Borders NHS Board

NHS BORDERS 2017/18 FESTIVE PERIOD REPORT

Aim

To update the Board on performance over the festive period only: 15th December 2017 until 2nd January 2018. This period was 19 days long with 3 weekends, which is the same as covered last year, 16th December 2016 until 3rd January 2017, making the periods comparative.

Background

NHS Borders like all Health Boards are 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. This year the plan was developed jointly with the Scottish Borders Health and Social Care partnership as a whole system plan. The 2017/18 plan was discussed at both the Health Board and Integrated Joint Board and subsequently approved at the 26th October 2017 NHS Borders Board meeting.

After each winter period the Winter Planning Board convenes to assess what worked well, what could have been improved, the learning from the period, and key recommendations are taken forward in preparation for the next winter period. A full report on the winter period will come to the Board in April 2018.

Executive Summary

The 2017/18 Festive Period was the most challenging period for 3 years, with performance against the Emergency Access Standard of 89.9% dropping below 95% for the first time since 2014/15.

There appear to be three main reasons for the pressures experienced in NHS Borders:

1. Acuity of patients. There was a large increase in people with medical conditions attending primary care out of hours (12%) and the Emergency Department/Acute Assessment Unit (13.5%). Indications are that a significant element of this increased acuity was related to an increase in respiratory conditions, with a 60% increase in respiratory-related consultations at BECS and 24% in ED. In spite of this, emergency admissions reduced by 7.3%, indicating that arrangements to avoid admissions were successful. However, as a result, patients admitted to hospital appeared to be more acutely unwell than in previous years, with length of stay increasing by 9.3%, equivalent to an additional 23 beds over the period compared to the previous year.

2. Low discharge rates over Christmas period. The hospital system was placed under greater pressure early in the festive period compared to previous years. Discharges

in the period immediately around Christmas (24th-26th December) fell by 42% compared to last year. As a result, 36 more patients were admitted than discharged; compared to 8 more last year.

3. Delayed Discharge numbers. There was a 30% increase in delayed discharges compared to last year. Mental Health delayed days reduced by 57%, Community Hospital delayed days increased by 15% and BGH delayed days increased by 201%. Although allowance was made within the plans for up to 34 additional beds to replace beds unavailable due to delayed discharges, the numbers increased more rapidly than expected. As a result, a peak of 42 beds were occupied by people delayed in their discharge over this period (10 more beds in the BGH and 3 more in community hospitals than last year), reducing the numbers of beds available to admit patients.

The effect of these pressures was to place significant pressure on health and social care services.

- BECS experienced particularly high demand over the New Year period (12% increase) and as a result 4-hour performance fell from 90% to 88%. However, staffing plans coped well with this increased demand.
- The Emergency Department experienced the highest number of breaches of the Emergency Access Standard for 4 years, with 37 patients waiting over 8 hours and 19 patients waiting overnight for greater than 12 hours in the department due to a lack of beds to admit to (compared to 0 last year). There were further increases in breaches waiting first medical assessment because the department had no space to see other patients. Despite these pressures, the average time from arrival to triage increased by just 8 minutes and the average time to medical review by 23 minutes. Planned additional medical and nursing staffing again worked well.
- Activity to avoid admission appeared to be effective. The percentage of patients admitted from ED fell from 32.4% to 31.5% and the number of patients managed through the ambulatory care urgent outpatient and treatment service increased by 44%.
- An additional 15 beds were opened to accommodate patient admissions, impacting on the maintenance of normal services, including the loss of the Acute Assessment Unit (for 7 days), with all A&E attendances going through the Emergency Department, and the loss of the Planned Surgical Assessment Unit (3 days), with a subsequent knock-on cancellation of day case procedures. Although the Winter Plan identified these two areas as contingency beds, the Plan was designed to avoid their use except in extreme situations due to their impact on services.
- During the New Year public holiday period, as last year, additional nurse specialist, AHP, diagnostic services and social work staff were on duty. There was an increase in numbers and range of specialties available to support patient review and discharge. However, as the Winter Plan did not clarify the level of clinical support services required over the festive period, service provision was based on availability of staff rather than service need. Earlier planning for next year would be beneficial.
- Early and relentless nurse recruitment and the plans for additional staffing across wards and hospitals helped ensure availability of staff – there were 18wte vacancies this festive period compared to 21 vacancies in December last year. However, staff sickness and the need to open additional beds meant that there was an increase in agency hours over the period from 274.75 to 311 hours.
- Additional medical staff were rostered, including an additional consultant to review boarders, meaning that all boarded patients were reviewed daily.

- The Winter Plan aimed to maintain access to care homes and home care provision over the festive period, including during public holidays and weekends. There was social work availability over weekends and public holidays, and access for transfers to Craw Wood and Waverley step down facilities during this period, which was not available last year. However, access to mainstream homecare and care homes places was not available at all during the public holidays or weekends. There should be earlier planning to contract with care providers to ensure both capacity and access to services.
- Despite a planned reduction in elective activity and a switch to day surgery to reduce demand for inpatient beds, there was an increase from 2.7% to 17.9% in hospital-related cancellations. This was due to availability of beds.

There was close working between health and social care in the two months leading up to the Festive Period and a range of measures to reduce the number of delayed discharges, including new step-down beds and additional intermediate care beds. However, actions to support social care capacity over the festive period, including the block-booking of care home capacity and the establishment of additional specialist dementia care beds, as well as arrangements for social care services to be operational over the public holidays were not in place for this festive period.

BECS Activity Summary

The 2017-18 Festive Period for BECS showed a 12% increase in volumes of patient care episodes compared to last year, with a total of 1589 patient contacts (+12.0% variance from last year), 372 telephone advice contacts (-6.3%), 715 patient attendances (+9.8%) and 502 home visits (+35.3%).

Table 1: BECS Activity Summary

Year	Telephone Advice Provided			Attendances			Visits			Total		
2012/13	293			763			432			1488		
2013/14	321	(+ 28)	+9.6%	559	(-204)	–26.7%	313	(-119)	–27.5%	1193	(-295)	-19.8%
2014/15	429	(+108)	+33.6%	650	(+91)	+16.3%	411	(+98)	+31.3%	1490	(+297)	+24.9%
2015/16	334	(-95)	–22.1%	620	(-30)	–4.6%	363	(-48)	-11.6%	1346	(-144)	-9.6%
2016/17	397	(+63)	+18.9%	651	(+31)	+5%	371	(+8)	+2.2%	1419	(+73)	+5.4%
2017/18	372	(-25)	-6.3%	715	(+64)	+9.8%	502	(+131)	+35.3%	1589	(+170)	+12.0%

*Variance from previous year

85.4% (-4.2%) of patients requiring a face to face consultation within the Primary Care Emergency Centre at Borders General Hospital were seen within the timeframe advised from NHS24 triage (includes patient travel time into BGH). 36.1% of patients seen were children.

