

**ITEM: 4**

**MEETING: TRUST BOARD**

**DATE: May 17 2006**

**TITLE: ACTIVITY REPORT FOR MARCH 2006**

**SUMMARY:**

The attached report provides information on a wide range of performance indicators for **MARCH 2006**. These include the indicators on which will the Trust will be monitored by the Health Commission in the 2005/06 Annual Health Check as well as a number of other areas subject to improvement programmes.

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, Deputy Director of Operations**



## Performance targets

Standards	Rationale	Target	Mar	YTD	Note
<b>ED Standards</b>					
Total Time in ED: % within 4 hours	NHS Plan Standard	>98.0%	97.4%	98.1%	
No of patients waiting over 12 hours for admission	NHS Plan Standard	0	0	0	
% Patients waiting over 4 hours for admission	NHS Plan Standard	>97% (England)	96.2%	97.3%	
<b>Inpatient Waiting List</b>					
No of patients waiting over 6 months	NHS Plan Standard	0	0		
No of patients waiting over 3 months	LDP Trajectory	1180 by Mar 06	542		
% Patients waiting under 3 months	Trust Goal	35%	78.9%		
<b>Outpatient Waiting List</b>					
No of patients waiting over 13 weeks	NHS Plan Standard	0	0		
% Patients seen within 13 weeks	Trust Goal	>83% (England)	94.7%		
<b>Booking and Choice</b>					
% Outpatients booked	NHS Plan Trajectory	100% by Dec 05	100%		<sup>2</sup>
% Elective admissions booked	NHS Plan Trajectory	100% by Dec 05	100%		<sup>2</sup>
<b>Cancer Plan Standards – Updated to March 2006</b>					
From <i>Referral until Seen</i> : % seen within 14 days	Cancer Plan Standard	100%	100%	99.9%	
From <i>Decision to Treat until Treatment</i> : % treated within 31 days					
Breast cancer	Cancer Plan Standard	100%	100%	100%	
All Cancers	Cancer Plan Standard	100% by Dec 05	100%		<sup>2</sup>
From <i>Urgent Referral until Treatment</i> : % treated within 62 days					
Breast cancer	Cancer Plan Standard	100%	100%	96.6%	
All Cancers	Cancer Plan Standard	100% by Dec 05	100%		<sup>2</sup>
<b>CHD NSF Standards</b>					
% GP referrals seen in RACP Clinic within 14 days	NHS Plan Standard	100%	100%	100%	
% Thrombolysis given within 1 hour ( <i>Call to Needle</i> )	NHS Plan Trajectory	60% (+10%)	Not Available	66.7%	
<b>Capacity Measures</b>					
% of patients cancelled for non-clinical reasons	NHS Plan Standard	< 0.7%	1.15%	0.72%	<sup>1</sup>
Outpatient DNA Rate: First Attendances	Trust Goal	<14%	14.1%	15.5%	
Outpatient DNA Rates: Follow Up Attendances	Trust Goal	<16%	16.0%	16.8%	
No of patients whose transfer of care is delayed	Trust Goal	<13	13		
Wait for MRI Scan: No waiting over 26 weeks	LDP Trajectory	0 by Mar 06	0		
Wait for CT Scan: No waiting over 26 weeks	LDP Trajectory	0 by Mar 06	0		
<b>Infection Control - C.Diff updated up to December 2005</b>					
MRSA Bacteraemia Rates (1000 bed days)	HPA Surveillance	0.22 (London)	0.22	0.25	
No of MRSA Infections	LDP Trajectory	<25 by Mar 06	3	34	
C. Diff Rates per 1000 bed days for Patients over 65	HPA Surveillance	0.89 (2004)	2.19	1.77	
No of C. Diff Infections for Patients over 65	HPA Surveillance	71 (2004)	13	136	

### Notes:

The summary table above contains the key activity and performance measures that the Trust must continue to maintain or improve in 2005/6. 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 indicates that the Trust is below the standard or is behind the required trajectory, whilst red shading indicates that the Trust has to significantly improve its performance if it is to achieve its goals.

1. Cancellations as a result of the London Incident on July 7<sup>th</sup> have been excluded from these figures.
2. Performance will be judged on performance from January to March 2006

## Activity and Performance Summary

Activity Type	04/05 Total	04/05 Avg	March	05/06 YTD
ED Attendances	78,252	6,521	7,425	84,641
Emergency Admissions	21,360	1,780	1,958	23,224
Elective Admissions	2772	231	211	2,858
Day Cases	6,,600	550	1,098	11,354
Maternity Deliveries	3,240	270	274	3,333
GP Referrals	46,116	3,843	4,266	46,284
First Outpatient Attendances	55,536	4,628	5,207	54,803
Follow Up Outpatient Attendances	115,680	9,640	10,129	113,594
Total Outpatient Attendances	171,204	14,267	15,336	168,397

✓ **NHS PLAN Targets – Key inpatient and outpatient access targets were achieved at year end, along with the cancer 14-day and 31-day standards.**

### Exception Report

**Cancer 62-day Standard** – There were two breaches of this standard in February – for Breast cancer and for Lower GI.

**Emergency Department** - Whilst the in month performance against the ED 4-hour standard was **97.4%** the full year cumulative performance was **98.1%**.

**Elective cancellations** – **1.15%** (fifteen patients) of elective operations were cancelled on the day in March. Our year to date position of 0.72% has now just exceeded the standard by 0.02%.

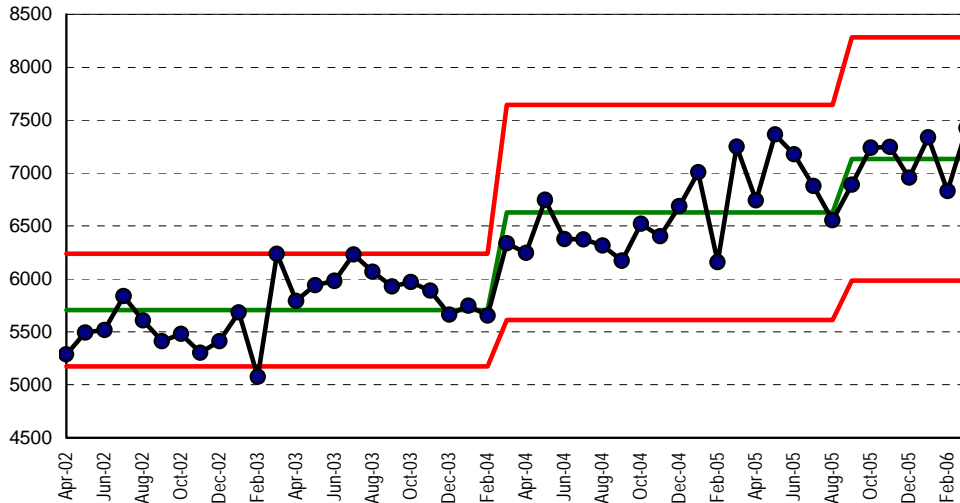
**Infection Control** – There were **3** new cases of MRSA Bacteraemia in February, which leaves the YTD total at **34**. There were a further **13** new cases of C.Diff for patients over 65. The year to date total now stands at **136**.

