

**ITEM: 4**

**MEETING: TRUST BOARD**

**DATE: 15 MARCH 2006**

**TITLE: ACTIVITY REPORT FOR JANUARY 2005**

**SUMMARY:**

The attached report provides information on a wide range of performance indicators for **JANUARY 2005**. 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	Jan	YTD	Notes
<b>ED Standards</b>					
Total Time in ED: % within 4 hours	NHS Plan Standard	>98.0%	97.6%	98.3%	
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)	97.4%	97.6%	
<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	533		
% Patients waiting under 3 months	Trust Goal	35%	78.4%		
<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)	91.7%		
<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 December 2005</b>					
From <i>Referral until Seen</i> : % seen within 14 days	Cancer Plan Standard	>98%	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 Trajectory	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%	100%	
All Cancers	Cancer Plan Trajectory	100% by Dec 05	92.3%		<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%)	-	66.7%	
<b>Capacity Measures</b>					
% of patients cancelled for non-clinical reasons	NHS Plan Standard	< 0.7%	0.9%	0.67%	<sup>1</sup>
Outpatient DNA Rate: First Attendances	Trust Goal	<14%	15.1%	15.7%	
Outpatient DNA Rates: Follow Up Attendances	Trust Goal	<16%	18.4%	17.5%	
No of patients whose transfer of care is delayed	Trust Goal	<13	10		
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)	0.24	0.24	
No of MRSA Infections	LDP Trajectory	<25 by Mar 06	3	29	
C. Diff Rates per 1000 bed days for Patients over 65	HPA Surveillance	0.89 (2004)	NYA	1.69	
No of C. Diff Infections for Patients over 65	HPA Surveillance	71 (2004)	NYA	96	

### 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 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. 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 2006

## Activity Summary

Activity Type	04/05 Avg	January	YTD
ED Attendances	6,521	7,338	70,385
Emergency Admissions	1,780	2,122	19,390
Elective Admissions	231	218	2,418
Day Cases	550	1,000	9,268
Maternity Deliveries	270	302	2,811
GP Referrals	3,843	3,709	38,401
First Outpatient Attendances	4,628	4,597	47,056
Follow Up Outpatient Attendances	9,640	9,501	97,360
Total Outpatient Attendances	14,267	14,098	144,416

### Performance Summary for the month

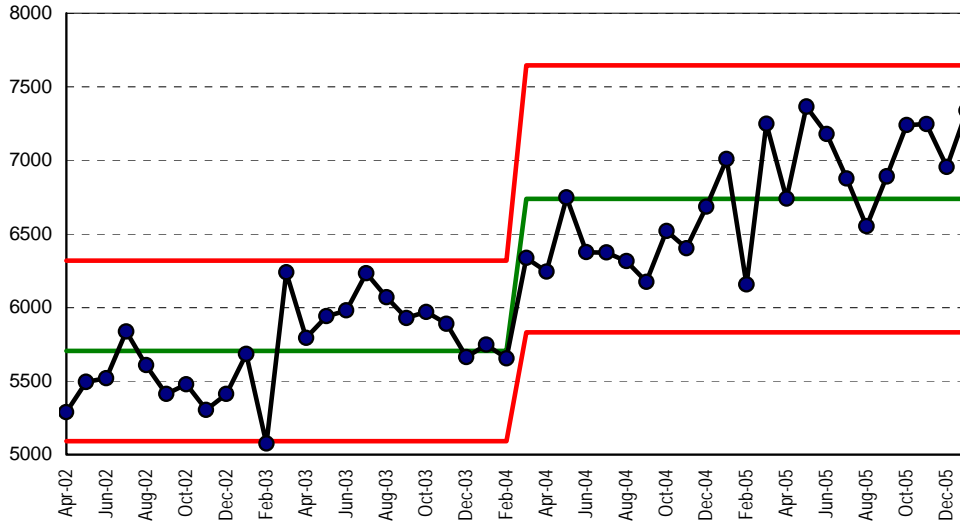
- ✓ **NHS PLAN Targets** – All inpatient and outpatient waiting time targets continue to be met.
- ✓ **Choose and Book** – The inpatient and outpatient booking targets have been achieved.
- ✓ **RACP Clinic** - The improvement actions that were implemented from January 2005 have been maintained and the Trust continues to achieve **100%**.
- ✓ **DToCs** – An average of **10** patients were subject to a delayed discharge in January.
- ✓ **Cancer 2 week waits** –The two-week standard was **achieved** in December.
  - Emergency Department** - The performance against the ED 4-hour standard was **97.6%** for the month but the year to date performance is still above the required standard at **98.3%**.
  - Cancer treatment waits** – The 31-day standard was **achieved** but there was a **breach** of the 62-day standard in December.
- ✗ **Elective cancellations** – **0.9%** (eleven patients) of elective operations were cancelled on the day in January. Seven of these cases were on General Surgery lists. However, our position needs to be less than 0.7% for the year and our year to date position remains within this at 0.67%.
- ✗ **Infection Control** – There were **3** new cases of MRSA Bacteraemia in January, which leaves the YTD total at **29**.

# 1. UNPLANNED OR EMERGENCY ACTIVITY

## 1.1 ED activity

ED Department activity in January 2006 was 7,338 attendances with the monthly pattern shown in figure 1 below. There have been five consecutive months of higher than average activity (five dots above the median).

Figure 1: ED Attendances Since April 2002



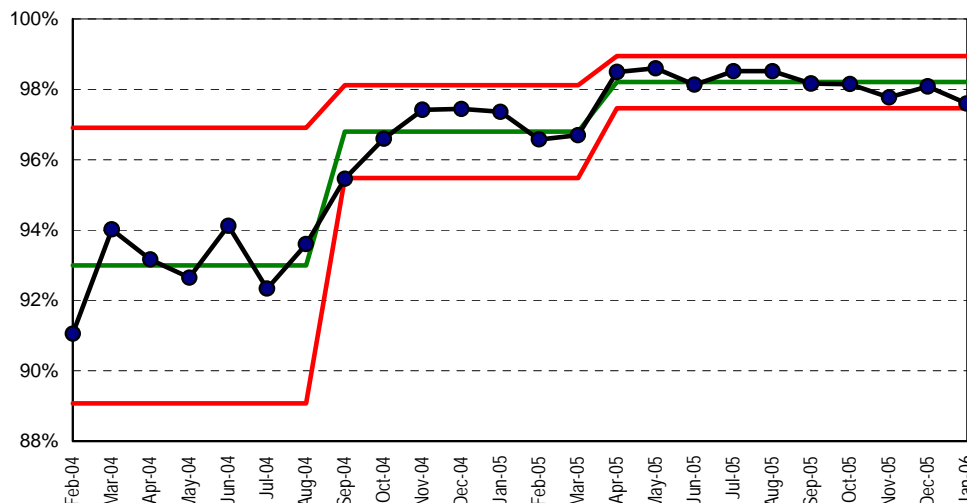
SPC Analysis: Moving Range; Note: Activity totalled for Type I Department and WIC only.