However only 64.1% (-12.4%) of patients requiring a home visit were seen within their designated triage times. This unfortunately sees a deterioration in performance against last year, almost certainly due to increased volumes. The wide geographical spread of home visits (Central 32.5%, South 20.9%, West 14.5%, East 29.1%) always presents a challenge, especially in bad/snowy weather.

Performance data against time priorities set by NHS24 is shown below:

Attends:

Year	1 hour		2 hour		4 hour		Total	
2015/16	39.1%		69.1%		93.2%		88.4%	
2016/17	35.7%	-3.4%	64.6%	-4.5%	92.7%	-0.5%	89.6%	+1.2%
2017/18	50.0%	+14.3%	61.5%	-3.1%	94.3%	+1.6%	85.4%	-4.2%

Home visits:

Year	1 hour		2 hour		4 hour		Total	
2015/16	55.6%		82.7%		94.7%		80.7%	
2016/17	65.4%	+9.8%	65.6%	-17.1%	87.2%	-7.5%	76.5%	-4.2%
2017/18	27.1%	-38.3%	65.4%	-0.2%	82.4%	-4.8%	64.1%	-12.4%

*Variance from previous year

It should be noted that timeframes for assessment are set by NHS24 triage, and the clock starts running from that point. So, for example, a 2-hour urgent priority call would require the patient to travel in to BGH (from wherever they live in the Borders) and have been seen by a BECS doctor within that time frame.

The service provided 131 more home visits (+35.3%) than during the same Festive period last year, probably as a result of large numbers of elderly patients presenting with flu-like respiratory illness. In addition, unforeseen driver shortages and staff illness meant that there were several key shifts (including one on Christmas Day) when only one or two vehicles were able to go out to do visits instead of the usual three and this will have impacted on waiting times for visits. 1-hour visits to the periphery of our area (e.g. Eyemouth, Newcastleton, West Linton) are always a challenge even in the best circumstances.

It is likely that the overall reduced performance against time priorities, compared to last year, is a direct consequence of the 12% increased overall service activity. Detailed festive planning meant that the service entered the festive period with full staffing, with additional clinician resource for the predicted busiest days, but unfortunately these assumptions were made on the basis of NHS24 predicted activity figures, and these have subsequently shown to have significantly underestimated demand, by as much as 60% during the two long festive 4-day weekends. In response to the Christmas pressures we added additional clinician shifts for the New Year, to improve resilience that weekend.

BECS performance can also be measured against its impact on secondary care services i.e. admission rate which includes referrals to 999, ED and secondary care specialities (-3.3% variance from last year), and its impact on primary care i.e. number of patients referred back to their own GP to contact for subsequent review (-3.5%). BECS also supports the front door of the hospital and relieves pressures on the Emergency Department by accepting appropriate walk-ins (+4.5%). At time of writing there have been no patient complaints and only one adverse event (relating to staff absence due to illness) recorded by Datix for this period.

BECS impact on other services:

Year	Refer to 999/ED/speciality			Own GP to contact patient for review		
2015/16	202			74		
2016/17	216	(+14)	+0.2%	57	(-17)	-1.5%
2017/18	189	(-27)	-3.3%	24	(-33)	-3.5%

*Variance from previous year

Top 10 conditions seen:

	2017/18		2016/17		2015/16	
1	Lower respiratory tract infection	205	Lower respiratory tract infection	152	Urinary tract infection	120
2	Urinary tract infection	146	Urinary tract infection	119	Upper respiratory tract infection	84
3	Upper respiratory tract infection	112	Upper respiratory tract infection	72	Lower respiratory tract infection	76
4	Skin infection	55	Medication requested	52	Abdominal pain	56
5	Palliative care	55	Palliative care	49	Skin infection	55
6	Vomiting	53	Abdominal pain	48	Palliative care	44
7	Medication requested	52	Attention to urinary catheter	45	Medication requested	42
8	Abdominal pain	49	Skin infection	39	Advice about treatment given	35
9	Advice about treatment given	47	Sepsis	37	Acute tonsillitis	33
10	Flu-like illness	40	Advice about treatment given	36	Sepsis	32

Emergency Department (ED) and Acute Assessment Unit (AAU) Activity Summary

Attendances at the Emergency Department and Acute Assessment Unit over the festive period rose by 13.5% (202) this period compared to last year (Table 1). This comprised an increase in Flow 1 (minor injuries and illness) patients this year of 9.9% (76), and a combined increase in Flow 2 & 3 attendances (i.e. mostly people with significant medical illness) compared to last year of 32.6%. Flow 2 (acute assessment) attendances increased by 49.1% (86) and Flow 3 (medical admissions) by 23.3% (73). There was a fall in Flow 4 (Surgical Admissions). This suggests a large increase in medically unwell patients attending ED and AAU this year, compared to last year. There were 185 more breaches in ED this year compared to last year (Table 5). As a result, performance against Emergency Access Standard dipped well below the national standard of 95% (Table 6). Combined AAU and ED performance over this period was 89.9% compared to 96.3% last year.

Although there were increases in most categories of breaches, 78% of the rise in breaches was related to significantly increased numbers of breaches due to bed availability (139 (55%) of all breaches) and an increase of 43 cases of breaches related to delays in assessment in ED. A major contributory factor to breaches related to delays in assessment was capacity within ED to review patients.

Throughout this period, there was close to attention to ensuring that patient in ED were assessed and appropriately treated in a timely fashion. Average time to triage, which is the initial point of review by a clinician, increased by just 8 minutes from 12 minutes to 20 minutes, and the maximum wait to triage was 224 minutes. Average time to first medical assessment increased by 18 minutes from 62 minutes to 80 minutes. Total average wait from arrival to discharge increased from 141 to 164 minutes. The largest proportion (44%)

of breaches due to wait for first assessment were for Flow 1 patients (i.e. patients with minor injury or illness). All patients waiting more than 8 hours were nursed on beds, where appropriate and additional nursing was provided to ensure appropriate nursing care was provided for patients waiting to access beds within the hospital.

AAU activity fell by 16% (Table 5). This reflects the fact that the Acute Assessment Unit was bedded and therefore not functional for 7 of the 18 days during this period.