# 1. UNPLANNED OR EMERGENCY ACTIVITY

## 1.1 ED activity

ED Department activity in March 2006 was 7,425 attendances with the monthly pattern shown in figure 1 below. There have now been seven consecutive months of higher than average activity and an in year step change has been added to reflect the growth. The ED now treats more than 7,000 patients per month

Figure 1: ED Attendances Since April 2002



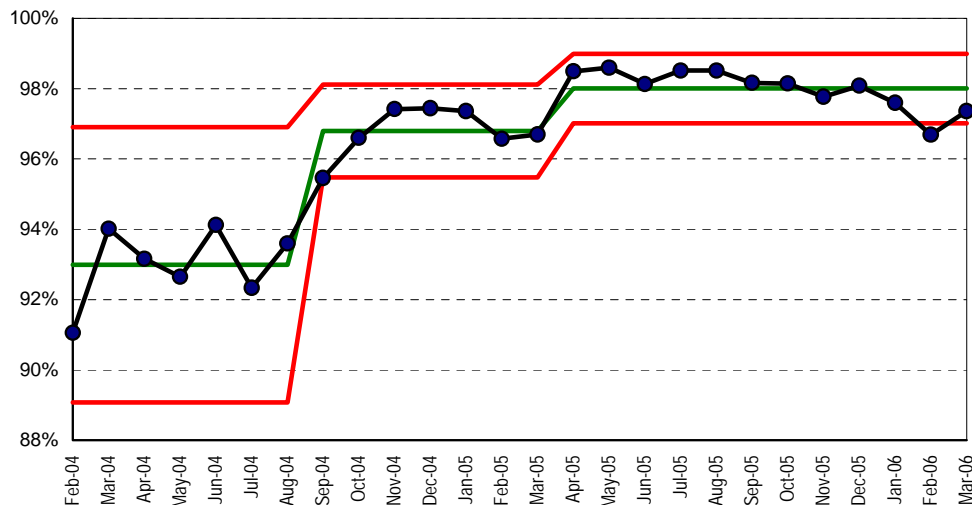
SPC Analysis: Moving Range; Note: Activity totalled for Type I Department and WIC only.

## 1.2 ED Access

Whilst the Trust under performed against the 98% 4-hour target in the month of March, the year to date target of 98% of patients being Admitted, Discharged or Treated within 4 hours has been achieved.

- ✓ Year to date ED position remains at 98.1%, (average over the last twelve months).
- ✗ 96.2% of patients in ED waited no longer than 4 hours for a bed

Figure 2: ED Waits - % ADT Within 4 Hours Since Feb 2004

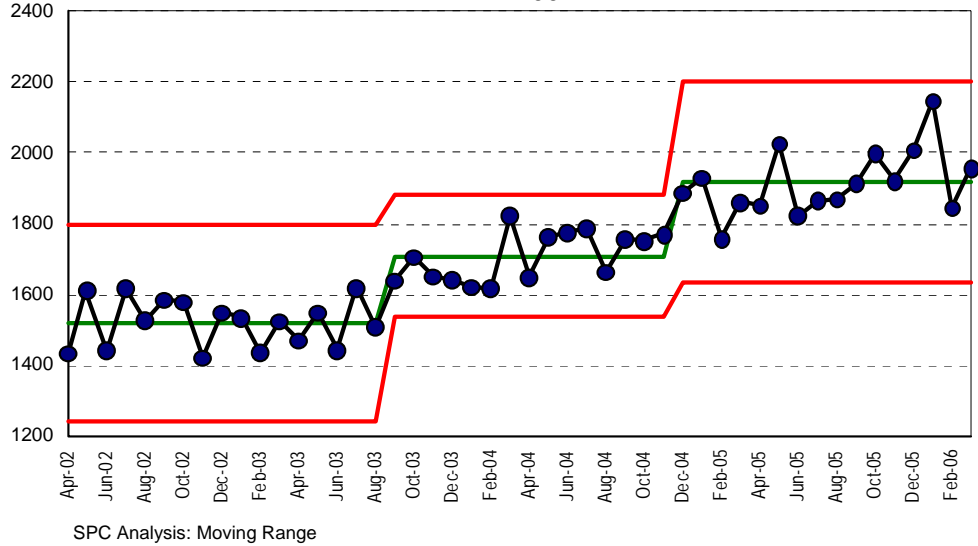


SPC Analysis: Moving Range

### 1.3 Emergency Admissions

Non-elective admissions by month are shown in figure 3. The second step change in the chart shows again that we are admitting on average 1900 patients each month. This is an increase of 400 admissions on the average for 2002/03.

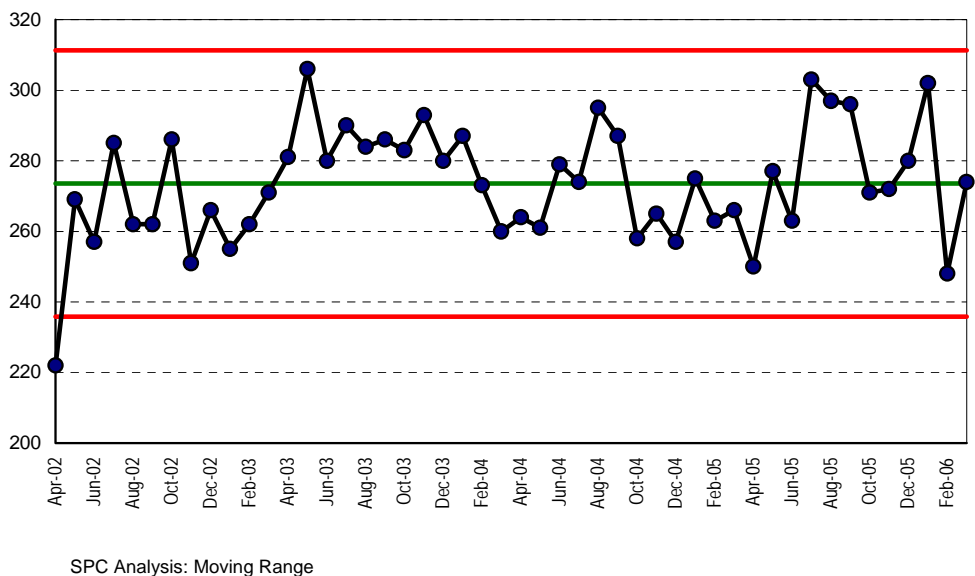
**Figure 3: Non-Elective Admissions (excluding Well Babies) Since April 2002**



### 1.4 Deliveries

There were 274 deliveries in March. 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 4: Deliveries Since April 2002**



