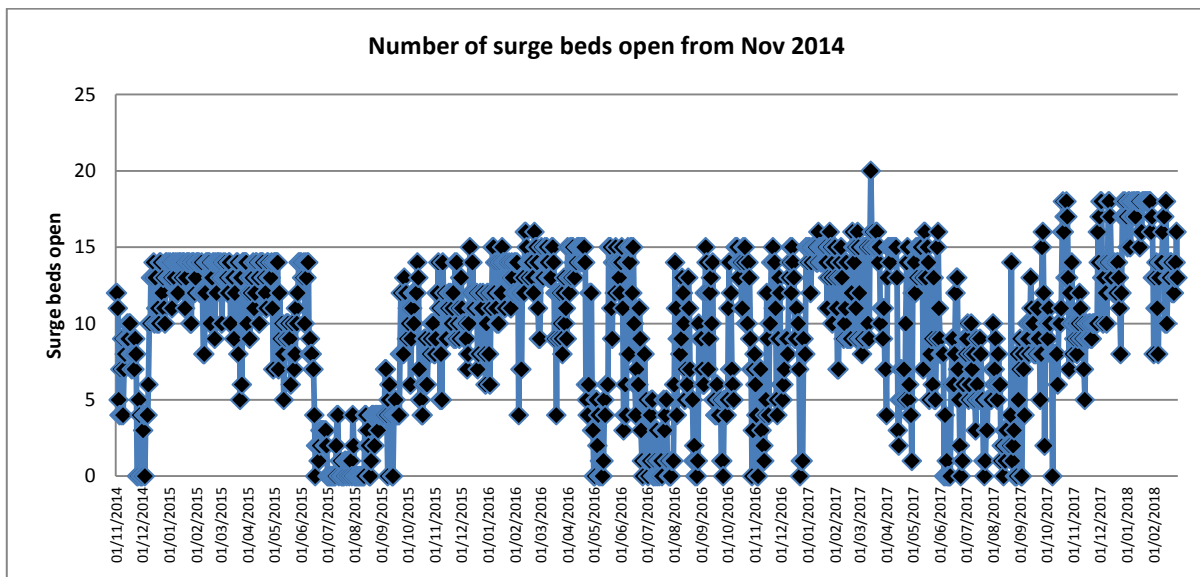
There were a further 58 patients who were held overnight for longer than 8 hours in the Emergency Department on 16 occasions during this period of which 16 were discharged from ED the next day. These patients will not be counted within the occupied bed numbers.

On average, 15 BGH surge beds were used each day this period, compared to an average 12 last year.

Table 10: BGH Surge Beds

	2015/16				2017/18			
	Nov- 15	Dec- 15	Jan- 16	Feb- 16	Nov- 16	Dec- 16	Jan- 18	Feb- 18
Beddays	319	294	476	495	196	243	564	308
Average beds open	10.6	9.5	15.4	22.5	6.5	7.8	18.2	22.6