Table 2: ED and AAU Total Attendances

Year	Total Attendance		Total Breaches		Weekend Attendance[2]		Weekend Breaches[2]		Public Holiday Attendance		Public Holiday Breaches	
2015/16	1,444		60		512		14		325		10	
2016/17	1,496	(+52) 3.6%	68	(+8) 13.3%	444	(-68) -13.3%	19	(+5) 35.7%	374	(+49) 15.1%	26	(+16) 160.0%
2017/18	1,698	(+202) 13.5%	253	(+185) 272.1%	542	(+98) 22.1%	61	(+42) 221.1%	372	(-2) -0.5%	62	(+36) 138.5%

*Figures in grey show the variance from previous year
[1] Previously reported data to the board included dates out with the reporting period which have now been updated.
[2] Please note: Weekend figures have adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Chart 1: Total ED and AAU Attendances by Day in the Festive Period

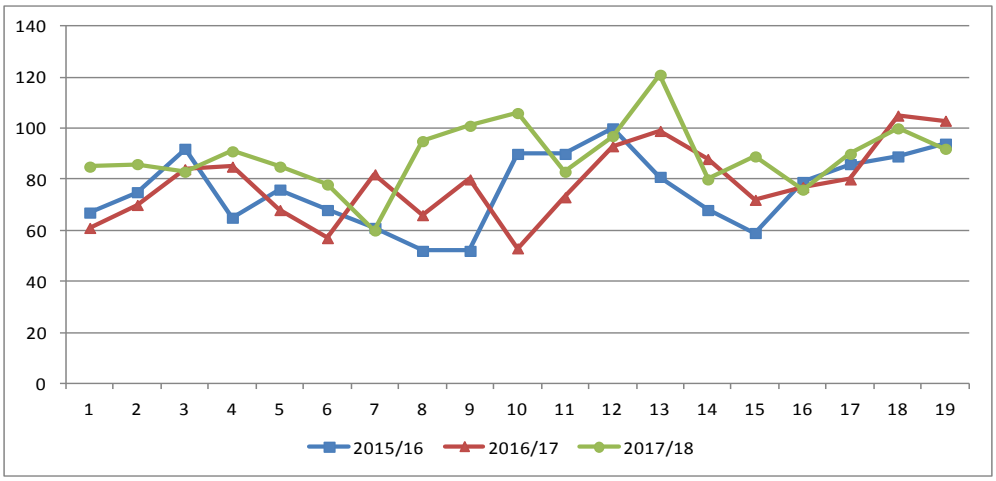


Table 3: ED and AAU Split of Total Attendances

Area	Total Attendance	Total Breaches	Weekend Attendance	Weekend Breaches	Public Holiday Attendance	Public Holiday Breaches
ED	1608	232	527	57	366	61
AAU	90	21	15	4	6	1
Total	1698	253	542	61	372	62

Table 4: ED Attendances by Flow

Patient Flow Description	Total Attendances			Percentage Difference on Previous Year	
	2015/16	2016/17	2017/18	2016/17	2017/18
Flow 1: Minor Injury & Illness	727	764	840	5.1%	9.9%
Flow 2: Acute assessment - includes major injuries	145	175	261	20.7%	49.1%
Flow 3: Medical Admissions	248	313	386	26.2%	23.3%
Flow 4: Surgical Admissions	136	137	121	0.7%	-11.7%
Total	**1256**	**1389**	**1608**	**10.6%**	**15.8%**

Table 5: Acute Assessment Unit Attendances

Year	Total Attendances		Weekend Attendances		Public Holiday Attendances	
2015/16	188		44		22	
2016/17	107	(-81) -43.1 %	18	(-26) -59.1%	18	(0) 0.0%
2017/18	90	(-17) -15.9%	15	(-3) -16.7%	6	(-6) - 54.5%

Table 6: ED and AAU Breaches by Reason for Wait Description

Breach Reason for Wait Description	2016/17	2017/18
Wait for bed	38	130
Wait for 1st ED Assessment	7	63
Other reason	3	17
Wait for Senior Review	6	4
Wait for treatment to end	1	6
Wait for transport	3	6
Clinical reason(s)	7	13
Wait for diagnostics test(s)	3	14
Total	**68**	**253**

There was an increase in overall number of breaches of the Emergency Access Standard in AAU of 1, from 20 to 21, over this period compared to last year.

Table 7: EAS Performance (ED and AAU)

Year	Total EAS Performance	Weekend EAS Performance[1]	Public Holiday EAS Performance
2012/13	94.3%	97.8%	97.2%
2013/14	98.8%	98.6%	99.9%
2014/15	88.1%	88.6%	92.9%
2015/16	97.1%	97.4%	97.7%
2016/17	96.3%	96.5%	94.4%
2017/18	89.9%	88.7%	83.3%

[1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Ambulatory Care Unit Summary

The Ambulatory Care service provides urgent outpatient access for people who do not require to be admitted but need to be seen or receive treatment urgently. The Ambulatory Care Unit relocated to a larger location during 2017. There were 140 attendances through the Ambulatory Care Unit during the festive period, (44% increase) with a 93% discharge rate. This compares to 97 patients attending Ambulatory Care in 2016/17 with a 91.8% discharge rate (Table 8).

The increased emphasis on the use of Ambulatory Care to avoid admission may partially explain why the increase in ED attendances did not translate to an increase in admissions. Further work is underway to confirm whether this was the case.

Table 8: Ambulatory Care Unit Attendances

Year	Total Attendances		Weekend Attendance		Public Holiday Attendance	
2015/16	81		14		14	
2016/17	97	(+16) 19.8%	17	(+3) 21.4%	20	(+6) 42.9%
2017/18	140	(+43) 44.3%	30	(+13) 76.5%	22	(+2) 10.0%

BGH Activity Summary

Total adult emergency admissions to the BGH decreased by 7.3% (44) compared to the previous year. Medical admissions remained unchanged (400 admissions in 16/17 and 403 admissions in 17/18). Emergency surgical admissions fell by 47% (205 in 16/17 and 158 in 17/18). Due to the short timescale to publication of this report, corrections and amendments to coding may cause these figures to change slightly.

Weekend admissions decreased by 10.1% (17 admissions). There was also a decrease in Public Holiday admissions of 13.8% (19).

The number of discharges decreased by 7.8% (45), compared to the previous year. However, weekend discharges increased by 22.9% (27). This is mainly due to the low number of discharges on Sundays last year, when both Christmas Day and New Years

Day fell on a Sunday. Public Holiday discharges decreased by 36.9 % (41) with an average of 19 discharges per day compared to a normal weekday discharge rate averaging 32 discharges.

There were 32 fewer emergency discharges than emergency admissions over this period, similar to the 2016/17 period where there were 31 fewer discharges. However, over the period 24th – 26th December, there was a mismatch between discharges and admissions totalling -37 (i.e. 37 more admissions than discharges) compared to a -8 mismatch in 2016. This mismatch has resulted in an ongoing deficit in admitting beds, leading to pressure across the BGH for the remaining festive period and beyond.

Patients' average length of stay for the festive period 2017/18 increased by 0.4 days to 4.7 days compared to 4.3 days last year, see Table 11 below.

There was a large increase in paediatric admissions of 42.9% (42) this festive period (Table 10), balanced by the same number of discharges. Paediatric average length of stay decreased for the festive period 2017/18 at 0.9 days (compared to 1.2 for 2016/17, see Table 11).

