AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 3 JUNE 2010

Title:	**PERFORMANCE INDICATORS REPORT & REVIEW OF KEY PERFORMANCE INDICATORS FOR 2010/11**
Responsible Director:	Executive Director of Delivery
Contact:	Andy Walker, Divisional Planning Manager Daniel Ray, Director of Informatics & Patient Administration

Purpose:	To update the Board of Directors of the Trust's performance against key indicators, including Care Quality Commission (CQC) targets, risk ratings against standards included in the Monitor Compliance framework, and performance against internal targets. To seek approval for changes in the indicators included in performance indicator reports for 2010/11
Confidentiality Level & Reason:	N/A
Medium Term Plan Ref:	Affects all strategic aims.
Key Issues Summary:	The following indicators are currently not in line with targets and therefore exception reports have been provided: • *C. difficile* • Quality of Stroke Care • 62 day first cancer treatments • Short term sickness • Agency spend • Follow-up outpatient cancellations • Electronic Patient Survey response rate • Omitted non-antibiotic doses • Readmission & non-emergency mortality audits response rates Further details and action taken are included in Appendix B. Following the annual review of performance indicators changes are proposed to the indicators to be included in Performance Reports for 2010/11 to reflect changes in national targets by Monitor and the Care Quality Commission and local priorities.

Recommendations:	The Board of Directors is requested to: **Accept** the report on progress made towards achieving performance targets and associated actions. **Approve** the proposed changes in the indicators reported and in the process for identifying exceptions.
Signed:	**Date:** 27 May 2010

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 3 JUNE 2010

PERFORMANCE INDICATORS REPORT & REVIEW OF KEY PERFORMANCE INDICATORS FOR 2010/11

PRESENTED BY THE CHIEF OPERATING OFFICER

1. **Purpose**

This paper provides the Board of Directors with an update on the Trust's performance against key indicators, including Care Quality Commission (CQC) targets, risk ratings against standards included in the Monitor Compliance framework and internal targets. Performance against these indicators is shown in Appendix A. Following the annual review of performance indicators this report also outlines proposed changes to the indicators that will be included in Performance Reports for 2010/11 to mirror changes in national targets by Monitor and the Care Quality Commission and to better reflect the Trust's priorities.

2. **Exception reports**

Exception reports where monthly data are available are contained in Appendix B. An update on quality of Stroke Care is included as the Trust has now submitted the CQC special data collection for 2009/10. The number of post 48 hour C. difficile cases exceeded the threshold in April therefore this indicator is included, as is a report on the cancer targets as the 62 day first treatment target is currently below target for the full year 2009/10. A&E 4 hour wait performance met the target in April so an exception report is not included.

The exception report this month only contains reports on those internal indicators that are red. Cancellation of follow-up outpatient appointments is included as this returned to red in April 2010. PDRS and mandatory training are both now amber with achievement of 85% and 84.1% respectively and slot unavailability in April was green with performance of 6.1 therefore exception reports are not included for these indicators in this report.

The following internal targets are currently red:

a) Short term sickness
b) Agency spend
e) Follow-up outpatient cancellations
g) Electronic Patient Survey response rate
h) Omitted non-antibiotic doses
i) Readmission & non-emergency mortality audits response rates

3. **Performance Indicator Review 2010/11**

3.1 As part of its ongoing work of reviewing and improving the quality of performance reporting the Planning & Performance Team has undertaken a review of the indicators that will be reported to the Board of Directors in 2010/11. This is an annual review carried out early in the financial year to ensure that the indicators reported reflect both national priorities and those of UHB. The following factors were drivers in reviewing the existing indicators and developing changes:

a) Changes in the Monitor Compliance Framework for 2010/11.
b) Expected changes in the targets used by the CQC for Periodic Review 2010/11.
c) Developments in the Trust's strategic priorities resulting from the development of the Trust Strategy and particularly from an increased emphasis on quality.

Proposed changes were then discussed with key members of staff and directors to ensure that they appropriately reflected the Trust's priorities for 2010/11 and that performance management using these indicators would be supported.

Appendix A of this report is a mock up of the proposed changes so that the effect on future reports can be assessed. No changes in the presentation format or categories used for performance indicator reports are proposed at this time as the existing format remains fit for purpose.

<u>Changes in External Indicators Reported</u>

3.2 Monitor has published the final version of its Compliance Framework for 2010/11 which introduces a number of changes to the targets and indicators used. The main changes are as follows:

3.2.1 A 31 day waiting target for subsequent radiotherapy treatments will be introduced from 1 January 2011. This will be matrixed together with the other 31 day subsequent treatment targets for surgery and anti-cancer drug treatments with an overall weighting of 1.0.

3.2.2 The target for MRSA screening will be expanded to cover emergency admissions from 1 January 2011. This carries a weighting of 0.5.

3.2.3 The trajectories used by Monitor for the MRSA and C. difficile indicators will be those contractually agreed with NHS South Birmingham. In addition the MRSA trajectory will now only include cases occurring later than 48 hours after admission.

3.2.4 Monitor have also introduced a quarterly self-certification with requirements regarding access to healthcare for people with a learning disability. This uses the same construction as the

3.3 The CQC has not yet published a high-level list of the indicators that will be used for the 2010/11 Periodic Review or detailed construction information and thresholds. It has however been possible to infer some of the changes that will be made this year and the report will be further amended as additional information becomes available.

3.3.1 The Core Standards are no longer included in the Periodic Review from 2009/10, instead being replaced by the Trust's registration status. This section of the report has therefore been removed and replaced by the Trust's compliance with its outcomes against the 16 essential registration standards. Further details of the ongoing assurance process for compliance will be included in the Quarterly Board Certification paper in July 2010.