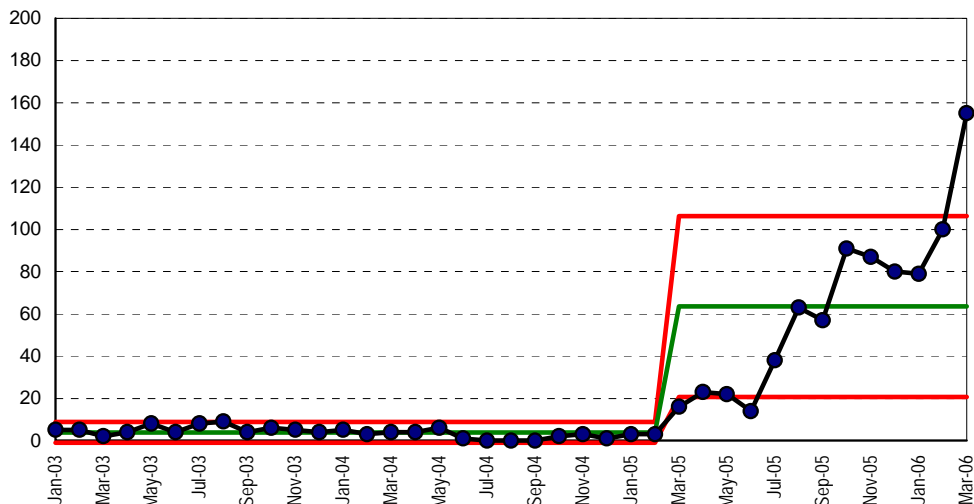
## 2. PLANNED ACTIVITY

### 2.1 Electronic Bookings

The ability of patients to choose their own dates with booking systems available at the point of referral is a key NHS initiative. 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 there have been **809** electronic referrals to date. Since October we have been consistently booking volumes of 80+ patients per month, but in March this number doubled. It is anticipated that these numbers will continue to rise, as from April 2006 GPs are given further financial incentive to increase the volumes of electronic bookings made.

**Figure 5: Choose and Book (electronic) Referrals Since January 2003**



SPC Analysis: Moving Range; 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.

### 2.2 Choice

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

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

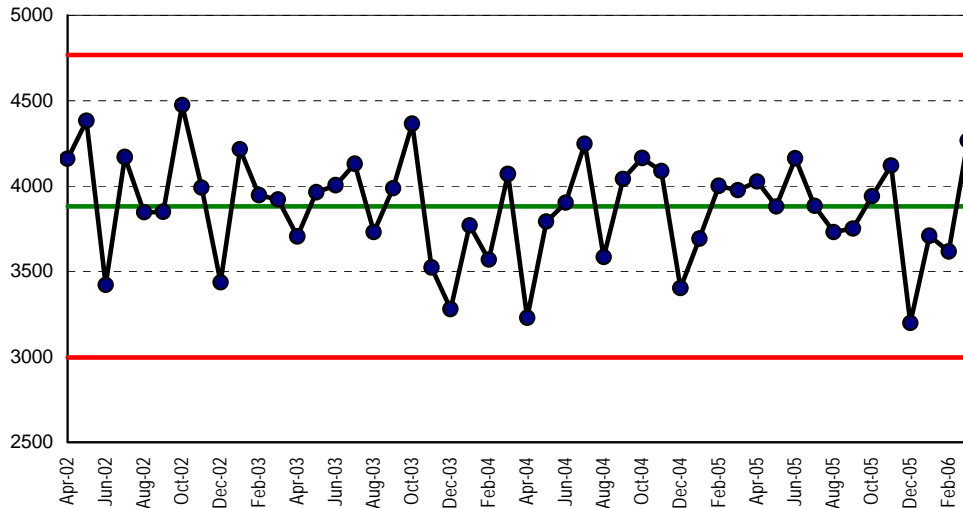
%Choice Offered	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
Outpatients	69	69	65	69	68	69	71	86	84	96	100	100	100
Day Cases <sup>1</sup>	100	95	93	92	96	93	94	96	98	98	100	100	100
Inpatients	36	51	51	42	57	45	45	72	77	76	100	100	100
All Elective	82	83	83	79	86	83	82	91	94	95	100	100	100

1. The SHA expected us to meet 100% of Day Case bookings by March 2005

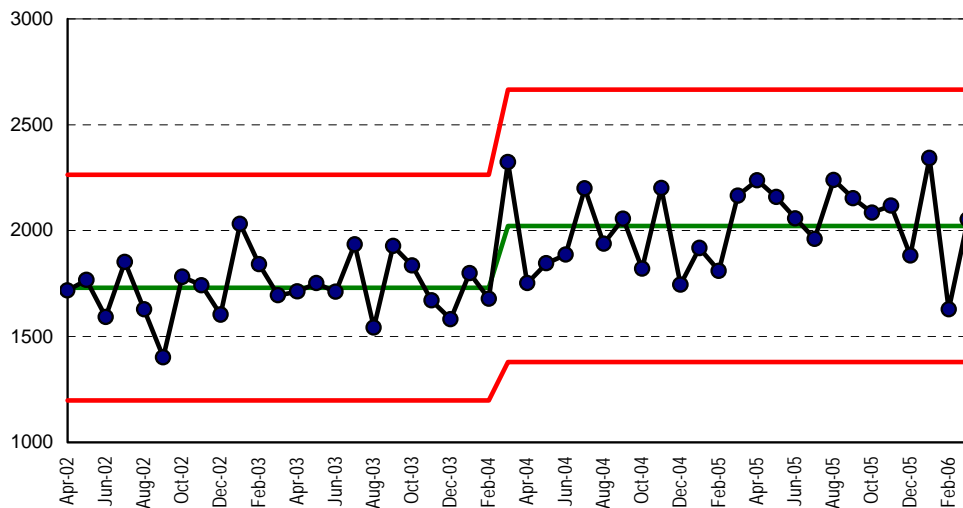
### 2.3 Outpatient Referrals

Figures 6 and 7 show the volumes of GP and Consultant referrals to outpatient Consultant clinics over the last three years. PCT demand management schemes are beginning to take shape, and Practice based Commissioning comes into effect until 1<sup>st</sup> April 2006. There is an expectation that both will have an impact upon GP referrals volumes and patterns, which may result in a reduction in referrals, whilst the expected increase in direct bookings may result in an increase in GP referrals.

**Figure 6: GP Referrals Since April 2002**



**Figure 7: Consultant (internal and external) Referrals Since April 2002**



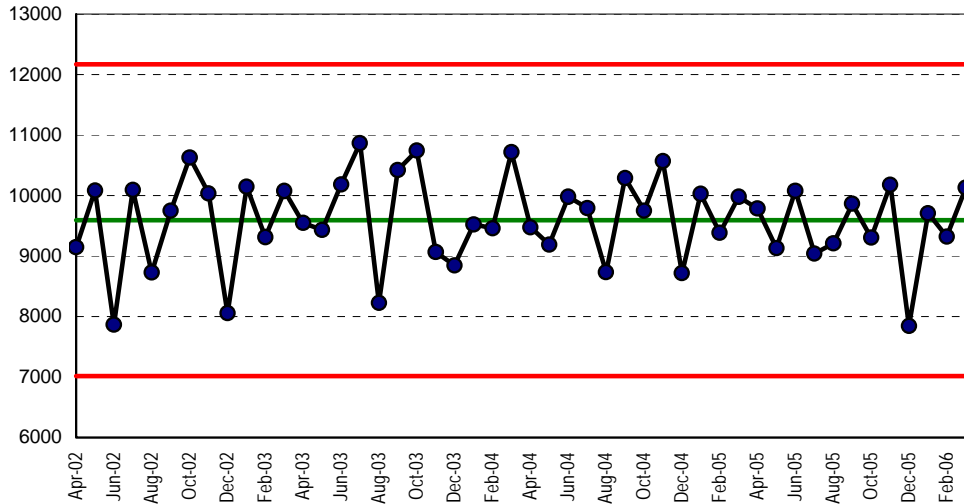
SPC Analysis: Moving Range

PCT demand management schemes will introduce controls around Consultant to Consultant (internal) referrals with an expectation that these will decrease.





