UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST

Quarterly Clinical Effectiveness and Outcomes Report:

Report to
Trust Board 29th November 2011

Report from
David Weeden, Associate Director Patient Safety
Martin Stephens, Associate Medical Director, Clinical Effectiveness

Sponsoring Executive
Michael Marsh, Medical Director

Aim of Report
1) To brief Trust Board on performance against the 2011/12 patient improvement targets (PIF) relating to outcome measures for quarter 2.

2) To highlight areas of progress and challenge, and identify the work streams in place to address these.

Review History to Date
Regular in-depth three monthly report on patient outcomes, covering period July-September 2011.

- This is the second review for this quarter report.
- Reviewed QGSG 19th October 2011
- Reviewed TEC 16th November 2011

Assurance Framework
Strategic Objectives:
To be trusted on quality
Delivering for tax payers
Excellence in healthcare

Recommendations
Trust Board is asked to:
1. For HSMR:
   a. Consultants to have greater direct input into the primary diagnosis and critical co-morbidities.

   b. To further develop Mortality & Morbidity Meetings so that all deaths with avoidable features are considered, and morbidities amenable to reduction by change in care are monitored against actions.

   c. Care Groups to develop specific actions plans for reducing HSMR.

2. For PROMS and emergency pathway reports, to note progress.

3. For Deteriorating adults:
   • To act on recommendations made by the audit & assurance committee in September.

4. To note the Outcomes CQuins (Cquin 6 Alcohol, and Cquin 7 ‘care in appropriate place’) quarter 2 progress,
## Summary for Outcomes Priorities of Patient Improvement Framework, and PCT Contract Outcome Cquin developments

<table>
<thead>
<tr>
<th>PIF Work-stream</th>
<th>2011/12 Target</th>
<th>Q2 RAG</th>
<th>Q3</th>
<th>Q4</th>
<th>Action /Comment</th>
<th>fye</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality Rates (HSMR)</td>
<td>90</td>
<td>98.8</td>
<td>92.8</td>
<td></td>
<td>Always one quarter in arrears Q2 due January report.</td>
<td>A</td>
</tr>
<tr>
<td>PROMS data contributed</td>
<td>80%</td>
<td>Hip 78% Knee 84%</td>
<td></td>
<td></td>
<td>No further actions, to note progress.</td>
<td>G</td>
</tr>
<tr>
<td>Emergency pathway</td>
<td>5 measures, see detail report</td>
<td>3/5 achieved</td>
<td></td>
<td></td>
<td>Sustained delivery on 3 measures, improvement in the remaining two.</td>
<td>Tbc</td>
</tr>
<tr>
<td>Out of hours/ hospital at night</td>
<td>tbc</td>
<td></td>
<td></td>
<td></td>
<td>Scoping meeting 14th October.</td>
<td>Tbc</td>
</tr>
<tr>
<td>Deteriorating adults</td>
<td>Reduce type PEA (pulseless electrical activity)</td>
<td>22 PEA</td>
<td>Verbal Update November</td>
<td></td>
<td>To continue root cause analysis to identify avoidable features.</td>
<td>G</td>
</tr>
<tr>
<td>CQUIN Care in appropriate place; reduction frequent attenders at ED/ AMU attendance</td>
<td>Treating patients in the most appropriate setting (minimising avoidable admissions and A/E attendance). Audit effectiveness.</td>
<td>Report &amp; analysis G</td>
<td>A</td>
<td></td>
<td>PCT delay in providing contact for joint pathway development.</td>
<td>G</td>
</tr>
<tr>
<td>CQUIN Alcohol related ED attendances</td>
<td>Q4: Audit of ED minors adult discharge summaries (target 90%): alcohol prevention has been shared, the weekly units of alcohol consumed</td>
<td>G</td>
<td></td>
<td></td>
<td>Task &amp; Finish group has met, all areas discussed. Minutes shared.</td>
<td>G</td>
</tr>
</tbody>
</table>
PIF
Context- Relationship to the SUHT 2011-12 Patient Improvement Framework

. Context and key changes
1.1. This governance report supports the priorities of:
• our 2011/12 Patient Improvement Framework (PIF) Outcomes framework
• Our Quality Account priorities identified
• Primary Care Trust (PCT) quality contract requirements
• The Department of Health (DH) Transparency in Outcomes proposals for NHS.

