Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**25 April 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery** **Dr Bernie Marden, Acting Medical Director**		
Author:	**Lisa Cheek, Deputy Director of Nursing and Midwifery**		
Appendices	**Appendix A - Nursing Quality Indicators Chart**		

1. Executive Summary of the Report

This report provides an update on quality with a focus on patient experience and key patient safety and quality improvement priorities reviewing November 2017 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2017/18 Patient Safety and Quality Improvement Triangle. Other items will be reported on an exception basis.

This month the report focuses on:

- Part A - **Patient Experience**:
  - Complaints and PALS monthly activity data
- Part B – **Patient Safety**
  - Clostridium Difficile
  - Acute Kidney Injury (AKI)
  - National Early Warning Score (NEWS)
  - Sepsis
- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report summary
  - Nursing Quality Indicators Exception report

2. Recommendations (Note, Approve, Discuss)

To note progress to improve quality, patient safety and patient experience at the RUH.

3. Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)

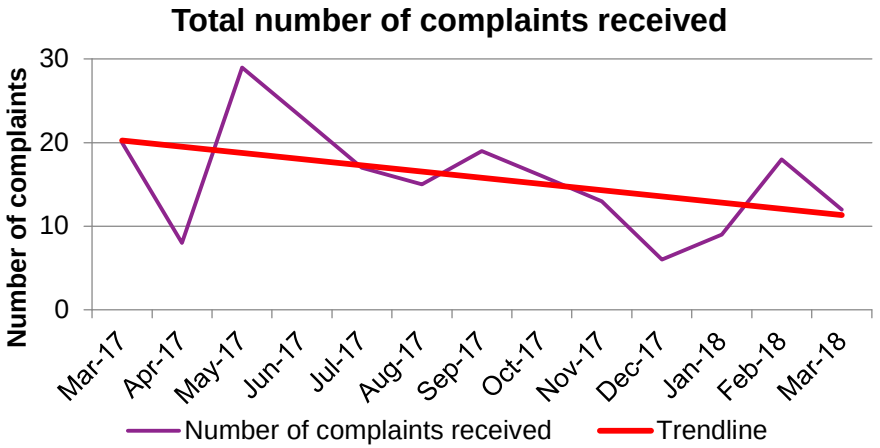
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

5.	Resources Implications (Financial / staffing)
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.	
6.	**Equality and Diversity**
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports to Management Board and Board of Directors	
8.	**Freedom of Information**
Public.	

QUALITY REPORT

PART A – Patient Experience

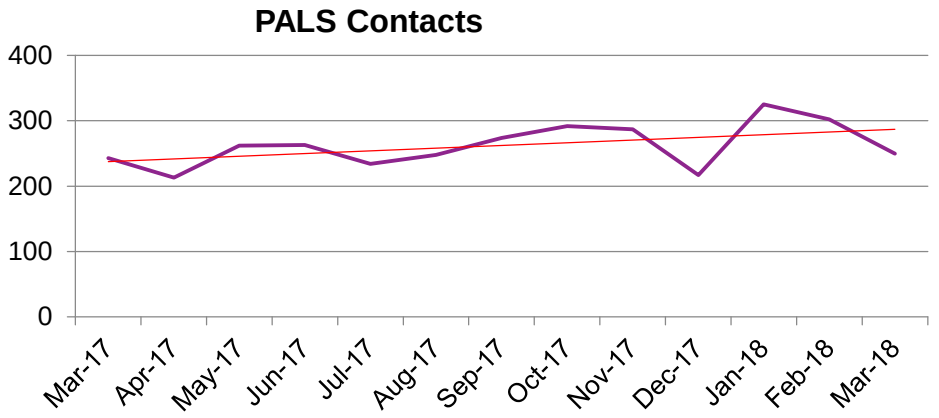
Complaints and Patient Advice and Liaison Report



There were **12** formal complaints received in March. **6** were for the Surgical Division; **5** for the Medical Division, **1** for the Women's & Children's Division. **6** complaints cited Clinical Care and Concerns as the main issue; **4** communication and information; **2** were regarding waiting times for appointments

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	6 (86%)	0	3 (66%)	9 (75%)
Breached 35 Day target	1 (14%)	1 (100%)	1 (33%)	3 (25%)
Total	7	1	4	12

One complaint breached in W & C as it was part of a Serious Incident investigation (which was not finalised within 35 days); one complaint breached in surgery due to a meeting; medicine complaint, delays in the process.