**Figure 10: Follow Up Attendances Since April 2002**



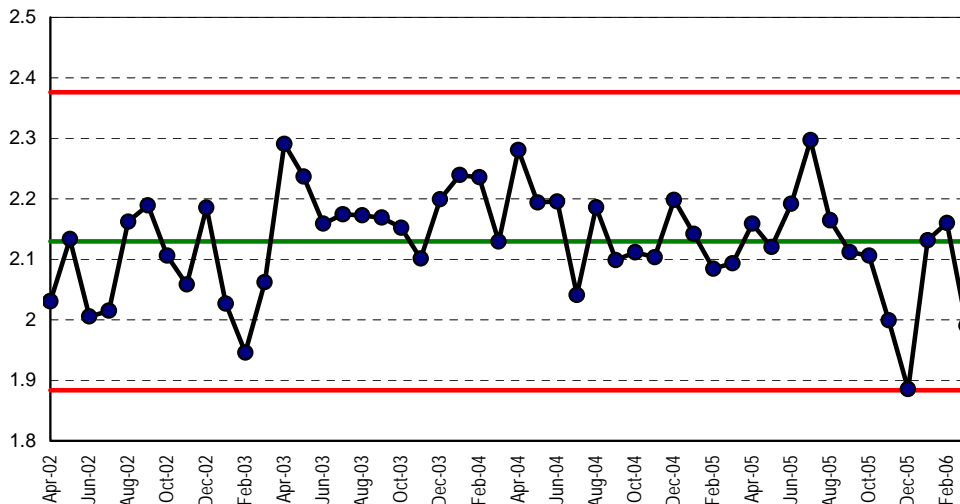
## 2.7 Outpatient Follow Up Rates

We aim to eliminate unnecessary follow up appointments - work-streams within the *Changing Outpatients* and *Making Best Use of Beds* projects are focusing on reducing unnecessary follow-ups. Initiatives include changing the diagnostic pathway, creating one stop services, the development of new care pathways for the management of long term conditions, including a greater community focus, and the introduction of virtual clinics and telephone consultations. Likewise PCT demand management schemes are also focused upon reducing unnecessary follow up appointments as well as shifting some follow up work into primary care.

With a score of **2.11** in March, the Whittington's **overall** follow-up rate is well below the national average of 2.30. However some specialities have higher than national average follow up rates, which will be subject to closer scrutiny over the next year.

Figure 11, below, shows the Trust's overall follow up rate over time for acute specialties only.

**Figure 11: First to Follow Up Ratio Since April 2002**

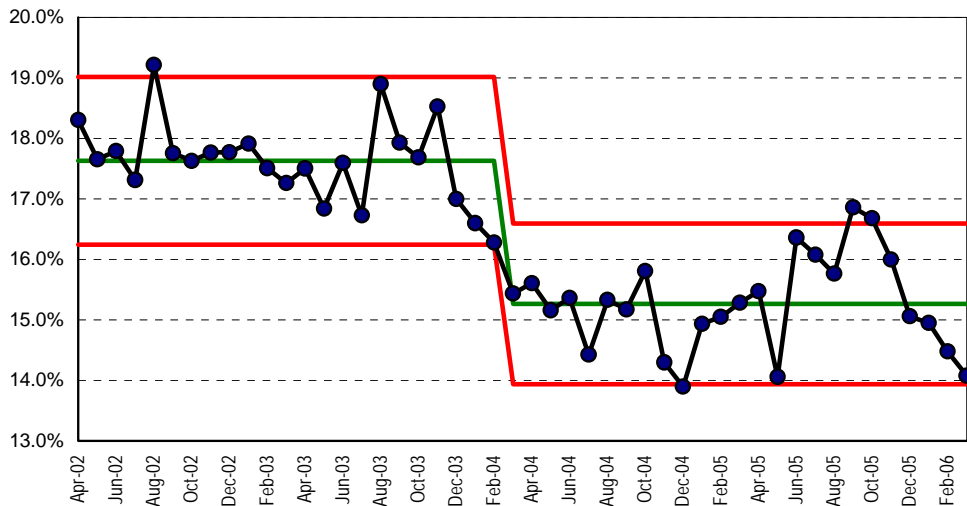


SPC Analysis: Moving Range

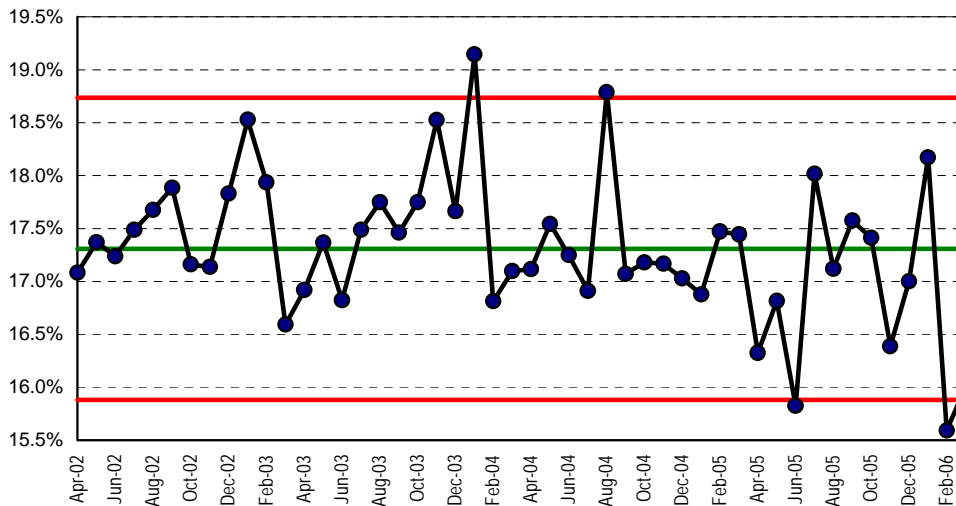
## 2.6 Outpatient DNA rates

Figure 12 shows an overall reduction in DNA rate for first outpatient appointment since the beginning of 2004 as a result of the proactive approach to managing this issue. The DNA rates were affected recently by the terrorist incidents in July 2005. The recommencement of SMS (text messaging) appointment reminders in December looks to be contributing again to the improvements in the DNA rate over the last few months.

