The Whittington Hospital NHS
NHS Trust

ITEM: 4

MEETING: TRUST BOARD

DATE: September 20th 2006

TITLE: Access Performance Report - July 2006

SUMMARY:

The Access Performance report measures the Trust's performance against '*Standards for Better Health'* the performance framework that sets out the level of quality that all organisations providing NHS care are expected to meet. Within this framework, '*National Standards, Local Action'* (DH, June 2004) sets out specific standards and targets that will form part of the performance assessment of the Trust by the Healthcare Commission in the 2006/07 Annual Health Check.

The attached report provides **July 2006** performance information.

A note regarding the analysis:

The primary form of analysis in this report makes use of statistical process control (SPC) charts. SPC charts present activity or performance data as dots joined by a black line. The variation between the dots is used to calculate the mean value (shown in green) and the upper and lower process limits (in red), which can be considered the 'normal' range of variation and describe the system in operation.

These lines are used to in a number of tests which illustrate whether a process is in or out of control and or whether a level of performance is being sustained. When the data shows that a test has been met the process limits are redrawn from the point at which the change in the system occurred.

ACTION: For Information

REPORT FROM: Mathew Towers, Information Manager

SPONSORED BY: Kate Slemeck - Director of Operations

Financial details supplied/checked by: Not Applicable
(Name of finance officer)

Recommendations contained within this paper have been checked for compliance with relevant statute and regulations/directions/policy as follows:

(Relevant law/direction etc.) **Not Applicable**

A Summary of Health and Social Care Standards

Standard	Criteria	Target	Jul	YTD
Priority I: Improve the Health of the Population				
Reducing Mortality from Heart Disease				
Wait from GP Referral until Seen in RACP Clinic	% seen within 14 days	100%	100%	100%
Wait from Call until Needle for Thrombolysis	% treated within 1 hour	60%	See Note 1	
Reducing Mortality from Cancer				
Wait from GP Referral until Seen	% seen within 14 days	98%	98.5%	99.6%
Wait from Decision to Treat until Treatment	% treated within 31 days	98%	100%	100%
Wait from GP Urgent Referral until Treatment	% treated within 62 days	95%	100%	97.2%
Reducing inequalities in Infant Mortality				
Smoking in pregnancy at time of delivery	% of all deliveries	17%	10.1%	12.4%
Rate of Breastfeeding at birth	% of all deliveries	78%	89.9%	87.8%
Priority II: Supporting People with Long-Term Conditions				
Reducing emergency bed days				
Number of emergency bed-days	5% Reduction by 2008	TBC	8,264	33,672
Days lost to delayed transfers of care	Reduced to minimal Level	TBC	379	1,911
Priority III: Access to Services				
Ensuring that existing national access standards are maintained				
Total treatment time in ED	% within 4 hours	98%	98.8%	98.3%
Wait from GP Referral until Seen as Outpatient	% seen within 13 weeks	99.97%	100%	100%
Wait from Decision to Treat until Admission	% seen within 26 weeks	99.97%	100%	100%
Ensuring that by 2008 no-one waits more than 18 weeks from GP referral to hospital treatment				
Wait from GP Referral until Seen as Outpatient	% seen within 11 weeks	TBC	98.0%	
Wait from Decision to Treat until Admission	% seen within 21 weeks	TBC	98.1%	
Wait for MRI Scan appointment	% seen within 26 weeks	100%	93.5%	
Wait for CT Scan appointment	% seen within 26 weeks	100%	100%	
Priority IV: Patient Experience				
Supporting patient choice and booking				
Choice of dates offered for Outpatient Appointments	% of new referrals	100%	100%	100%
Choice of dates offered for Elective Admission	% of decisions to treat	100%	100%	100%
Ensuring patient right of redress following cancelled operations				
Operations cancelled for non-clinical reasons	% of elective admissions	<0.7%	1.5%	0.9%
Offers of new binding date	% within 28 days	100%	100%	100%
Reducing Infections (mandatory surveillance items)				
MRSA Bacteraemia Rates (1000 bed days)	London Benchmark	0.22	0.16	0.26
Number of MRSA Infections	20% Reduction	18	2	13
C. Diff Rates per 1000 bed days for Patients over 65	Trust Benchmark	1.77 (2005)	3.38	2.48
Number of C. Diff Infections for Patients over 65	Trust Benchmark	136 (2005)	15	58

Notes:
The summary table above contains the key activity and performance measures that the Trust must continue to maintain or improve in 2006/7. Current month and Year To Date (YTD) performance is colour coded against the current target or trajectory. Green shading indicates that Trust performance is at or above the required standard. Amber shading indicator that the Trust is below the standard or is behind the required trajectory, whilst red shading indicators that the Trust has to significantly improve its performance if it is to achieve its goals.

1 The Trust is not likely to receive enough eligible patients (min 20) to be assessed against this indicator. Activity will continue to be monitored in case the situation changes in year

Priority I: Improve the Health of the Population

Improving the health of the population focuses upon health promotion and ill health prevention, seeking to keep people out of the care system wherever appropriate. Reducing mortality for a number of key areas such as cancer and heart disease are public health targets set out in '*Our Healthier Nation'* to be met by 2010. The main focus for the Trust are the condition-specific access targets, whilst the others included focus on reducing infant mortality.

1.1 Reducing Mortality from Heart Disease

There are two standards from the *National Service Framework for Coronary Heart Disease* that form part of the national performance targets. These standards concern GP access to Rapid Access Chest Pain services and the availability of thrombolytic drugs following an ambulance arrival at ED.