There were **250 contacts with the PALS** in March 2018:

- 124 required resolution (50%)
- 103 requested information or advice (41%)
- 16 were compliments (6%)
- 7 provided feedback (3%)

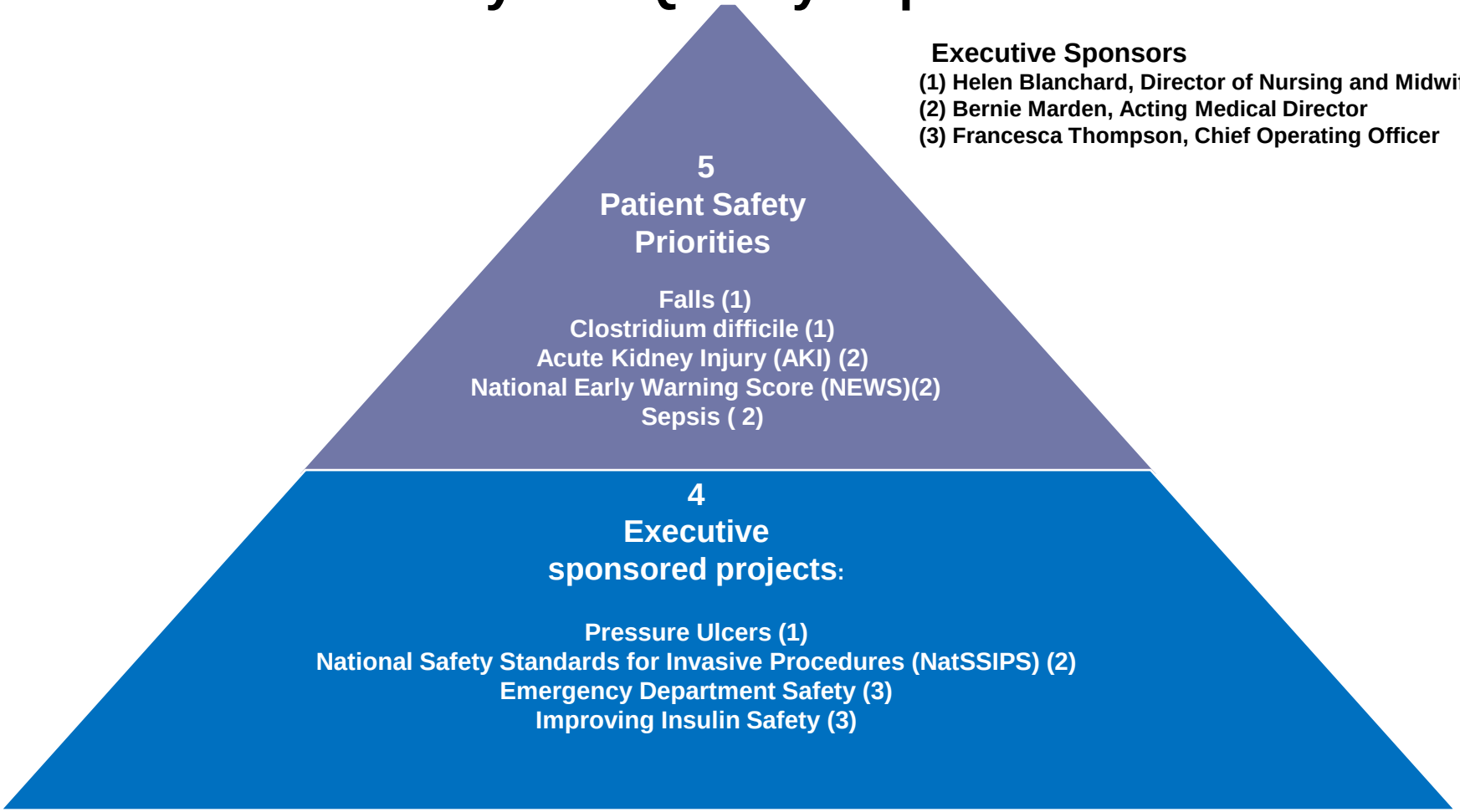
The **top three subjects requiring resolution** were:

Clinical Care and Concerns - there were **26** contacts with queries relating to Clinical Care and Concerns. **24** of these were general enquiries. **1** regarding diet requirements, **1** regarding medication No trends or themes in relation to these contacts have been identified.
Communication and Information – there were **21** contacts **16** referred to General Enquiries for communication and information **2** were enquiries regarding response letters; the rest were spread across the field with no clear trend
Appointments - there were **21** contacts regarding appointments. **6** of the contacts relating to the length of time for a new appointment. **6** relating to length of time for follow up appointment.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement

Executive Sponsors
(1) Helen Blanchard, Director of Nursing and Midwifery
(2) Bernie Marden, Acting Medical Director
(3) Francesca Thompson, Chief Operating Officer



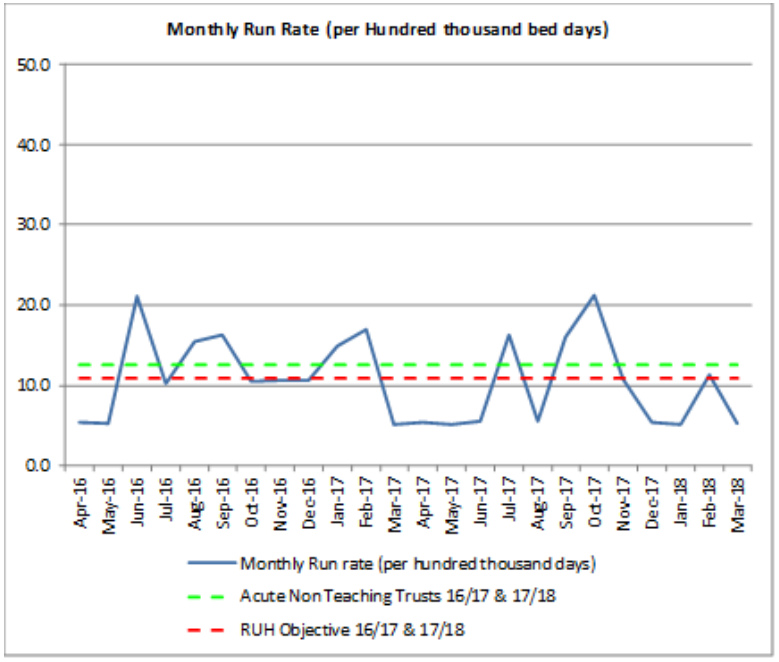
Patient Safety – Clostridium Difficile

Helen Blanchard

Background

The RUH target for 'Trust apportioned' *Clostridium difficile* in 2017/18 was 22 cases. *Clostridium difficile* toxin positive stool samples taken 3 or more days after admission are 'Trust apportioned'. At the end of Q4 there had been 31 cases, 10 of which had been successfully appealed. Two further appeals are outstanding.

Current Performance



Analysis of cases January - March 2018

4 cases, all RCAs received within 21 days

- All patients over 65 years of age
- Length of stay ranging from 8-19 days, average 13 days
- 2 patients were known to be *Clostridium difficile* colonised prior to infection
- Ribotyping has been carried out where there has been 2 or more cases on a ward during the last 12 months: there is no evidence from the results of cross-infection.

There were lapses of care identified in two of the cases:

- There were issues with antimicrobial stewardship in both cases
- In one of the cases there were delays in stool sampling, documentation omissions, a delay in isolation, poor hand hygiene compliance, training compliance was low (in particular with the C diff Workbook) and there were concerns regarding the ward environment.