**Figure 12: DNA Rate - First Appointments Since April 2002**



**Figure 13: DNA Rate - Follow-up Appointments Since April 2002**

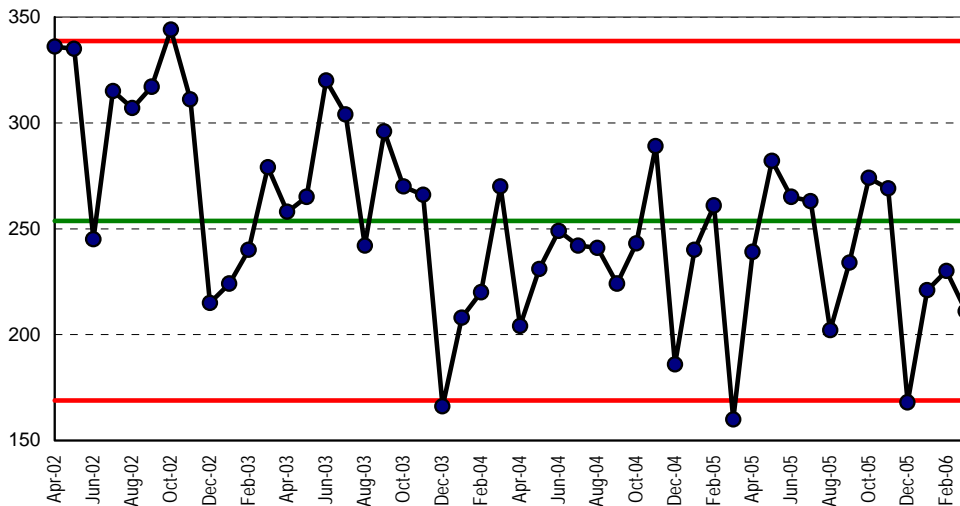


SPC Analysis: Moving Range

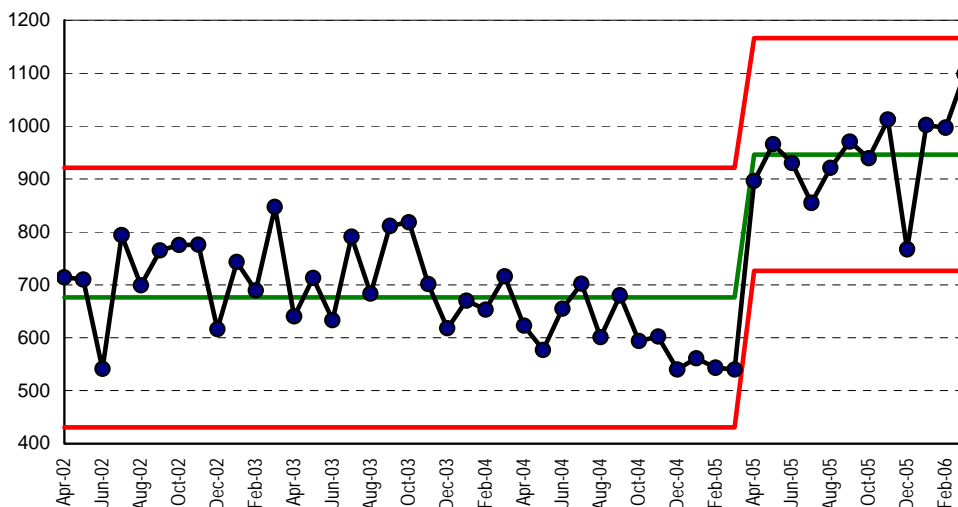
## 2.7 Elective Inpatient and Day case activity

Figures 14 and 15 show the numbers of inpatient and day case admissions over the past three years. Both charts show a high degree of variability in the data. Inpatient activity remains lower than the norm due to a planned reduction in the inpatient activity programme in the latter months of the financial year. The corresponding increase in day cases reflects the drive to undertake additional day case activity during the reduced inpatient activity period.

**Figure 14: Elective Inpatient Admissions Since April 2002**



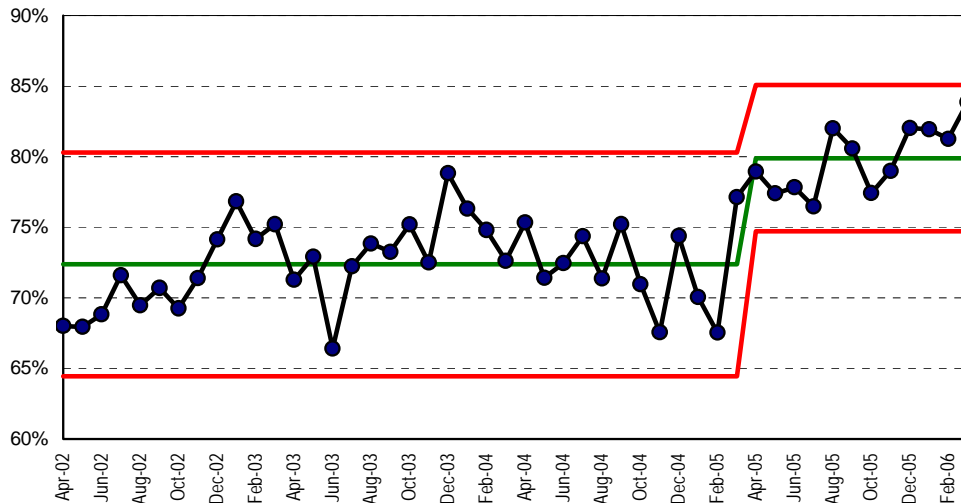
**Figure 15: Elective Day Case Admissions Since April 2002**



The significant change in the numbers of day cases from April 2005 onwards can be attributed to a change in recording practice for endoscopies where brings us into line with the recording practice at a number of local providers in North Central London. Endoscopy procedures at the Whittington have been previously recorded the point of care in an outpatient rather than day care setting. We have agreed with our local PCTs to rectify this recoding issue in-year.

The change in day case rates (based on the data in figures 14 and 15) shown in figure 16 also show a high level of variability from month to month but as would be expected, the change in recording practice as well as the success of the Day Case rate project has resulted in a step change with the year to date average over 80%. In addition to this, a higher number of day cases are being undertaken in the back end of the year to reduce the demand upon beds.

Figure 16: Day Case Rate Since April 2002



SPC Analysis: Moving Range. These figures are for admissions in all specialties.

## 2.8 Inpatient Access Times

As with the outpatient waits, the *NHS Plan* specified a number of waiting list targets to be achieved by December 2005. The current target requires no patient to wait longer than nine months for admission, and reduced to six months at the end of 2005.

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

Following on from the NHS Plan, a wait of eighteen weeks from referral to treatment has been publicised by the Department of Health as the maximum that patients should expect by the end of 2008. As progress to this target, patients should wait no longer than 3 months for admission by March 2008.

✓ Currently 79% of our patients wait less than 3 months so we are well placed to meet the 2008 target.