## 1.2 ED Access

ED access targets are now well-established standards. The Trust continues to meet all targets in ED, with the year to date position above 98%, shown at Figure 2.

- ✓ Year to date ED position remains at 98.2%, (average over the last ten months).
- ✗ However, **97.6%** of ED Patients were Admitted, Discharged or Transferred (ADT) within 4 hours in January (last month 97.8%).
- ✓ No patients in ED waited longer than 12 hours for a bed
- ✓ **97.4%** of patients in ED waited no longer than 4 hours for a bed

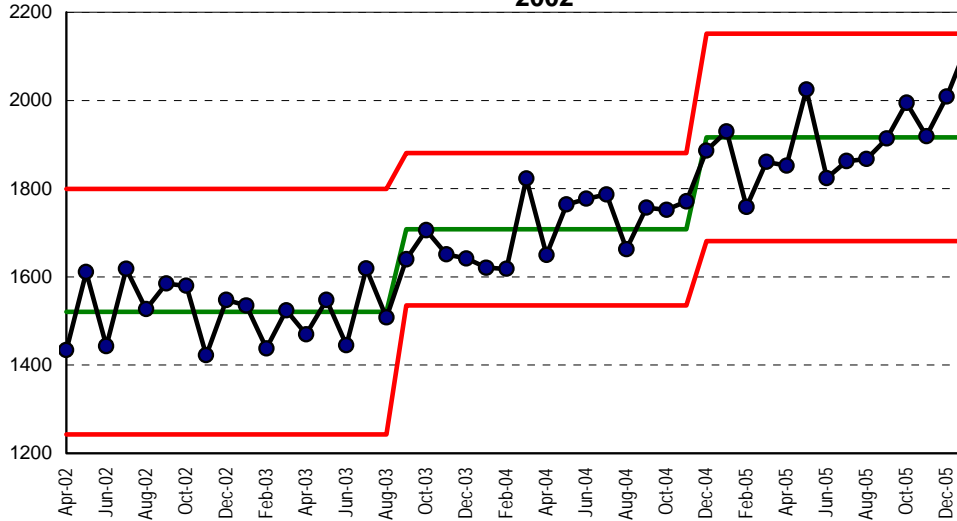
Figure 2: ED Waits - % ADT Within 4 Hours Since Feb 2004



### 1.3 Emergency Admissions

Non-elective admissions by month are shown in figure 3. January 2006 has the highest total non-elective admissions on record. 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**

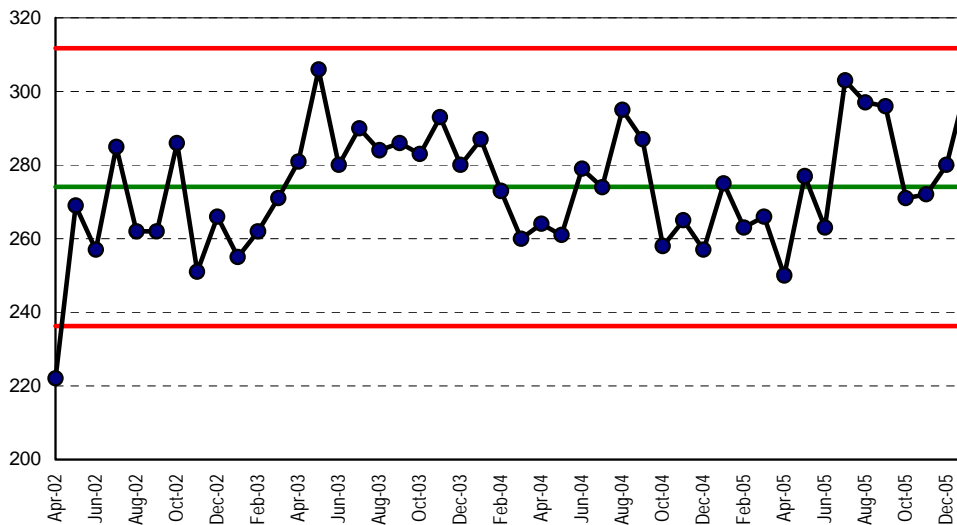


SPC Analysis: Moving Range

### 1.4 Deliveries

There were 302 deliveries in January. This is only the third time that there have been more than 300 deliveries in a month. Figure 4 also shows higher delivery numbers during the early part of 2003 that 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**



SPC Analysis: Moving Range

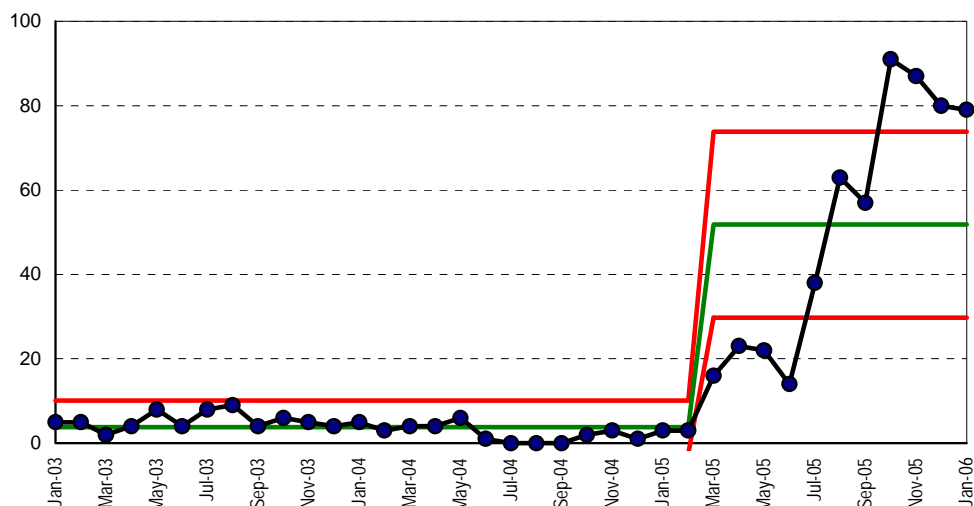
## 2. PLANNED ACTIVITY

### 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 570 electronic referrals to date. Since October we have been consistently booking volumes of 80+ patients per month. Despite expanding the range of ‘bookable’ services, GP take up has been slow and electronic referrals currently only represents about 2.5% of the total.