Table 9: BGH Adult Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2015/16	657		529		203		120		124		80	
2016/17	605	(-52) -7.9%	574	(+45) 8.5%	168	(-35) -17.2%	118	(-2) -1.7%	138	(+14) 11.3%	111	(+31) 38.8%
2017/18	561	(-44) -7.3%	529	(-45) -7.8%	151	(-17) -10.1%	145	(+27) 22.9%	119	(-19) -13.8%	70	(-41) -36.9%

* Figures in grey show the variance from previous year [1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Table 10: BGH Paediatric Emergency Admissions & Discharges

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2015/16	89		86		30		27		17		12	
2016/17	98	(+9) 10.1%	100	(+14) 16.3%	27	(-3) -10.0%	29	(+2) 7.4%	25	(+8) 47.1%	18	(+6) 50.0%
2017/18	140	(+42) 42.9%	140	(+40) 40.0%	41	(+14 51.9%	50	(+21) 72.4%	26	(+1) 4.0%	19	(+1) 5.6%

Table 11: BGH Length of Stay for Festive Period 2016/17 compared to 2017/18

Year	Adults				Paediatrics			
	Occupied Bed Days	ALoS (Days)	Occupied Bed Days Variance	ALoS Variance	Occupied Bed Days	ALoS (Days)	Occupied Bed Days Variance	ALoS Variance
2016/17	3657	4.3			123	1.2		
2017/18	4076	4.7	11.5%	8.4%	125	0.9	1.6%	-23.7%

Figures exclude obstetrics.

To improve patient flow in the BGH the aim is to discharge as many patients as possible before 11am and 12 midday. The number discharged before both 11am and 12pm was slightly higher this year compared to last, at 48 (8.0%) and 69 (11.5%) respectively (Table 12).

Table 12: 11am and 12 midday discharges achieved

Year	Total Discharges		Weekend Discharges		Public Holiday Discharges	
	11am	12 midday	11am	12 midday	11am	12 midday
2012/13	56 (7.4%)	95 (12.5%)	9 (1.2%)	15 (7.8%)	8 (5.0%)	21 (13.0%)
2013/14	78 (10.2%)	127 (16.7%)	14 (1.8%)	24 (19.5%)	25 (22.1%)	35 (31.0%)
2014/15	55 (8.0%)	103 (15.0%)	18 10.8%)	30 (18.0%)	9 (8.8%)	16 (15.7%)
2015/16	48 (7.9%)	71 (11.8%)	20 13.8%)	28 (19.3%)	6 (4.6%)	7 (5.3%)
2016/17	22 (3.5%)	46 (7.3%)	14 (9.9%)	22 (15.5%)	2 (1.6%)	5 (4.0%)
2017/18	48 (8.0%)	69 (11.5%)	19 (9.1%)	29 (13.9%)	7 (11.3%	7 (11.3%)

Indicators that beds are under pressure are the number of boarders that are in the hospital at any one time and the number of overnight transfers. There were more boarders each day over the festive period than in previous years (Chart 2). Overnight transfers were similar to 2016/17.

Chart 2: Boarders Comparison 2015/16, 2016/17 and 2017/18

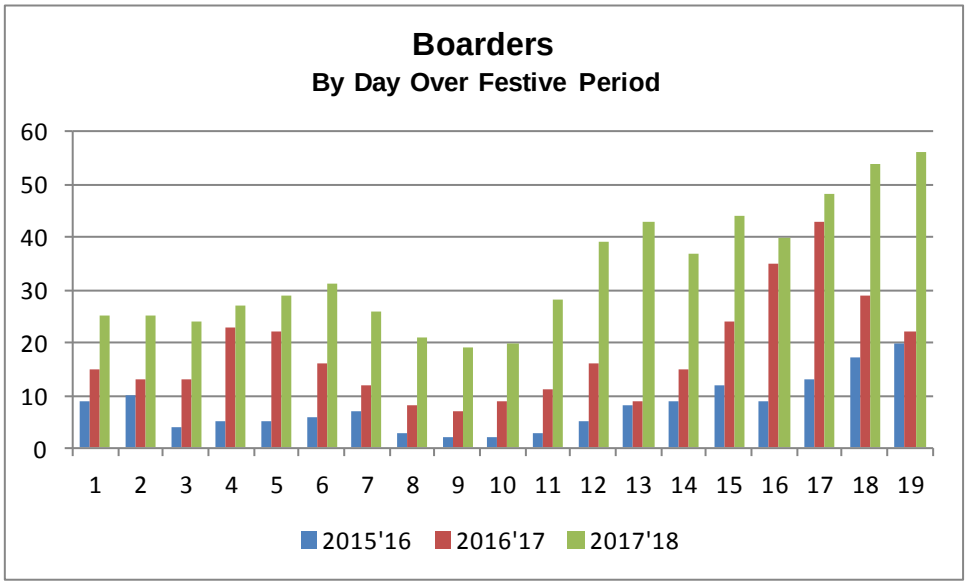


Table 13: Boarders Comparison 2016/17 with 2015/16

Total Boarders	As at 16/12/2016	As at 23/12/2016	As at 30/12/2016	As at 04/01/2017
Total	**15**	**8**	**29**	**30**

Please note: these data show a snapshot of current boarders on each day as specified

Total Boarders	As at 17/12/2015	As at 24/12/2015	As at 31/12/2015	As at 04/01/2015
Total	**9**	**3**	**12**	**20**

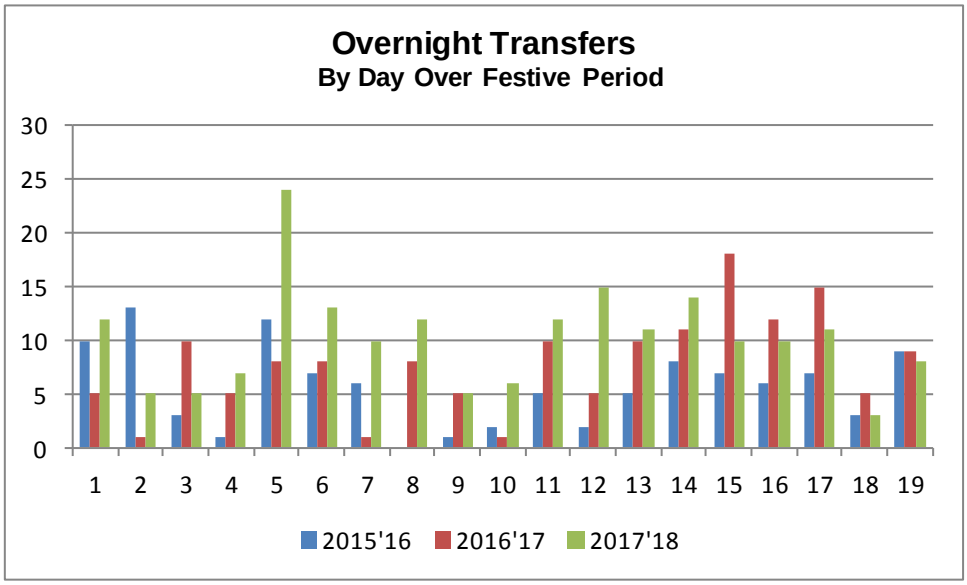
Please note: these data show a snapshot of current boarders on each day as specified