% 3 month standard	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
All Patients	83	80	80	82	81	80	83	86	96	81	78	78	79

## 3. CONDITION-SPECIFIC STANDARDS

### 3.1 Cancer Access Times

Cancer waiting times have been a national performance indicator since the publication of the *Cancer Plan*. There are a number of targets covering the patient pathway from GP referrals to treatment in hospital. The following relate to **March** performance:

✓ *All GP urgent referrals for all cancers were seen within 2 weeks.*

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

✓ *All GP urgent referred cancer patients were treated within 62 days from the referral date.*

There were two breaches of the 62-day standard for the treatment of breast cancer and for a lower GI cancer in February.

### 3.2 Cancer Access Times for All Sites

31 day standard	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
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
Haematological	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
Skin	100	100	100	100	100	100	-	100	100	-	100	100	100
Gynaecological	100	0	100	-	100	-	100	100	-	100	100	100	-
Head & Neck	-	-	-	100	-	-	-	-	100	-	-	-	-
Other	100	-	-	-	-	-	100	-	-	100	-	-	-
Upper GI	-	100	-	-	-	100	-	100	100	100	-	100	100
Urological	100	89	95	100	85	100	100	100	100	100	100	100	100
Breaches	0	2	1	0	2	0	0	0	0	0	0	0	0
Patients		31	38	23	33	28	38	44	30	38	35	33	35

62 day standard	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
Breast	100	100	100	100	-	100	100	100	100	100	100	86	100
Lower GI	100	-	100	-	100	100	100	-	100	0	100	0	100
Haematological	100	-	100	-	100	-	-	100	-	100	100	100	100
Gynaecological	100	-	-	-	-	-	100	-	0	-	100	-	-
Lung	50	-	-	0	100	100	100	100	100	100	-	-	100
Other	100	-	-	-	-	-	-	-	-	-	-	-	-
Skin	-	0	-	-	100	-	-	100	100	100	100	100	100
Upper GI	-	100	-	-	-	-	-	-	-	-	-	-	-
Urological	0	100	100	67	33	100	100	100	100	100	100	100	100
Breaches	3	1	0	2	2	0	0	0	0.5	1	0	2	0
Patients		5	10	5	8	10	10	10	11.5	13	9.5	14.5	13.5

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

The national standards take effect from January 1<sup>st</sup> 2006 onwards. Our understanding is that the tolerances are to be 98% for 31 day target and 95% for 62 day target and that performance will be measured on achievement of the target for Q4 (January-March 2006). The updated Quarter 4 position is as follows:

- ✓ 14 day – 100%
- ✓ 31 day – 100%
- ✗ 62 day – 94.8%

### 3.3 CHD NSF Access Times

There are two standards from the National Service Framework for Coronary Heart Disease that are 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. The RACP target has consistently been met throughout the year.

- ✓ *All GP referrals to Rapid Access Chest Pain Service were seen within 2 weeks*

14 day standard	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
All Clinics	98	100	100	100	100	100	100	100	100	100	100	100	100

- ✗ *There was no recorded ambulance time for the eligible patient.*

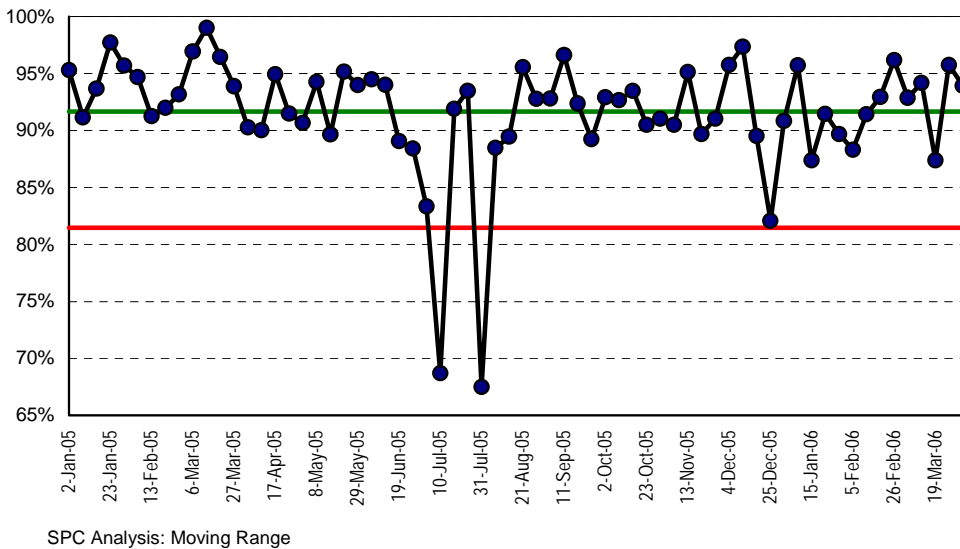
60 minute standard	Mar 2005	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006	Feb	Mar
% Patients	50	50	0	NA	NA	NR	100	100	NA	0	NA	NA	NR
No. Eligible	2	2	1	0	0	1	1	3	0	1	0	0	1

## 4. CAPACITY

### 4.1 Bed Occupancy

Figure 17 depicts a series of weekly snapshots of the Trust's bed occupancy. The major swings in July's data demonstrate the Trust's Major Incident Response to the potential impact of the terrorist attack on occupancy rates. From August onwards, the bed occupancy rate has resumed its usual level at around 91%. The two large 'dips' in the pattern reflect elective admission slow downs over Christmas closures.

**Figure 17: % Acute Bed Occupancy Since Jan 2005**

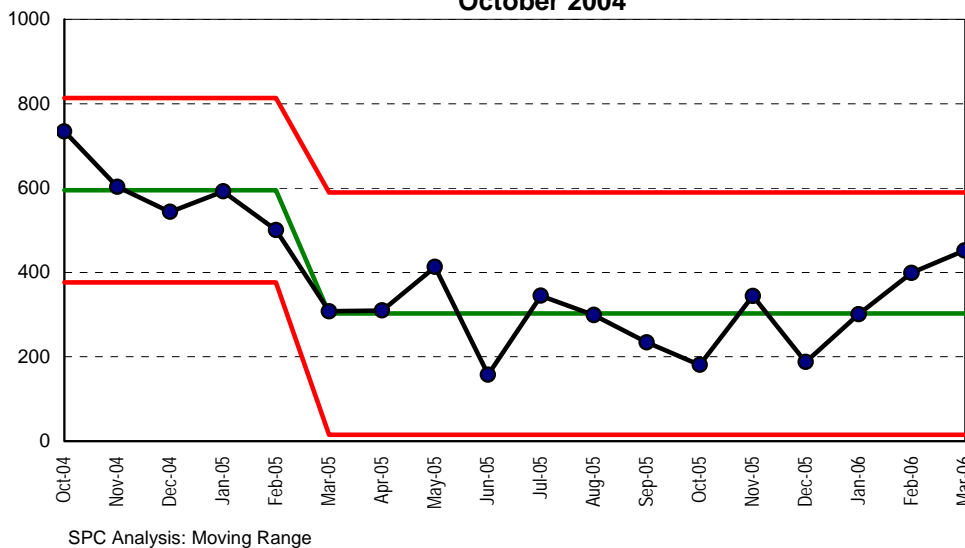


### 4.2 Delayed Transfers of Care

February saw an average of 14 delayed patients, higher than average. A more realistic indicator of performance improvement in this area can be seen in figure 18, below, which depicts the number of days delayed in each month since data was first collected in October 2004.

