NHS Borders

Health & Sports Committee

15th December 2020

CONTENTS

COVID-19: INITIAL RESPONSE, REMOBILISATION & RESURGENCE

As we move out of the initial respond phase to COVID-19 and remobilise our services in the context of resurgence and winter, NHS Borders is continually reviewing what went well during the response phase and what lessons can be learnt. Feedback has been sought from key stakeholders across the organisation over a series of discussions. This resulted in a number of key themes being identified around positive changes that have been introduced as a result of the pandemic which staff want to retain. These are summarised below:

Positive' changes / behaviours to retain:

- Rapid deployment of digital tools and alternative contacts for activities like one-to-one patient consultations, inpatient family contact and internal staff meetings such as Near Me / Telephone etc…
- Central COVID-19 Hub and assessment area to provide streamlined care
- Integrated working / increased social care capacity – reduced delayed discharges
- Clear intermediate care pathway utilising AHP's, hospital to home service "Home First" & bed based intermediate care in 24 hour care settings
- Primary Care enhanced access to diagnostic interventions – supporting urgent cancer referral decisions
- Creation of multi-disciplinary, multi-agency locality hubs involving health, social care and third sector
- Greater use of physiotherapists in delivering respiratory care
- A smaller inpatient footprint for paediatrics and re-imagined ways of managing day cases
- A new admission process for MH inpatient admissions (including out of hours) to reduce risk of infection
- MH Crisis Service – introduced service changes which enabled reduced presentations to ED
- Centralised functions mobilised to support response e.g. staff accommodation, absence line, transport hub, redeployment & staff hub
- Implementation of Staff Wellbeing Plan / Psychological Hub 'Here 4 u'

These ideas are being considered as part of individual services remobilisation plans and will be considered within our local prioritisation process.

In addition to the above we have undertaken conversations with the leadership team across NHS Borders to identify some key points that we would want to learn from moving forward. These include the following:

- Clinical / Staff empowerment
- Clinical leadership / ownership / engagement
- Patient led & clinician driven treatment – Realistic Medicine principles
- "improved" & streamlined decision making
- Greater collaboration between NHS services and partner services
- Stronger links between health & social care

- Increased use ‘self management techniques’
- Streamlined, simple, rapid processes (without losing outcomes)
- Improved communication with care home managers

As part of our engagement programme around remobilising our services we continue to share these points and will add to them as required. We have shared these initial thoughts with colleagues in social care and the IJB, who have confirmed similar findings through their reflections on responding to COVID-19.

Early on during the COVID-19 period, we recognised the need to hear how staff were experiencing the positives and the challenges of coping with COVID-19. To do this, we have been working with OpenChange an external agency in a project titled ‘Collecting Your Voices’. We have gathered contributions from a wide range of staff, through interviews, contributions, messages and posters with over 2,000 themes and comments.

As our “collecting voices” project feedback is analysed we will add key points to the lessons learned. We have been asked through various agency groups to contribute to formal debriefing exercises and will use the above points in doing so, but would welcome an overall and single route for lessons learnt across the whole of Scottish Government rather than a series of debrief requests which would detract capacity from our remobilisation activities.

Successes

NHS Borders is truly heartened by the response from its staff and the efforts that have been made, contributing to the following successes;

- Setting up a Deployment Hub and successfully deploying a significant number of staff across the organisation; in particular to COVID wards, the testing team and track & trace.
- Successfully setting up and coordinating a Transport Hub
- Mobilising a Sickness Absence Line
- Reconfiguring various clinical areas over a short period of time to support COVID and non-COVID activity
- Successfully delivering urgent care throughout
- Here4u staff support service has been set up
- Increased pace to successfully provide a virtual clinic platform which has been well received by both patients and clinicians

The following pages provide NHS Borders data for the COVID-19 response.

NHS Borders - Covid Phase 2	Admissions from 1st Aug to 24th Nov 2020	Cumulative Positive Cases	Cumulative Discharges	Cases since 1st Aug 2020
		956	105	609

Covid Positive Admissions	39

ITU Admissions	9

Covid Positive Deaths	6

Admissions linked to Outbreaks	15

Postcode Sector for Admissions	
EH45	7
ML12	3
TD1	5
TD2	1
TD3	0
TD4	0
TD5	4
TD6	1
TD7	0
TD8	3
TD9	11
TD10	1
TD11	1
TD12	0
TD13	0
TD14	1
TD15	1

Gender of Covid Positive Patients	
Male	20
Female	19

Gender of ITU Admissions	
Male	9
Female	0

Gender of Covid Deaths	
Male	5
Female	1

Gender of Covid Deaths	
Male	5
Female	10

Age Group	Number	%
<45	2	5%
45 - 64	8	21%
65 - 74	8	21%
75 - 84	14	36%
85 +	7	18%

