SOUTHAMPTON UNIVERSITY HOSPITAL NHS TRUST

ACCESS TIMES & OPERATIONAL PERFORMANCE

JUNE 2006

Report to:	Trust Management Board
Report from:	Barbara Cogman, Head of Patient Access
Sponsoring Executive	Simon Jupp, Director of Operations

Purpose of report	This report outlines the Trust's position against key access and performance targets during 2006/07.
Recommendation	Trust Board is asked to note the position on the access times and other targets.

JUNE 2006

STANDARDS & TARGETS FOR 2006/07 Operating Framework 2006/07 Service Priorities underlined					
	Standard		**Target 30/06/06**	**Actual position**	**Traffic light**
A&E 98%	No patient to wait more than 4 hours in A&E, across the local health community		98%	98.77%	**Green**
Sustaining Cancer waits	Maximum waiting time of 31 days from diagnosis to treatment for all cancers.		98%	98.95% predicted	**Green**
	Maximum waiting time of 62 days from urgent GP referral to treatment for all cancers.		95%	92.0% predicted	**Red**
18 week maximum wait by 2008	Outpatients following GP/GDP referral	Maximum wait of 13 weeks	0	0	**Green**
		Internal target – maximum wait of 11 weeks from the end of June 2006	0	1	**Green**
	CT/MR scans – maximum wait of 26 weeks reducing to 13 weeks by March 2007 (national target)		0	307	**Red**
	Other diagnostics – maximum wait of 26 weeks reducing to 13 weeks by March 2007 (national target)		0	229	**Red**
	Inpatients & Day cases	Maximum wait of 26 weeks	0	17	**Red**
		Internal target – 20 weeks for all specialties except some specific exemptions by the end of July 2006	188	404	**Amber**
MRSA	MRSA performance against trajectory		10	15	**Red**
Patient Choice & Booking	100% outpatient booking for patients referred for a first consultant appointment by their GP or dentist.		100%	100%	**Green**
	100% elective (inpatient/daycase) booking		100%	100%	**Green**
Cancelled operations	Cancellations at the last minute for non-clinical reasons as a percentage of admissions from the waiting list		<1.5%	1.17%	**Amber**
Access time standards	▪ 2 weeks for all urgent suspected cancer referrals		100%	100%	**Green**
	▪ 2 weeks for Rapid Access Chest Pain Clinic		100%	100%	**Green**
	▪ 3 months for cardiac revascularisation		100%	100%	**Green**
Delayed ToC	Reduce delayed transfers to a minimal level by 2006		1.9%	3.6%	**Red**
Thrombolysis	68% of people with heart attack to receive thrombolysis within 60 minutes of calling for professional help		68%	26.7% Q1 2006/07	**Red**

Emergency access

- 98% of patients to wait 4 hours or less in A&E from arrival to admission, discharge or transfer, across the local health community.
- Reduce delayed transfers to a minimal level by 2006

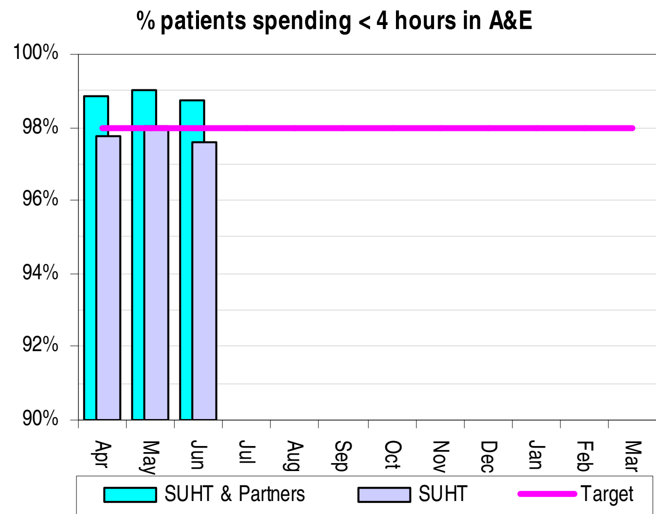
The graph shows the performance of SUHT and the local health community in achieving the A&E target. The figures are provided by the Strategic Health Authority and come from the weekly SitReps reporting.