3.3.2 The Department of Health indicated in the Operating Framework for 2010/11 that the 26 week inpatient, 13 week outpatient and 13 week revascularisation performance targets were being discontinued as they have been superseded by the 18 week referral to treatment target. The 18 week referral to treatment target and 2 week urgent referral for cancer to first outpatient appointment have been enshrined as entitlements under the NHS Constitution. The operational detail of how these entitlements will work has yet to be finalised but performance against these measures will continue to be reported.

3.3.3 Additionally, when the CQC removed the Transient Ischaemic Attack (TIA) element of the Quality of Stroke Care indicator in 2009/10 they indicated that this would be restored in 2010/11. This indicator will therefore assume that the TIA element will be included. Quarterly data on performance against both the stroke and TIA elements of this indicator is available from the July report.

<u>Changes in internal indicators reported for 2010/11</u>

3.4 The review has also identified proposed changes in the internal indicators reported to better reflect the Trust's priorities and the risks associated with the delivery of the Trust's strategy and annual plan. Key to the changes is the introduction of the Trust's Commissioning for Quality and Innovation (CQUIN) measures to the internal indicators reported. These indicators are developed from the Trust's priority areas for quality improvement and innovation and also carry significant

financial (1.5% of contract value) and reputational risk for the Trust. Consequently their delivery is key and performance against these measures needs to be included in future performance reports. Only one of these indicators (omitted doses) is currently included in performance reports. These key areas for quality improvement are also reflected in the Trust's quality report as part of a coordinated approach to the Trust's quality reporting and improvement activity.

3.4.1 Workforce – Resources

It is proposed to report the internal agency (Locate) rate as well as the external agency rate. This will ensure that all agency costs associated with gaps in the permanent workforce are reported. In addition, on an ongoing basis it will allow the effectiveness of Locate in providing bank staff to be measured. The indicator for maternity, paternity and adoption leave has been removed as this indicator has been consistently green and cannot, in itself, be managed to improve performance.

3.4.2 Workforce - Capability

It is proposed that the mandatory training, which in 2009/10 only included fire training, will be widened to report the percentage of staff who are up to date on all mandatory training. This expansion will take place on an incremental basis so that the focus can be on individual component of mandatory training at a time; the first of these will be infection control training, followed by major incident training. The consultant appraisal indicator will be removed as the consultant appraisal process only occurs between January and March and is effectively managed through other means. The thresholds for corporate and local induction have been revised to reflect the annual plan; the green threshold is now 90% and the amber threshold 85%.

3.4.3 Efficiency – Innovation

This section of the report will include the CQUIN to improving the detection of and intervention for acutely sick and deteriorating patients by the roll-out of the electronic observation chart. This will replace the indicator for EPR implementation. The proposed research and development indicators will cover research income (commercial), research income (non-commercial), research studies/trials in progress, patients accruals and research publications. Further work is required to further refine the performance metrics, and identify appropriate targets/trajectories. A robust IT system to collect and report R&D activity, in particular patient accrual, is also required. These indicators will therefore be introduced once the Head of Research and Development (Operations), for which interviews are taking place at the end of May 2010, is in post.

3.4.4 Efficiency – Process

The data timeliness statistics produced by the Department of Health have not been used by the Care Quality Commission as was originally proposed therefore this indicator has been removed. Following technical delays the data to support the indicator measuring the time from outpatient letters being dictated to becoming available on the clinical portal will be available from August. Length of Stay will be reported based on the modelled percentage bed occupancy in the New Hospital based on current length of stay and activity.

3.4.5 Patient Care – Experience

This section of the report will include the CQUIN which measures responsiveness to the personal needs of patients.

3.4.6 Patient Care – Safety

This section of the report will contain an additional four indicators which are CQUINs. They are:

a) Reducing venous Thromboembolism (VTE) through the use of the VTE risk assessment.
b) Improving the management of patients who are at risk of falling by increasing the completion of falls assessments.
c) Reducing delays between the prescription and administration of antibiotic drugs.

The omitted drugs indicator already included in this section is also a CQUIN in 2010/11.

3.4.7 Patient Care – Outcomes

This section of the report will contain an additional two indicators which are CQUINs. They are:

a) Reducing the rate of central venous catheter associated bloodstream infections.
b) Reducing the rate of UHB acquired pressure ulcers.

3.4.8 Governance

As the programme of health and safety audits in the Trust has been suspended, as agreed by the Trust Health and Safety Committee, this indicator has been suspended until the programme is recommenced.

3.4.9 Annual Plan Progress

This section of the report has been updated to reflect the new structure of the 2010/11 annual plan. Performance will be reported at the strategic enabler level.

4. Exception Reporting

4.1 The Board will continue to receive performance reports by exception and details will be provided in Appendix B if exceptions are identified. As part of the KPI review the parameters for determining exceptions have also been reviewed. It is proposed that exception reports will now be provided for any external indicator that is amber or red for the latest month and/or for the year to date. This will allow the earlier identification and reporting of any indicators where performance has fallen below target, before year to date performance also drops below target.

4.2 Exception reports for internal indicators will be provided where an indicator is red for the latest month or amber for the latest three months on a rolling basis. This will ensure that exception reports for internal indicators are only provided where recent performance is below target.

5. Future Changes to Indicators Reported

5.1 It is proposed, in future, to take a more dynamic approach to the review of indicators. In *The Coalition: Our Programme for Government* the new government has indicated that the CQC will be strengthened to become a more effective quality inspectorate and that Monitor will become a solely economic regulator. It is therefore likely that there will be fundamental changes to the regulatory and performance management regime over the next year. The Government has also indicated that it will in future use targets that focus on health outcomes such as survival following cancer or stroke. It is therefore expected that there may need to be a number of changes made to the indicators reported during the year. In addition it is likely that the Trust's priorities will change in response to the priorities of the new government and the internal indicators reported will need to be adapted to reflect these priorities. The move to the New Hospital may potentially require changes to the internal indicators reported to reflect the new challenges and opportunities presented.