Age Group	Number
<45	0
45 - 64	2
65 - 74	4
75 - 84	3
85 +	0

Age Group	Number
<45	0
45 - 64	0
65 - 74	1
75 - 84	4
85 +	1

Age Group	Number
<45	1
45 - 64	1
65 - 74	3
75 - 84	6
85 +	4

% Positive Cases Adm since 1st Aug	Avg LoS Phase 2
6.4%	8.99 days

% Adm to ITU Phase 2	ITU Avg LoS Phase 2
23.1%	13.77 days

% Adm Died Phase 2	Avg LoS Deceased
15.4%	16.97 days

Outbreak Setting	
Jed/SB Cares	3
Dial/SB Cares	2
Deanfield	3
Dovecot Court	7

Admission Outcome	
Current Inpatient	13
Discharged	20
Deceased	6

ITU Admission Outcome	
Current Inpatient	3
Discharged	3
Deceased	3

Number Deaths Phase 1	37
% of Adm Died Phase 1	30.8%

Admission Outcome	
Current Inpatient	5
Discharged	10
Deceased	0

Ethnicity	
Scottish	17
Other British	4
Not Known	18

Latest Performance

Latest performance, which shows the impact of COVID-19 on standards from the Annual Operational Plan (AOP), is shown below.

Cancer Treatment:

Cancer referrals, diagnostic pathways and subsequent treatments remain a priority activity for clinical team. Referral numbers where cancer is suspected recovered strongly over the summer, and have been consistent with or above expected numbers across the majority of cancer pathways. The notable exception has been colonoscopy activity which has been well below historical levels due to the suspension of the National Bowel Screening programme. This programme restarted during October and we are now seeing activity levels recovering strongly as a consequence.

It should be noted however that we are starting to see urgent waiting times creeping up as diagnostic services come under pressure from increasing routine waiting times and appropriate clinical reprioritisation. This increases the proportion of urgent work. This is obviously a concern and diagnostic waiting times will remain under regular review, with appropriate action agreed as the situation dictates in order to prioritise urgent and particularly cancer patients.

Surgical waits for patients treated locally remain excellent across all tumour groups.

Performance for September 2020 is detailed below; this is the latest performance data available due to a one month lag time:

- 100% of patients with a **Suspicion of Cancer to be seen within 62 days** were seen in time during September 2020.
- 100% of patients requiring **Treatment for Cancer to be seen within 31 days** were seen in time during September 2020.

Waiting Times:

The Recovery Planning Group (RPG) which was established in April continues to meet virtually on a weekly basis with representatives from across Health and Social Care, to co-ordinate a system wide response to our recovery. The focus has been to bring services back on stream that are safe, effective and person centred within the constraints of living with COVID-19. Work is currently being undertaken to evaluate the role and remit of the group as we continue to live through the pandemic.

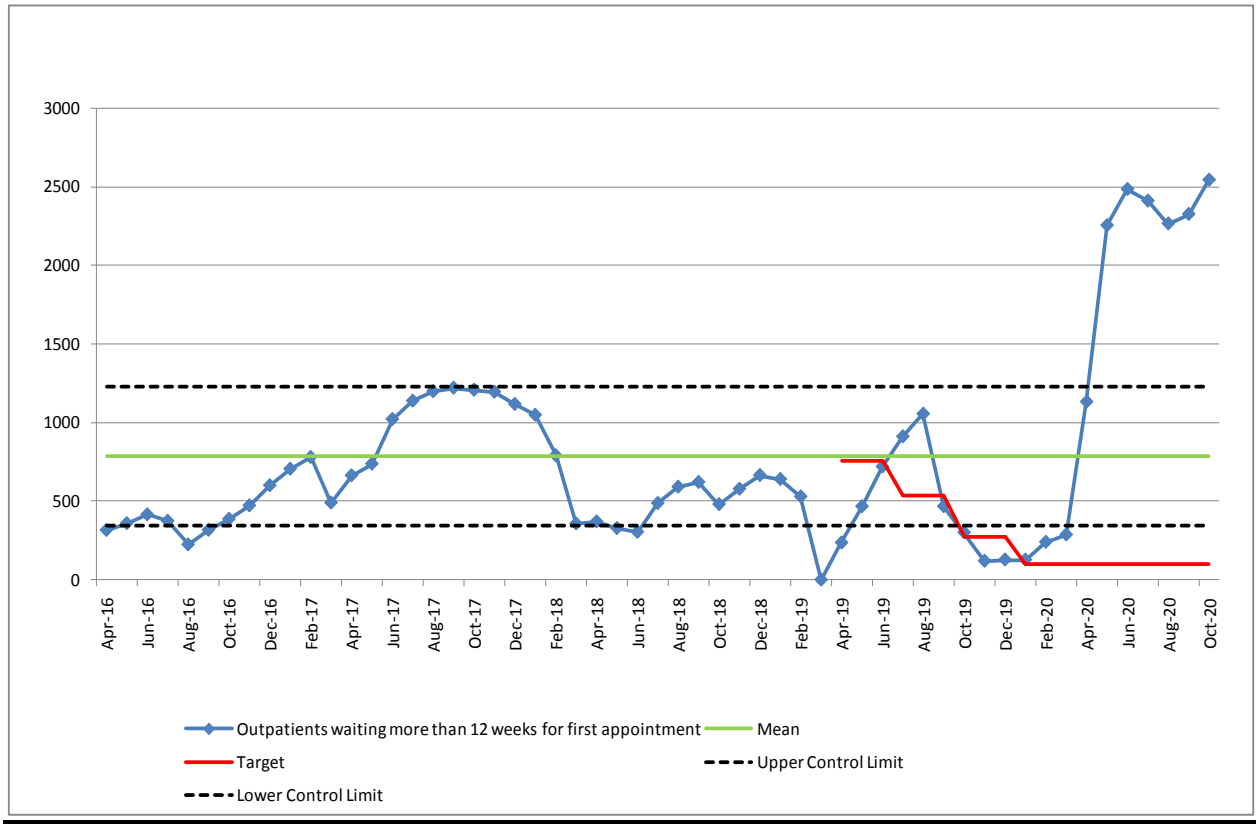
On 31st August 2020 we commenced 50% of our pre-COVID-19 activity with patients being asked to self isolate for 14 days prior to their operation. The self isolation has been reviewed by the Clinical Prioritisation Treatment Group (CPTG) and revised to 3 days, with some high risk patients still being asked to self isolate for 14 days. The revised self isolation commenced on the week beginning 19th October 2020.