Table 14: Boarders by Ward 2017/18

Total Boarders	As at 15/12/2017	As at 22/12/2017	As at 29/12/2017	As at 02/01/2017
Ward 4	1	0	0	0
Ward 5	0	1	0	0
Ward 7	5	4	15	12
Ward 9	3	2	4	9
MKU	1	3	0	0
Ward 16	9	5	13	14
BSU	1	4	4	4
PSAU	0	0	1	3
Total	**20**	**19**	**37**	**42**

Please note: these data show a snapshot of current boarders on each day as specified

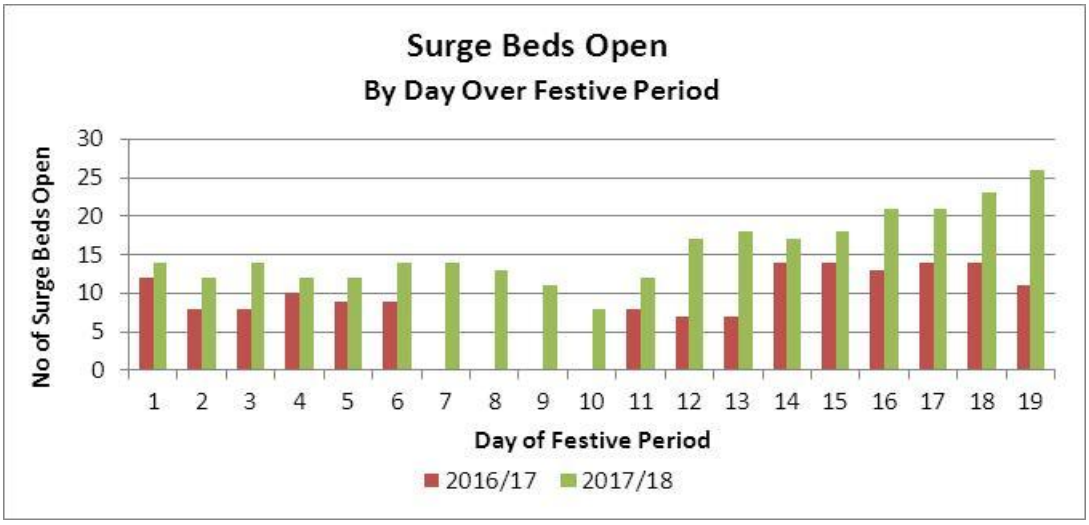
Chart 3: Overnight Transfers (8pm – 8am) by Ward



Surge Beds

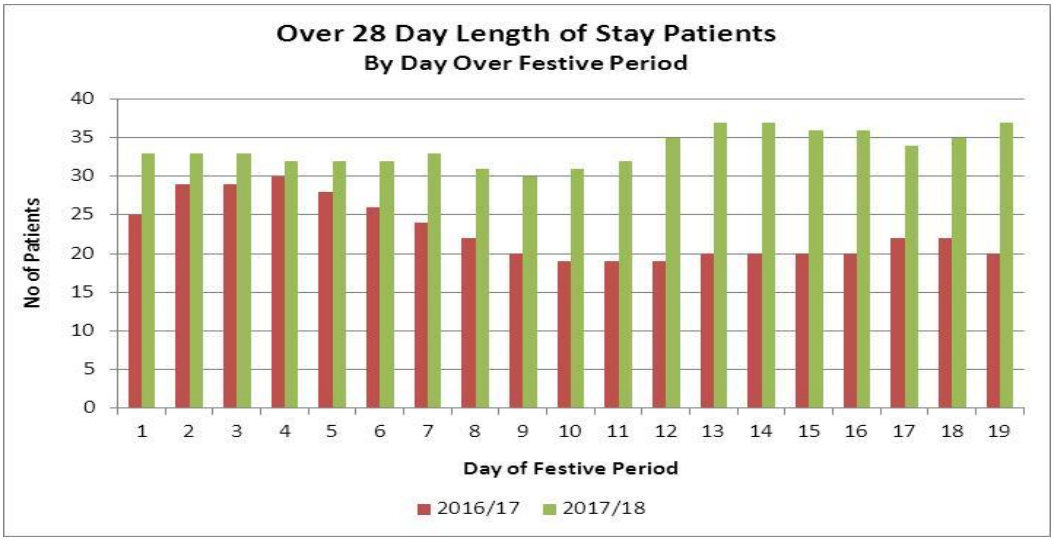
There were 297 days of surge beds used during this period compared to 158 bed days for 2016/17, an increase of 88% (Chart 4). This included the unplanned use as inpatient areas of Acute Assessment Unit (7 days) and the Planned Surgical Assessment Unit (PSAU) (3 days). This data does not include the 4 days when a total of 6 patients were held overnight in the Emergency Department due to a lack of beds to admit them that were then discharged from ED the next morning without becoming an inpatient.

Chart 4: Surge Beds Open over Festive Period



Delayed Discharges

Chart 5: Patients with a length of stay over 28 days



There was a 30% increase in bed days lost to delayed discharges from 573 for 2016/17 to 747 in 2017/18. The largest increase in bed days lost is due to the significant rise in complex cases, which rose from 92 bed days lost to 172 bed days lost.
Average delayed discharge cases over the festive period also rose by 30% in 2017 (35) compared to 2016 (27). This is reflected in a similar 30% rise in numbers of patients with length of stay over 28 days (see Chart 5 above).

The number of delayed discharge cases over 2 weeks as at 4th January 2018 was 27, compared to 23 in the same week in 2017.

There was a significant increase in the number of complex cases on the list from an average of 4.25 in 2016/17 to an average of 10 this reporting period. However, this is a return towards the average of 2015/16, which was 12.5. It is not felt that the festive period contributed to this increase.

The top three reasons for being recorded as a delayed discharge are:

- Awaiting a package of care, with an average of 12 over the period and representing 33% of all delays
- Currently being assessed by social work, with an average of 6 over the period
- For 'Adults requiring a placement in 24 hour care settings', there is a weekly average of 10, or 30% of all delays (categories 24B, 24C and 24F). These cases account for 31% of the standard delayed bed days in the festive period in 2017/18.

Table 15: Delayed Discharges comparison by week

Total Delayed Discharges	As at 14/12/17			As at 21/12/2017			As at 28/12/2017			As at 04/01/2018		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
BGH	7	7	7	7	4	3	10	10	3	9	9	7
Community Hospitals	22	20	16	23	12	10	19	19	10	19	17	16
Mental Health	6	6	5	5	5	5	5	5	5	5	4	4
Total	**35**	**33**	**28**	**35**	**21**	**18**	**34**	**34**	**18**	**33**	**30**	**27**

Please note: these data show a snapshot of current delayed discharges on each day as specified, excludes complex cases.