Action plans are in place for both cases and will be monitored through the C difficile Working Group.

Actions

Improvement plan developed post NHSi visit, ongoing actions include:

- Seeking assurance on antibiotic guidelines from external review and from Infection Control Doctors.
- Implementation of a deep clean programme and revision of the Cleaning policy to reflect Estates commitment to cleaning air vents and radiators
- Investment in Band 1 support workers to support nursing staff with stock rotation and cleaning of equipment
- Investigate methods of enhanced cleaning: hydrogen peroxide vapour and ultra violet light.
- Implementation of the Spring Clean Action Team involving Infection Prevention and Control, Estates and Quality Improvement staff.
- 90% of clinical staff to have received Infection Prevention and Control training in the last 2 years (currently at 88%)

Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Awareness and Training

- 1557 (57%) of staff have received the training (see fig 1).
- The AKI work has been linked with the sepsis and NEWS work streams to a deteriorating patient launch is planned for April 2018
- The ward managers in each area have received their training figures and been asked to identify the remaining staff for training and to facilitate release of these staff to receive the training.
- However, one of the main challenges is releasing the staff to receive training due to staff shortages and the workload on the wards.

AKI Bundle compliance

- Trust wide data continues to be collected from 20 random patient notes per month, and compliance shows sustained improvement since baseline data in July 2015 (see run charts fig 2.0-2.4 on next page).
- Focused work on inpatient acquired AKI within each speciality is planned, commenced in February, starting with Trauma and General Surgery. Maternity and Paediatrics.

Discharge Summary Information

- Trust wide data from the same patients as above is collated monthly and shows improvement from baseline (see run charts Fig 3.0 - 3.2) which has been sustained.
- Work has been completed to automatically link the AKI alert to the discharge summary but this is still awaiting IT implementation. This is required for further improvements.

Improvement work

- Pharmacy
  - A new AKI champion has been identified and is working with pharmacists to proactively identify medications for review.
- Fluid balance Chart
  - The amended fluid balance chart is due to be launched in May.
- Hydration and Contrast
  - The hydration chart and contrast sticker are now well established.
- We are linking with our regional contacts to develop a risk assessment tool.

Outcome data

- Since July 2017, following work on increasing awareness, implementation of the amended hydration chart, and implementation of contrast sticker, AKI acquired during inpatient admissions has significantly decreased by 12% from 48% to 36% (see run chart 4.0).
- Length of stay for AKI patients has also started to significantly decrease (see run chart 4.1).

Next Steps

- To increase training for AKI training
- Ward accreditation team to include AKI management as a measurement for sliver accreditation
- Develop “Deteriorating patient” ward champions
- Launch fluid balance chart all areas
- Develop risk assessment tool for AKI

Patient Safety – Acute Kidney Injury (AKI)

Bernie Marden

Fig 1. staff trained by inpatient ward or dept.

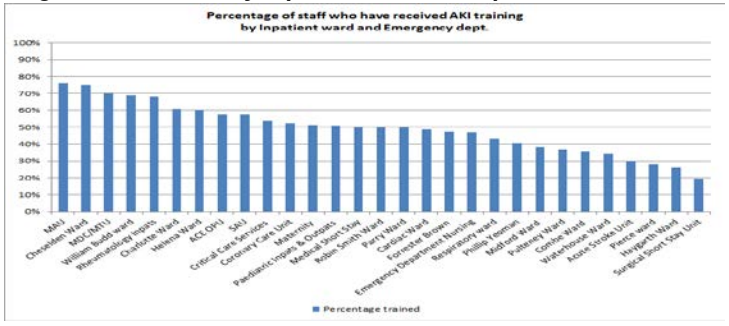
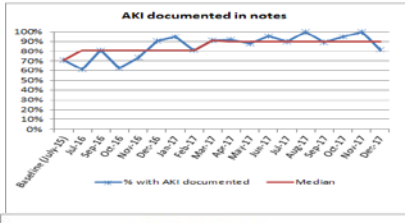
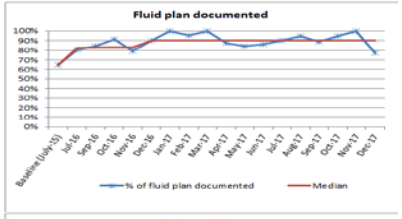
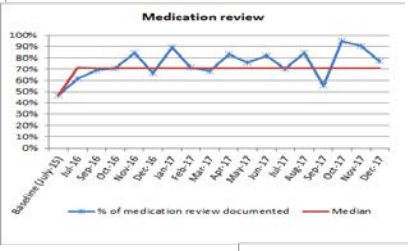
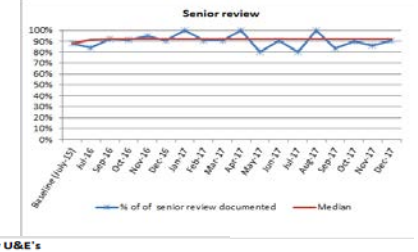