5.2 Consequently an organic approach will be taken to both the external and internal indicators reported with amendments made to the indicators reported as further information is received about regulatory changes and where the Trust's priorities change. The details of any changes made will be included in future performance indicator reports.

6. **Recommendations**

The Board of Directors is requested to:

Accept the report on progress made towards achieving performance targets and associated actions.

Approve the proposed changes in the indicators reported and in the process for identifying exceptions.

Tim Jones
Executive Director of Delivery

Top level grouping		2nd level grouping	KPI	Weighting	New?
National Performance	Amber	Monitor targets	MRSA	1	
			C. difficile	1	
			Cancer 31 days first	0.5	
			Cancer 31 days subs - drugs	1	
			Cancer 31 days subs - surgery	1	
			Cancer 31 days subs - radiotherapy	1	
			Cancer 62 days - GP referral	1	
			Cancer 62 days - screening	1	
			Cancer 2 wks	0.5	
			Breast 2 wks	0.5	
			18 wks - admitted	1	
			18 wks - non-admitted	1	
			A&E 4 hr waits	0.5	
			MRSA screening	0.5	
			Learning Disabilities	0.5	
		Existing Commitments	Patient ethnic group recorded	1	
			Delayed transfers of care	1	
			A&E 4 hr waits	1	
			RACPC 2 wk waits	1	
			Cancelled operations	1	
			Primary PCI	1	
		National Priorities	Engagem't in Clinical Audit	1	
			Heart disease audits	1	
			Stroke care	1	
			MRSA	1	
			C. difficile	1	
			18 wks	1	
			Cancer 31 days	1	
			Cancer 62 days	1	
			2 wks - cancer & breast	1	
			Patient experience	1	
			Staff satisfaction	1	
			Learning Disabilities	1	New
		Core Standards	1	1	New
			2	1	New
			4	1	New
			5	1	New
			6	1	New
			7	1	New
			8	1	New
			9	1	New
			10	1	New
			11	1	New
			12	1	New
			13	1	New
			14	1	New
			16	1	New
			17	1	New
			21	1	New

Patient Care	**Experience**	Responsiveness to patient needs CQUIN	1	New
		Complaint response	1	New
		Cancelled appts - new	1	
		Cancelled appts - F/up	1	
		Slot availability	1	New
		Electronic patient survey response rate	1	New
	Safety	Incidents	1	New
		Never events	1	New
		VTE risk assess't CQUIN	1	
		Falls assess't CQUIN	1	
		Antibiotic prescription to admin delays CQUIN	1	
		Omitted drugs	1	New
	Outcomes	SMR (103.97)	1	New
		CVC infection CQUIN	1	
		Pressure ulcer CQUIN	1	
		Readmission audit response rate	1	New
		Non-emergency mortality audit response rate	1	New
Workforce	**Resources**	Sickness - short term	1	
		Sickness - long term	1	
		Internal Agency rate	1	New
		External Agency rate	1	
		Vacancy rate	1	New
	Capability	PDRS	1	New
		Mandatory training	1	New
		Corporate induction	1	New
		Local induction	1	New
Efficiency	**Innovation**	Electronic obs chart CQUIN	1	New
		Research income (commercial)	1	New
		Research income (non-commercial)	1	
		Studies/trials in progress	1	New
		Patient accruals	1	
		Research publications	1	New
	Process	DNAs - new	1	New
		DNAs - F/up	1	New
		OP letters - dictation to post	1	
		Theatre list utilisation	1	
		Theatre session utilisation	1	
		Daycase rate	1	
		LOS to meet bedholding	1	
Governance	**Clinical & Corporate Governance**	Health and safety	1	New
		Risk registers	1	New
		National Clinical Audits	1	New
	MTP progress	Clinical Quality 1	1	New
		Clinical Quality 2	1	New
		Clinical Quality 3	1	New
		Clinical Quality 4	1	New
		Patient Experience 1	1	New
		Patient Experience 2	1	New
		Patient Experience 3	1	New
		Patient Experience 4	1	New
		Education & Training 1	1	New
		Education & Training 2	1	New
		Education & Training 3	1	New
		Education & Training 4	1	New
		Research & Innovation 1	1	New
		Research & Innovation 2	1	New
		Research & Innovation 3	1	New
		Research & Innovation 4	1	New

Last updated
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APPENDIX A

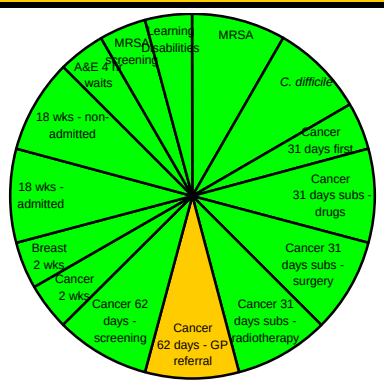
University Hospitals Birmingham NHS
NHS Foundation Trust

2010/11 Key Performance Indicator Report

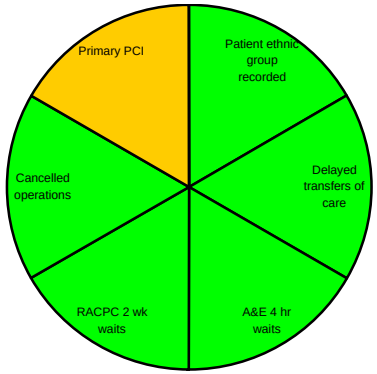
Where data is not currently available indicators have been assigned 'amber' unless considered high risk where they have been assigned 'red'.