1.1.1 CHD NSF Access Times

✓ ***100%*** *of GP referrals to Rapid Access Chest Pain Service were seen within 2 weeks*

o *The Trust is not currently required to report Call to Needle Times due to the low number of eligible patients.*

1.2 Reducing Mortality from Cancer

The interventions which will result in the largest reductions in deaths from cancer by 2010 are earlier detection; shorter waiting times for diagnosis and treatment along the care pathway (as set out in the NHS *Cancer Plan*); and optimal treatment and support of people diagnosed as having cancer.

1.2.1 Cancer Plan Access Times for All Sites

The following are based on provisional figures for **July** performance:

✓ *There were two breaches of the standard where all GP urgent referrals should be seen within 2 weeks***.** *However, measured performance is still above the acceptable tolerance.*

✓ *All Patients were be treated within 31 days of decision to treat all cancers*

✓ *All GP urgent referrals were treated within 62 days from the referral date.*

The tables, overleaf, provide a detailed analysis of performance shown as a percentage of patients meeting the 31-day and the 62-day standards for each monitored cancer site for the 12 months up to **June 2006**.

The Whittington has a relatively small number of patients being treated under the 62 day standard, which means that a single breach will often mean a drop in performance below the tolerance threshold of 95% for that month.

The waiting times for treated patients are sometimes shared with another providers. This is shown as half a patient. A shared patient that also breaches the standard will show up as 0% in performance terms.

31 day standard	Jun 2005	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar	Apr	May	Jun
Breast	100	100	100	100	100	100	100	100	100	100	100	100	100
Lung	100	100	100	100	100	100	100	100	100	100	100	100	100
Lower GI	100	100	100	100	100	100	100	100	100	100	100	100	100
Haematological	-	100	100	100	100	100	100	100	100	100	100	-	100
Upper GI	-	-	100	-	100	100	100	-	100	100	100	100	100
Skin	100	100	100	-	100	100	-	100	100	100	-	-	100
Gynaecological	-	100	-	100	100	-	100	100	100	-	-	100	-
Head & Neck	100	-	-	-	-	100	-	-	-	-	-	-	-
Other	-	-	-	100	-	-	100	-	-	-	-	-	100
Urological	100	85	100	100	100	100	100	100	100	100	100	100	100
Breaches	0	2	0	0	0	0	0	0	0	0	0	0	0
Patients	23	33	28	38	44	30	38	35	33	35	38	28	44

62 day standard	Jun 2005	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar	Apr	May	Jun
Skin	-	100	-	-	100	100	100	100	100	100	-	-	100
Haematological	-	100	-	-	100	-	100	100	100	100	-	-	100
Breast	100	-	100	100	100	100	100	100	86	100	100	100	100
Lung	0	100	100	100	100	100	100	-	-	100	-	100	100
Urological	67	33	100	100	100	100	100	100	100	100	100	100	100
Lower GI	-	100	100	100	-	100	0	100	0	100	100	-	71
Gynaecological	-	-	-	100	-	0	-	100	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-
Upper GI	-	-	-	-	-	-	-	-	-	-	-	0	100
Breaches	2	2	0	0	0	0.5	1	0	2	0	0	0.5	1.0
Patients	5	8	10	10	10	11.5	13	9.5	14.5	13.5	15.0	8.0	23.5

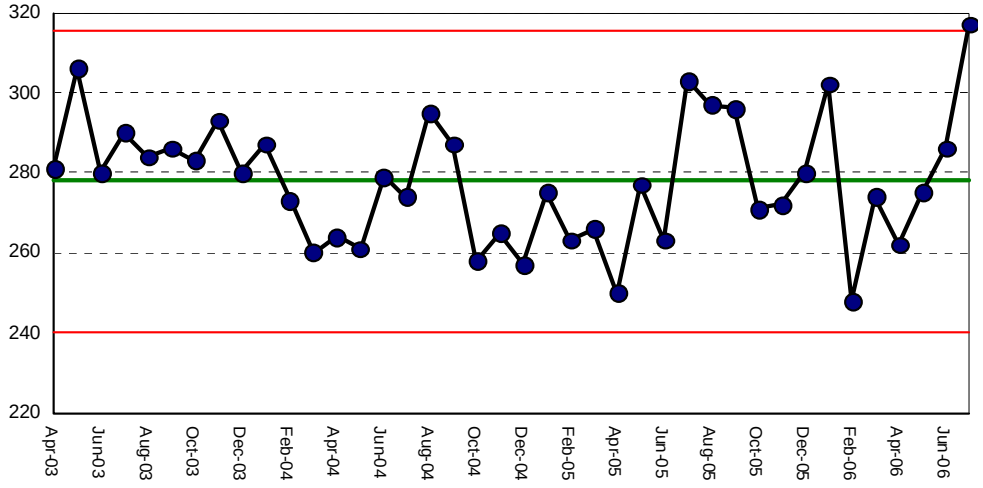
1.3 Reducing inequalities in health outcomes for infants

Key interventions for this Trust in reducing health inequalities includes a focus on reducing smoking during pregnancy and breastfeeding initiation rates.

1.3.1 Activity Context: Deliveries

There were 317 deliveries in July – the highest recorded. The higher delivery numbers during the early part of 2003 were caused by the increased numbers of women we cared for during the refurbishment of the Royal Free maternity unit.