1.2. This is a regular three monthly in-depth patient outcomes report for 2011-12 for the quarter 2 period July- September 2011.

1.3. The progress detailed within this report needs to be seen within the overall context of the Trust’s activity. Year to date April 2011-August 2011, there have been 56,403 in-patient and day-case spells accounting for 171,186 bed days; and 171,942 outpatient attendances, with a slight upward trend over the year April 2010-date. Since 2008 our overall mortality rate (unadjusted) has maintained a slight but steady decrease, with seasonal peaks in January for each of the past three years.

1.4. A key Trust measure of outcomes and effectiveness is our raw mortality rates, which are reported monthly in the trust Board KPI report.

1.5. The full Cquin quarterly summary and other measures included in the quality schedule 3.4 are attached at Annexe A.

1.6. Cquins detail in this report will focus only on those relating to outcomes. The remainder being addressed in the respective safety and patient experience detail reports, with a performance summary included in the Trust Board KPI report. Financial updates to be included in the contracting regular reports to Trust Board.

2. Patient Outcomes Work streams
PIF:

HSMR (Lead David Weeden)

2011/12 Target 90 (April 2011 to March 2012 using 2010/11 benchmark)

Progress: current position

SUHT
- Although the overall Trust and SGH site HSMR fell in March and April it has rose again in May and June and there is still evidence of poor primary diagnosis and comorbidity recording. The Trust's HSMR for the year April 2010 to March 2011 is **104.6** and so the Trust will be in the “as expected” group
  - The downwards trend in crude mortality continues
  - We should focus on improving standards of clinical care to reduce observed (crude) mortality and so lower HSMR

SGH
- The fall in the HSMR in the area of Trust providing for majority of acute care

PAH
- High HSMR reasons as previously highlighted. The risk model deals very poorly with stillbirths but as numbers are small they have a relatively minor impact on the Trust’s overall HSMR
  - The Trust’s HSMR for other perinatal conditions remain satisfactory when compared to equal level 3 obstetric and neonatal units.

CMH
- The CMH HSMR fell for the year April 2010 to March 2011 from **153.7** to **139.9**.

Other actions in place to improve our hospital mortality include:
- The e-discharge summary went live in May
- Developing more choice of diagnosis within the e-discharge to

<table>
<thead>
<tr>
<th>Period</th>
<th>SUHT</th>
<th>SGH</th>
<th>PAH</th>
<th>CMH</th>
<th>Negative CUSUM (99%)</th>
<th>Positive CUSUM (99%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 08 – Mar 09</td>
<td>141.6</td>
<td>131.0</td>
<td>274.8</td>
<td>415.5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Apr 09 – Mar 10</td>
<td>114.7</td>
<td>110.1</td>
<td>195.3</td>
<td>165.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr 10 – Mar 11</td>
<td>104.6</td>
<td>100.6</td>
<td>213.9</td>
<td>139.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr 11 – Aug 11</td>
<td>92.8</td>
<td>87.5</td>
<td>269.1</td>
<td>140.5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

All figures throughout this report are bench marked to 2009-10

The Trust’s overall HSMR for the year from April 2010 to March 2011 after re-benchmarking was **104.6** and so will lie within the “as expected” group in 2011 Dr Foster Good Hospital Guide.
support coding accuracy

- To link the doctors’ work-list with e-discharge to improve continuity of information flow
- Improve the ‘coders list’ for co-morbidity
- Coding directly from notes
- A coding HMR working group remains in place, chaired by Jane Hayward