**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 who have 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 1 January 2006 and we achieved this across all types of booking for the month.

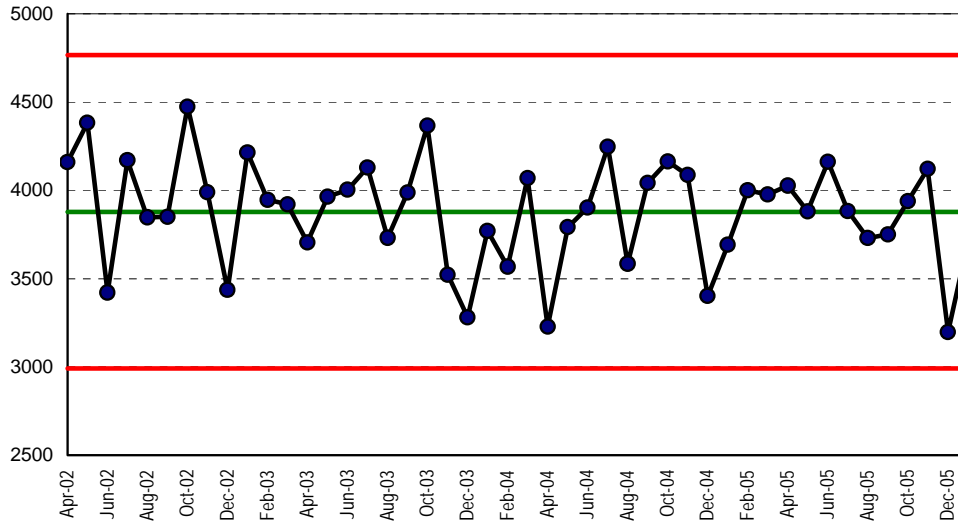
✓ *Both the elective and the outpatient targets were **achieved**.*

%Choice Offered	Jan 2005	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Outpatients	71	70	69	69	65	69	68	69	71	86	84	96	100
Day Cases	90	93	100	95	93	92	96	93	94	96	98	98	100
Inpatients	49	38	36	51	51	42	57	45	45	72	77	76	100
All Elective	79	79	82	83	83	79	86	83	82	91	94	95	100

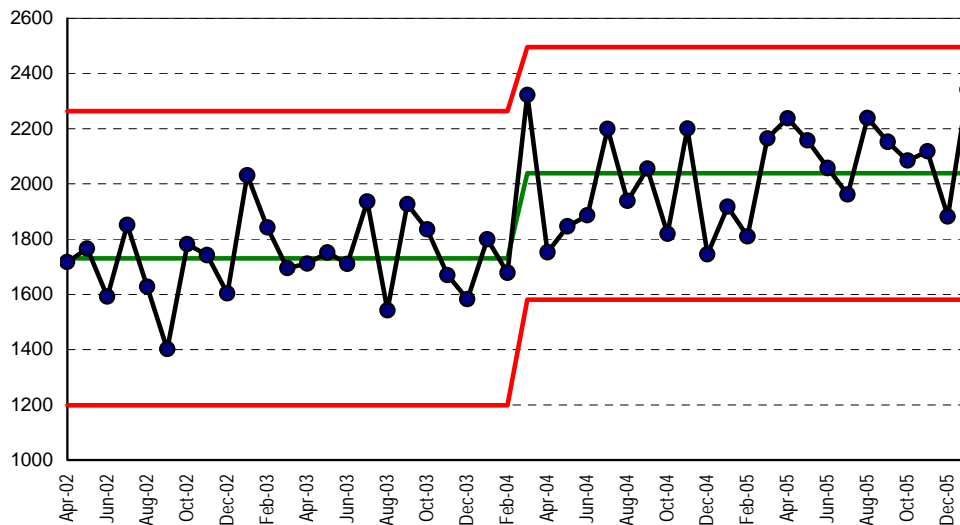
## 2.3 Outpatient Referrals

Figures 6 and 7 show the volumes of GP and Consultant referrals to outpatient Consultant clinics over the last three years.

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



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



SPC Analysis: Moving Range

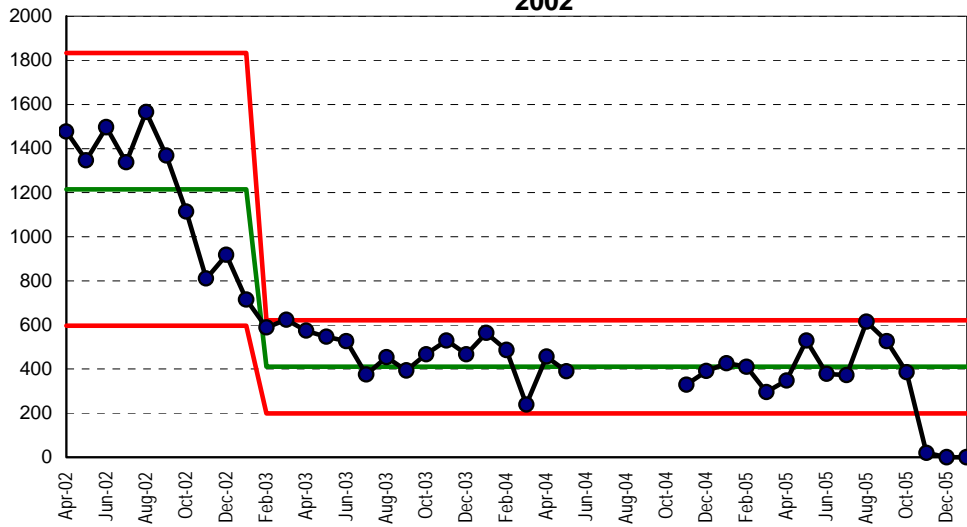
## 2.4 Outpatient Access Times

Reducing waiting times for outpatients is a rolling programme initiated by the five year *NHS Plan* published in 2000. The current targets demand that no GP referred patient waits longer than 17 weeks from referral for an appointment and that this maximum waiting time reduced to 13 weeks by 31 December 2005.

- ✓ *No patients were waiting over seventeen weeks in January 2005.*
- ✓ *No patients were waiting over thirteen weeks in January 2005.*

Figure 8 shows the number of patients waiting the 13 -17 weeks time band over the last few years.