SUHT is now partnered for this monitoring with Southampton City PCT (100%) and New Forest PCT (74%).

The figures for June are:

SUHT	97.61%
SUHT & Partners	98.77%
SUHT + Partners cumulative	98.86%

The Healthcare Commission assesses the Trust's on cumulative performance across the year based on quarterly reporting.

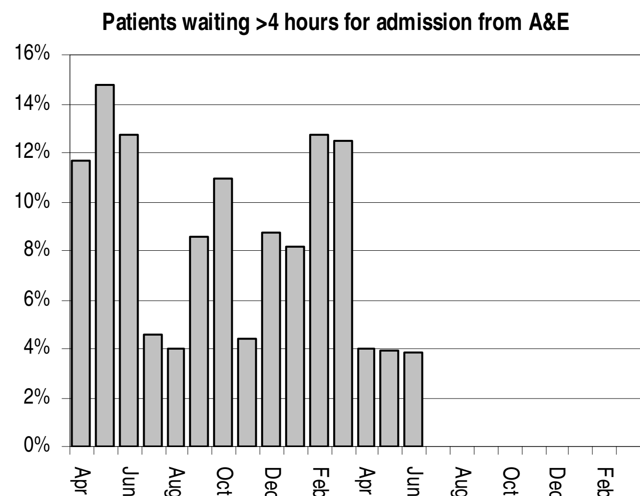


Waiting times for admission from A&E were reviewed through the Acute Hospitals Portfolio 2005/06.

The graph opposite shows the patients' waiting time following a decision to admit, as a percentage of emergency admissions through A&E.

The Acute Hospitals Portfolio (AHP) reviewed the waiting time for admitted patients from arrival at A&E rather than from decision to admit.

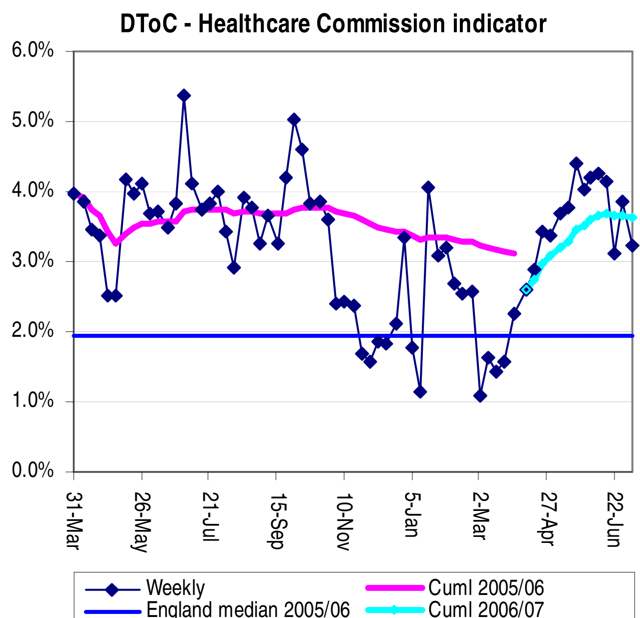
The AHP view will be presented next month for the Board.



Delayed transfers are patients who are medically fit for discharge. The Healthcare Commission indicator looks at the number of patients who are delayed transfers and who are in acute beds. This indicator uses cumulative figures across the financial year.

The median value for England for 2005/06 was 1.9%.

Cumulative performance at the end of June was 3.6% delayed transfers of care as a percentage of patients in acute beds.