Figure 1: Deliveries Since April 2003

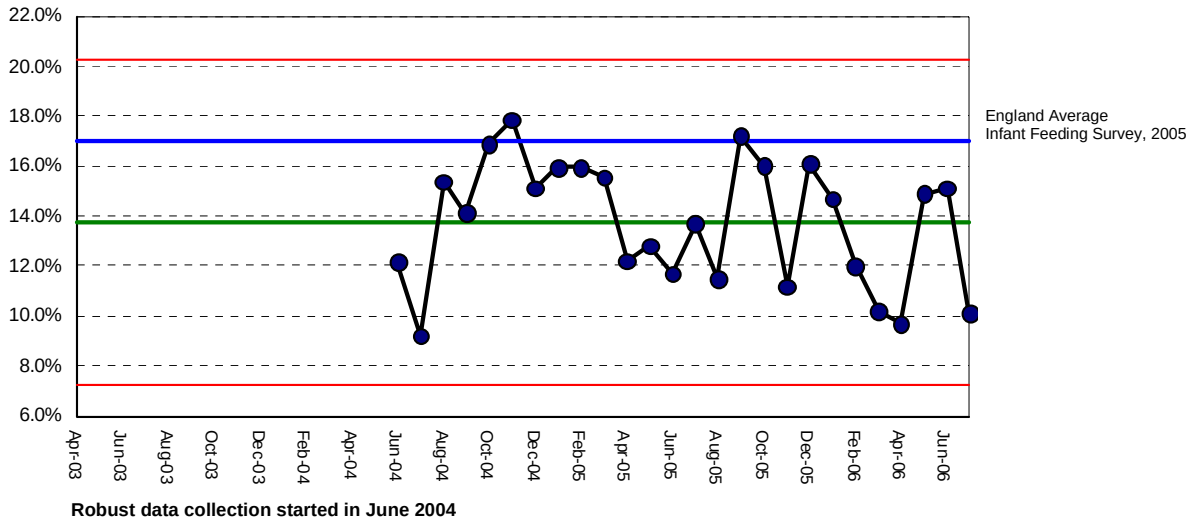


1.3.2 Smoking in Pregnancy

✓ *10.1% of mothers delivering in June 2006 were known to be smokers***.**

Smoking during pregnancy is reported at three points: 12 months before the pregnancy; at booking; and at the time of delivery. The data in figure 2 measures mothers smoking at time of delivery.

Figure 2: Mothers Known to be Smoking (at Delivery) Since June 2004



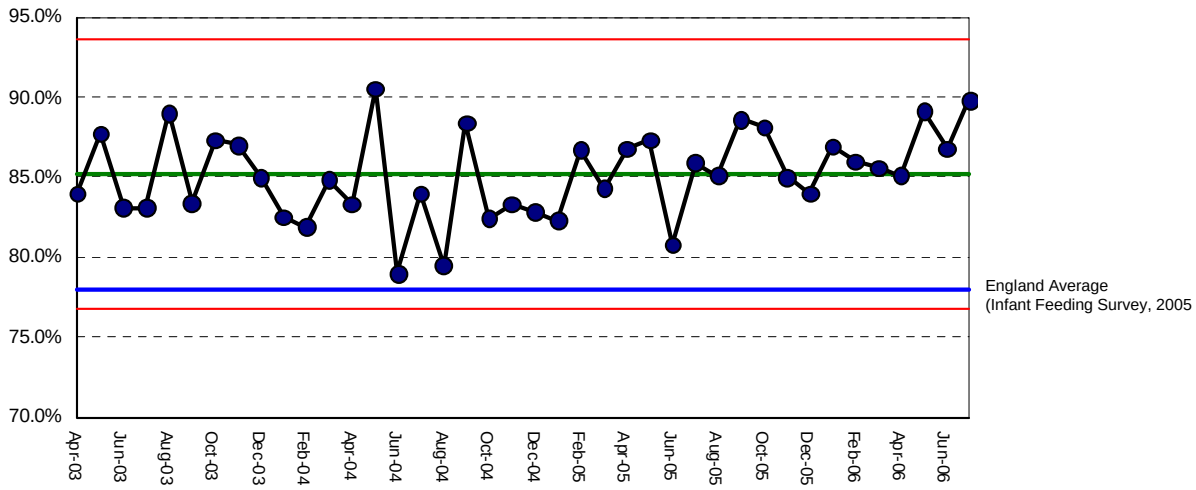
Robust data collection started in June 2004

1.3.3 Breastfeeding Rate

✓ *89.8% of mothers delivering in June 2006 initiated breastfeeding at birth***.**

Figure 3, demonstrates the Trust's breastfeeding initiation rates as consistently being well above the England average (measured in 2005). Contributing to these high rates is our postnatal support midwife who has helped with providing additional support to mothers whilst they are initiating breastfeeding. We also have a dedicated breastfeeding working group which trains all staff and health care assistants in the team to support mothers with feeding, and a Speech and Language Therapist who provides specialist advice and support to mothers who are experiencing problems.

Figure 3: Breastfeeding Rate Since April 2003



Robust data collection started in April 2003

Priority II: Supporting People with Long-Term Conditions

This priority area is designed to avoid the need for hospitalisation by promoting better self-care and treatment in a community setting or in people's homes. The principle area of focus for this Trust is the DH target to reduce emergency bed days by 5% (using the 2003/04 total as a baseline).