Chart 4: BGH surge beds

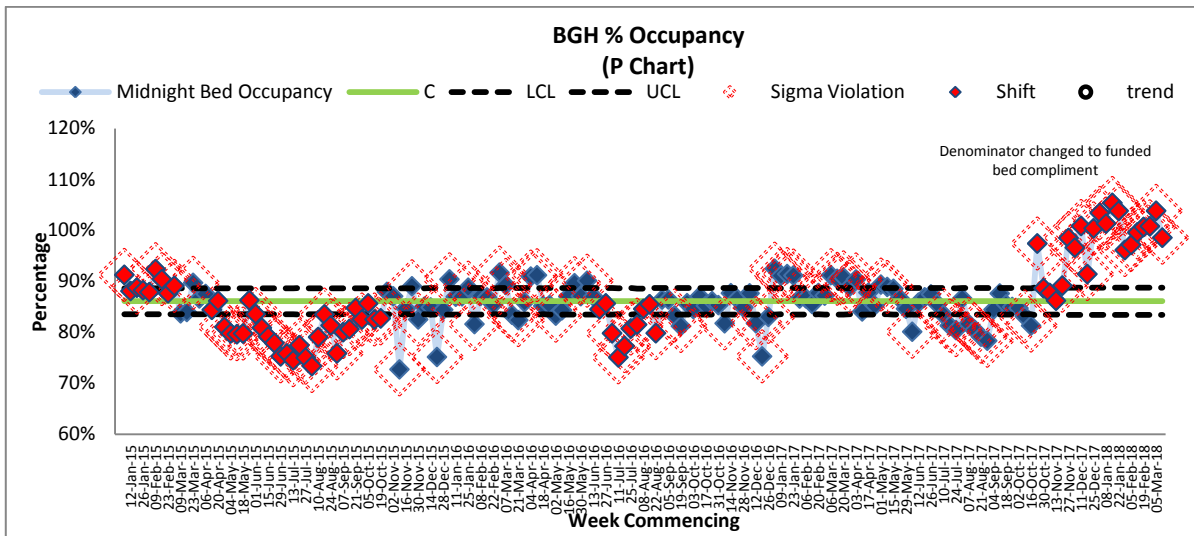


Bed occupancy

Calculations for bed occupancy were changed in early November. Previous occupancy had been based on total number of beds occupied at midnight. The new occupancy rate is based on total beds occupied as a percentage of the core bed establishment. As a result, bed occupancy can now exceed 100%. This means that comparisons with previous years are not possible.

Bed occupancy ran at 99.92% of core bed numbers throughout the winter period and exceeded 100% of core bed complement during 9 of the 16 weeks. Community Hospital bed occupancy ran at an average 102.17% against core bed capacity with 13 weeks when occupancy was over 100%.

Chart 5: BGH Percentage Occupancy



Boarding

There was a 65% increase in the number of patients boarded to wards outwith their speciality during this period compared to last winter. The vast majority of boarders were medical. Boarding included patients moved to additional bed capacity in PSAU.

Boarding numbers rose from an average 14 per day last winter to an average 24 per day this winter. Boarding numbers increased above 30 boarders per day for 38 days from 25th December onwards and remained above this level for all but one week in this period. There was a peak of 48 during New Year week.

In order to manage the extra number of medical patients, additional junior doctors and consultants were rostered from January onwards.

NB: the boarding data source changed in Nov 17. This may affect comparisons with previous data.

Chart 6: Patient Boarding

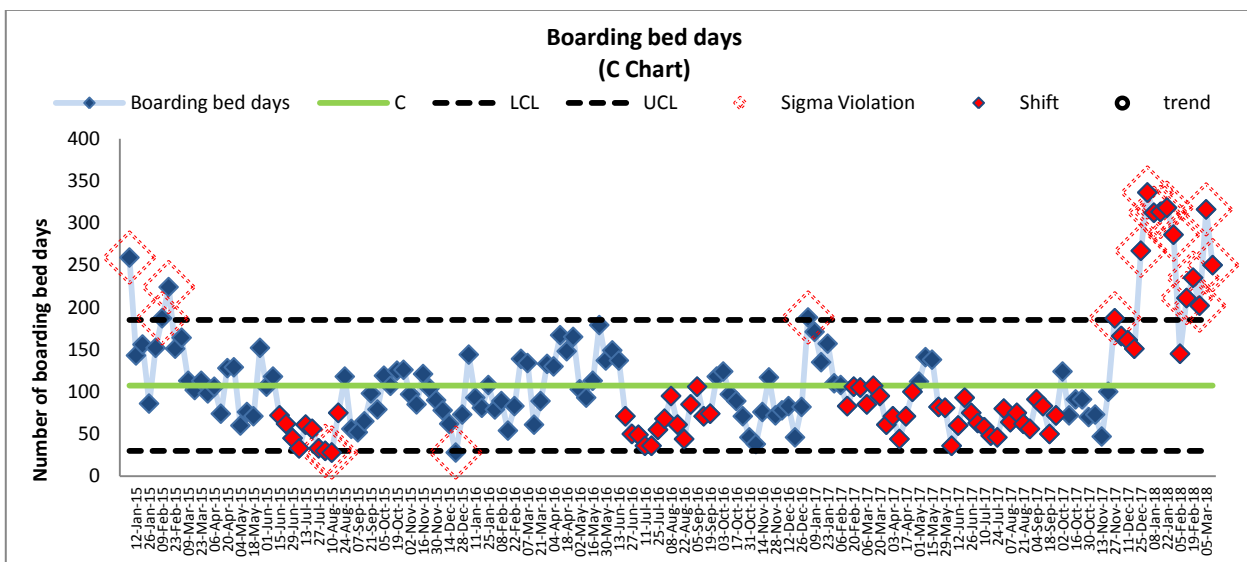


Table 11: Weekly Boarding Beddays

Week starting	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
17/18	70	73	47	100	187	166	161	151	267	336	312	313	318	286	145	211	235	202
16/17	46	38	76	117	72	78	83	46	82	188	171	135	157	110	108	83	106	105