Sustaining Cancer waits

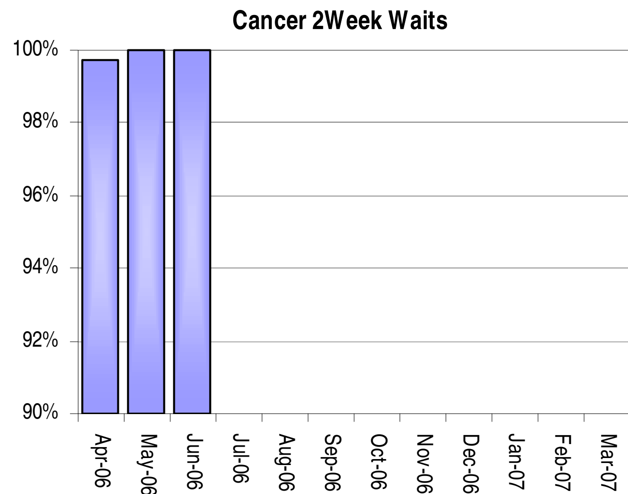
- Maximum 2-week wait from urgent GP referral to first OPA for all urgent suspected cancer referrals
- Maximum 31-day wait from diagnosis to treatment for all cancers
- Maximum 62-day wait from urgent referral to treatment for all cancers

14 days from urgent referral by GP to first outpatient consultation

The graph shows the percentage achievement of this target from April 2006.

The Trust achieved 100% in June.

The preview (predicted) figure for Quarter 1 2006/07 is 99.93%.

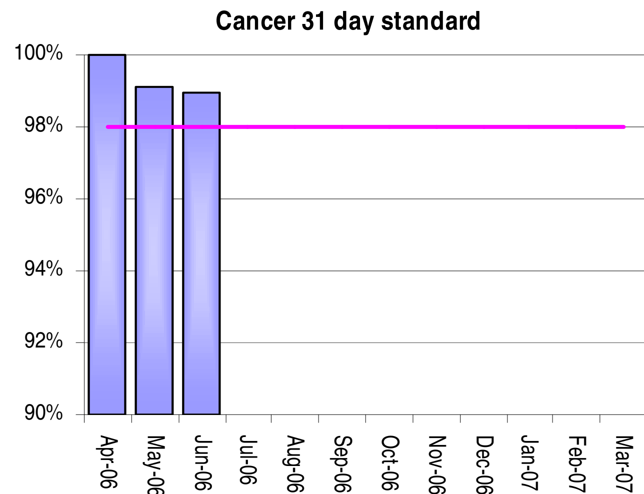


31 days for the time from decision to treat to start of treatment

The predicted figure for June is 98.95%.

The standard is 100% with a 2% tolerance. The Trust's results for April – June were all within this tolerance and the preview (predicted) figure for Quarter 1 is 99.32%.

Where patients are transferred between NHS trusts as part of their care pathway and breach the standard, the breach is allocated equally between the NHS trusts involved.

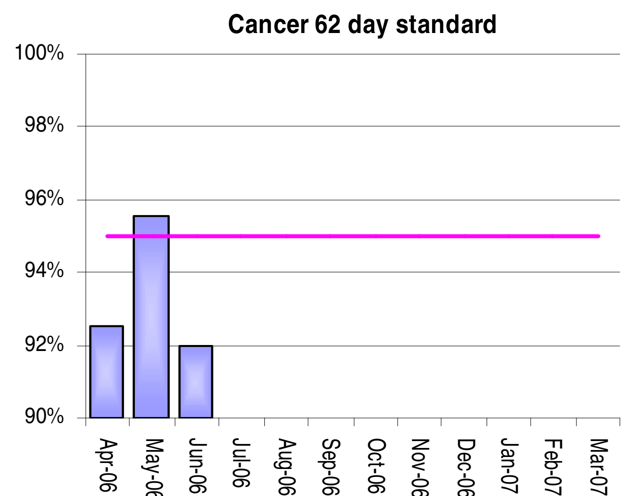


62 days from urgent referral by GP to start of treatment

The predicted figure for June is 92%.

The standard is 100% with a 5% tolerance. It has now been confirmed that the Trust achieved 95% in May. The preview (predicted) figure for Quarter 1 is 93.62%.