National Performance

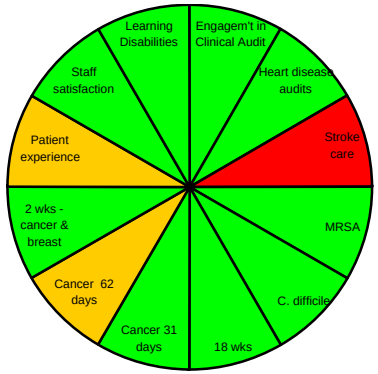
Monitor Governance Rating



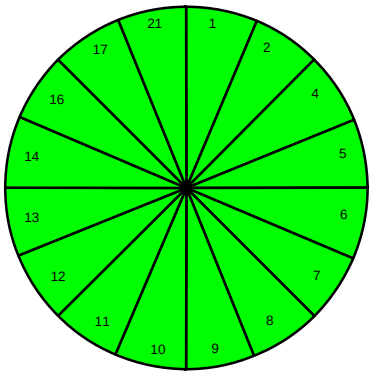
Care Quality Commission Existing Commitments



Care Quality Commission National Priorities

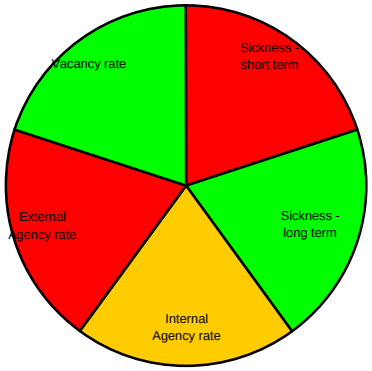


Registration Outcomes

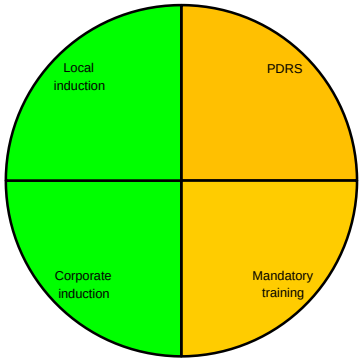


Workforce

Resources

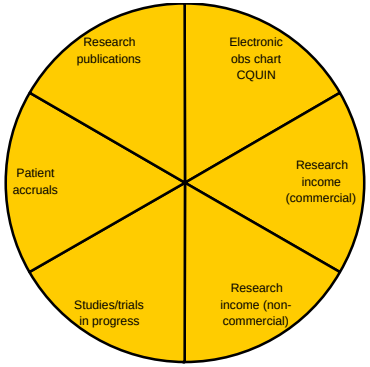


Capability

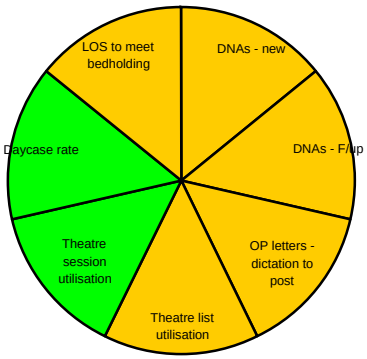


Efficiency

Innovation



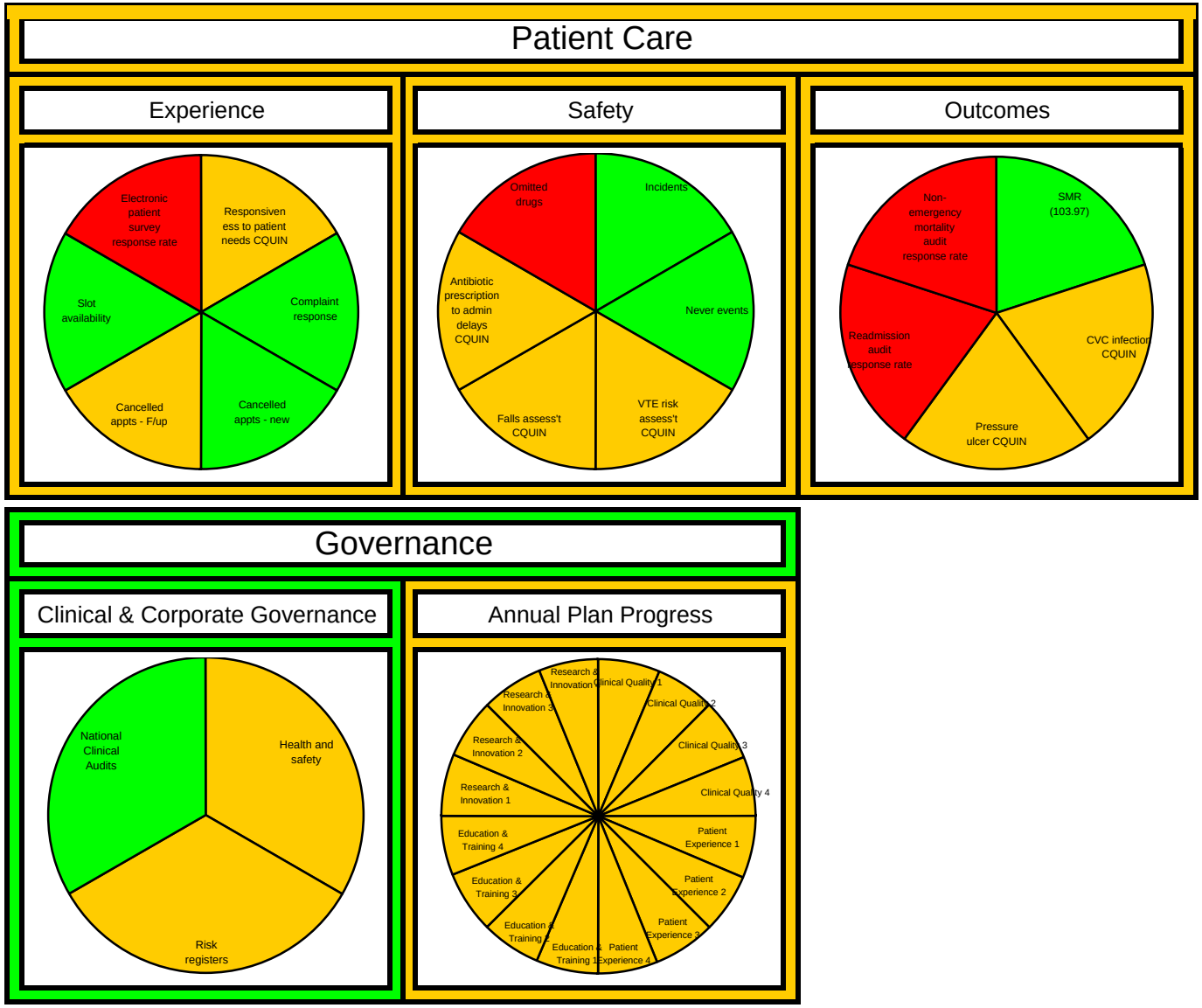
Process



20 May 2010

APPENDIX A

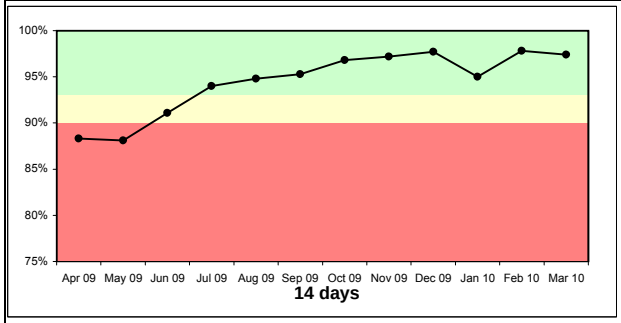
University Hospitals Birmingham NHS
NHS Foundation Trust



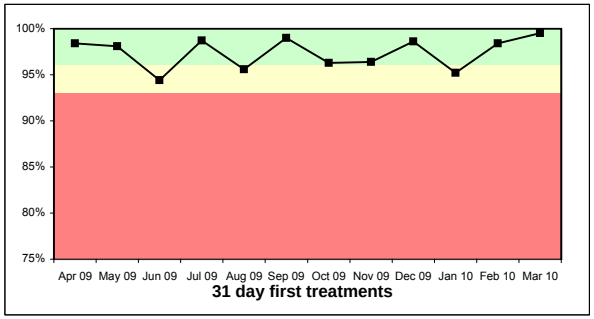
APPENDIX B

Exception Report for 3 June 2010 Board of Directors' Performance Report

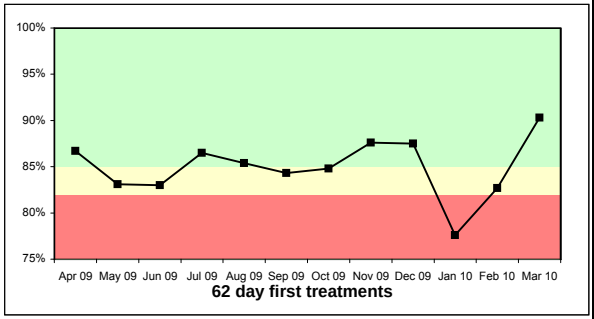
Expanded Cancer Targets												National Targets		
	Target	**Apr 09**	**May 09**	**Jun 09**	**Jul 09**	**Aug 09**	**Sep 09**	**Oct 09**	**Nov 09**	**Dec 09**	**Jan 10**	**Feb 10**	**Mar 10**	**YTD**