**Figure 8: OP Waits - Over 13 Weeks (month end snapshots) Since April 2002**

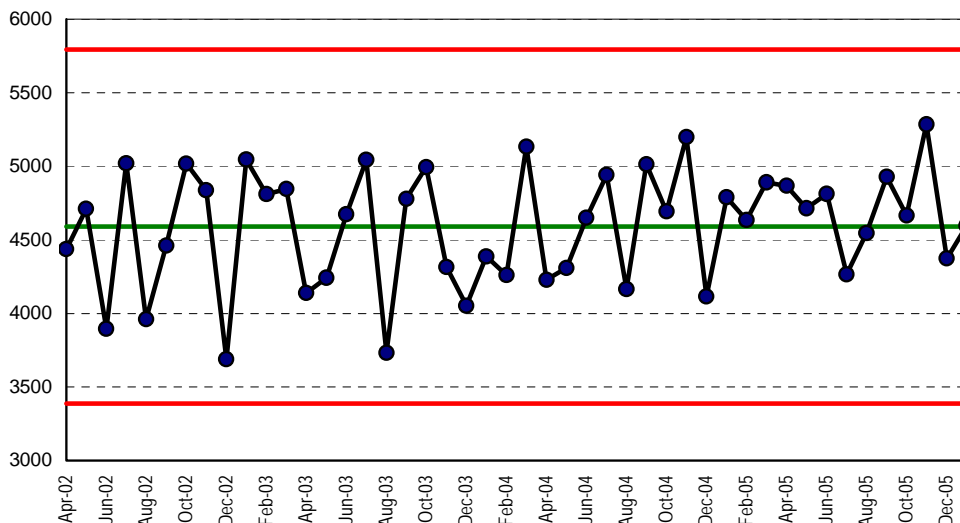


SPC Analysis: Moving Range; There was a problem with the data extraction programme between June and November 2004. Data points relating to this period have therefore been removed from the charts.

## 2.5 Outpatient Activity

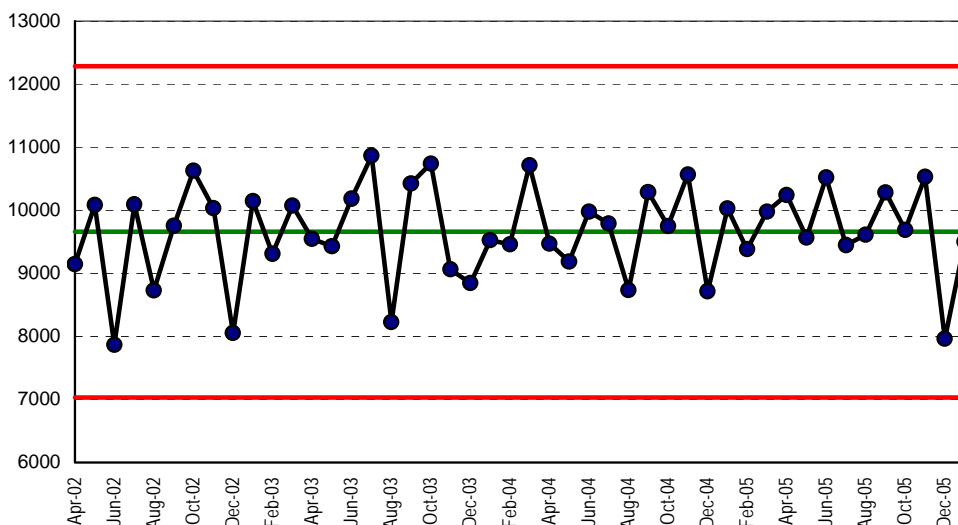
Figures 9 and 10 show first and follow up outpatient clinic activity for all acute specialties. The variation in these charts is largely caused by the numbers of available working week days in the month.

**Figure 9: First Attendances Since April 2002**





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



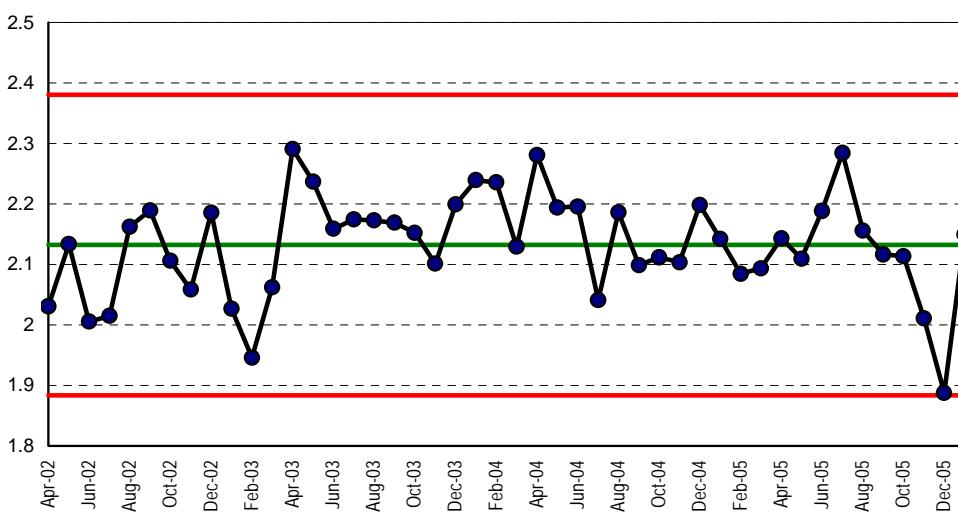
SPC Analysis: Moving Range

## 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.

With a score of **2.15** in January, the Whittington's overall follow-up rate is well below the national average of 2.30. Figure 11, below, shows the Trust's overall follow up rate over time for acute specialties only.

**Figure 11: Outpatient Follow Up Rate Since April 2002**

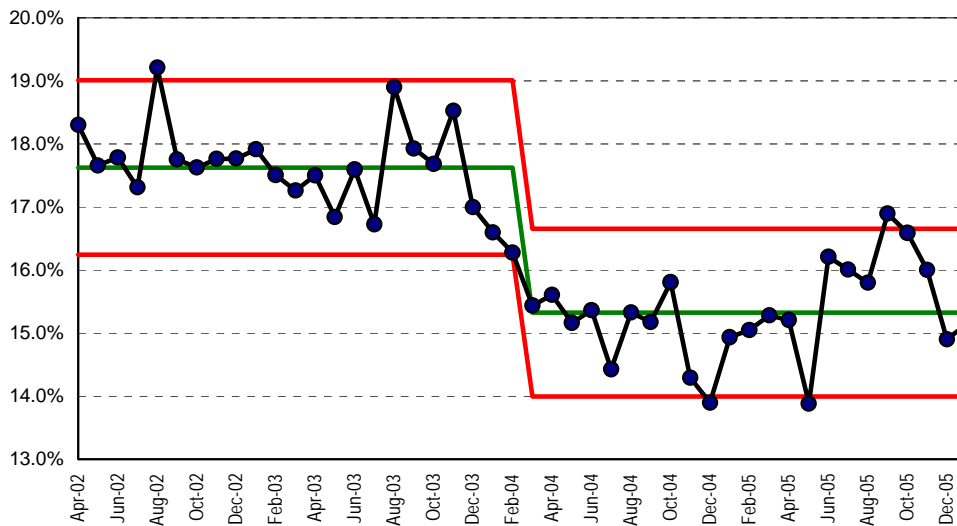


SPC Analysis: Moving Range

## 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. Text messaging reminders recommenced during December and looks to be contributing to the improvements.