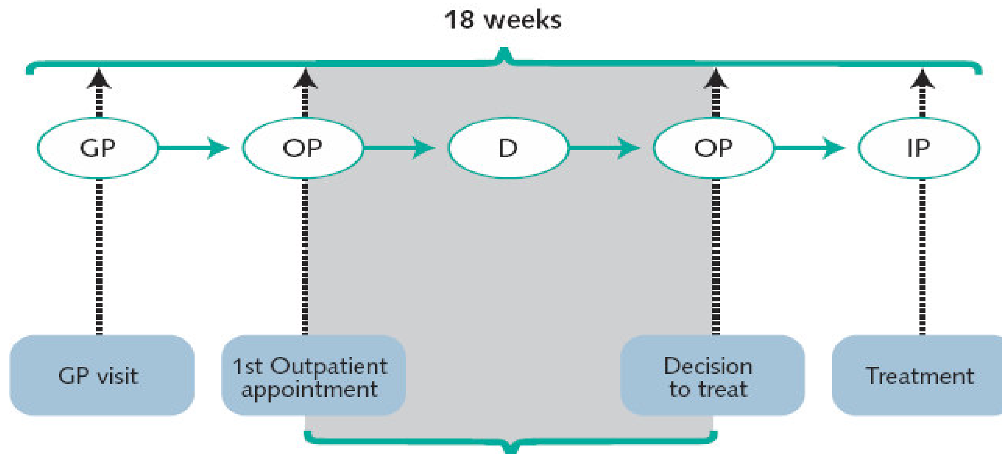
Where patients are transferred between NHS trusts as part of their care pathway and breach the standard, the breach is allocated equally between the NHS trusts involved.



18 weeks

Maximum wait of 18 weeks from GP referral to treatment by the end of December 2008

The diagram below, taken from the Department of Health's 18 week site, represents the patient pathway from GP referrl, through outpatient appointment and diagnostics, to treatment.



The Department of Health has moved up its timetable and a baseline exercise across all providers is taking place. Acute providers, such as SUHT, are required to submit their results by 28th July.

Outpatients

No patient to wait more than 13 weeks for a first outpatient appointment following GP/GDP referral, reducing to 11 weeks by the end of May (internal target) with a few agreed exceptions. 11 weeks to be fully achieved by the end of June.

There were no patients waiting over 13 weeks following referral by GP or GDP (dentist) at the end of June.

The Trust achieved an 11-week maximum wait by the end of June with 1 (one) exception.

The Trust is now set to maintain 11 weeks, eliminate in-month breaches of this standard and move on to the next target.

Patient Choice & Booking

- Patients are able to exercise choice in the date and time of all new outpatient appointments; 100% new appointments to be pre-booked by December 2005
- The Trust supports the provision of Choice by taking part in the national surveys on Choice.

Choice

From January 2006, PCTs are required to offer choice of at least 4 providers to patients who are referred to secondary care and where this meets their health needs.

The Department of Health commissioned a survey of patients recently referred to acute providers. This was carried out at the start of June and aimed to find out if they had been offered choice of provider by their GPs. Certain groups of patients, including for example children, were excluded.

The next survey is due to take place at the end of July/start of August.

Booking

All appointments and admissions should now be negotiated with the patient. The figures for the end of May were:

- Outpatients – 100%
- Inpatients – 100%

This is an improvement on the last few months, when Outpatient booking in some areas was a cause for concern.