14 day cancer	93%	88.3%	88.1%	91.1%	94.0%	94.8%	95.3%	96.8%	97.2%	97.7%	95.0%	97.8%	97.4%	**94.6%**
14 day breast symptom	93% by 1 Jan 2010	15.7%	27.1%	26.7%	40.6%	43.2%	45.9%	74.5%	58.9%	95.6%	98.9%	100.0%	97.4%	**98.6%**
31 day first treatments	96%	98.4%	98.1%	94.4%	98.7%	95.6%	99.0%	96.3%	96.4%	98.6%	95.2%	98.4%	99.5%	**97.4%**
31 day subsequent treatments - Surgery	94%	96.9%	94.1%	95.5%	95.6%	96.1%	98.5%	95.8%	98.6%	96.2%	94.7%	98.5%	98.6%	**96.6%**
31 day subsequent treatments - Drugs	98%	98.7%	96.2%	98.0%	99.0%	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**99.1%**
62 day first treatments	85%	86.7%	83.1%	83.0%	87.3%	86.3%	84.3%	84.8%	87.6%	87.5%	77.6%	82.7%	90.3%	**84.98%**
62 day consultant upgrades	No target set	100.0%	94.4%	82.8%	78.7%	78.3%	84.6%	76.7%	92.5%	100.0%	79.6%	78.9%	86.5%	**85.7%**
62 day referrals from screening	90%	100.0%	100.0%	87.5%	95.8%	100.0%	75.0%	85.7%	100.0%	90.0%	80.0%	100.0%	100.0%	**91.9%**