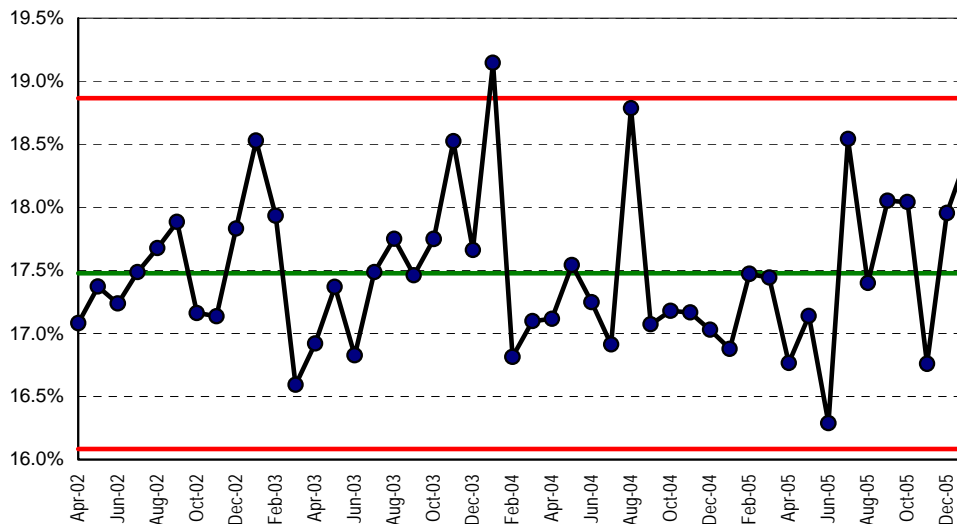
**Figure 12: DNA Rate - First Appointments Since April 2002**



SPC Analysis: Moving Range

Figure 13 shows the DNA rate for follow up appointments. Partial booking is being rolled out in the next few months and is expected to significantly reduce the number of follow-up DNAs.

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

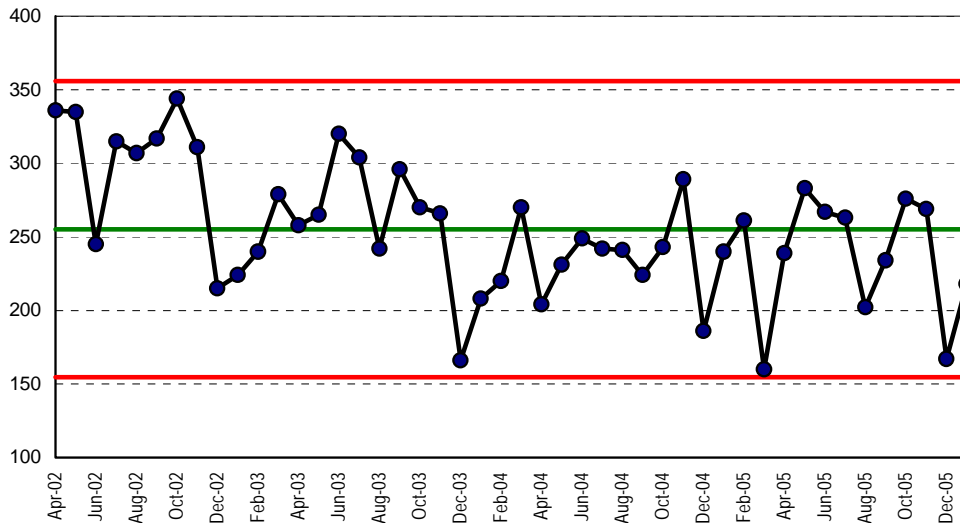


SPC Analysis: Moving Range

## 2.7 Elective Inpatient and Day case activity

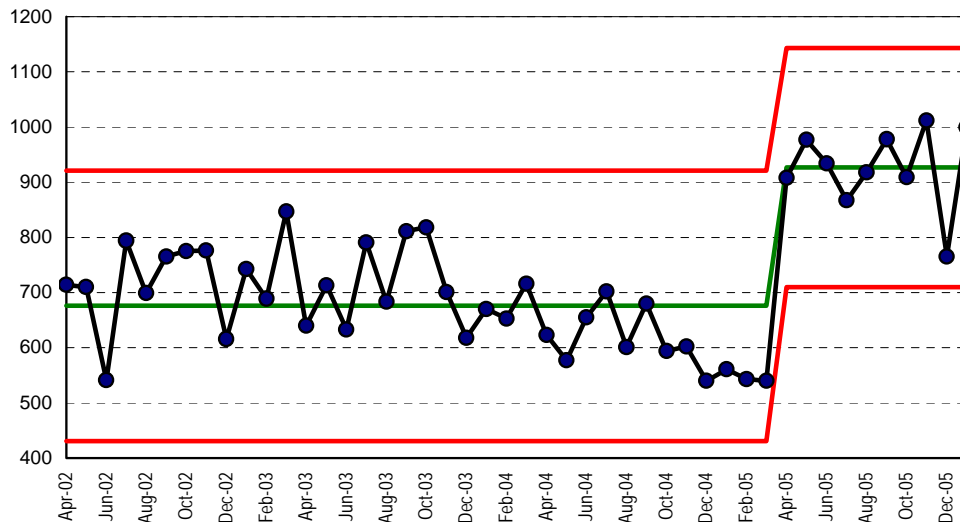
Figures 14 and 15 show the numbers of inpatient and day case admissions over the past three years. Both charts show a high degree of variability in the data with a small step change demonstrable for inpatient admissions.