Diagnostic waiting times

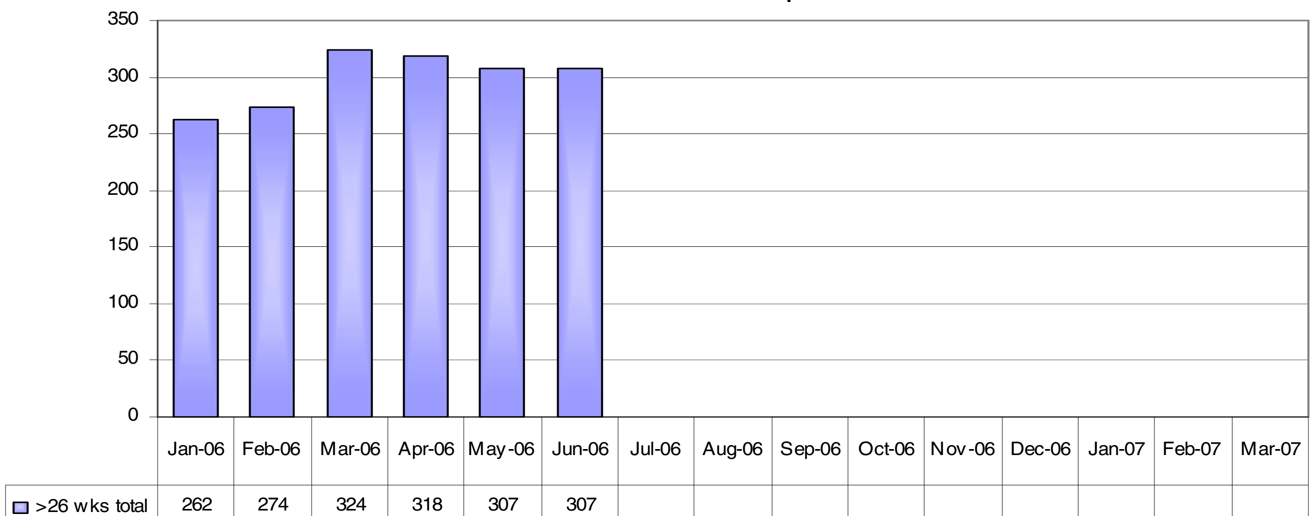
- Maximum wait of 26 weeks for MRI and CT scans
- Maximum wait of 13 weeks for all diagnostic tests or procedures by March 2007 (LDP target of 10 weeks)

The monthly Diagnostics return covers:

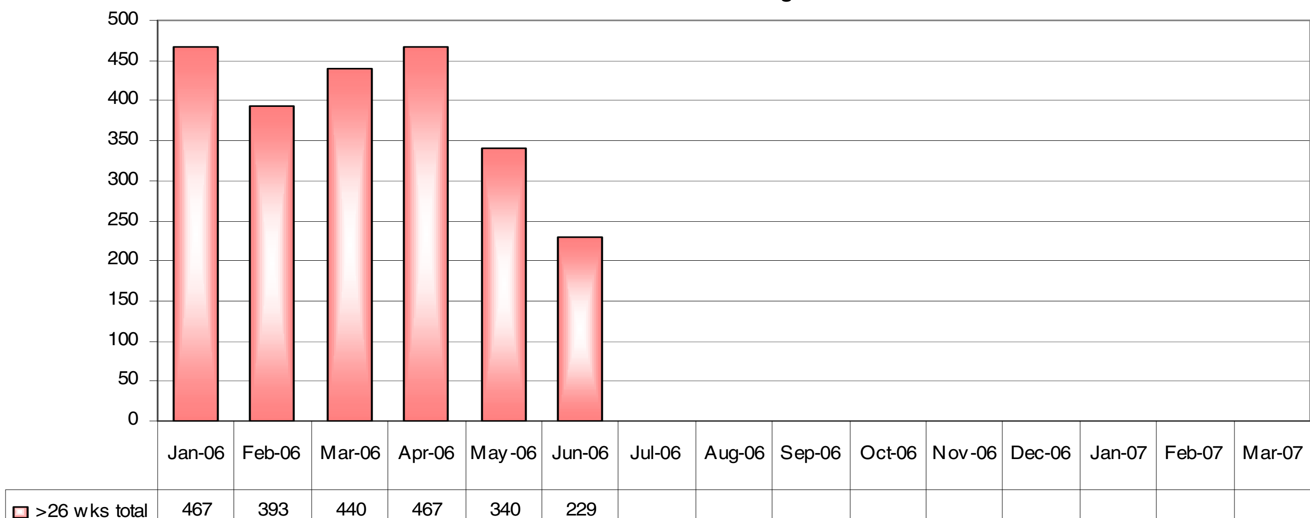
Imaging	MRI and CT scans non-obstetric ultrasound; barium enema; dexa scans.
Physiological measurement:	Audiology – pure tone measurement; Cardiology – echocardiography and electrophysiology; Neurophysiology – peripheral neurophysiology; Respiratory physiology – sleep studies.
Endoscopy:	Colonoscopy; flexi sigmoidoscopy; cystoscopy; urodynamics; gastroscopy.