Over the last few months there is an average of 280 bed day attributed to delayed transfers of care. This equates to about 3% of the total occupied beds over this time and is now under half the average when monitoring first began in 2004.

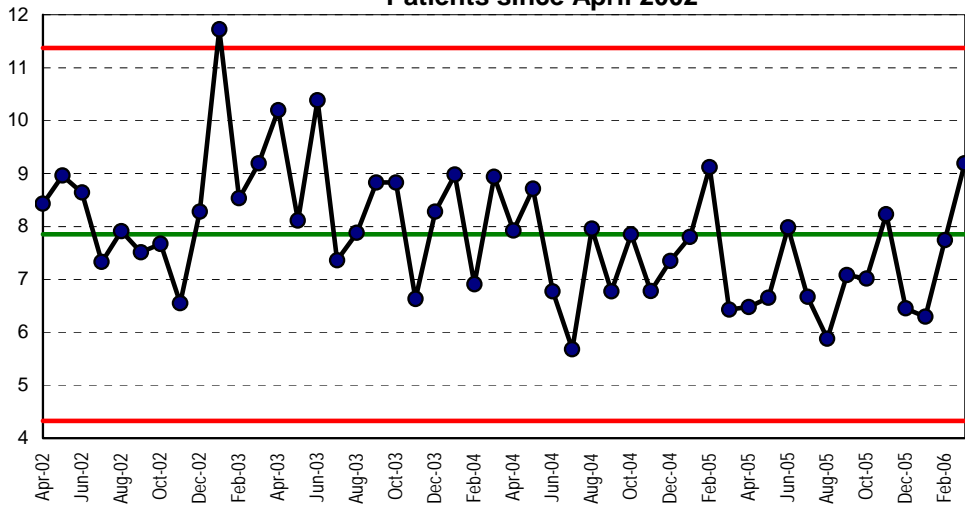
**Figure 18: Total Days Delayed from Delayed Discharges of Care from October 2004**



## 4.2 Average Length of Hospital Stay

Figures 19 to 21 provide an analysis or baseline for length of stay for acute services (medicine and surgery) by admission type (elective and non elective). This data shows the average lengths of stay for discharges on a monthly basis from April 2002.

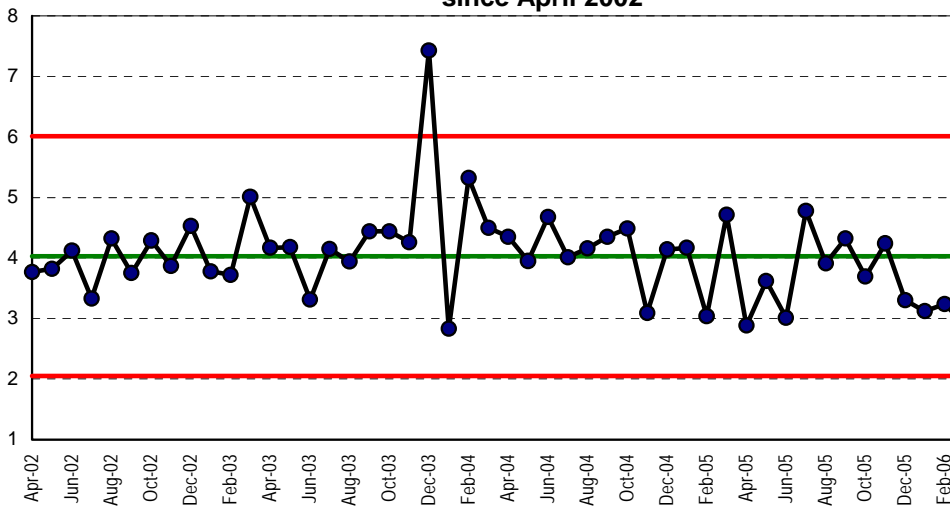
**Figure 19: Average Length of Hospital Stay - Non-Elective Surgical Patients since April 2002**



SPC Analysis: Moving Range

In figure 20, there is a reasonably stable level of variation (apart from a single blip) over the monitored period for elective surgical patients. The recently opened Patient Admission Unit opened is having a significant impact on the start times of operating lists and should contribute to reductions in elective length of stay as well as operating theatre efficiency.

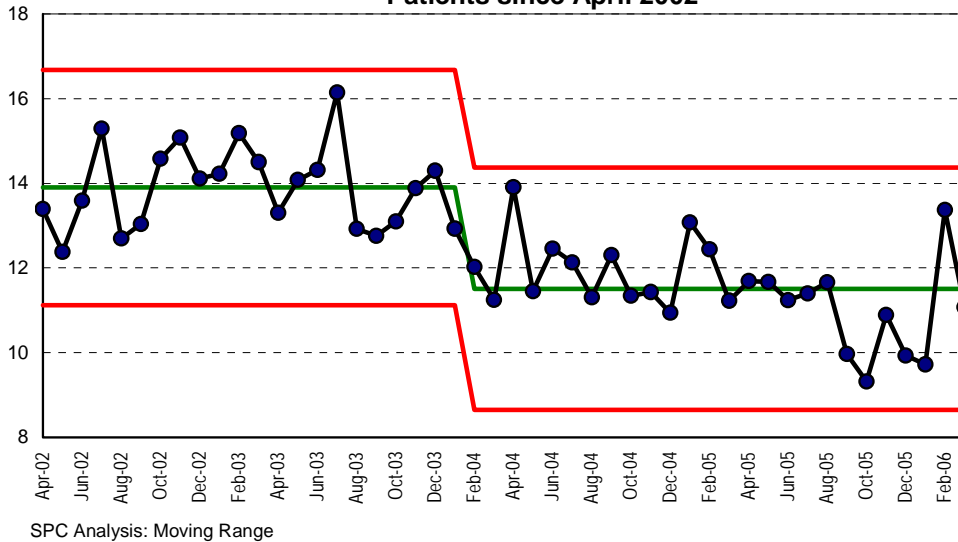
**Figure 20: Average Length of Hospital Stay - Elective Surgical Patients since April 2002**



SPC Analysis: Moving Range

Medical length of stays are shown in figure 21 overleaf. The rise in length of stay in February is considered to be attributable to the high numbers of particularly sick patients admitted in month, staff (particularly AHP staff) sickness and an increase in the number of DTocS. The LoS in March reduced again.