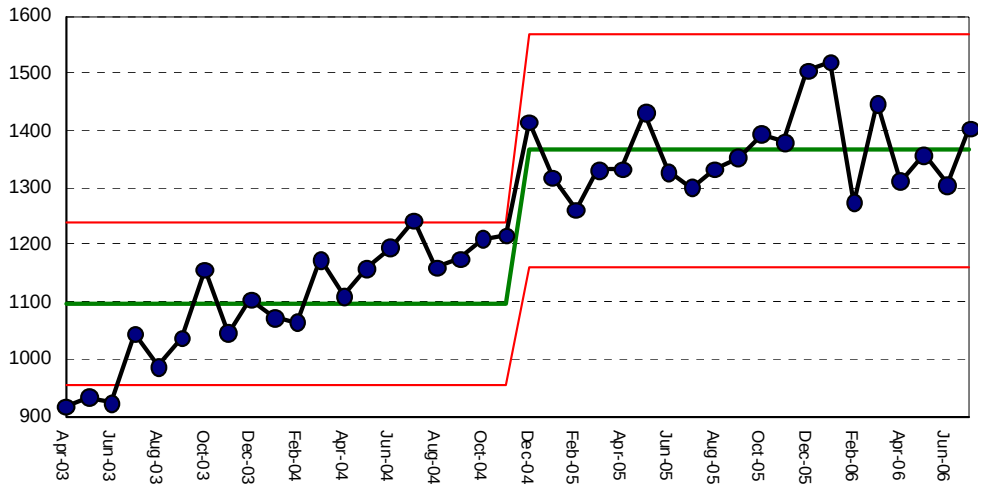
2.1 Reducing Emergency Bed Days

Reducing emergency bed days is a key service improvement project for 2006/07 for the Trust. Partner organisations in primary care are also keen to reduce hospitalisation through improvements in care delivered in primary care and community settings.

2.1.1 Activity Context: Emergency Admissions

Emergency admissions by month are shown in Figure 4. The step change in the chart shows again that we are admitting on average 1350 patients each month. This is an increase of 400 admissions on the average for 2002/03.

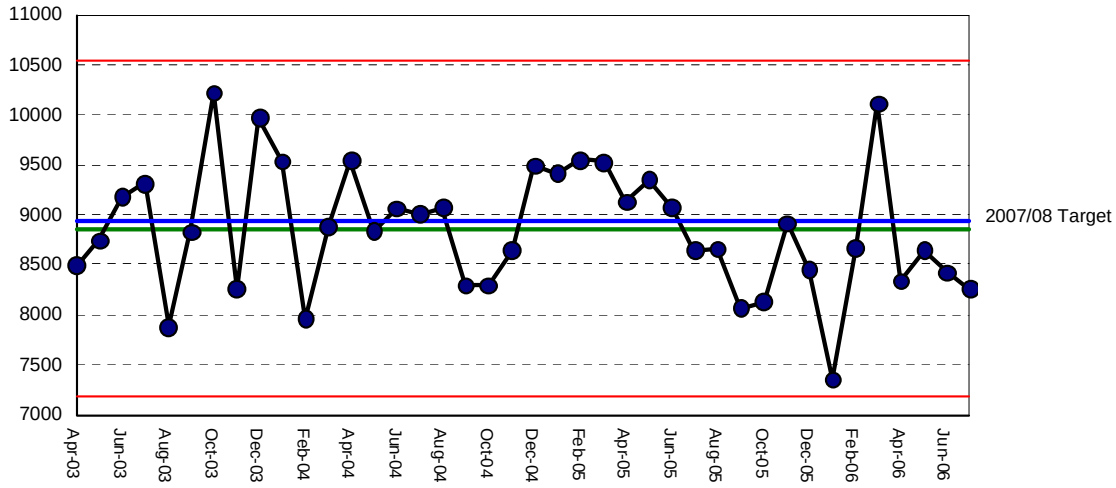
Figure 4: Emergency Admissions Since April 2003



2.1.2 Emergency Bed Days

Emergency bed days are shown in figure 5. In order to achieve a 5% reduction on the 2003/04 total, the average for 2007/08 needs to remain below the blue goal line.

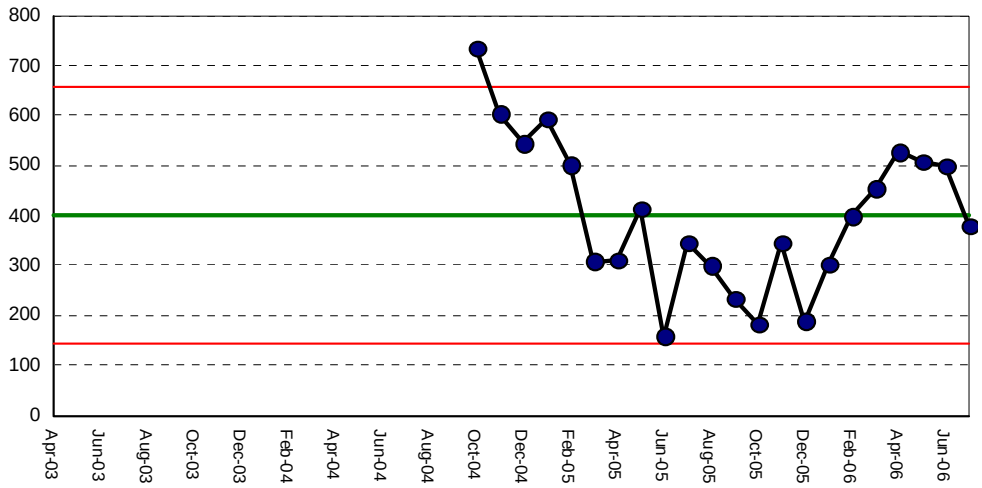
Figure 5: Emergency Bed Days Since April 2003



2.1.3 Delayed Transfers of Care

Delayed transfers of care can significantly affect the Trust's ability to achieve the required reduction in emergency bed days. Figure 6, below, depicts the number of days delayed in each month since data was first collected in October 2004.