Table 16: Delayed Discharges by reason for delay

Delayed Reason	As at 14/12/17			As at 21/12/2017			As at 28/12/2017			As at 04/01/2018		
	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks	Total	>3 days	>2 wks
11A Awaiting commencement of post-hospital social care assessment (including transfer to another area team)	1	1	1							1	1	1
11B Awaiting completion of post-hospital social care assessment (including transfer to another area team)				9	1	1	8	8	1	7	7	7
24B Awaiting place availability in Independent Residential Home	5	5	5	4	1	1	3	3	1	5	4	3
24C Awaiting place availability in Nursing Home (not NHS funded)	4	4	2	2	1	1	2	2	2	2	2	2
24F Awaiting place availability in care home (EMI/Dementia bed required)	4	4	4	4	4	3	4	4	3	2	2	2
25D Awaiting completion of social care arrangements to live in their own home - awaiting social support (non-availability of services)	18	16	13	12	11	9	13	13	8	12	10	8

25F Awaiting completion of social care arrangements - Re-Housing provision (including sheltered housing and homeless patients)	1	1	1	1	1	1	1	1	1	1	1	1
51 Legal issues (including intervention by patient's lawyer), - e.g. informed consent	1	1	1	1	1	1	1	1	1	1	1	1
67 Disagreement between patient/carer/family and health/social care	1	1	1	2	1	1	2	2	1	2	2	2
Total	**35**	**33**	**28**	**35**	**21**	**18**	**34**	**34**	**18**	**33**	**30**	**27**

Please note: these data show a snapshot of current delayed discharges on each day as specified

Table 17: Delayed Discharge Occupied Bed Days – Comparison between festive periods 2015/16, 2016/17 and 2017/18

Delayed Discharge Occupied Bed Days	**Festive Period 2015/16**			**Festive Period 2016/17**			**Festive Period 2017/18**		
	Standard	Complex	Total	Standard	Complex	Total	Standard	Complex	Total
BGH	14	51	65	93	0	93	210	70	280
Community Hospitals	155	160	315	307	54	361	348	68	416
Mental Health	83	17	100	81	38	119	17	34	51
Total	**252**	**228**	**480**	**481**	**92**	**573**	**575**	**172**	**747**

Table 18: Complex Delayed Discharges by area - Comparison between festive periods 2016/17 and 2017/18

Delayed Discharges	**As at 16/12/2016**	**As at 23/12/2016**	**As at 29/12/2016**	**As at 06/01/2017**	**As at 14/12/17**	**As at 21/12/2017**	**As at 28/12/2017**	**As at 04/01/2018**
	Complex	Complex	Complex	Complex	Complex	Complex	Complex	Complex
BGH	0	0	0	0	3	3	2	3
Community Hospitals	3	3	3	3	5	4	4	4
Mental Health	2	1	1	1	4	3	3	3
Total	**5**	**4**	**4**	**4**	**12**	**10**	**9**	**10**

Please note: these data show a snapshot of current delayed discharges on each day as specified

Overall, the largest proportion of recorded delays (for 2016/17 and 2017/18 festive periods) are in community hospitals, with a small increase in actual numbers from 14 in January 2017 to 16 in January 2018. There has been an increase in proportion of BGH delayed discharges from 16% of total delayed discharges in 2016/17 to 37% in 17/18, with an equivalent reduction in proportion of delayed discharges in Mental Health (Tables 17 and 18).

Elective Theatre Cancellations

33 patients' procedures were cancelled over the festive period. 24 of these were for a non-clinical reason (17.9%) which is over the local target set of 1.5% and is a deterioration in performance from the previous year (2.3%). This local target is based on the Scottish Board average for May – August 2015. The majority (12 patients) were cancelled due to no ward or ITU bed being available. Exceptional pressures over this period meant that our elective footprint was turned over to unscheduled demand (including PSAU) from 27th December.

Table 19: Cancellations by type

Year (Scottish Average)	Total Procedures	Total cancellations	Cancellation Type			
			Hospital (Target 1.5%)	Clinical (Target 2.8%)	Patient (Target 3.7%)	Other (Target 1%)
2015/16	110	11	6	2	3	0
2016/17	133	9	3	1	5	0
2017/18	134	33	24	4	5	0
Cancellation Rate 15/16	-	10.0%	5.5%	1.8%	2.7%	0%
Cancellation Rate 2016/17	-	6.8%	2.3%	0.8%	3.8%	0%
Cancellation Rate 2017/18	-	24.6%	17.9%	3.0%	3.7%	0%

Table 20: Cancellations by Reason

Reason	2015/16	2016/17	2017/18
No surgeon/anaesthetist to cover list			
Emergency took priority		2	4
Out of time	2		3
Inappropriately listed			
Scheduling Issue			1
No theatre staff			
No nursing staff – DPU			
No beds (inc ITU beds)	3	1	16
Equipment Issue	1		
Total	**6**	**3**	**24**

Waiting Times

Treatment Time Guarantee (TTG)/ Referral To Treatment / Stage of Treatment

There was a planned reduction in elective activity during the festive period due to the public holidays, consultant availability and expected bed availability between Christmas and New Year. Additionally, a large number of patients were cancelled mainly due to bed availability which has had a significant impact on the TTG waits especially within Orthopaedic Surgery.

There were 24 cancellations over the festive period, 16 of these were due to a lack of bed capacity. This combined with a reduction in elective activity due to public holidays and consultant availability has seen lower than normal numbers of patients treated, with a total of 47 elective patients treated over the two festive weeks. This has significantly increased the TTG Breach numbers over this period with a total of 136 patients reported as breaching on the 7th January 2018 within Orthopaedic Surgery, General Surgery, Oral Surgery, ENT and Urology. This compares to 16 TTG breaches on 6th January 2016 (15 within Orthopaedic Surgery and 1 General Surgery).

18 Week Referral to Treatment performance has been continuously below 90% mainly due to long waits in Outpatients for a first appointment. We are currently organising extra activity for at risk specialties until the end of March 2018 to rectify this. There was reduced outpatient activity over the festive period due to the public holidays and consultant leave that will have a small impact on patient journeys and the Referral to Treatment Target.

Table 21 Festive Period TTG Breaches - 2016/17 and 2017/18 Comparison

Date 2016/17	Number of TTG Breaches	Date 2017/18	Number of TTG Breaches
02/12/2016	21	03/12/2017	71
09/12/2016	20	10/12/2017	79
16/12/2016	14	17/12/2017	82
23/12/2016	14	24/12/2017	94
30/12/2016	14	31/12/2017	123
06/01/2017	16	07/01/2018	136

31 and 62 day Cancer Waiting Times

The festive period has not had an impact on Cancer Waiting Times performance; targets continue to be met.