Discharges

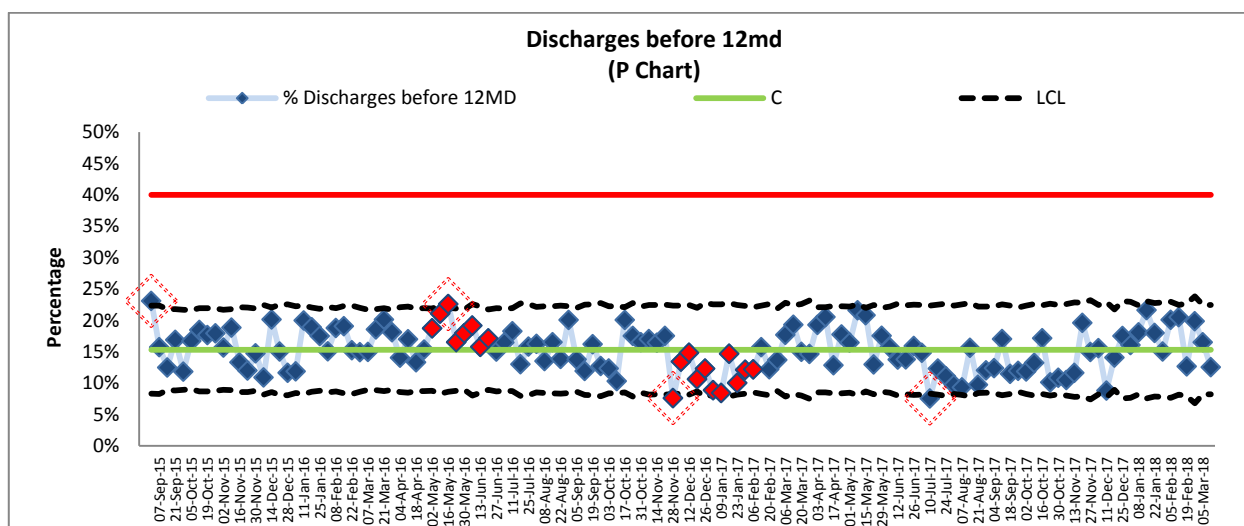
The Winter Plan set out to;

- Increase number of morning discharges to 40%
- Increase the number of weekend discharges by 25%
- Reduce delayed discharges to 10

Morning discharges

Morning Discharges increased from 13% to 15.6% against a target of 40%.