Figure 6: Total Days Delayed from Delayed Discharges of Care from October 2004



Mandatory data collection started in January 2005

DToCs are higher than the 2005/06 average and have been rising in recent months. There are a number of reasons for this – with the most influential one being the availability of care home places and interim placements.

Priority III: Access to Services

Ensures that people have fair and prompt access to care, to the point where waiting should no longer be an issue for the majority of service users. The key national target in this area is the drive to ensure that no one waits more than 18 weeks for the total patient journey from referral to treatment by 2008. There are a number of trajectory standards to be met for the constituent parts of the patient journey, which for this year will be measured separately. Additionally, existing national access targets must be maintained.

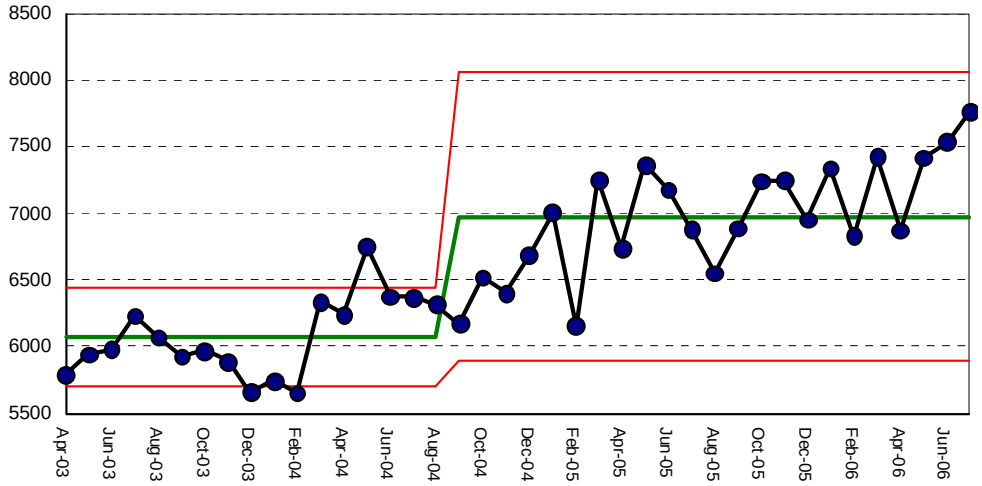
3.1 National Access Standards

This section includes the national access standards that this organisation is required to maintain. The core standards that are to be met are in the Emergency Department, during waits for Admission, and during waits for a consultant appointment.

3.1.1 Activity Context: Emergency Department Attendances

ED Department activity in July 2006 was 7,761 attendances with the monthly pattern shown in figure 7 overleaf. July 2006 is the highest total on record (with the second highest being June 2006). The department is now regularly treating more than 7,000 patients per month.

Figure 7: ED Attendances Since April 2003



Note: Activity totalled for Type I Department and WIC only.

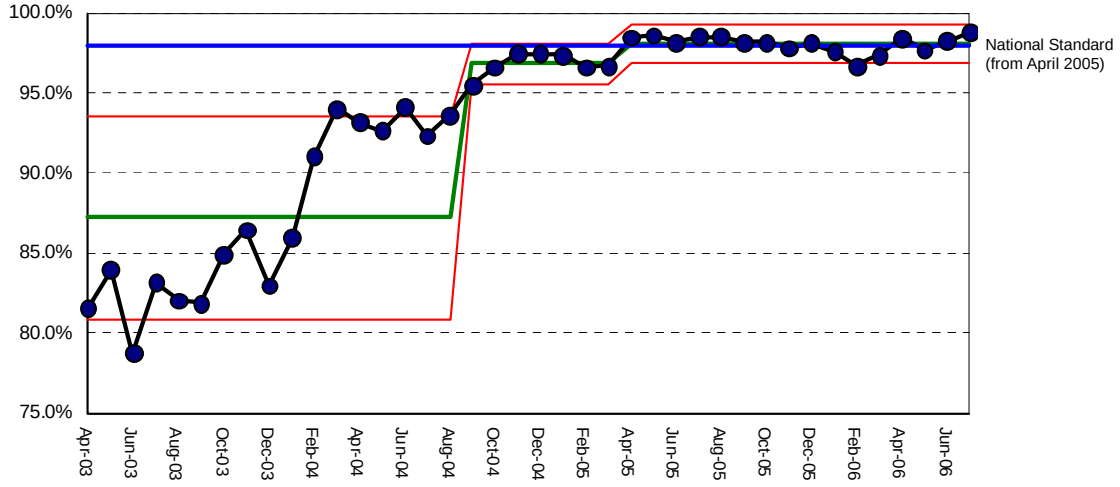
3.1.2 ED Access

Access to the emergency Department remains a key standard, which requires 98% of attendances to wait no longer than four hours from arrival until admission, discharge, or transfer (to another provider).

✓ *ED performance was 98.8% in July 2006. The YTD position is also above 98%.*

Figure 8, shows the monthly pattern of performance over the last three years.

Figure 8: ED Waits - % ADT Within 4 Hours Since April 2003



Performance in this area in 2002/03 averaged 60% rising to 70% in 2003/04.