Fig 2.0-2.4 Bundle compliance audits based on 18—25 patients per month









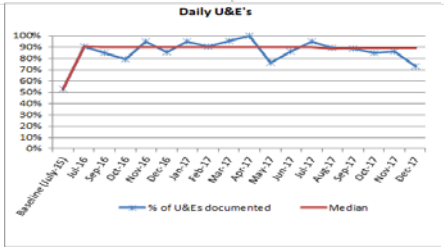
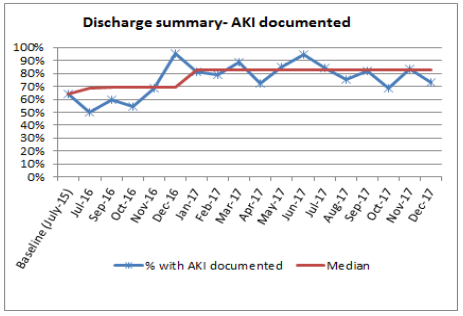
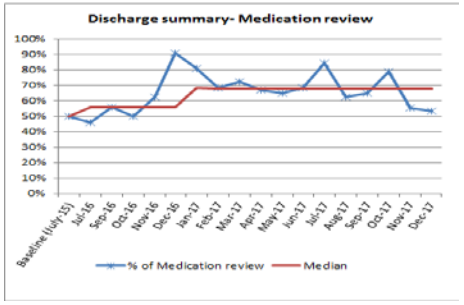
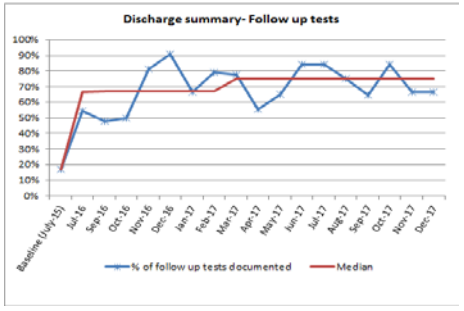


Fig 3.0- 3.2 Discharge summary compliance Audits based on 18—25 patients per month







OUTCOME DATA

Fig 4.0 Incidence AKI acquired during a hospital admission

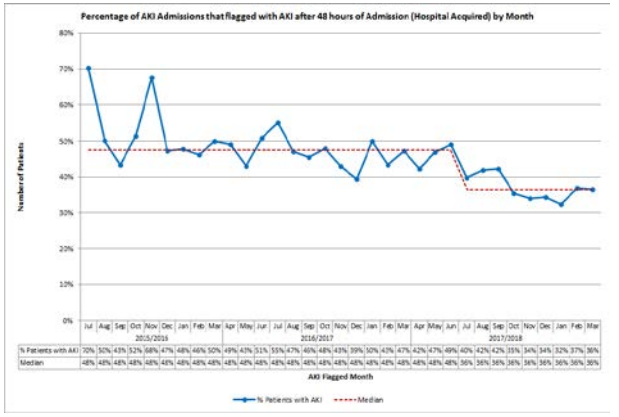
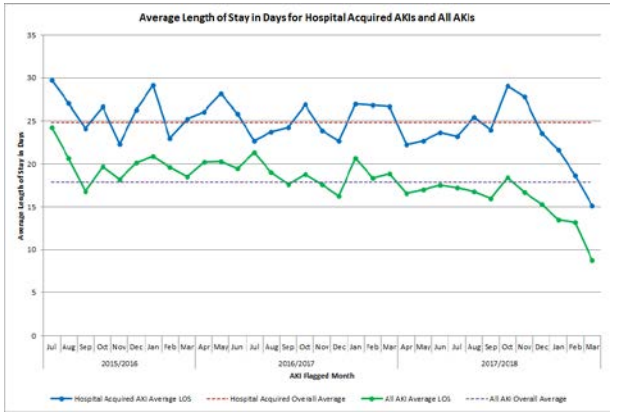