Currently 40% of pre-COVID-19 activity for patients who need face to face outpatient appointments now takes place. Where clinically appropriate patients are now being seen virtually, it is anticipated going forward that 52% of outpatient appointments will be delivered virtually. The total waiting list size continues to increase as a result of increased capacity within primary care and reduced capacity to match referral rates. The acute team continues to monitor this and work on a remobilisation plan aimed at increasing this level of activity.

Work remains ongoing across the organisation in relation to remobilisation and our preparedness for a resurgence of COVID-19 as we begin see an increase in COVID-19 related inpatient activity.

The charts below demonstrate impact against agreed performance measures for both outpatient and inpatient waits and the amount of lost activity

Outpatients:



Performance against agreed AOP trajectory:

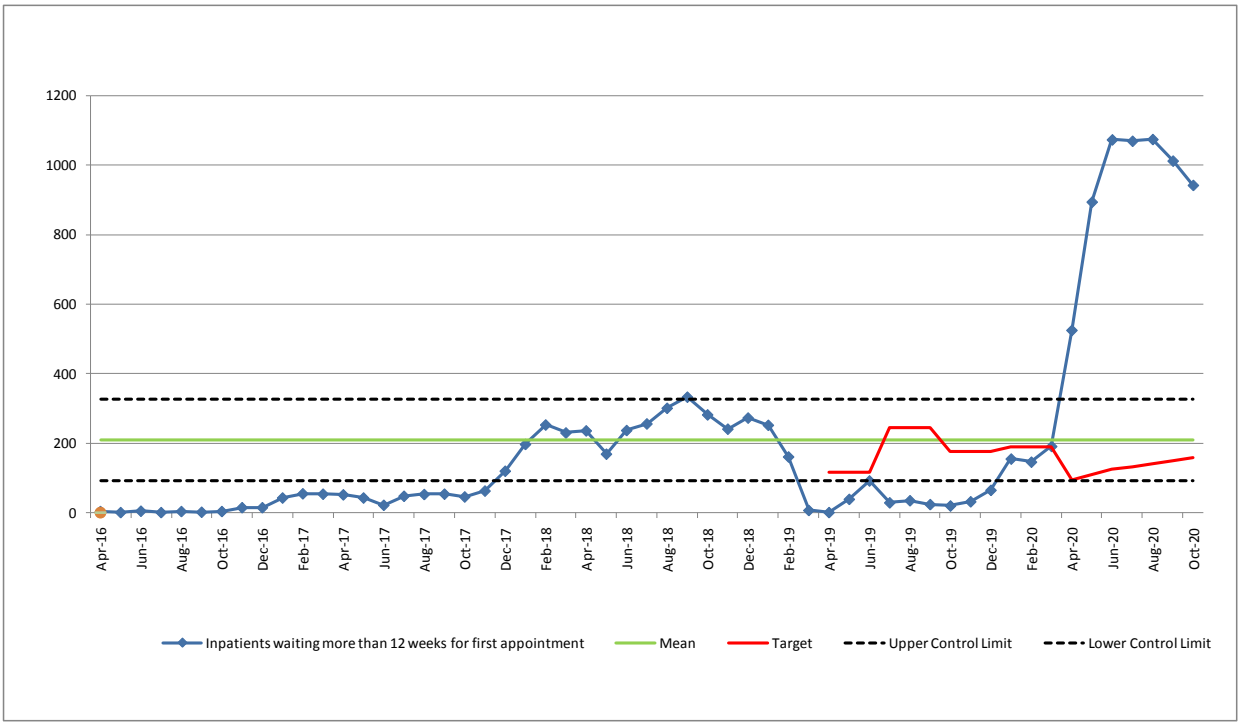
	31/08/20	31/09/20	31/10/20
Trajectory	100	100	100
Breaches	2265	2325	2543