Chart 7: Morning discharges

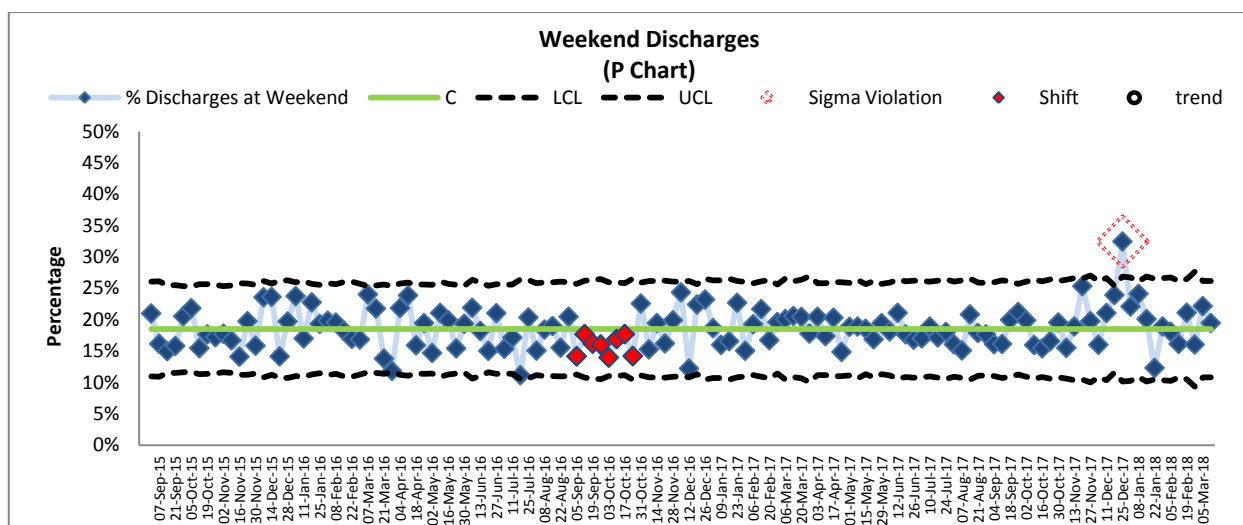


Weekend discharges

Weekend discharges increased slightly from 19% to 20.3% against a target of 28%. There was a peak of weekend discharges around the festive period (similar to last year).

From the festive period to the end of February, weekend staffing was increased to include 7-day cover from the Rapid Assessment and Discharge Team. Pharmacy was open on Sunday as well as Saturday during January, but there was low utilisation of this service.

Chart 8: Weekend Discharges



Community Hospitals

Average length of stay in Community Hospitals rose from 31.33 days last winter to an average 34.06 days this winter

An additional 9 beds were opened in Community Hospitals above core capacity to accommodate additional patient demand. Community Hospital bed occupancy ran above 100% of core capacity for the majority of this period. 83% of admissions into Community Hospitals were transfers from the BGH.

Table 12: Community Hospital LOS

	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
Hawick	53.7	26.7	22.4	30.6	25.8	30.8	21.6	11.8	37.8	51.0	23.0	80.0	16.6	23.3	17.6	21.3	37.5	29.8
Haylo dge	35.0	159.0	39.0	31.0	39.0	30.2	38.8	25.3	38.8	51.7	27.3	23.4	26.3	54.0	47.0	188.0	35.2	-
Kelso	15.4	36.5	20.4	36.8	36.3	35.8	48.3	22.4	145.0	49.0	32.6	160.0	26.5	31.8	22.6	40.0	80.5	160.0
Knoll	33.0	33.8	33.8	167.0	28.0	158.0	29.4	17.4	29.4	27.8	24.6	28.2	28.7	18.8	86.5	58.0	34.4	173.0
Total	28.8	39.6	27.2	41.5	31.2	40.4	31.5	17.9	42.7	41.5	26.4	40.8	23.6	27.4	31.4	44.7	41.2	94.9

Delayed Discharges

The winter plan focused on developing alternatives to hospital care for patients who required ongoing care. Additional measures put in place included;

- Opening of Craw Wood as a Discharge to Assess facility in December 2017 with a further 7 beds opening in January 18
- Expansion of the transitional care beds in Waverley Care Home in August 2017
- Development of a rapid access homecare team in Berwickshire and a Hospital to Home care team in Teviot.

There was an overall 39% increase in delayed discharge occupied beddays during this winter compared to the previous winter, with the numbers of delayed discharges falling sharply from January onwards. The decrease in delayed discharge numbers was in patients awaiting homecare and residential care. This reflects the opening of the additional

Craw Wood beds at the beginning of January and an improvement in availability of carers in some areas of the Borders. The numbers waiting nursing home care remained unchanged.

The time taken to establish the new alternatives to hospital meant that only Craw Wood impacted on numbers of delayed discharge and this did not come into effect fully until January. The new care models were not operational during this period.

Table 13: Delayed Discharges

	30-Oct	06-Nov	13-Nov	20-Nov	27-Nov	04-Dec	11-Dec	18-Dec	25-Dec	01-Jan	08-Jan	15-Jan	22-Jan	29-Jan	05-Feb	12-Feb	19-Feb	26-Feb
Number of Delayed Discharges on Sunday	43	45	46	54	51	51	50	42	40	39	36	47	34	36	34	47	34	36
DD Occupied Bed Days (includes OBDS discharges) for week	300	291	329	385	370	367	357	327	282	294	287	311	290	286	250	311	290	286