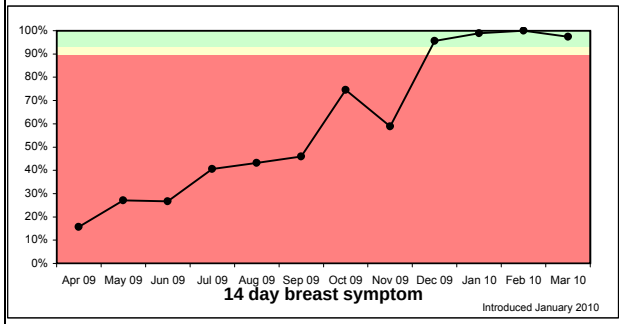
14 days



31 day first treatments

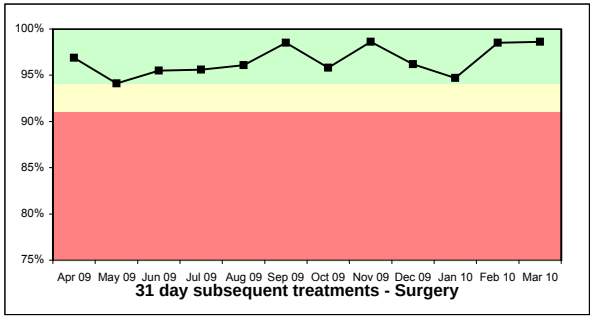


62 day first treatments

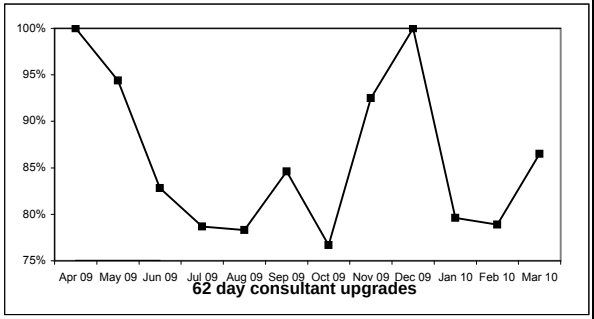


14 day breast symptom

Introduced January 2010



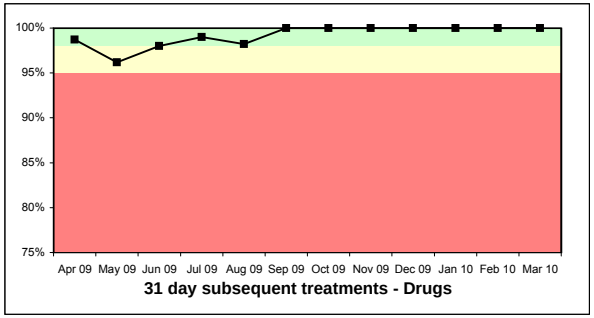
31 day subsequent treatments - Surgery



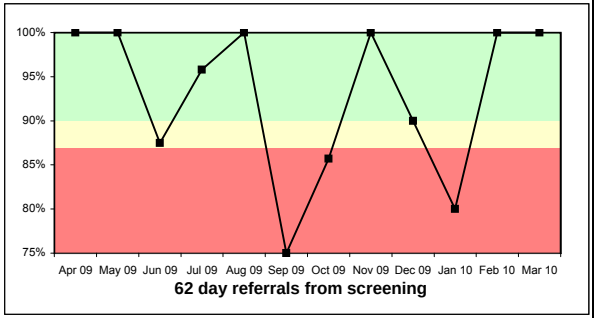
62 day consultant upgrades

The Trust met all the cancer targes in March 2010. It has therefore met all the targets for the full year with the exception of 62 day first treatments. The Trust has now agreed 5 reallocations of breaches of this target which has increased performance for the full year to 84.98%; just below the target of 85%. A further 10 reallocations are currently in negotiation with the referring trust. If a further reallocation is agreed the Trust will have met the target for the full year. A further reallocation has been agreed with a referring trust via email however the reallocation needs to be signed and accepted by the CQC before the Trust's figures can be amended.

Monitor has placed the Trust on monthly monitoring for the 62 day first treatment target due to underperformance against this target in Quarter 4.



31 day subsequent treatments - Drugs

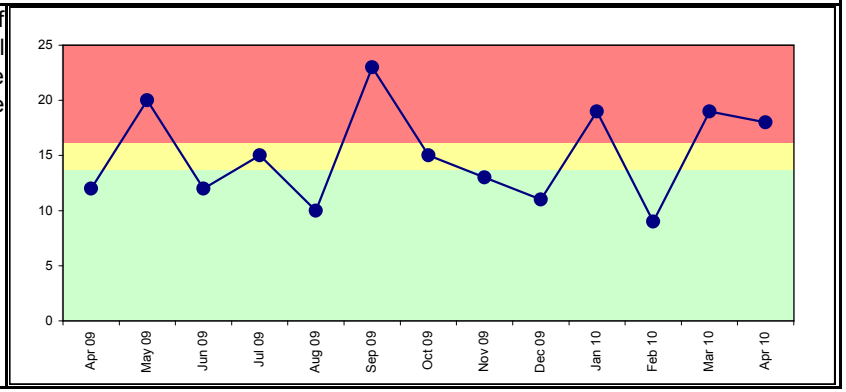


62 day referrals from screening

APPENDIX B

***C. difficile* - Post 48 hour cases**					**Monitor & CQC National Priorities**						> 193	≤ 193	≤ 164
	Apr 10	**May 10**	**Jun 10**	**Jul 10**	**Aug 10**	**Sep 10**	**Oct 10**	**Nov 10**	**Dec 10**	**Jan 11**	**Feb 11**	**Mar 11**	**YTD**
C. difficile	18												**18**