3.1.3 Outpatient Access Times

Reducing waiting times for outpatients is a rolling programme initiated by the five year *NHS Plan* published in 2000. As with the outpatient waits, the *NHS Plan* specified a number of waiting list targets to be achieved by December 2005 and maintained throughout 2006/07.

✓ *The NHS Plan standards have been maintained into June 2006.*

3.2 Meeting the 18-Week Target

Following on from the NHS Plan, a period of eighteen weeks from referral to treatment has been publicised by the Department of Health, as the maximum time patients should expect to wait by the end of 2008. In order to make progress towards this target, there are a number of expected milestones to be achieved for each of the constituent parts of the total patient journey.

✓ 98% of patients wait less than 11 weeks to see a consultant in outpatients
✓ 98% of patients wait less than 21 weeks for admission following a decision to treat.
× Diagnostic waiting time standards have not been maintained into July 2006.

According to electronic records, there were 33 breaches of the waiting time standard for patients awaiting an MRI scan. At the time of writing this report these numbers are being checked as evidence suggests that the electronic records may be incorrect. Paper records are currently being retrieved from storage in order to confirm whether this is the case.

Priority IV: Patient Experience

This priority is concerned with the provision of information and promotion of choice, in pursuit of delivering a positive experience to ensure that service provision is more consumer focused.

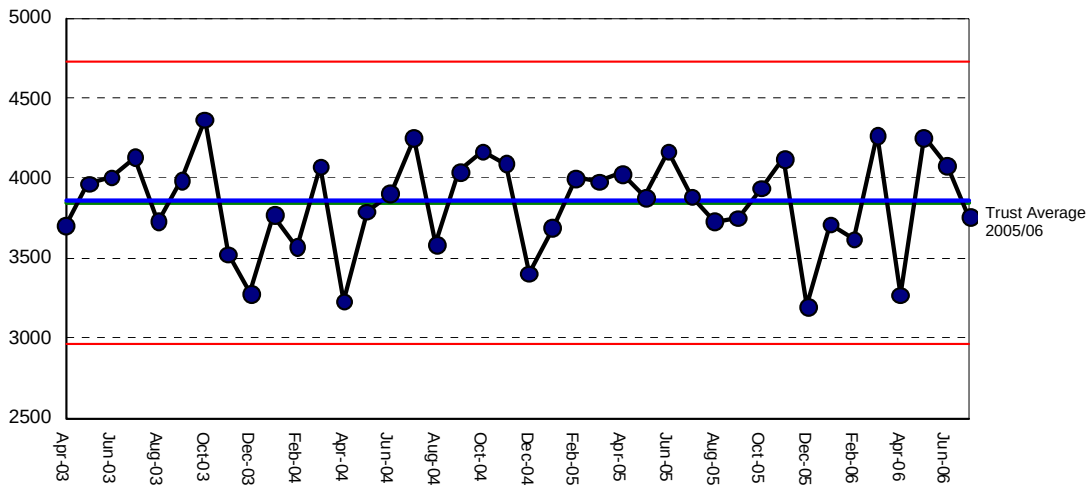
4.1 Supporting Patient Choice and Booking

Within the Choose and Book programme, targets have been set to monitor the level of choice of dates for treatment being offered to patients on the waiting list and those referred to us by a GP in the usual manner. Choice in this context includes but also extends beyond the e booking of appointments at the point of referral.

4.1.1 Activity Context: GP Referrals

GP referrals have remained static over the last three years – although the last few months have seen some large swings.

Figure 9: GP Referrals Since April 2003



4.1.2 Choice of Dates Offered to Patients

The 100% target took effect from January 1st 2006 and we achieved this across all types of booking for the month.

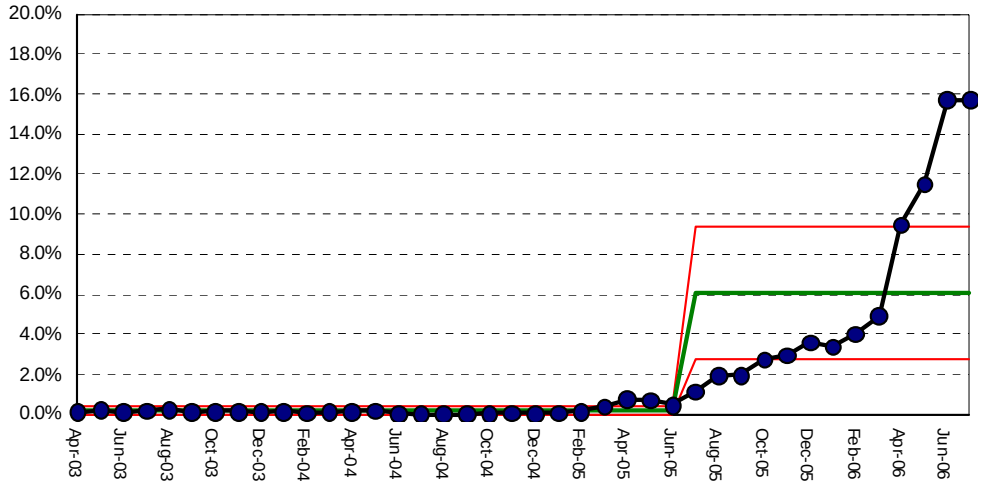
✓ *Both the elective and the outpatient targets were **achieved**.*

4.1.3 Electronic Bookings

Choose and Book (C&B) is a national initiative that combines electronic booking with the provision of choice for patients. Referrals are made using the web based Choose & Book application that sits between the GP systems and hospital Patient Administration System (PAS). The Trust is one of the first early implementers of e booking in England and our health community has been named as the "Flagship" for Choose & Book within the NHS.