Fig 4.1 Average Length of Stay in Days for AKI



Patient Safety - National Early Warning Score (NEWS) Work stream report

Bernie Marden

Work stream update

The aim of the National Early Warning Score (NEWS) work stream is to ensure that NEWS is reliably and accurately used to monitor adult patients' vital signs, that care is appropriately and reliably escalated and that correct actions are taken to ensure optimal care for the patient.

Progress to work plan:

- Measurement of the recording and accuracy of Paediatric Early Warning Score (PEWS) and Maternity Early Warning Score (MEOWS) is now being routinely reported on.
- PEWS recorded on within an hour of admission data is shown in figure 1.Sustained at 100% since July 2016.

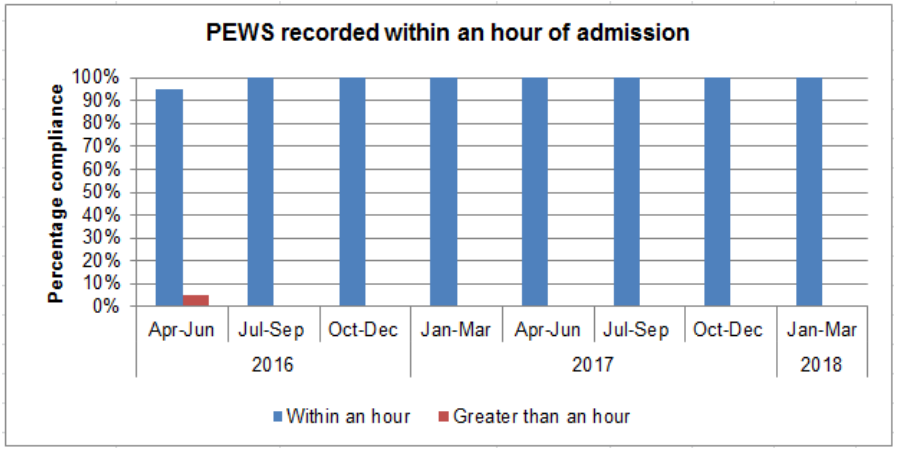


Figure 1

PEWS recorded, accuracy and acted upon is shown in figure 2

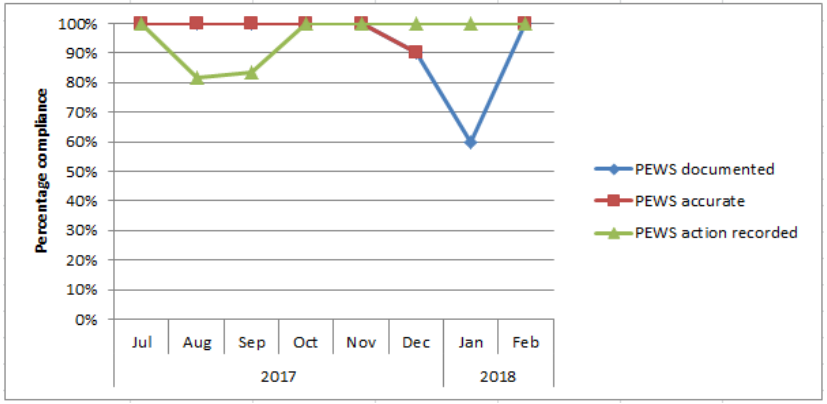


Figure 2 : n = 20 charts per month

NEWS recorded within 1 hour of admission data is collected. Figure 3 shows compliance in 50 patients per quarter in ED, direct admit to MAU,SAU or ASU.