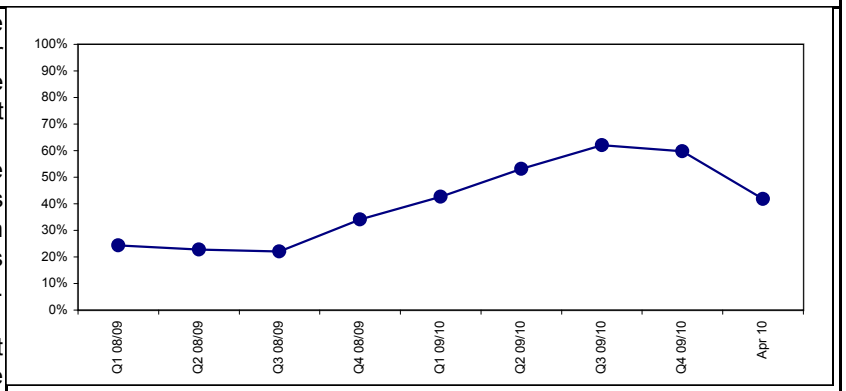
There were 18 post 48 hour *C. diff* cases in April which is above the trajectory of 13.66 to meet the full year trajectory of 164. The CQC sets the underachieve/fail threshold as the trajectory plus 3 standard deviations. This means the underachieve/fail threshold for 2010/11 will be 193 cases for the full year. Please refer to Chief Nurse's Infection Control Report for further details and action taken.



Quality of Stroke Care								**CQC National Priorities**			Thresholds not available		
	Apr 10	**May 10**	**Jun 10**	**Jul 10**	**Aug 10**	**Sep 10**	**Oct 10**	**Nov 10**	**Dec 10**	**Jan 11**	**Feb 11**	**Mar 11**	**YTD**
Stroke	41.8%												**41.8%**

The Trust has submitted its return to the CQC for performance in the stroke target for 2009/10. In total 64.6% of patients spent greater than 90% of their length of stay on a stroke unit. These figures include time spent on the rehabilitation stroke unit at Moseley Hall Hospital (MHH). The CQC has not yet published the thresholds for this target in 2009/10.
In April 41.8% of patients spent 90% of their length of stay on the acute stroke unit at Selly Oak Hospital. This does not include MHH length of stay which is only available on a quarterly basis as agreed contractually with NHS South Birmingham but the percentage should improve when it is included. Previous performance shown on the graph includes MHH length of stay.

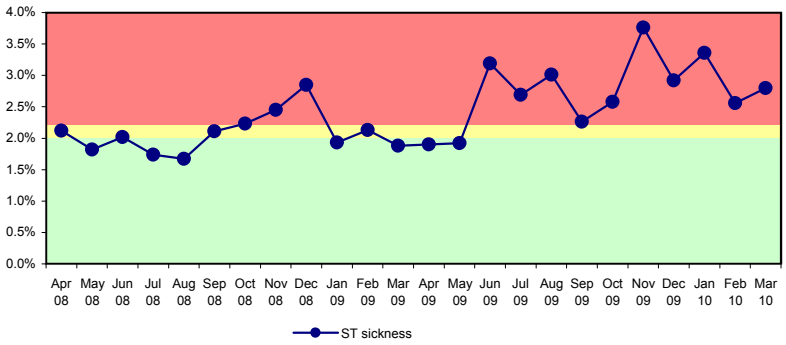
Division 3 has allocated 2 dedicated admission beds on the stroke unit however capacity problems seen at Selly Oak over recent weeks have made achievement of this target difficult. Health Informatics are developing a report that will identify all patients with suspected stroke in the Trust which will allow this target to be operationally managed and allow clinicians to identify patients who need to be transferred to the unit.



APPENDIX B

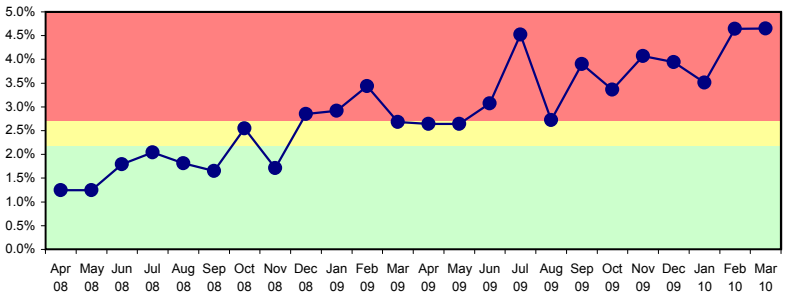
Sickness rate - short term Sickness rate - long term								Workforce - Resources			> 2.2% > 2.6%	2.0-2.2% 2.3-2.6%	≤ 2.0% ≤ 2.3%
	Apr 09	**May 09**	**Jun 09**	**Jul 09**	**Aug 09**	**Sep 09**	**Oct 09**	**Nov 09**	**Dec 09**	**Jan 10**	**Feb 10**	**Mar 10**	**YTD**
ST sickness	1.90%	1.92%	3.19%	2.69%	3.01%	2.26%	2.58%	3.76%	2.92%	3.36%	2.56%	2.80%	2.49%
LT sickness	1.96%	1.91%	0.96%	1.84%	1.21%	1.70%	1.66%	1.22%	2.26%	1.83%	1.83%	1.85%	2.03%

As at the end of March 2010, the Trust sickness absence rate was 4.65%; a slight increase from 4.39% in the previous month. Short term absence increased to 2.80% from 2.56% and the long term absence rate remained fairly static at 1.85%.
The hotspot areas are: Unregistered nursing (8.82%), West 2 (7.56%), East 4 (9.64%), Stroke Unit (11.62%), A3/A5 (15%), Pharmacy logistics (16%) Catering (20%) and Theatres (10.2%). Reasons include D&V, post-surgery recovery, stress and musculoskeletal issues. Absence in these areas is being closely monitored. A comprehensive action plan remains in place to particularly focus on short term absence.
Following the initial 'deep dive' on absence further analysis is being undertaken on one division to identify trends.