<table>
<thead>
<tr>
<th>Apr 11</th>
<th>Position</th>
<th>SUHT</th>
<th>Range</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Group</td>
<td>18/13</td>
<td>84.3</td>
<td>69.3 – 95.5</td>
<td>82.7</td>
<td>84.3</td>
</tr>
<tr>
<td>University Hospitals</td>
<td>21/50</td>
<td>84.3</td>
<td>0.0 – 112.6</td>
<td>81.0</td>
<td>79.3</td>
</tr>
<tr>
<td>Crude mortality</td>
<td>35/50</td>
<td>4.4%</td>
<td>0 – 7.2%</td>
<td>3.8%</td>
<td>3.85%</td>
</tr>
</tbody>
</table>

**Actions/next steps**

- Consultants to have greater direct input into the primary diagnosis and consider alternative ways of recording diagnostic information to avoid, when possible, multiple differential diagnosis lists.

- To ensure critical co-morbidities are recorded for every admission and ensure that this vital clinical data is available to the coders.

- To further develop mortality & morbidity meetings so that all deaths with avoidable features are considered. This requires a screening tool for all deaths within the Trust administered within specialties.

- To identify a series of specialty specific morbidities amenable to reduction by change in care are monitored against actions.

- Care groups must develop specific actions plans for reducing HSMRs over 110. Some actions will be about data management but some may require improved clinical care.
**PIF**
**PROMS – Patient Reported Outcome Measures**  
(lead: Martin Stephens AMD Clinical Effectiveness)

### Aim
To participate and learn from local results.

### Target
80% contribution

### Progress
We contribute to the PROMs programme and appear to have results in line with the national average. Knees and hip replacements are the two relevant to the Trust.

No further information has been received regarding the National PROMS Revascularisation Project.

<table>
<thead>
<tr>
<th>Numbers</th>
<th>Proportion included of eligible patients</th>
<th>Health index gain (mean)</th>
<th>% reporting health gain</th>
<th>% reporting health unchanged</th>
<th>% reporting health got worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>22,270</td>
<td>80%</td>
<td>0.405</td>
<td>87%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Southampton</td>
<td>71</td>
<td>87%</td>
<td>0.384</td>
<td>100%</td>
<td>0% *</td>
</tr>
<tr>
<td><strong>KNEE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>23,318</td>
<td>84%</td>
<td>0.301</td>
<td>78%</td>
<td>11%</td>
</tr>
<tr>
<td>Southampton</td>
<td>107</td>
<td>84%</td>
<td>0.322</td>
<td>70%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Data as reported by the Information Centre for April 2010 to March 2011 – ‘provisional’ i.e. subject to later correction by the centre. They now split data in line with financial years. * only 60 records reported by information centre – others may have had answers missing

### Actions/ next steps
To continue to feed results back to Trauma & Orthopaedics.

Note: data are built up over time and no attempt has been made nationally to identify trends; local numbers are relatively small so that identifying significant differences between local and national data is not possible.

### Recommendations
None at this point.

We would need to consider actions if our % submission falls or if our ‘gains’ begin to diverge from the national average.

**Explanation:**

PROMs use pre and post operative questionnaires, administered nationally, to assess the impact on health related quality of life each intervention makes.

The health gain reported is based on an index of 0 to 1, with 1 as ‘perfect health’. Typically, pre-op patients have scores below 0.5 and move to around 0.75 if the intervention works for them.
**PIF**

**Emergency Pathway (5 project streams)**

1. **Unplanned Re-attendances**
   
   **Aim**
   To reduce avoidable re-attendances at A&E by improving the care and communication delivered during the original attendance.

   **Targets:**
   Rates above 5% are likely to reflect poor quality care but rates below 1% may reflect excessive risk aversion.

   **Summary:**
   Q1 performance maintained through Q2 between 3 and 4%.

2. **Total time spent in the A&E department**
   
   **Aim**
   To improve the timeless and monitoring of care to ensure patients do not have excessive waits in A&E before leaving the department.