Table 14: Delayed Discharges by reason

Monthly Delayed Discharge Cases				
Reason for Delay	Nov-17	Dec-17	Jan-18	Feb-18
Regular Cases				
11A Community Care Assessment - awaiting commencement	1	1	0	0
11B Community Care Assessment - awaiting completion	2	9	7	4
24B Community Care Arrangements - Place Availability Residential Home	13	13	12	6
24C Community Care Arrangements - Place Availability Nursing Home (non NHS funded)	11	8	6	7
24F Community Care Arrangements - Place Availability EMI/Dementia in Care Home	6	5	8	6
25D Community Care Arrangements - Care Arrangements own home - social support	30	26	26	15
25E Community Care Arrangements - Care Arrangements own home - procurement/ delivery of equipment	1	0	1	0
25F Community Care Arrangements - Care Arrangements Specialist Housing provision (inc sheltered housing)	2	1	2	0
51 Patient/Carer/Family-related reasons - Legal/Financial	1	1	2	2
67 Patient/Carer/Family-related reasons - Disagreements	2	2	2	2
74 Patient/Carer/Family-related reasons - Other	0	0	1	1
Total	69	66	67	43
Complex Cases				
25X Complex case arrangements in order to live in own home		1		
51X Patient/Carer/Family-related reasons - Legal/Financial Adults with incapacity act	15	14	9	9
71X Patient/Carer/Family-related reasons - Other Interim move under the choice of accommodation	2			
Total	17	15	9	9
Total Delayed Discharges	86	81	76	52
Source: EDISON				

Elective operating

A key feature of the Winter Plan was to maintain elective operating without disruption due to unscheduled pressures. In order to achieve this, it was agreed to ring-fence a reduced number of elective beds and to reduce inpatient operating during the first 3 weeks in January, increasing daycase surgery instead.

In fact, the pressures on the acute hospital during January meant that we were unable to maintain elective inpatient operating from 27th December as the elective beds were required to accommodate unscheduled patients. Although 1 elective bay was established on occasions during this period, we were unable to re-establish full elective inpatient capacity throughout the winter period. The Planned Surgical Admissions Unit was also converted at short notice into an inpatient area on two occasions in January for a total period of 28 days, requiring all daycase surgery to operate through the Day Procedure Unit.

Bed pressures also resulted in patients being delayed in leaving ITU. This led to a number of cancellations of urgent cancer and other patients requiring post-operative ITU care. All urgent patients were rescheduled for operation within 2 weeks of original date.

As a result, cancellations due to hospital-related reasons increased by 26% compared to last year. Cancellations data refers to procedures cancelled within 48 hours of planned date.

Total procedures undertaken during this winter fell by 8% from 1457 last winter to 1336 this winter.

Patients exceeding the 12-week Treatment Time Guarantee also increased from 63 to 254 patients between November and February.

Table 15: Cancellations of Elective Procedures

2015/16				2016/17				2017/18			
Nov-15	Dec-15	Jan-16	Feb-16	Nov-16	Dec-16	Jan-17	Feb-17	Nov-17	Dec-17	Jan-18	Feb-18
51	36	59	49	44	30	60	30	33	51	67	56

Sickness

Sickness absence over the winter period was higher than for the remainder of the year and 6% higher compared to the same period last year. There was a spike in absences due to cold, cough flu in January 2018.