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



SPC Analysis: Moving Range

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

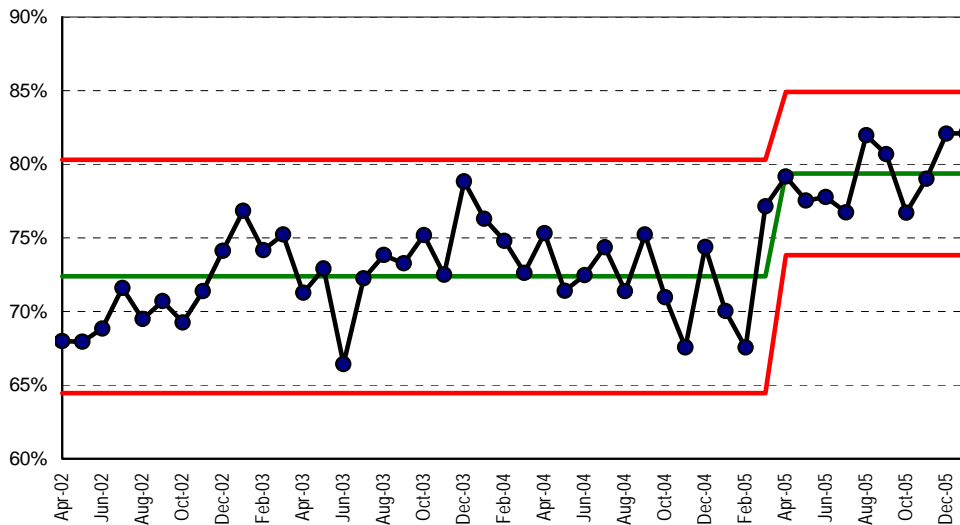


SPC Analysis: Moving Range

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%. (Note that this is the overall Day Case rate for the Trust, not just Surgical Day Cases).

Figure 16: Day Case Rate Since April 2002



SPC Analysis: Moving Range

## 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 January 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 78% of our patients wait less than 3 months so we are well placed to meet the 2008 target.

% 3 month standard	Jan 2005	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006
All Patients	71	73	83	80	80	82	81	80	83	86	96	81	78

## 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. Targets for breast cancer have been part of the national performance-monitoring regime for the last three years. These targets will be extended to all cancer sites by December 2005.

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

✓ *All Patients were be treated within 31 days of decision to treat breast cancer*

✓ *All GP urgent referrals for breast cancer were be treated within 62 days of referral*

### 3.2 Cancer Access Times for All Sites

These targets take effect from 1 January 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 tables below show the level of performance in the key treatment target times by cancer site up to the end of December 2005.

31 day standard	Dec	Jan 2005	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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
Skin	-	100	100	100	100	100	100	100	100	-	100	100	-
Gynaecological	100	-	100	100	0	100	-	100	-	100	100	-	100
Head & Neck	-	100	-	-	-	-	100	-	-	-	-	100	-
Other	100	-	100	100	-	-	-	-	-	100	-	-	100
Upper GI	-	-	-	-	100	-	-	-	100	-	100	100	100
Urological	100	40	100	100	89	95	100	85	100	100	100	100	100
Breaches	0	3	0	0	2	1	0	2	0	0	0	0	0
Patients					31	38	23	33	28	38	44	30	38

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

In December our performance was **100%** for the 31 day standard and **92.3%** for the 62 day standard.

Our shadow-monitored performance for the Quarter (Q3 2005/6, September-December 2005) was therefore:

- ✓ 100% for 31 day (98% tolerance) **achieved**
- \* 94% for 62 day (95% tolerance) **not achieved**

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.

### 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.

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

14 day standard	Jan 2005	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006
All Clinics	35	88	98	100	100	100	100	100	100	100	100	100	100

✓ *There were no eligible patients.*

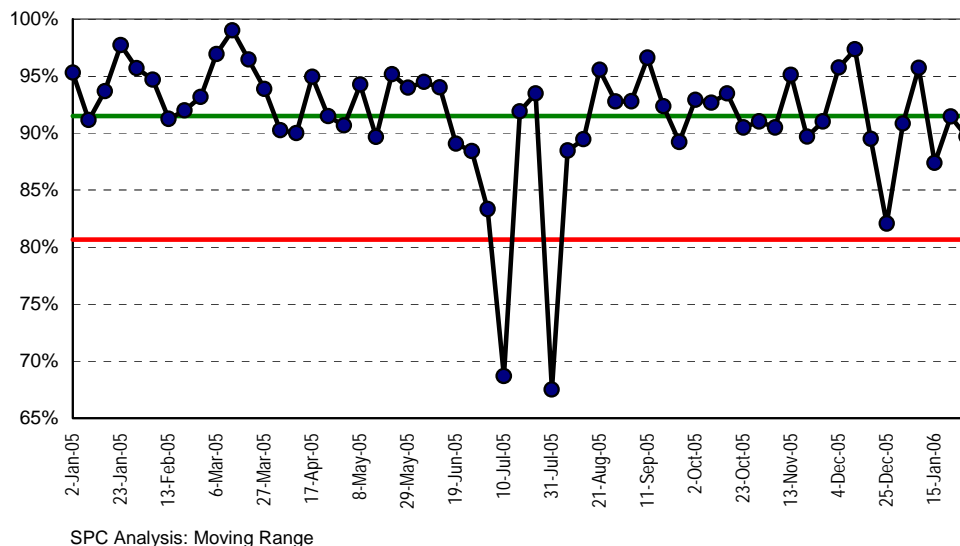
60 minute standard	Jan 2005	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2006
% Patients	50	50	50	50	0	NA	NA	NR	100	100	NA	0	NA
No. Eligible	2	2	2	2	1	0	0	1	1	3	0	1	0

## 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 drop in the last week in December reflects the ward closures over the Christmas period.