Activity Lost per week:

	21/09/20	28/09/2020	05/10/2020	12/10/2020	19/10/2020	26/10/2020
Variance	-722	-1017	-929	-287	-841	-714
Cumulative Lost Outpatient Activity = 38217 appointments						

Inpatients:

Performance against agreed AOP trajectory:

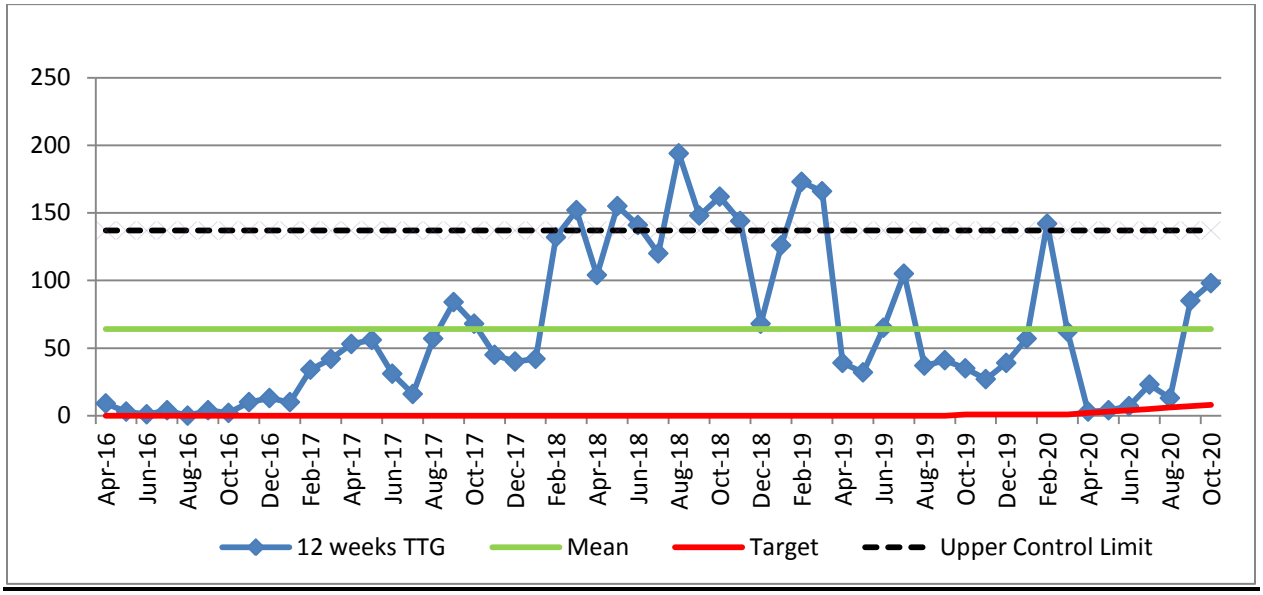


	31/08/20	31/09/20	31/10/20
Trajectory	142	150	158
Breaches	1074	1012	942

Activity Lost per week:

	21/09/20	28/09/2020	05/10/2020	12/10/2020	19/10/2020	26/10/2020
Variance	-61	-55	-51	-55	-57	-60
Cumulative Lost Inpatient/ Day Case Activity = 2317						