**Figure 21: Average Length of Hospital Stay - Non-Elective Medical Patients since April 2002**

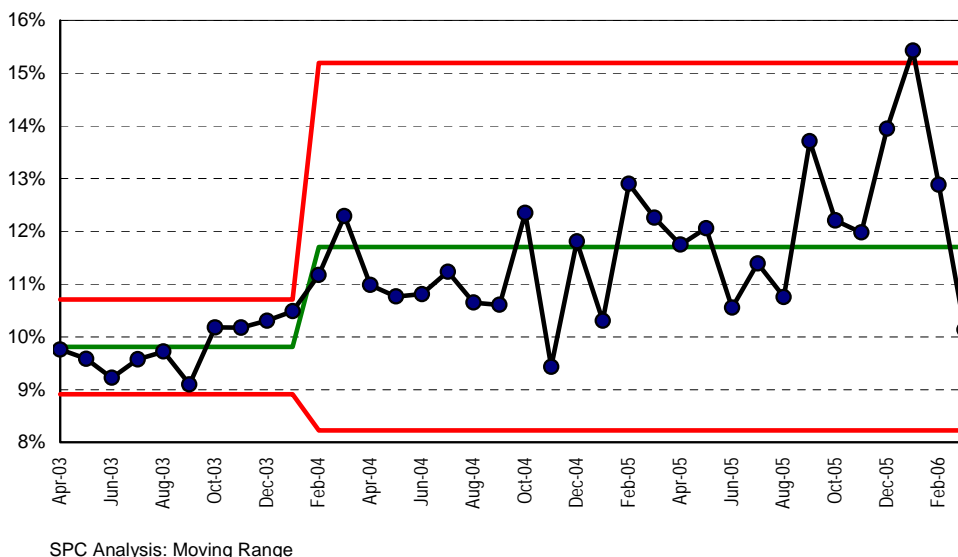


LOS reduction will be a key focus for the Trust in 2006/7, with resources being re-aligned to support further reductions. As a consequence, this section of the report will be developed to report progress.

### 4.3 Readmission Rates

Figure 22 presents re-admission rates, based as far as possible (but not standardised for age, sex and clinical complexity) on the national methodology used for intra-trust comparisons. The change in variation from January 2004 onwards can be attributed to the higher numbers of patients admitted through the Emergency Department and improved data collection. The January, February and March rates show some dramatic shifts in variation.

**Figure 22: Emergency Re-admission Rate Since April 2003**



Note: It is not possible for individual Trusts to fully replicate the methodology used in national comparisons because re-admissions at other providers should be included. The data counts emergency re-admissions within 28 days of a patient's last discharge and excludes day cases, patients under the age of 16, maternity admissions and admissions



that include a diagnosis of cancer. The rate is shown as a percentage of all live adult discharges that comply with the conditions above.

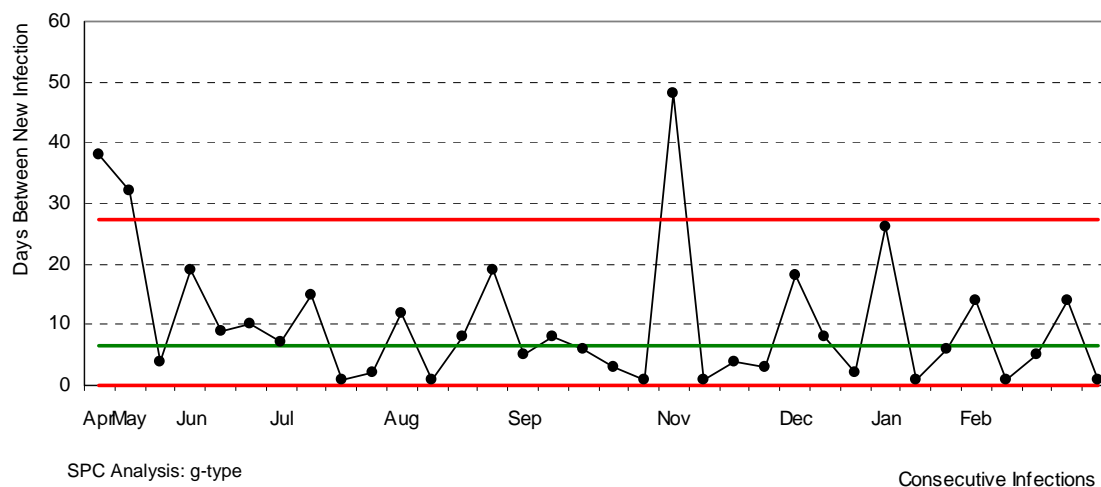
## 5. INFECTION CONTROL

### 5.1 MRSA bacteraemia

Over the current financial year there has been an average of 8 days between each detected incidence of MRSA bacteraemia. In the last twelve months there appears to be a relatively stable system with no evidence of epidemic infections.

- ✗ There were **3** new incidences of MRSA in the Trust in March, leaving the YTD total to **34**. We have now exceeded the trajectory ceiling of 29.

**Figure 23: Incidences of new MRSA Bacteremias by the Number of Days Between Infection Since April 2005**

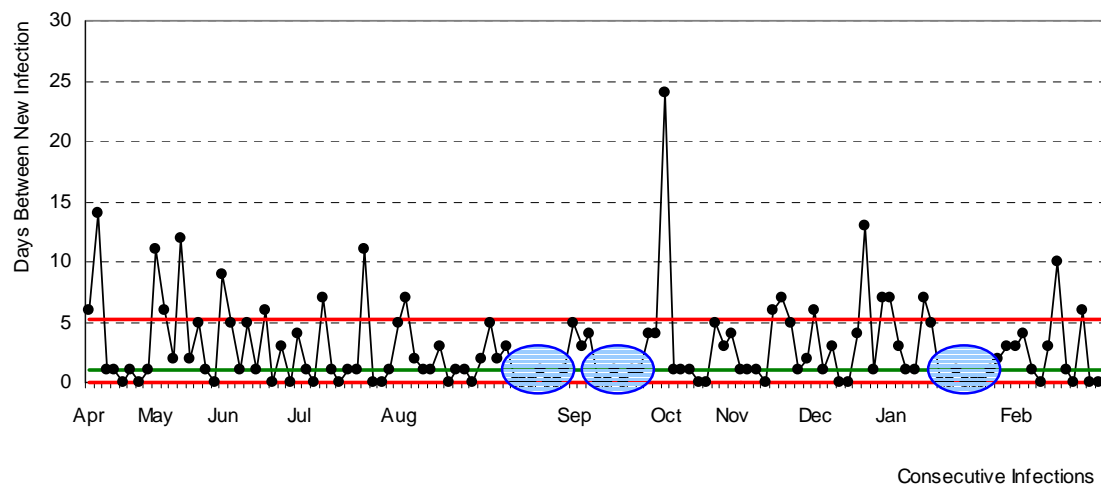


### 5.2 Clostridium difficile

The incidences of C.Diff infections are more common than MRSA bacteraemia with a new infection detected on average every day. From the data presented in figure 24, overleaf, it can be seen that there are a large number of same day infections throughout August and early September, and again in January 2006, which indicates a significant increase in the infection rate. These periods are highlighted below.

- ✗ There have been **136** Clostridium Difficile Infections for Patients aged over 65 in the period April 2005 to March 2006.

**Figure 24: Incidences of new C. Diff Cases by the Number of Days Between Infection Since April 2005**



SPC Analysis: g-type