Community Activity Summary

During the Festive Period Community Hospital admissions decreased by 3 (6%) and discharges increased by 1 (2%) when compared with the same period last year. Due to the small numbers this may reflect normal levels of variation in this data and does not indicate a significant shift (Table 22).

Table 22: Community Hospital Admissions & Discharges over the Festive Period

Year	Total Admissions		Total Discharges		Weekend Admissions[1]		Weekend Discharges[1]		Public Holiday Admissions		Public Holiday Discharges	
2012/13	68		63		6		10		9		7	
2013/14	54	(-14) -20.6%	55	(-8) -12.7%	5	(-1) -16.7%	5	(-5) -50.0%	3	(-6) -66.7%	5	(-2) -28.6%
2014/15	61	(+7) 13.0%	67	(+12) 21.8%	10	(+5) 100%	13	(+8) 160.0%	3	0 0.0%	9	(+4) 80%
2015/16	59	(-2) -3.3%	53	(-14) -20.9%	11	(+1) 10%	8	(-5) -38.5%	5	2 66.7%	4	(-5) -55.6%
2016/17	52	(-7) -11.9%	49	(-4) -7.5%	5	(-6) -54.5%	12	(+4) 50%	13	(+8) 160%	5	(+1) 25%
2017/18	49	(-3) -5.8%	50	(+1) +2.0%	10	(+5) +100%	5	(-7) -58.3%	2	(-11) -84.6%	4	(-1) -20.0%

* Variance from previous year given in grey

[1]Please note: Weekend figures have been adjusted for all years to include 3 full weekends (6 days) to enable an accurate year on year comparison.

Table 23: Community Hospital Activity for December 2016 and December 2017

	December Activity				*Percentage Increase on Previous Year*		
Month	**Admissions**	**Discharges**	**Occupied Bed Days**	**ALoS (Days)**	***Admissions***	***Discharges***	***Occupied Bed Days***
2016/17	88	94	2572	27.4			
2017/18	83	86	2740	31.9	-5.7%	-8.5%	+6.5%

During December the average length of stay was up by 4 days when comparing with December last year, and occupied bed days have increased correspondingly by 6.5%. Due to the nature of individual patient length of stay in Community Hospitals this probably reflects a pattern of normal variation. This is also reflected in the length of stay of the different hospitals (Table 24).

The Community Hospitals were prepared to open 5 additional beds from 2nd January 2018. Due to pressures on beds in the BGH these were opened from 28th December 2017.

Allied Health Professionals covered key periods during the public holidays to ensure timely assessment and treatment in the BGH.

The first stage of Hospital at Home pilot was introduced in Berwickshire with staff going through induction during the Festive Period ready to commence in January.

Table 24: Community Hospital Festive Period Length of Stay Comparison

Hospital	December 2016/17 Average Length of Stay (Days)	December 2017/18 Average Length of Stay (Days)
Hawick	19.3	30.9
Hay Lodge	20.4	26.8
Kelso	40.0	51.3
The Knoll	56.4	27.8
Total	27.4	31.9

Infection Control

During the festive period (15th December 2017 – 2nd January 2018), there were no closures for infection control reasons.

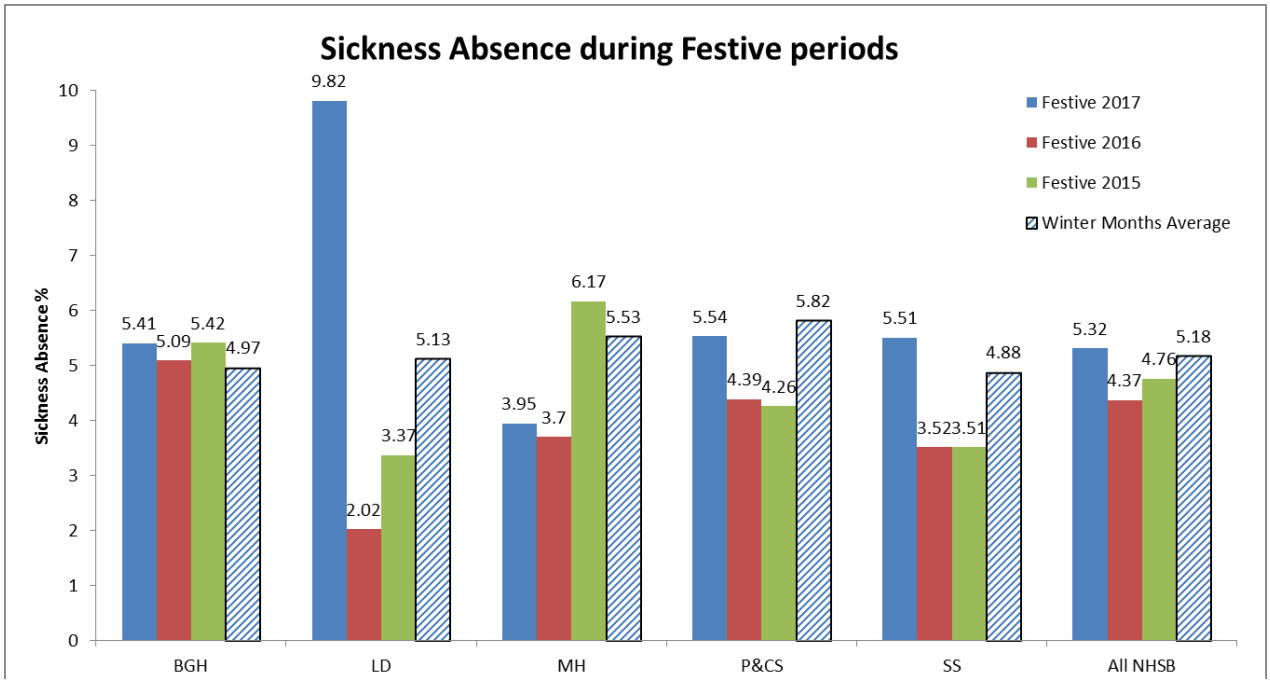
Staff Sickness Absence

The sickness absence rate over the festive period for 2017/18 was 5.32%. This rate saw an increase of 0.95 % on the sickness absence rate from the previous year (2016/17) when the rate was 4.37%. On average over the winter months the absence rate sits at approximately 5.18%.

This Festive period saw an increase in rate of absence for all directorates compared to last year's festive period. Mental Health and P&CS reported a lower rate of sickness absence during this period compared to their average rate of sickness absence during the winter months.

The total absence rate for NHS Borders over this festive period was 0.15% higher when compared to the average rate of sickness absence during the winter months. Please see the chart below.

Chart 6 Sickness Absence comparison by area, 2015/16 to 2017/18



During this festive period 8 departments (headcount > 14) report a sickness absence rate greater than 10% compared to the previous year where there were 7 departments (Table 25 below).