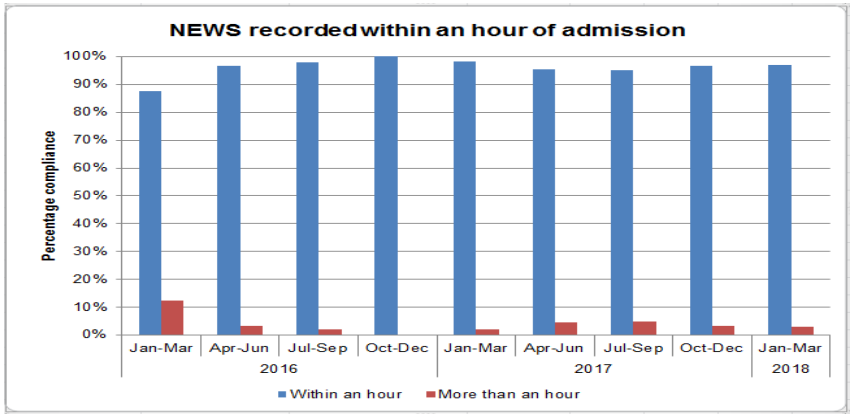


Figure 3

Patient Safety - National Early Warning Score (NEWS) Work stream report

Bernie Marden

Monthly audits continue to measure NEWS recorded and accuracy (Table 1)
Data is reported as part of the Divisional scorecard .

NEWS recorded has been sustained trust wide at 98% since December 2016.

Table of current performance of NEWS accuracy

The percentage score shown in Table 1 is the percentage of observations performed where a NEWS is accurate.

NEWS accuracy	2018												
Ward	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ACE OPU	92%	90%	75%	86%	83%	95%	80%	81%	77%	85%	92%	96%	91%
ASU	91%	87%	95%	95%	95%	87%	93%	90%	88%	92%	93%	91%	98%
Cardiac	88%	98%	91%	90%	94%	84%	100%	94%	96%	96%	84%	81%	85%
CCU	100%	92%	89%	91%	96%	82%	94%	66%	89%	95%	97%	83%	89%
Charlotte	94%	96%	96%	100%	100%	96%	96%	92%	95%	92%	96%	100%	96%
Cheselden	84%	98%	96%	94%	100%	96%	100%	92%	100%	96%	100%	100%	96%
Combe	94%	96%	91%	94%	93%	87%	89%	85%	92%	83%	81%	83%	82%
ED Obs	96%	96%	86%	97%	81%	90%	95%	85%	100%	100%	100%	93%	88%
Forrester Brown A	90%	89%	85%	93%	92%	90%	82%	85%	90%	98%	81%	95%	72%
Haygarth	98%	94%	98%	92%	100%	94%	95%	88%	100%	100%	94%	94%	94%
Helena	94%	96%	98%	94%	98%	90%	96%	96%	100%	100%	96%	100%	95%
MAU	96%	76%	88%	96%	86%	90%	87%	84%	92%	91%	98%	90%	88%
Midford	88%	72%	96%	90%	92%	86%	90%	91%	71%	72%	96%	80%	88%
MSSU	92%	89%	100%	86%	91%	95%	94%	100%	77%	91%	100%	94%	95%
Parry	96%	98%	94%	90%	89%	85%	92%	94%	100%	100%	96%	96%	84%
Philip Yeoman	96%	93%	88%	81%	89%	88%	90%	76%	74%	94%	92%	82%	88%
Pierce	94%	86%	92%	83%	98%	94%	88%	81%	91%	83%	90%	96%	94%
Pulteney (previously Wat	82%	87%	93%	86%	88%	88%	96%	92%	100%	100%	94%	83%	92%
Respiratory	88%	79%	96%	96%	92%	88%	92%	96%	92%	92%	91%	90%	94%
Robin Smith	92%	96%	90%	91%	100%	92%	80%	94%	92%	83%	96%	100%	93%
SAU	96%	91%	100%	96%	92%	94%	94%	100%	100%	96%	100%	96%	100%
SSSU	96%	87%	88%	100%	100%	92%	89%	100%	84%	85%	91%	90%	96%
Violet Prince	87%	84%	82%	83%	97%	94%	92%	97%	100%	63%	90%	100%	98%
Waterhouse (previously F	94%	92%	96%	90%	92%	85%	94%	93%	98%	70%	90%	93%	88%
William Budd	98%	90%	80%	90%	90%	96%	84%	96%	94%	92%	88%	92%	90%
Grand Total	**92%**	**90%**	**92%**	**91%**	**93%**	**90%**	**91%**	**90%**	**91%**	**89%**	**92%**	**92%**	**91%**