Percentage of total staff costs spent on agency staffing								Workforce - Resources			> 2.7%	2.2 - 2.7%	≤ 2.2%
	Apr 09	**May 09**	**Jun 09**	**Jul 09**	**Aug 09**	**Sep 09**	**Oct 09**	**Nov 09**	**Dec 09**	**Jan 10**	**Feb 10**	**Mar 10**	**YTD**
Agency %	2.64%	2.64%	3.07%	4.52%	2.72%	3.90%	3.36%	4.07%	3.94%	3.51%	4.64%	4.65%	**3.58%**

The percentage of staff costs spent on agency rose slightly in March to 4.65% from 4.64% in February with spend continuing to be high in Divisions 3, 5 and Finance. Divisions 3 were required to staff Ward D5 due to winter pressures until April. Division 5 continue to have difficulty in recruiting to senior medical vacancies in Dermatology and Diabetes and junior medical cover in Trauma. Finance spend is high due to additional temporary work in Procurement and the Warehouse preparing for the New Hospital. In addition agency usage in Payroll is high due to covering vacancies at the Stoke Office which is due to close at the end of August 2010.

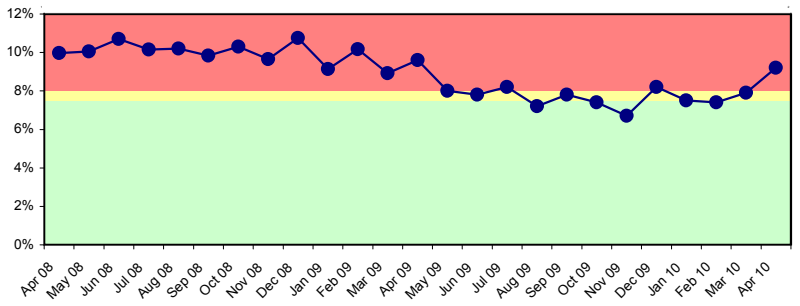


APPENDIX B

Follow-up outpatient appointments cancelled by UHB	Patient Experience	≥ 8%	7.5%-8%	< 7.5%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Follow-up	9.2%												**9.2%**

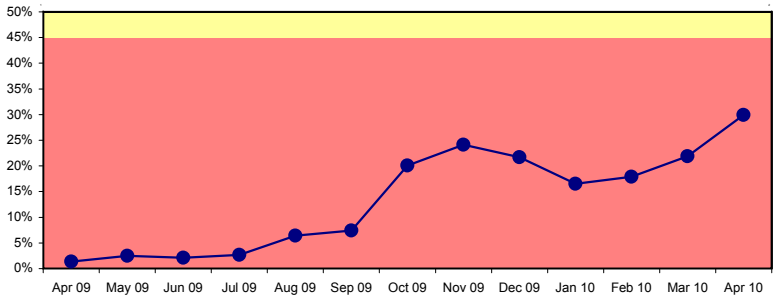
There was a significant rise in cancellations in April with 9.2% of appointments cancelled compared to 7.9% in March. The Easter holidays is likely to have contributed to there being a larger number of clinics than usual that needed to be rearranged. April 2009 was also a month with particularly high cancellations at 9.6%. The Operational Performance Team will be carrying out a review of hot spot areas for cancellations when the current review of DNAs has been completed.



Electronic Patient Survey Response Rate	Patient Experience	< 45%	45 - 50%	≥ 50%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Latest
% Response	29.9%												**29.9%**

Patient feedback in April rose to 29.9% in April from 21.9% in March. This is the highest level of feedback ever achieved. Both Divisions 4 and 5 achieved greater than 50% feedback over the month. There are now 9 wards receiving greater than 50% feedback and 21 receiving greater than 20% feedback. Only one ward which does not have bedside televisions did not report any feedback in April. Divisional action plans to improve participation continue to be implemented.

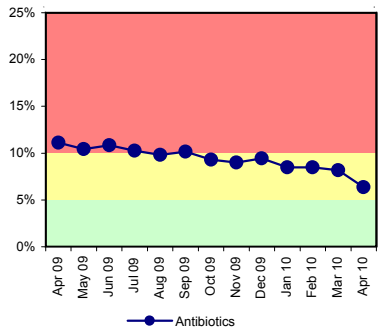


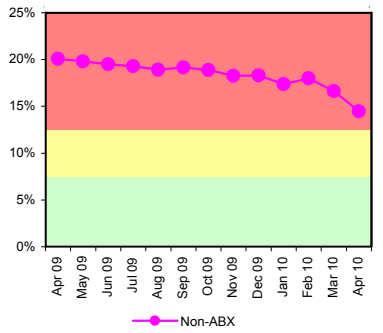
APPENDIX B

Omitted drugs - Antibiotics Omitted drugs - Non-antibiotics	Patient Safety	> 10% > 12.5%	5-10% 7.5-12.5%	≤ 5% ≤ 7.5%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Antibiotics	6.4%												**6.4%**
Non-ABX	14.5%												**14.5%**

The percentage of omitted antibiotic doses fell in April to 6.4% from 8.2% in March. The percentage of omitted non-antibiotic doses also fell from 16.6% to 14.5%. This is the largest month-on-month drop yet seen for both indicators. The next root cause analysis meeting will be on 26 May when progress against divisional action plans will be reviewed as well as further root cause analyses undertaken.





Readmission audit response rate Non-emergency mortality audit response rate	Patient Outcomes	< 80% < 90%	80-90% 90-100%	> 90% 100%

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	YTD
Readmissions	27.1%												**27%**
Non-Em Mortality	87.5%												**87.5%**
Forms sent out	7												**7**
Forms completed	8												**8**

The response rate for readmission audits for April 2010 is 27.1%. This is the highest monthly response rate seen since the audit was commenced. Completion of non-emergency mortality audits for the full month of April has improved significantly since the last report with 87.5% of audits completed to date and only one response outstanding.