The first graph below shows the number of patients waiting over 26 weeks for an MRI or CT scan at the end of each month. The second graph shows the same picture for other diagnostic tests.

This is the first month that the Radiology figures could be taken from the new Information System (CRIS). They have previously depended on manual data collection. There are some reservations about the data quality, so the Trust has submitted May's figures as a proxy for June.



	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07
>26 wks total	262	274	324	318	307	307									



	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07
>26 wks total	467	393	440	467	340	229									

Inpatients

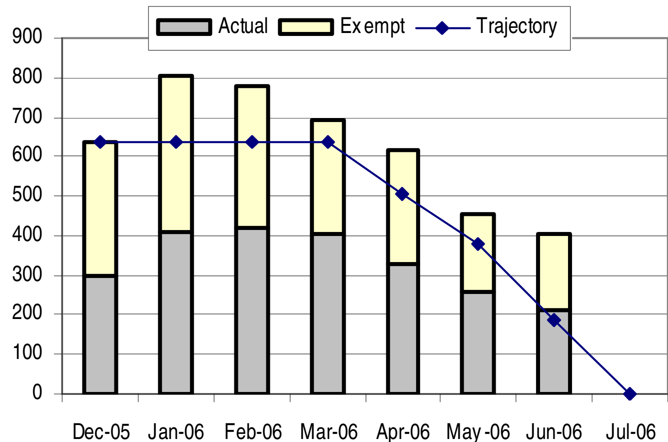
Maximum wait of 26 weeks for admission for treatment, reducing to 20 weeks by the end of July (internal target).

There were 17 breaches of the 26-week standard at the end of June. All of these patients were waiting for procedures in Electrophysiology. The Trust is working with the Strategic Health Authority and the PCTs to transfer patients to alternate providers for treatment in the short term, while working on strategies to increase capacity in-house.

The trust aimed to reach a maximum wait of 20 weeks by the end of July 2006 and the graph shows the trajectory submitted as part of the LDP process.

It has now been decided that some specialties, namely, Orthopaedics, Paediatric Orthopaedics, Paediatric Cardiology and Electrophysiology, are exempt from this target.

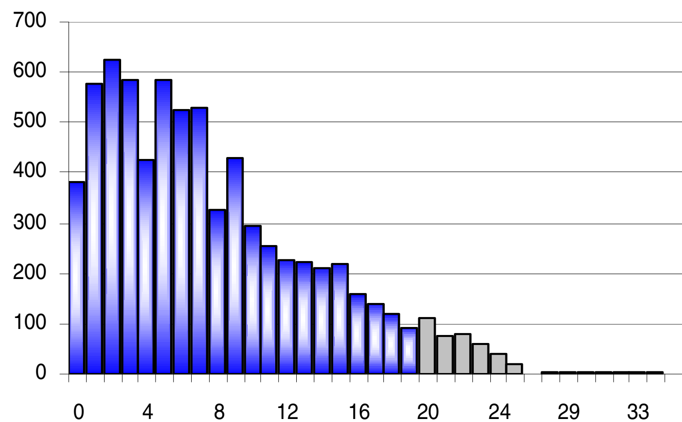
The graph shows that these specialties have nevertheless made good reductions in the number of patients waiting over 20 weeks. Orthopaedics has done particularly well, reducing from 291 in December to 141 at the end of June.



The numbers over 20 weeks are monitored weekly.

The graph shows the waiting list (excluding suspended patients) at the end of June, split by weeks waiting.