Figure 17: % Acute Bed Occupancy Since Jan 2005

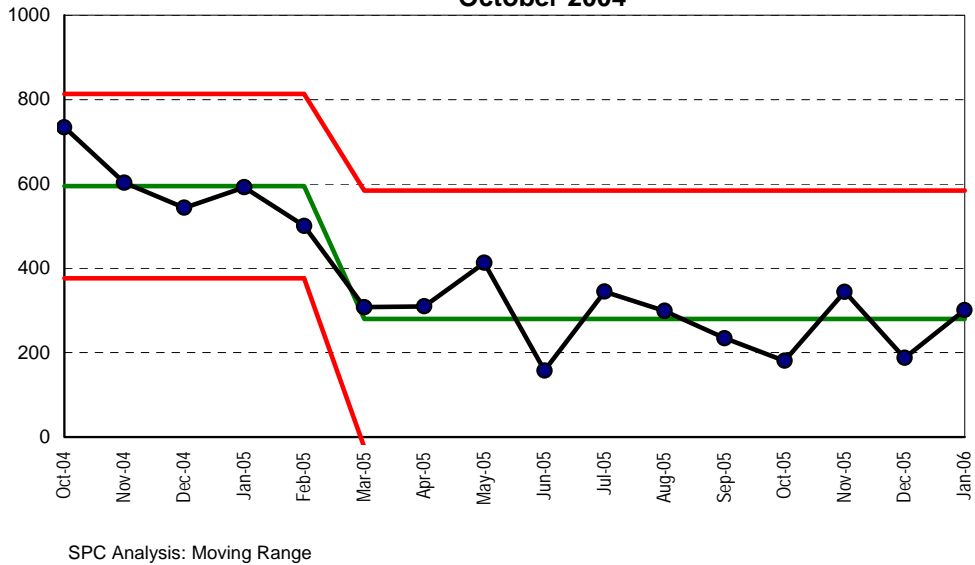


### 4.2 Delayed Transfers of Care

January saw an average of 10 delayed patients. 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**

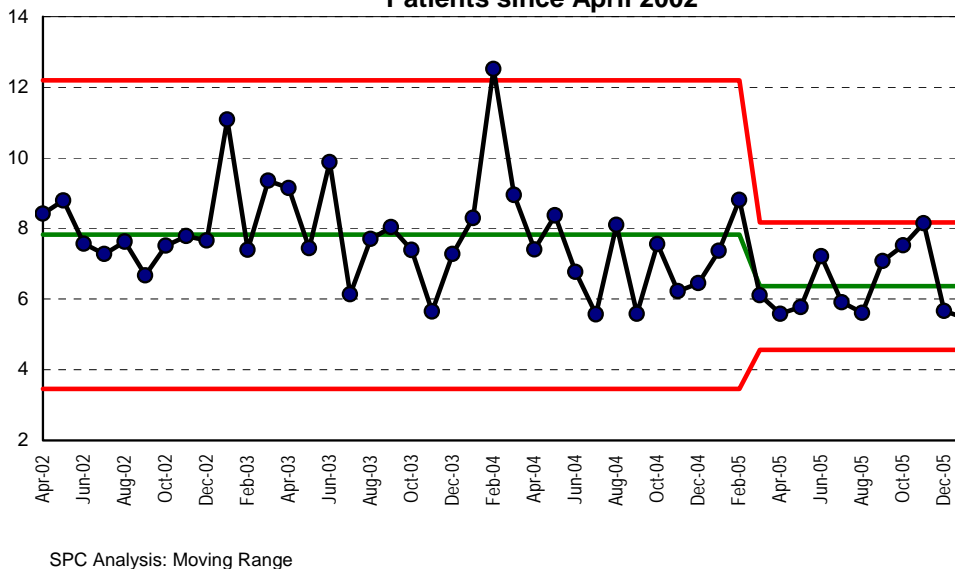
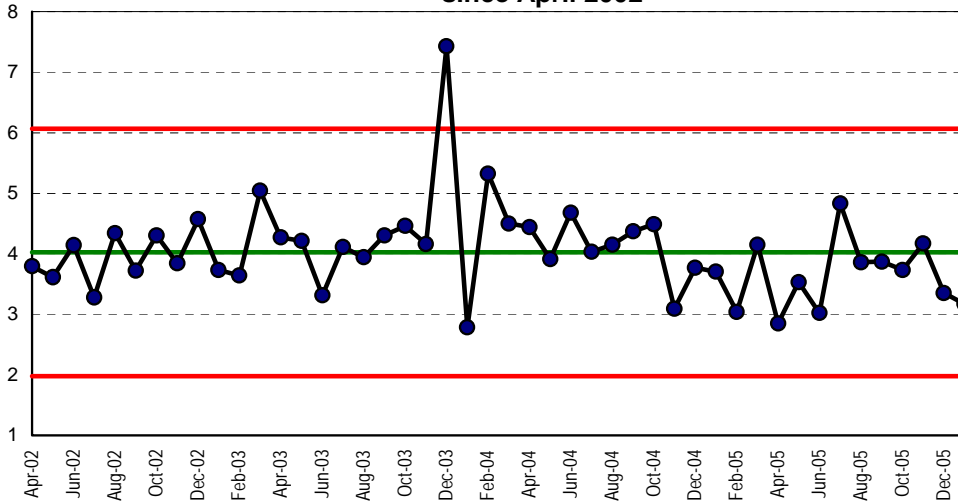


Figure 19, for elective surgical admissions, depicts a step change both in the average length of stay and in the variation. The average over the last eight months is a little over 6 days.

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 Patient Admission Unit opened during the period. This 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.

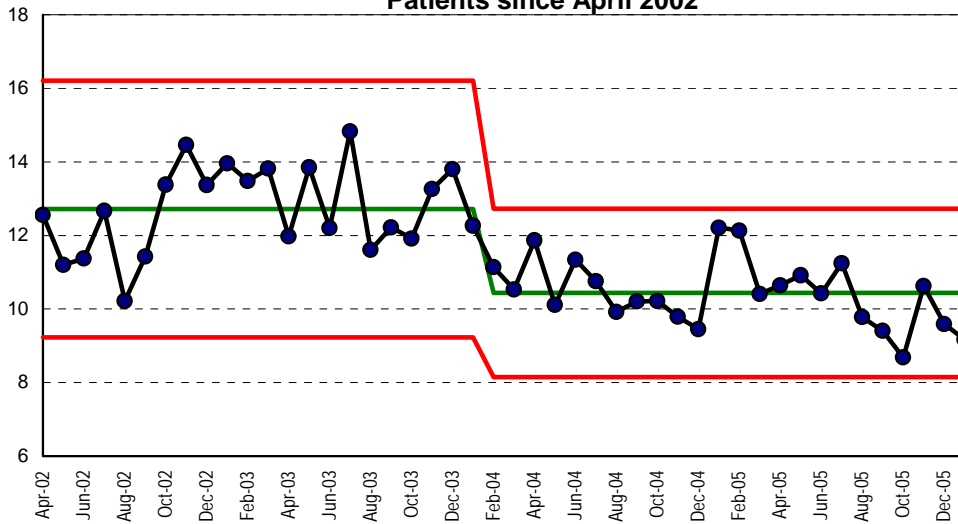
**Figure 20: Average Length of Hospital Stay - Elective Surgical Patients since April 2002**



SPC Analysis: Moving Range

Medical length of stay, shown in figure 21 overleaf, has been stable over the last year, but statistically significantly lower than the 2003 levels (note the run of points above the centre line in 2003 and below in 2004). The Making Best Use of Beds project is focusing on making further reductions to the length of stay.