Table 25: Teams (>14 headcount) with sickness absence > 10 % during Festive 2017/18 period

Headcount	Sub-Department	Festive 2017	Festive 2016	Festive 2015	Winter Months Average %
19	District Nursing Tweeddale	15.06	4.62		
37	Hawick Hospital	14.42	14.65	3.76	10.21
38	Ward 4	13.27	15.97	8.45	9.72
40	Ward 12	12.92	12.67	2.52	7.90
19	Health Visiting Eildon	12.74	1.13		
48	Ward 7 and PSAU	11.16	11.51	10.91	8.23
24	Training Development	11.07	0.00	0.00	7.30
37	Ward 9	10.47	12.41	7.07	11.23

This Festive period has seen a noticeable increase (4%) of '*cold, cough, and flu' related absences* from last year. The *'other unknown causes'* reasons used when recording absence on SSTS was almost 5% higher when compared to the same period last year. With the exception of the two reasons outlined above, the distribution of sickness absence reasons during this year's festive period is similar to the pattern evidenced during the winter months (Table 26 below).

Table 26: Most common reasons of sickness absence during 2016/17 Festive period

SA Reason	Festive 2017	Festive 2016	Festive 2015	Winter Months Average %
Anxiety/stress/depression/other psychiatric illnesses	19.86	21.60	23.80	20.11
Cold, cough, flu - influenza	12.86	8.76	4.19	8.87
Unknown causes/not specified	11.77	6.84	7.82	8.00
Other known causes - not otherwise classified	9.95	8.01	13.41	9.44
Back problems	9.80	6.64	5.66	7.07
Injury, fracture	8.66	6.40	6.93	7.45
Other musculoskeletal problems	7.97	9.73	8.33	9.86
Gastro-intestinal problems	6.21	9.06	8.06	7.36

As reported through SSTS, during this festive period there were 404 occasions of sickness absences within NHS Borders. 7 members of staff had more than one episode of sickness absence within this period.

No external locums were required for sickness during the period, however due to the sudden absence of an ED doctor, nights in the Emergency Department over Christmas Day and Boxing Day public holidays were covered at short notice through a rota swap by a trainee in orthopaedics.

In accordance with the Winter Plan, the rotas at middle grade and training grade level in the key acute specialties of general medicine, general surgery, orthopaedics and the Emergency Department were modified for the festive period specifically to ensure safe cover on the public holidays and adjoining weekends. The cover ranged from a level of weekend cover + 1 to normal staffing on Tuesday 2nd January. Through rota planning

additional medical cover was in place from our substantive doctors, between the period 22nd December 2017 – 6th January 2018

In addition for the Emergency Department, 6 extra "surge" shifts were filled by well known external locums on priority days (between 26th December 2017 – 2nd January 2018), taking account of historical activity trends. There were 60 hours of external locum appointed for this purpose at a cost of £5,000.

Communications Focus over Festive Period

Once again, both weeks of the festive period had a four day weekend so the focus of local communications activity was information on GP surgery and pharmacy opening hours and reminding the public in advance to endure they had adequate supplies of prescription medicines that they would require. The emphasis was placed on when surgeries and pharmacies were open (rather than closed) in an attempt to encourage people to plan ahead. These messages were enhanced by the national activity co-ordinated by NHS24 which again featured the 'Doctor Owl' character under the strap-line 'be healthwise this winter'.

The other key message was 'know who to turn to' message, using the 'Meet Ed' campaign, reminding people only to at the Emergency Department in a real emergency situation, and utilise instead support and advice available from GPs, Pharmacies and Minor Injury Units. The 'Weekly Winter Update' format was used again, both for internal and external audiences and this year included a focus on 'Winter Stars' – staff members who go the extra mile to keep services running over the Winter period. This was well received.

With flu having a significant impact across Scotland this season we also continued to reinforce the vaccination message, as well as more general 'keep well' advice for those suffering with cold and flu like symptoms.

In common with other health boards the communications focus has shifted significantly towards social media, supported by local print and broadcast media informed by press releases and statements. We also use the NHS Borders website, SB Connect publication and information screens in our hospitals and GP surgeries.

Due to the exceptional pressures over the Christmas holiday period, on 28 December 2017 our emergency response communications were activated and the public were advised that we were experiencing unprecedented demand, and told that if they did need

to attend the hospital that their waits would be longer etc. The statement published on our NHS Borders facebook page was shared more than 400 times on the 28th alone. The communications response continued into the New Year as the volume of attendances and resulting admissions and system pressures continued.

Initial Recommendations for Future Festive Period Planning

Feedback has been sought from managers, clinicians and front-line staff on issues identified over the festive period. Although these are still being discussed, early suggestions for further work to build upon are:

- The focus for the Winter Plan was the New Year period, based on an expectation that there would be sufficient capacity over the Christmas period, as in previous years. Early and detailed planning should be applied to the Christmas period as well as the New Year period, including the modelling of the impact of different admission and discharge levels to ensure that adequate services are available
- The ongoing work to reduce delayed discharges and ensure improved access to community hospitals and alternatives to hospital care should be completed in good time to ensure that new ways of working are tested and established before the festive period
- A further review of elective operating arrangements should be undertaken to determine whether maintenance of elective operating is feasible during this period
- A dedicated additional medical ward may be helpful to ensure appropriate allocation of staff and to reduce boarders. This may involve the redesignation of an existing ward
- Work to explore other areas for establishing additional beds should be undertaken as a matter of urgency to allow time for early planning to prepare these for winter
- The Duty and Site Team arrangements for the festive period should be reviewed. Rotas should allow for adequate site team support across both daytime and night times and sufficient capacity to ensure resilience amongst the site management team
- Staff based in non-clinical areas should receive training in skills useful to be able to support wards (e.g. ward-based admin tasks) and have clearly defined roles when deployed to support clinical areas
- Patient Flow escalation policies should be reviewed and action taken to ensure they are followed consistently

Thanks to the following people for the compilation of this report:

Rebecca Green, GP Clinical Lead BECS
Heather Tait, Clinical Services Manager, Planned Care and Commissioning
Erica Reid, Lead Nurse, Community
Jane Prior, General Manager, Patient Flow
Steven Litster, Waiting Times Manager
Sam Whiting, Infection Control Manager
Clare Oliver, Communications Manager
Karen Shakespeare, Planning and Performance Manager

Recommendation

The Strategy and Performance Committee to **note** the 2017/18 Festive Period Report, the performance of the system during this period and the outline recommendations for future winter planning.

A full Winter Period Report is to be brought to the next Board meeting.

Rationale for submission to Strategy & Performance Committee	To note the performance of the system during this period and the outline recommendations for future winter planning.
Policy/Strategy Implications	Request from Scottish Government that all Health Boards produce a Winter Plan signed off by their Board in support of quality patient care. This report will inform the Winter Planning Process 2018/19
Consultation	Feedback was provided by the Winter Planning Group, Clinical Services and Managers and Partner organisations
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	
Resource/Staffing Implications	Resource and staffing implications were addressed within the Winter Plan

Approved by

Name	Designation	Name	Designation
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