Chart 9: Sickness Absence Rates

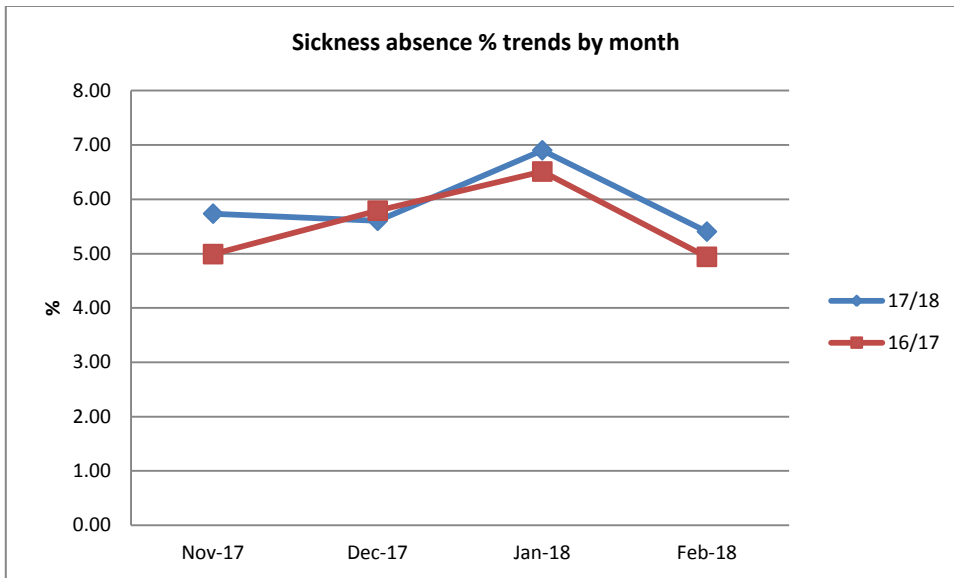
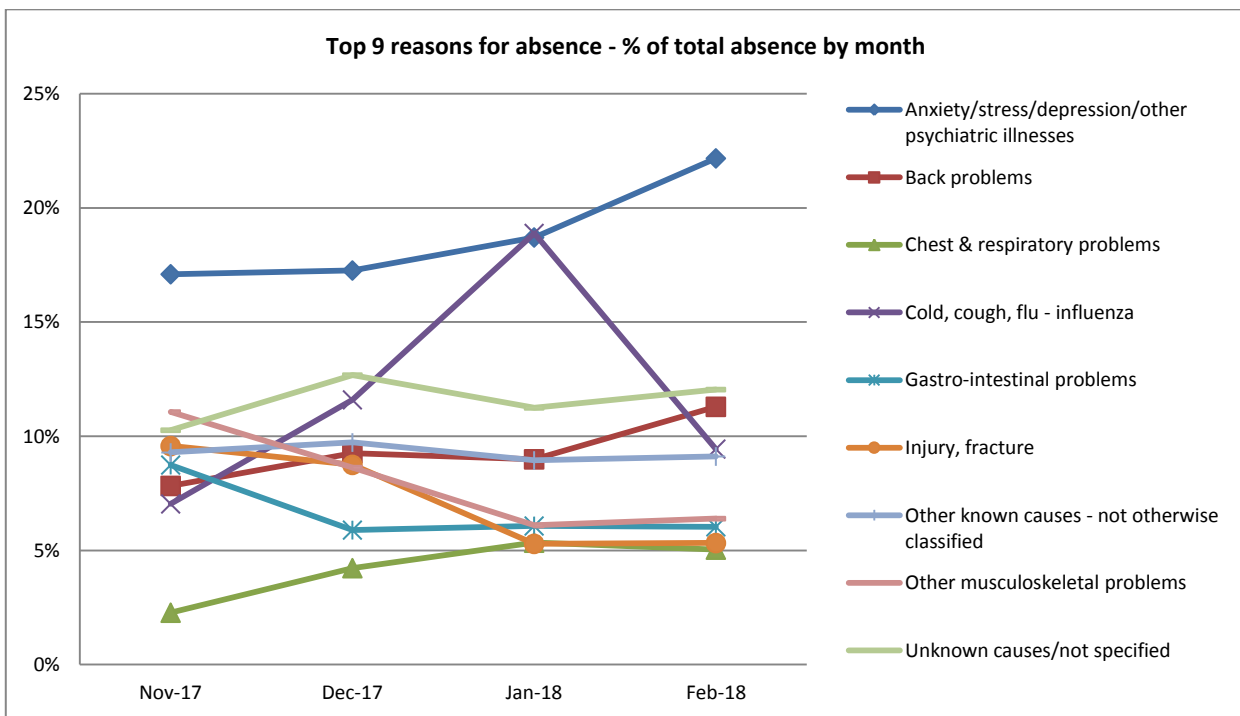


Chart 10: Reasons for absence by month



Outbreaks

The impact of flu on the availability of beds within BGH and Community Hospitals was low and less than last year. However, there was a big increase in the number of beds closed to admissions due to norovirus this winter compared to last winter, but a similar number to the previous year.

This had some impact on the management of patient flow, particularly in November 2017.