TTG

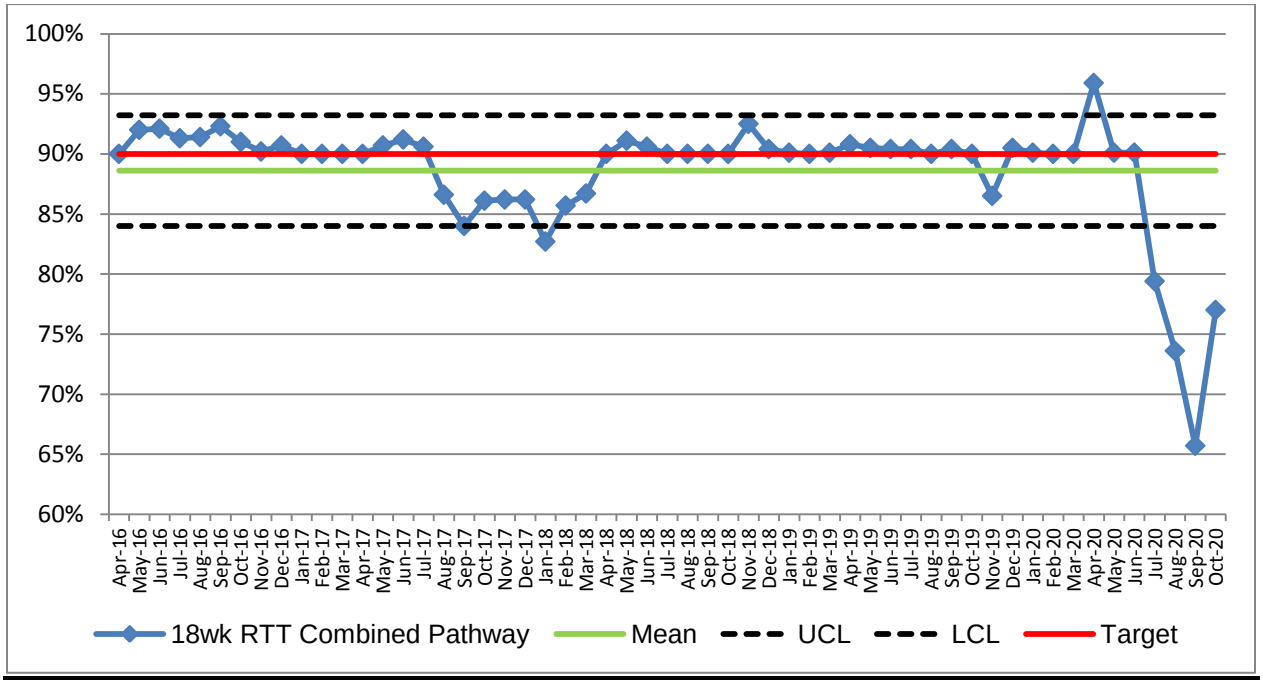


In response to the COVID-19 pandemic, NHS Borders ceased all non-urgent surgery which resulted in increasing waits for surgery and a reduction in the number of patients treated on a TTG pathway as indicated above. This resulted in cancellations of elective operating lists and planned weekend operating lists utilising independent sector staffing.

98 patients are reported as breaching their respective 12 weeks Treatment Time Guarantee in October 2020.

Whilst non-urgent operating was suspended, the Board has maintained Urgent and Emergency operating throughout our COVID-19 response and remobilisation. Routine elective surgery was recommenced in limited capacity in August 2020, as set out in our Remobilisation Plan.

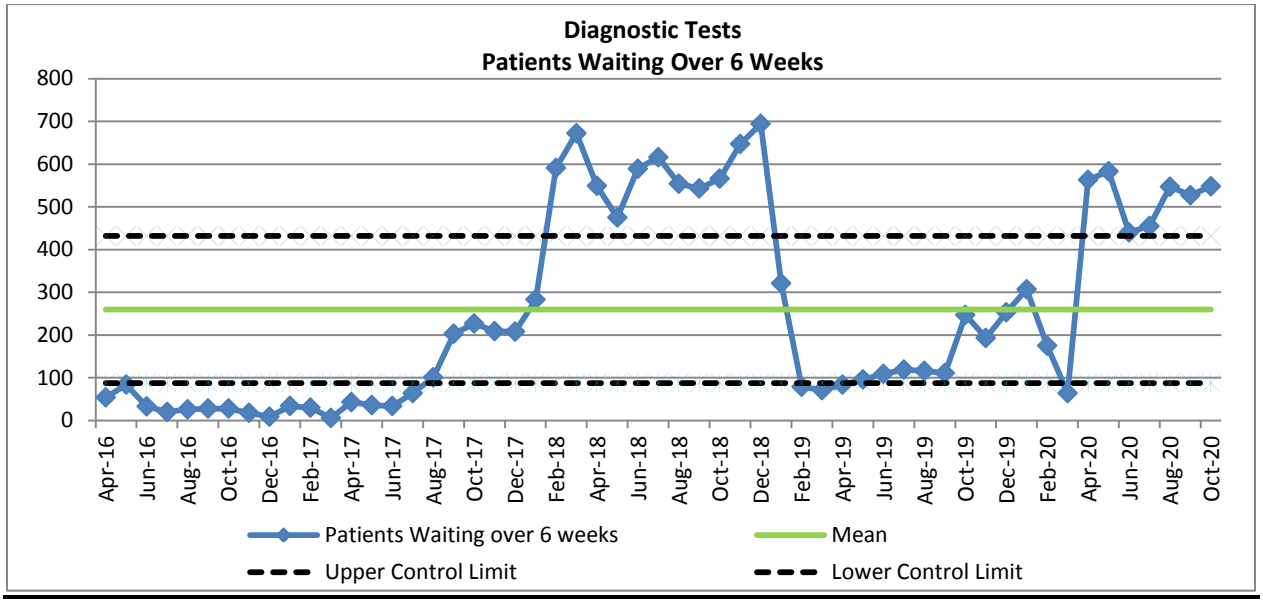
18 Weeks



The 18 weeks RTT performance improved through the Pandemic due to only urgent Outpatient and Surgical patients progressing on pathways. This resulted in fewer patients reported as completing their waits at the end of each month and an improving performance.