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



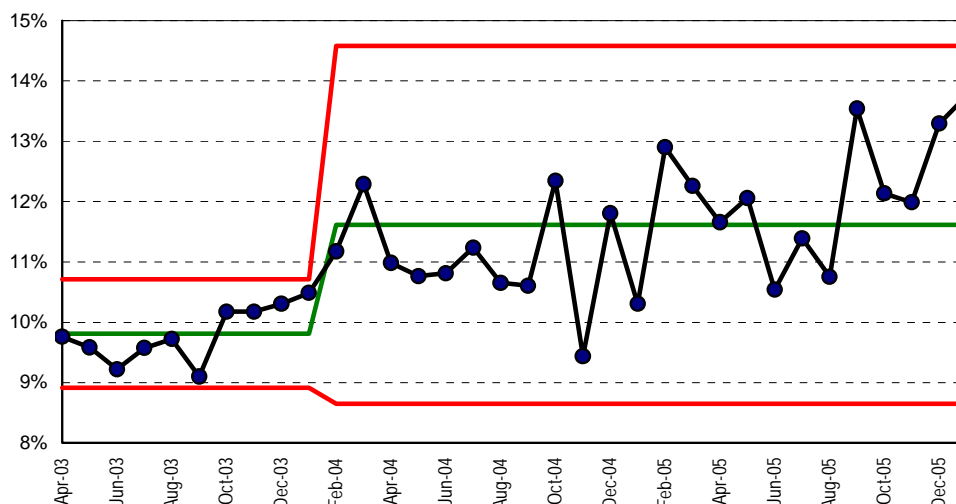
SPC Analysis: Moving Range



### 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 rate, while remaining within the expected range, is the fifth consecutive dot above the mean.

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



SPC Analysis: Moving Range

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.

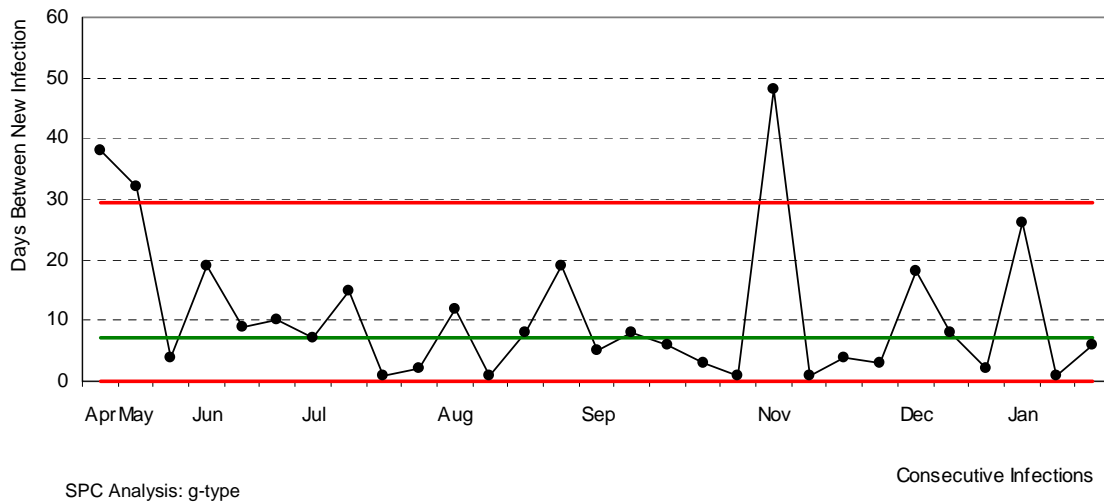
## 5. INFECTION CONTROL

### 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 period from May until September there appears to be a relatively stable system with no evidence of epidemic infections. Whilst, there were no new infections detected in October (which accounts for the large spike in the graph), further infections in November and December has meant that we have now exceeded the DH target to reduce incidences of MRSA.

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

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

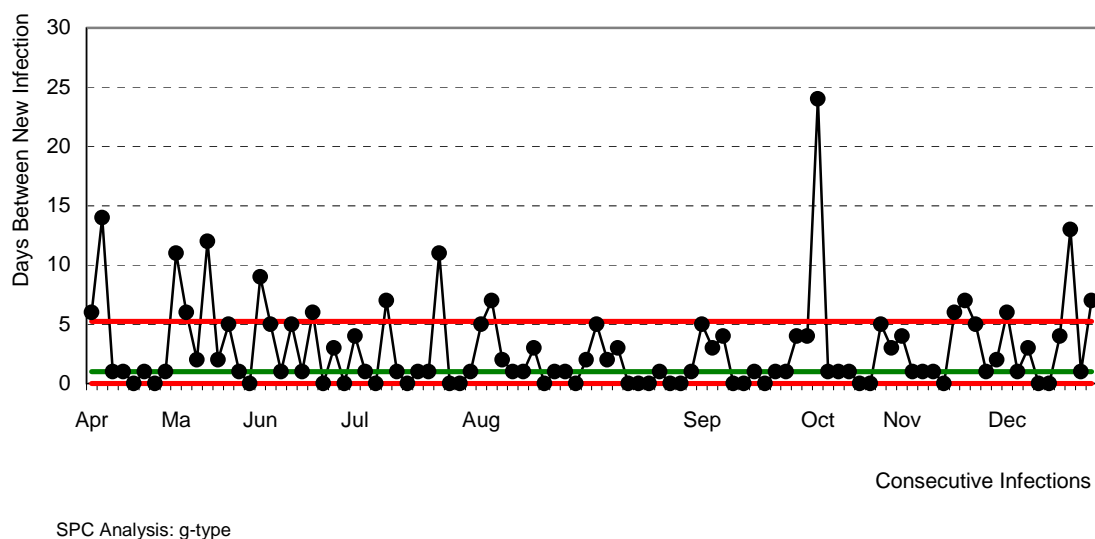


## 5.2 Clostridium difficile

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, which indicates a significant increase in the infection rate. Both the number of infections and the rate has declined from October to December 2005.

- ✘ There have been **96** Clostridium Difficile Infections for Patients aged over 65 in the period April to December 2005.

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



Note: The SPC analysis presented in figures 23 and 24 differs slightly from that in the rest of the paper. Each point presents an incidence of infection and is plotted against the number of days since the last detected infection. This approach is used as there is a

relatively low rate of infection and thus there is not enough data for one of the more common methods of analysis.