   **Targets:**
   The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted and non-admitted patient.

   **Summary:**
   95th percentile for Q2 performance = 03.59 target reached and improvement of 31 mins from Q1.

3. **Left without being seen**
   
   **Aim**
   To improve patient experience and reduce the clinical risk to patients who leave A&E before receiving the care they need.

   **Targets:**
   The left without being seen rate should be minimal and it appears that best practice would be to have level below 5%.

   **Summary:**
   Q2 performance 3.5%, achieving target and an improvement from Q1 performance 4.9%.
3. Time to initial assessment

Aim
Reduce clinical risk associated with the time the patient spends un-assessed in A&E

Targets:
A 95\textsuperscript{th} percentile time to assessment above 15 minutes may trigger intervention as this is one of the five A&E quality indicators included in national oversight in the NHS Operating Framework for 2011/12.

Progress: Process map in partnership with SCAS. New agreed pathway within majors developed that is both consistent with the ethos and principles of initiating a ‘meaningful assessment’ and meets the time requirements of both SCAS and ED.

New process fully implemented 19\textsuperscript{th} Sept

Summary:
Q2 performance improved to 27 mins from 30 mins Q1. In-week performance since implementation of new process = 8 mins.

4. Time to Treatment

Aim
To reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in A&E

Targets:
A median above 60 minutes from arrival to seeing a decision-making clinician across all patients may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Summary: Q2 2 Consultants identified to lead on developing and implementing the role of ‘Medical Driver’. Performance = 1hr 8 mins, an improvement of 8 mins on Q1 performance
| PIF  
| Out of Hours/ hospital at night |
|-----------------|--------------------------------------------------|
| Hospital at Night was launched as a pilot project in the Trust in 2008, and currently includes patients in divisions A, B and parts of D. The programme is clinically driven, using teams with skills crossing professions and specialties. The hospital at night approach adds support to medical training and service delivery, and aims to achieve safer care by having staff with a full range of skills and competencies to meet the immediate needs of patients. |
| Actions/ next steps |
| Following a successful bid by Division B to the South Central Strategic Health Authority to spread the pilot throughout the Trust, further senior nurse practitioner support will be developed this year to cover the hours 5pm to midnight. However, a bid to increase consultant support was unsuccessful. |
| Recommendations |
| To support further development of the hospital at night programme and spread to all areas of the hospital. |
PIF Verbal UPDATE NOVEMBER
Deteriorating Adults

Aim
1. To reduce the number of cardiac arrests due to ‘pulseless electrical activity’ (PEA) at ward level.
2. To improve early recognition and management of patient deterioration to enable timely admission to GICU, and reduce unexpected admissions into GICU.

Observation of Data:
PEA and asystole are the dominant causes of cardiac arrests at ward level. Both are non-shockable rhythms. Research estimates that up to 80% of PEA arrests are avoidable if patients are observed and appropriately managed.

This report will be further updated in November prior to TEC submission, when analysis is completed on the quarter 2 results.

Recommendations
1. This report will be updated from Q1 to Q2 in November when analysis becomes available.
### 1. Care in appropriate place; reduction frequent attenders at ED/AMU attendance

**Target**
Process development, and audit of effectiveness  
Value 0.15% Cquin scheme

**Quarter 2 Objectives:**
- Develop care pathways with Solent Health and Primary Care for the top 3 or commonest issues that cover 25% of the patients.  
- Develop a process whereby patients who have attended ED more than three times in the last three months, are notified to their GP.  
- Complete the 3 main pathways identified, with Solent Health and Primary Care, agree a process for monitoring.

**Progress:**
Top 3 commonest issues have been identified as
- Management of alcohol misuse  
- Management of mental health problems  
- Management of chronic pain  
Pathway development by SUHT is on track.  
There has been a delay by commissioners in identifying the contact point for SUHT to work jointly with at Solent Healthcare. A formal request has been made to the commissioning lead, that the deadline for achievement of the joint working be reviewed as a result.