This however is predicted to reduce significantly following the phased restart of Outpatients and elective operating which will begin by appointing the longest waiters of which the majority are over 18 weeks at their first appointment. It is also anticipated that the Board will not achieve the 18 Weeks Referral to Treatment target of 90% until the backlog of waiters has been cleared.

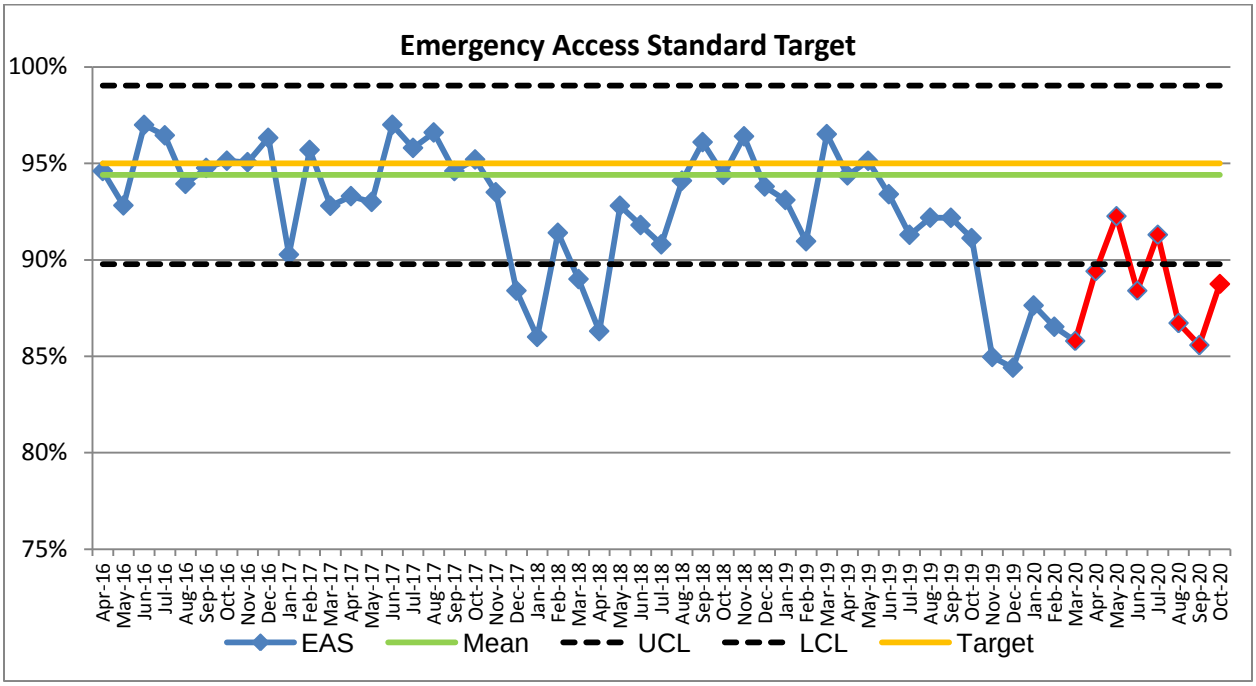
Diagnostic WT



Routine scanning activity was suspended in March 2020, however Urgent activity has continued without interruption. From late June clinically prioritised non-urgent activity recommenced. The reduced capacity during March – October has required the need to only scan clinically prioritised patients; this has resulted in a significant percentage of patients who were considered 'routine' when their referrals were received in February / March to be no longer considered as such. It is anticipated that it will be possible to see a maximum of 20-25% of patients who would previously considered routine within the new overall 60% Diagnostic capacity of pre-COVID-19 activity.

A&E 4 Hour Target

The graph below demonstrates performance in relation to the 4 Hour Emergency Access Standard, with the COVID-19 period highlighted in red:



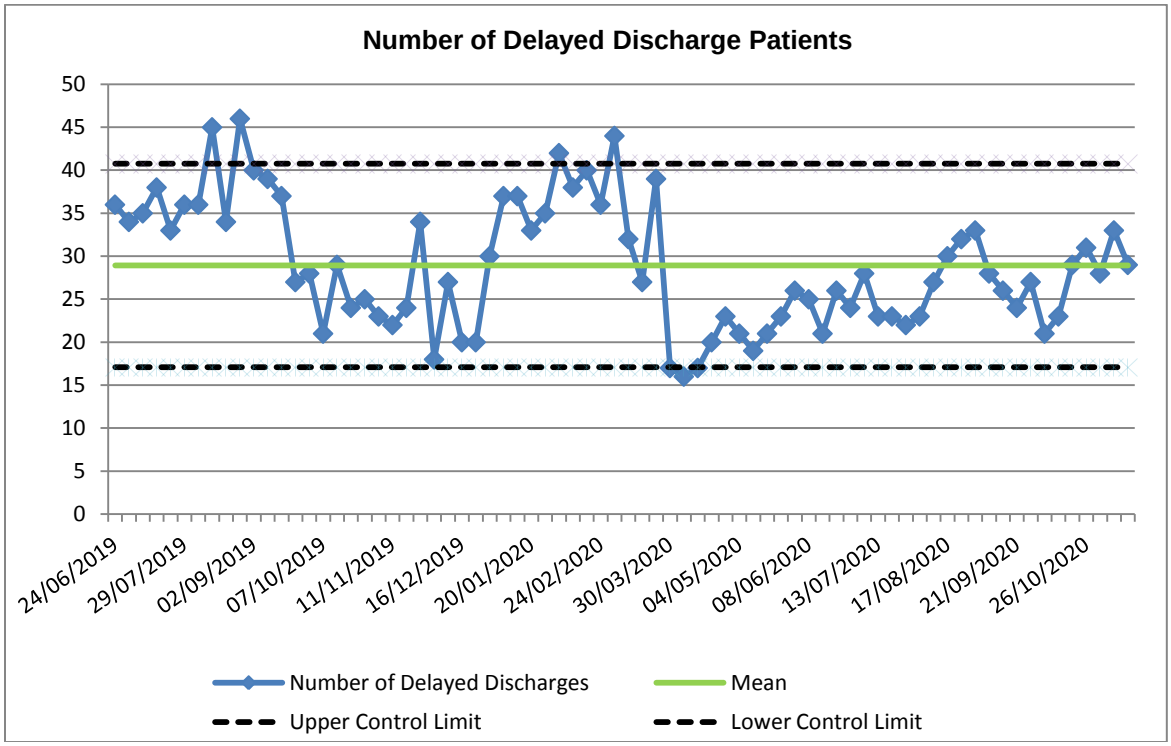
While the Emergency Department has embraced different ways of working this hasn't come without significant challenges as we have seen ED attendances increase to pre COVID-19 activity (and above). The Scottish government initiative to transform and Reshape Urgent Care is being taken forward in phases and we are working through the pathways of scheduling patients and re routing to the appropriate services. This will reduce the footfall through the Emergency Department. The development and testing of minor injuries pathway is being progressed.

Delayed Discharges

Delayed discharge performance (which includes Mental Health delays), against the target of no standard cases over 3 days is shown in the table below:

Standard	July-20	Aug-20	Sept-20	Oct-20
DDs over 2 weeks	10	14	17	10
DDs over 72 hours (3 days includes delays over 2 weeks)	14	25	22	21
Occupied Bed Days (standard delays)	674	793	824	681

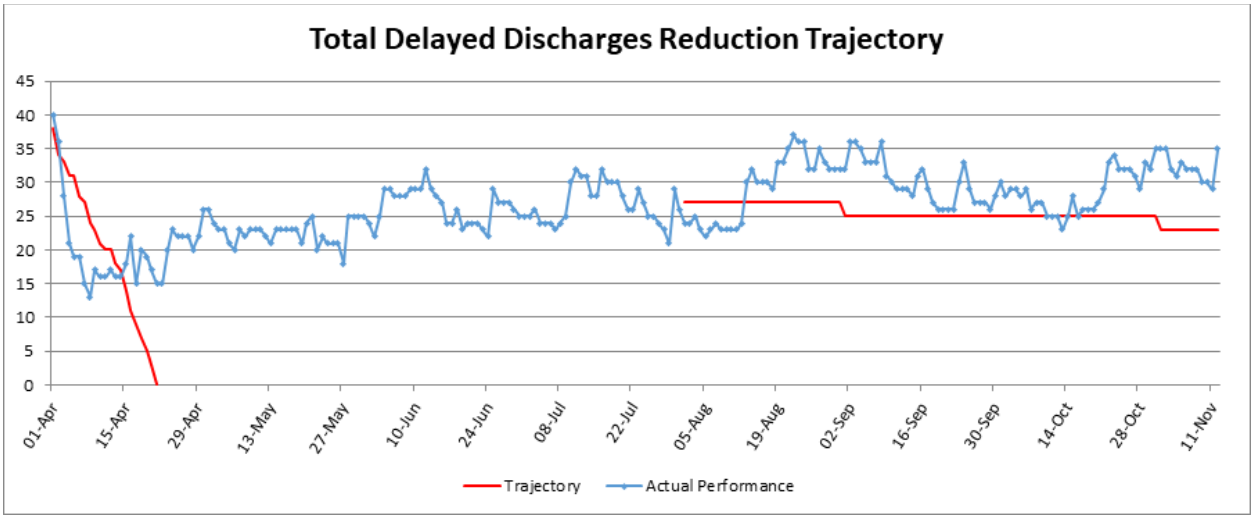
To prepare for the initial COVID-19 wave there was a sustained effort to reduce Delayed Discharges to as close to zero as possible to urgently free up bed space. The chart below shows that the weekly totals for the number of delayed discharges across the system decreased in April 2020 but have started to increase through to September 2020.