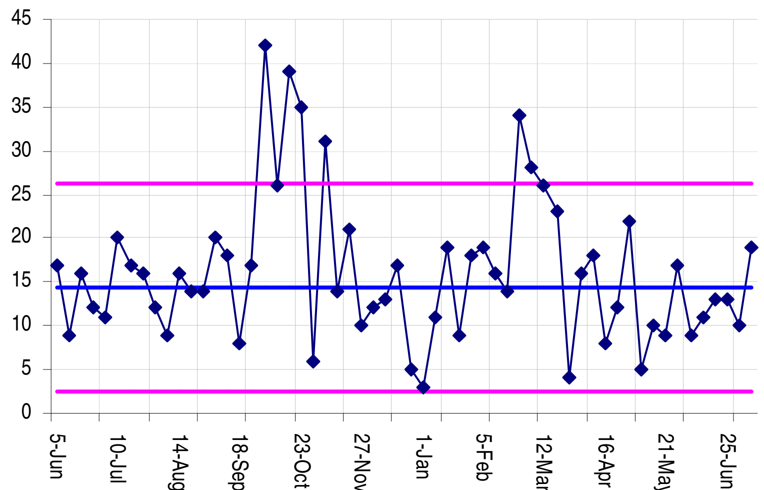
The effect of the May Bank Holidays, on the number of patients added to the list each week, show at the 4 and 8-week points.



Cancelling a patient's operation, especially at short notice, is not a good experience for the patient and it takes certainty out of "convenience & choice".

The graph shows the weekly figures as reported through SitReps for patients cancelled on the day of admission or after admission.

The reasons include: urgent or emergency patient taking priority, lack of ITU bed, equipment issues, etc.



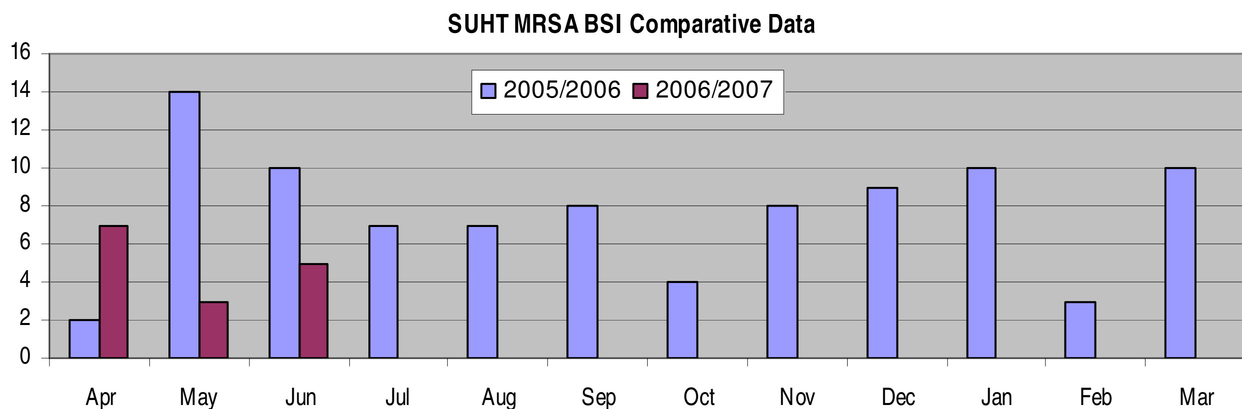
MRSA
Achieve year-on-year reductions in MRSA levels, as set out in LDPs for 2006/07

Each division and care group is given feedback on a monthly basis, highlighting performance against the target.
The tables below show the scoring used and performance to the end of June.

G	**GREEN**: Number of MRSA bacteraemia is below the target figure (or zero, in the case of care groups with a zero target). Action required to maintain control measures.
A	**AMBER**: Number of MRSA bacteraemia has reached the target number, but not exceeded it. Action required to prevent further increase.
R	**RED**: Number of MRSA bacteraemia has exceeded the maximum target figure. Urgent action required to reduce the number.

	Monthly target	Actual	Monthly performance	Target to date	Actual to date	Performance to date
Womens and Childrens	**0**	**0**	**G**	**0**	**0**	**G**
O&G	0	0	G	0	0	G
Child	0	0	G	0	0	G
Unscheduled Care	**1**	**1**	**A**	**4**	**6**	**R**
Cancer care	0	0	G	1	2	R
MEC	1	1	A	3	4	R
Specialist Services	**2**	**2**	**A**	**5**	**5**	**A**
Critcare	1	2	R	2	3	R
CT	1	0	G	2	1	G
Neuro	0	0	G	1	1	A
Surgery	**1**	**2**	**R**	**1**	**2**	**R**
Ophth	0	0	G	0	0	G
Surg	0	2	R	1	2	R
T&O	0	0	G	0	0	G
Radiology, Pathology & Support Services	**0**	**0**	**G**	**0**	**0**	**G**
Community	**0**	**0**	**G**	**0**	**2**	**R**

The graph below compares performance in 2006/07 with 2005/06. By the end of Quarter 1 in 2005/06, the Trust had recorded 26 instances of MRSA bacteraemia, compared with 15 in the same period in 2006/07.