**Next steps: Quarter 3 Objectives:**
Demonstrate, that a system to make e-care plans from the community services and SCAS easily available to SUHT staff, has been explored.

### 2. Alcohol related ED attendances

**Target**
90% assessed by Q4  
Value 0.15% Cquin scheme

**Quarter 2 Objectives:**
To set up task and finish group to look at:  
Developing a mandatory field on GP discharge summary,  
Begin to develop an approach to using a self assessment tool  
To agree targets against each of the above specified areas,  
To display in all public areas, posters on alcohol prevention and where to seek help.

**Progress:**
A first meeting has been held covering all areas required by the Cquin detail. Further dates are in hand.  
The assessment questions have been built into Symphony, plan agreed to go live 1\textsuperscript{st} November.  
Agreed the process for the GP discharge letter (ie, high risk on separate letter)  
Awaiting sign off from the Drugs Committee chairman to adapt the withdrawal and vitamin supplementation algorithms.  
Following feedback from Spencer House, to re-look at the community referrals.

**Next steps: Quarter 3 Objectives:**
Produce a progress report against the task and finish group objectives for the CQRM.  
Implement all areas agreed by task and finish group, which at a minimum would include:  
- use of mandatory field on GP discharge summary  
- provision of the agreed self assessment tool and patient information  
- proactive engagement with wider alcohol initiatives
Summary Actions updated from Quarter 1 report:

<table>
<thead>
<tr>
<th>Meeting Actions</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>QGSG 20th July Updates to content as data available</td>
<td>updated</td>
</tr>
<tr>
<td>TEC 3rd August</td>
<td></td>
</tr>
<tr>
<td>Trust Board 27th September to move CQuins detail to contracting report</td>
<td>See this Q2 report format</td>
</tr>
</tbody>
</table>

3. Conclusion

This report provides an update on progress against the patient outcome elements of the Patient Improvement Framework.

Trust Board is asked to:

1. For HSMR:
   a. Consultants to have greater direct input into the primary diagnosis and critical co morbidities.
   b. To further develop Mortality & Morbidity Meetings so that all deaths with avoidable features are considered, and morbidities amenable to reduction by change in care are monitored against actions.
   c. Care Groups to develop specific actions plans for reducing HSMR.