Figure 5 shows the level of electronic bookings made by local GPs to this Trust since January 2003. The data clearly depicts the take-off of the new programme in March 2005, and another significant increase in April 2006, as practices are financially 'incentivised' to electronically book patients. There have been **2,030** electronic referrals since April 2006 – double the number referred during the whole of 2005/06.

Figure 10: Choose and Book (electronic) Referrals Since April 2003



From January 2003 until May 2004, a limited number of GPs could book appointments using Revive software. This was replaced in October 2004 by the Choose and Book programme.

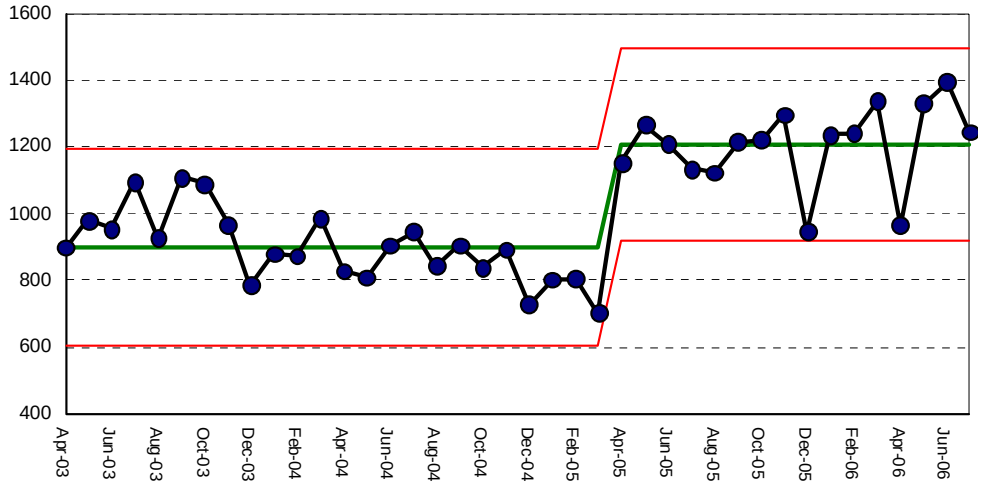
4.2 Ensuring Right of Redress following Cancelled Operations

The Trust is expected to maintain a low rate of elective operations cancelled for non-clinical reasons. Any patients whose operation was cancelled on the day have the right to be rebooked for admission within 28 days of the cancellation. This date is binding and patients who are subject to breaches of this standard are entitled to choose another time and hospital funded at the expense of this Trust.

4.2.1 Activity Context: Elective Admissions

Total elective admissions are shown, overleaf, in figure 11. Reclassifying certain procedures as day cases (previously counted as outpatients) is partly responsible for the large shift upwards from April 2005.

Figure 11: All Elective Admissions Since April 2003



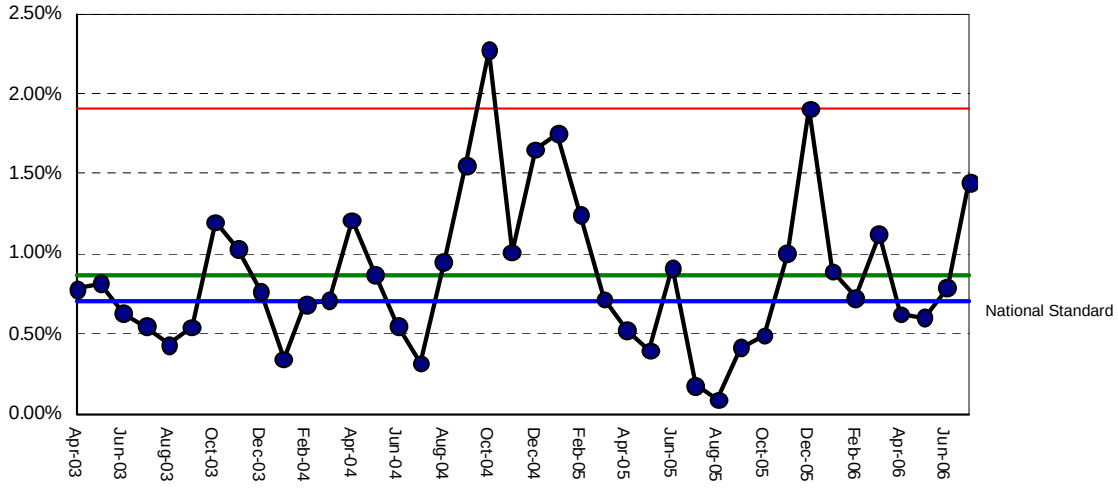
4.2.2 Cancelled Operations on the day for non-clinical reasons

✘ *At 1.45% this standard was exceeded the 0.7% target in July 2006. The YTD position is now just above this figure.*

Eighteen operations were cancelled on the day in July. Five of these occurred on July 25th due to a power failure. Another seven occurred because of staff shortages or illness. The remaining cases were a result of scheduling issues.

The cancelled operation rate for the last three years is shown in figure 12 against the national standard.

Figure 12: Elective Cancellation Rate Since April 2003



4.2.3 Cancelled Operations Rebooked with 28 Days

✓ *100% of cancelled operations were rebooked within 28 days*.

All patients were offered a date within 28 days but a number of patients exercised patient choice and chose a date after the 28-day period. This means that these patients are excluded from the breach monitoring process.