Table 17: Blocked Bed Days due to outbreaks

		Nov 13 - Feb 14	Nov 14 – Feb 15	Nov 15 – Feb 16	Nov 16 – Feb 17	Nov 17 - Feb 18
Flu	Blocked Beds	0	135	30	70	44
	Blocked Empty Beds	0	39	2	3	0
D&V	Blocked Beds	1492	60	342	66	308
	Blocked Empty Beds	246	12	67	6	46
Total	Blocked Beds	1492	195	372	136	352
	Blocked Empty Beds	246	51	69	9	46

Overall Assessment

A Winter Plan debrief was held on 14th March 2018 to consider lessons learned and develop recommendations for future planning.

The conclusions drawn from this debrief and the information contained in this report are;

- Develop a Winter Plan based on tried and tested measures.
 - a) There are a range of actions that are taken each winter to manage winter pressures (eg, additional front door staffing, proactive recruitment, festive period staffing). The data suggests that these measures worked well and these should form the basis of a standard winter planning framework.

There are a number of areas where interim or short-term measures are put in place to improve patient flow over the winter period (e.g. weekend RAD and AHP services, weekend social work, additional clinical staffing). These are seen as effective but their short-term nature and the lack of identified funding to establish them make them problematic to staff and sustain. Service feedback suggests that these could have been more effective if they were commissioned early as part of the routine planning for winter.

- Establish shared ownership of the Winter Plan. The Winter Plan has largely been developed from within NHS and predominantly focused on managing hospital flow. A positive feature of this winter period was the joint ownership of patient flow and discharge management. However, joint working was managed on an ad-hoc and informal basis and opportunities for communication and cross-agency support could have been improved.
- Deliver transformational change separately from the Winter Plan. This year, as in previous years, the winter plan has been used as a driver to develop new models of care provision. The debrief session identified a number of other areas where new ways of working may reduce inpatient demand and keep people at home. These are important initiatives that should be progressed in a robust and managed way. However, relying on these new projects to address activity demand for winter results in individual projects being progressed at too rapid a rate and, if they do not deliver, there is inadequate alternative provision within the Winter Plan to manage activity.

- Ensure that the Winter Plan is realistic. Winter Planning needs to build in sufficient buffer capacity to ensure effective unscheduled patient flow and to maintain ring-fenced elective capacity. There were insufficient acute medical beds during this winter and the boarding of patients to other wards was both operationally challenging and introduced delays in discharges. The additional capacity needs to be available in the right places: these are likely to be additional acute medical beds, the maintenance of elective working through ring-fenced beds and access to social care beds that can accommodate patients waiting for nursing homes as well as those completing assessment for home.

Recommendations for Future Winter Planning:

Detailed recommendations will be published in due course and included in the planning for next winter. However, the key recommendations from the evaluation of this year's winter plan are;

1. Establish a core Winter Plan based on predicted pressures and tested actions. These should include;
 - a. The implementation of the set of agreed actions that are taken each winter to manage winter pressures.
 - b. The establishment of sufficient surge capacity to maintain smooth and effective patient flow. Consideration should be given to identifying additional appropriately staffed medical inpatient capacity
 - c. The Winter Planning Group should be re-established with clear remits for delivering on each of the workstrands within the Winter Plan and an organisational commitment to support the Group
 - d. Winter Planning should be carried out over a 2-3 year period. This would ensure that plans are in place early enough to be implemented in time, and would help identify both the timescales for changes that will shift the balance of care and the interim measures that need to be put in place to maintain services until this happens.
2. Funding should be allocated formally to the Winter Plan to allow services to plan early to recruit and support additional activity
3. A more formal joint operational management process should be established to ensure that all agencies are aware of the challenges faced across the patient pathway and to enable rapid and consistent management of pressures
4. Transformational service redesign projects should be managed through a separate mechanism and work to appropriate timescales, rather than winter timescales. The impact of these redesign projects should not be incorporated into winter planning until they are fully implemented and sustained.

Staff and services across health and social care worked extremely hard and very effectively to maintain high quality and person-centred care for patients and clients whilst dealing with the challenges of a very difficult winter. However, the need to develop contingency plans rapidly and late in the day meant that patient experience was not as good as it could have been, that staff were put under great pressure to make changes and that planned activity was disrupted. The experience from this winter is that early investment and action to establish the appropriate services would have made the delivery of care much more effective, improved patient experience and have avoided the expense of rapid and short-term operational decision-making.