2. For PROMS and emergency pathway reports, to note progress.

3. For Deteriorating adults:
   • To act on recommendations made by the audit & assurance committee in September.

5. To note the Outcomes CQuins (Cquin 6 Alcohol, and Cquin 7 ‘care in appropriate place’) quarter 2 progress.
<table>
<thead>
<tr>
<th></th>
<th>Year-end Target</th>
<th>Q1 submit to PCT (Sept)</th>
<th>Q2 submit to PCT (Dec)</th>
<th>Q3 submit to PCT (Mar)</th>
<th>Q4 submit to PCT (Jun)</th>
<th>Forecast year-end</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. VTE: ALL DIVISIONS</strong></td>
<td>90% adult inpatients have VTE risk assessment on admission</td>
<td>Apr 91%</td>
<td>May 91.48%</td>
<td>Jun 90.74%</td>
<td>Jul 91.69%</td>
<td>Sep 90.03%</td>
</tr>
<tr>
<td></td>
<td>1: National Survey scores 65.5 or better.</td>
<td>na na na na na na na na na na</td>
<td></td>
<td></td>
<td></td>
<td>na na na</td>
</tr>
<tr>
<td></td>
<td>2: Local patient survey conducted by SUHT (Picker) scores 82.0 or better.</td>
<td>83.1 73.6 81.5 77.6 80</td>
<td>na na na na na na na na na na</td>
<td></td>
<td></td>
<td>na na na</td>
</tr>
<tr>
<td><strong>3. Patient Experience: ALL DIVISIONS</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1: National Survey scores 65.5 or better.</td>
<td>na na na na na na na na na na</td>
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<td></td>
<td></td>
<td>na na na</td>
</tr>
<tr>
<td></td>
<td>2: Local patient survey conducted by SUHT (Picker) scores 82.0 or better.</td>
<td>83.1 73.6 81.5 77.6 80</td>
<td>na na na na na na na na na na</td>
<td></td>
<td></td>
<td>na na na</td>
</tr>
<tr>
<td><strong>3. Gateway ALL DIVISIONS</strong></td>
<td>100% Achievement of KPIs (16 metrics)</td>
<td>12/16</td>
<td>14/16</td>
<td>14/16</td>
<td>13/16</td>
<td>15/16</td>
</tr>
<tr>
<td><strong>4. HAIC, Urinary Catheters ALL DIVISIONS</strong></td>
<td>90% staff as identified in TNA trained in urinary catheter insertion Tbc% reduction in number of patients who have a catheter inappropriately inserted.</td>
<td>75% propose 20%</td>
<td>87.50% updated</td>
<td>87.50% updated</td>
<td>81.30% updated</td>
<td>93.80% updated</td>
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<tr>
<td><strong>5. Death in Place of Choice. LEAD DIVISION A</strong></td>
<td>1: by end of Q4 75%, of identified staff trained in the use of ACP EoL strategy shared TNA report shared report 15/092011</td>
<td>G</td>
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</tr>
<tr>
<td></td>
<td>2: by the end of Q4, 20% of patients identified as being at the end of their life have an ACP</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td><strong>6. Treating patients in the most appropriate setting LEAD DIVISION B</strong></td>
<td>Treating patients in the most appropriate setting (minimising avoidable admissions and A/E attendance). Audit effectiveness.</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td><strong>7. Alcohol-related attendances at ED. LEAD DIVISION B</strong></td>
<td>Q4: Audit of ED minors adult discharge summaries (target 90%): alcohol prevention has been shared, the weekly units of alcohol consumed Task &amp; Finish group has met, all areas discussed. Minutes shared.</td>
<td>G</td>
<td>G</td>
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</tr>
</tbody>
</table>
### Specialist Services CQUIN Standards (Progress against Requirements)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Q1 Submit to PCT (Sept)</th>
<th>Q2 Submit to PCT (Dec)</th>
<th>Q3 Submit to PCT (Mar)</th>
<th>Q4 Submit to PCT (Jun)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve BMT Outcomes (Adult 100 day survival rate)</td>
<td></td>
<td></td>
<td>G</td>
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</tr>
<tr>
<td>Improve Cardiac Outcomes</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Readmissions to PICU following cardiac surgery &lt; 10%</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Mortality at 30 days post cardiac surgery to &lt; 4%</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Improve Neonatal Outcomes</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Reduction in local baby capacity-related transfers</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Reduction in capacity-related neonatal refusals</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Improve Neonatal Outcomes</td>
<td></td>
<td></td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Number of Neonatal Serious Untoward Incidents (SUIs)</td>
<td></td>
<td></td>
<td>G</td>
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</tbody>
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### Schedule 3.4

<table>
<thead>
<tr>
<th>Other Outcomes Measures</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Ja n</th>
<th>Feb</th>
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<tbody>
<tr>
<td>#NOF Quarterly Improvement towards best practice tariff</td>
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<td>Respiratory Undertake Annual audit</td>
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<td>AUKUH Completion of audit</td>
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<tr>
<td>Emergency readmissions Analysis of readmissions (Baseline)</td>
<td>7.58%</td>
<td>7.39%</td>
<td>6.52%</td>
<td>7.05%</td>
<td>7.09%</td>
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<td>Smoking 95% appropriate adult elective receive advice</td>
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<td>PROMS 80% participation rate</td>
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<td>Enhanced recovery By Qtr 4 meet (or exceed) 'National expected' length of stay</td>
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<td>IQP 95% of patients included in IQP audit pathways</td>
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