Cardiac Heart Disease

- Maintain a maximum 2-week wait standard for Rapid Access Chest Pain Clinics
- Maximum waiting time of 3 months for cardiac revascularisation
- 10 percentage point increase per year in the proportion of people suffering from heart attack who receive thrombolysis within 60 minutes of calling for professional help

There were no patients waiting over 3 months for cardiac revascularisation at the end of June.

The Trust has achieved 100% in May and June for the percentage of patients referred urgently within 24 hours by their GPs with chest pain who were seen within 14 days of referral. 178 patients were seen in June.

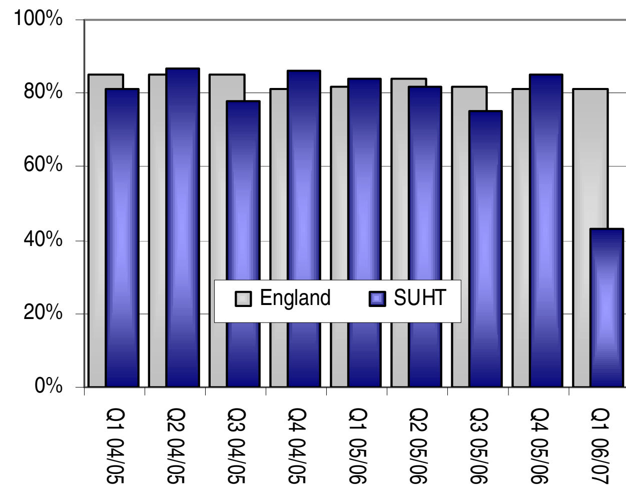
The standard for thrombolysis is a composite standard across ambulance and acute trusts. The call to needle time is a shared responsibility. The graphs below show the figures since the start of 2004/05.

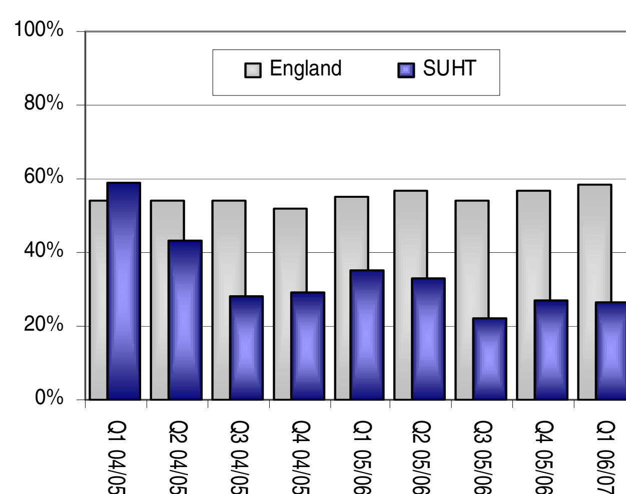
The Health/care Commission monitors on “Call to needle” time, which is an indicator shared between acute trusts and ambulance trusts, as well as PCTs in their commissioning role.

The national target for 2005/06 was that 68% of people suffering from heart attack should receive thrombolytic therapy within 60 minutes of calling for professional help.

Trusts already above 68% in 2004/05 or who will exceed it in 2005/06 are expected to have shown improvement. SUHT’s figure for Q1 2006/07 was 26.7%.

Increasingly, patients are being treated by paramedics prior to arrival at hospital. SUHT is providing training support for this through the BHF Lead Nurse. The overall Call – Needle time is expected to improve over the year.





Recommendation

Trust Board is asked to note the position on the access times and other targets.

Simon Jupp
Director of Operations
June 2006