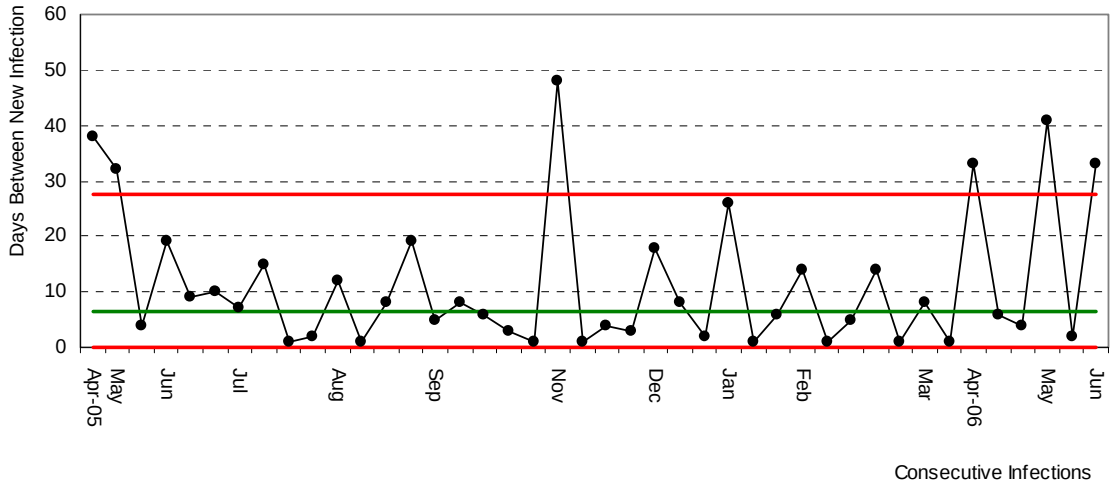
4.3 Reducing Infections

The Trust is expected to achieve year on year reductions in MRSA levels and other health care associated infections subject to mandatory surveillance.

4.3.1 MRSA bacteraemia

✘ There were 2 new incidences of MRSA bacteraemia in July. The YTD total has reached 13, which is 63% ahead of the published trajectory.

Figure 13: Incidences of new MRSA Bacteremias by the Number of Days Between Infection Since April 2005



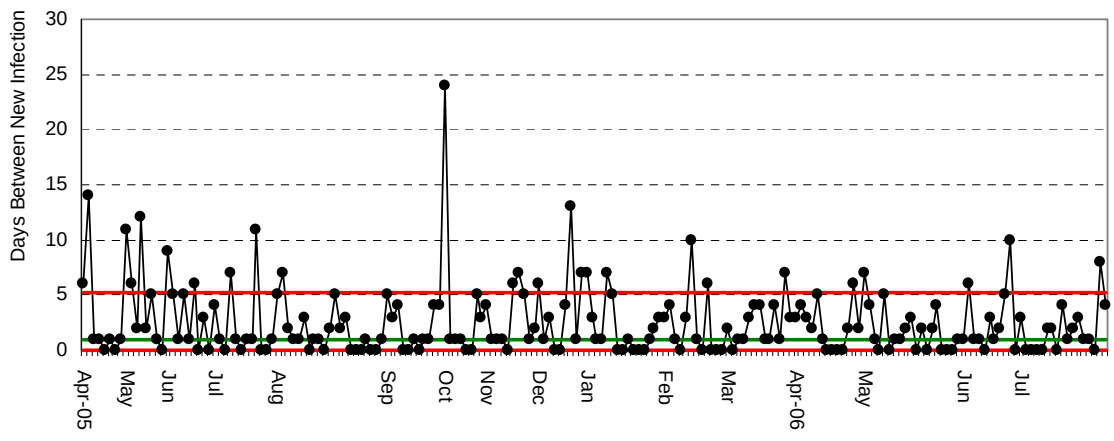
July case details not available at the time of report

4.3.2 Clostridium difficile

The incidences of C.Diff infections are more common than MRSA .

✘ There have been **15** Clostridium Difficile Infections for Patients aged over 65 in July 2006. The YTD total has now reached 58 and is exceeding the 2005/06 levels by 28%.

Figure 14: Incidences of new C. Diff Cases by the Number of Days Between Infection Since April 2005



Appendix: Activity Summary

The table below summarizes the current activity across the Trust. A comparison is drawn for the current month against the same month in the previous year. The year to date position is also compared to the same period in the previous year.

	2005/06			2006/07			
Activity Type	**05/06 Total**	**05/06 YTD**	**Jul-05**	**Jul-06**	**% Change on Month**	**06/07 YTD**	**% Change on Year**
ED Attendances	84,641	28,162	6,876	7,761	12.9%	29,587	5.1%
Emergency Admissions	16,594	5,391	1,300	1,404	8.0%	5,378	-0.2%
Elective Admissions	2,879	1,052	263	245	-6.8%	851	-19.1%
Day Cases	11,487	3,704	869	999	15.0%	4,078	10.1%
Maternity Deliveries	3,333	1,093	303	317	4.6%	1,140	4.3%
GP Referrals	46,284	15,954	3,883	3,759	-3.2%	15,358	-3.7%
First Outpatient Attendances	59,478	19,198	4,374	4,941	13.0%	19,651	2.4%
Follow Up Outpatient Attendances	123,648	41,054	9,844	10,448	6.1%	41,592	1.3%
Total Outpatient Attendances	183,126	60,252	14,218	15,389	8.2%	61,243	1.6%