As part of the Mobilisation Plan submitted to Scottish Government a trajectory to reduce Delayed Discharges to 0 by 21st April 2020 was included, this was not achieved. A revised target for March 2021 has subsequently been submitted to Scottish Government, which proposes that there will be a 64% reduction in delayed discharges achieved from a baseline of July 2020.

NHS Borders is working closely with our partners at the Scottish Borders Council and the IJB on programmes specifically designed to reduce patients delay, increase flow

and reduce the number of occupied bed days due to delays. Within the three clinical boards integrated huddles have been established daily to concentrate on patients who are medically fit for discharge as well as those who are delayed in the system. This multi-disciplinary approach has meant that patients and complex discharges can be discussed with correct agencies to enable people to move on to their next care destination in safe and timely manner. The chart below demonstrates our position at the time of writing this report:



*Note the 1st trajectory in April 0 was the immediate COVID-19 Response; the 2nd is our updated Recovery/ Resurgence Trajectory.

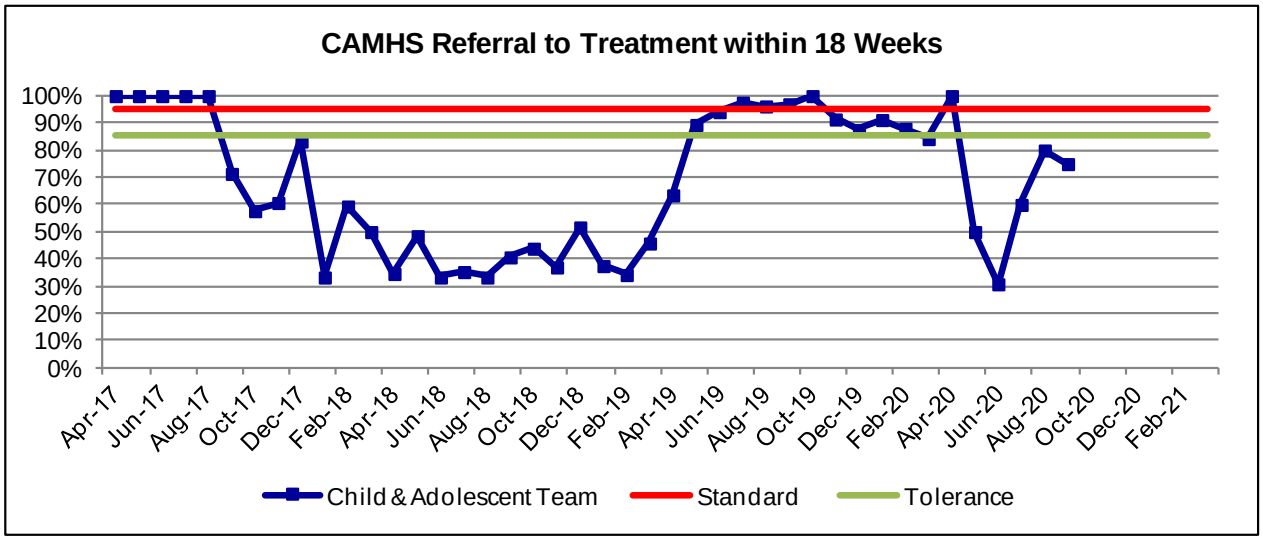
Type of Delayed Discharge	As at 27/08/2020	As at 24/09/2020	As at 29/10/2020
Standard Cases	31	29	28
Complex Cases	5	3	5
Total	**36**	**32**	**33**

During the COVID-19 response the admission criteria for the Intermediate care bed facilities were relaxed to increase bed capacity. A dormant facility was opened to provide additional nursing home beds within the system. These allowed a model of *Discharge to Assess* to be implemented.

The Partnership is currently strengthening the *Moving on Policy* to ensure full implementation and compliance. This will be rolled out in conjunction with an Educational approach. The Partnership will also focus on lessons learned from the COVID-19 response to ensure successful elements are taken forward.

Child and Adult Mental Health Service

Pre-COVID CAMHS was performing at approximately 90% against its RTT target. The impact of COVID-19 has significantly, adversely impacted upon its ability to assess and treat patients. In relation to autism and neuro developmental assessments it has stalled its ability to do so altogether due to the need for direct observations. We are looking at introducing a waiting list initiative and redesigning our processes as part of our mobilisation plans.



Psychological Therapies

Although Psychological Therapy interventions were impacted at the start of the pandemic, the situation has subsequently improved. Near Me has been widely available and once suitable environments to deliver the clinical interventions were identified we have been able to resume to a significant level our delivery of assessment and treatment. A further impact was and continues to be the redeployment of staff to deliver staff support and increased support to our Well Being service. The latter being in response to COVID-19 related referrals from Primary Care.