Table 1: n=10 charts each ward x 5 sets of observations

Key: Adherence > 90% | Adherence 80% – 89% | Adherence < 80%

Next steps:

- Areas where compliance is below 80% have been contacted to offer support and further training. Data is also shared on the Divisional scorecard
- A Deteriorating Patient proforma has been developed and tested in 2 wards, this will replace the NEWS Escalation sticker. The proforma has been developed under the umbrella of the Deteriorating Patient work plan combining joint working by the NEWS, Sepsis, and AKI.
- A Deteriorating Patient campaign is planned for April 2018, to further align the work in these 3 areas.
- Development of elearning package for NEWS has commenced with an expected completion by July 2018
- Jointly working with Sepsis and AKI work stream to develop combined Deteriorating patient team in wards and departments.
- Support and help drive the securement of an electronic observation system.

Patient Safety – Sepsis

Bernie Marden

CQUIN for Sepsis

- National CQUIN for 2017/18 and 2018/19 combines the previous Sepsis and Antimicrobial Stewardship CQUIN. (includes adult and paediatric direct admissions and inpatients)
- Targets for Sepsis Screening and Antibiotics are both 90%.
- Overall Q3 data for screening was 77% and for antibiotics ≤60 minutes from diagnosis was 89% both of which received a partial payment.

Patient's admitted with Sepsis (see run charts fig 1)

- Average compliance with Sepsis screening is 84% of adults and 85% of paediatric admissions. Sepsis screening tool is a mandatary field in First Net, although it does not appear to be fully mandatory as yet and is being investigated.
- Compliance with antibiotics in an hour is 65% up to October 2017. The data is being reviewed to get up to date data, with January data currently being reviewed
- The medical lead for sepsis is testing improvements aiming to increase earlier identification of patients and increase antibiotic delivery times. Focused teaching has also occurred.
- Paediatric screening has improved over the year with increased engagement with the use of the PEWS scoring. Screening is currently at 80% and there is further work to do to ensure this occurs in 100% of at risk children.
- Antibiotics ≤60 minutes for children – small numbers identified only. The majority have received antibiotics in an hour and all are reviewed. The commonest delay is difficulty in intravenous access and the possibility of giving intramuscular antibiotics, while access is being obtained in these difficult patients, is being discussed with Bristol Children's as a possibility for improving care.

Management of Inpatients with sepsis (see run chart fig 2 and 3)

- Screening data for inpatients is from random note reviews trust wide. Antibiotic data is obtained through screening, identified from Outreach or Sepsis team (average 18-20 patients per month). This remains onerous.
- Screening for adults has been difficult to maintain due to manual recording of screening - on average 70% of adults are screened.
- Screening for Paediatric inpatients has continued to improve and has been 100% since December 2017.

Management of Inpatients with sepsis (see run chart fig 2 and 3)

- Antibiotics treatment ≤60 minutes for adult inpatients with Sepsis has improved over the year with an average of 81% being delivered within 60 minutes of signs.
- The small numbers of paediatric inpatients are identified with sepsis , 4 children being identified between December and January, all of whom received antibiotic within 60 minutes from signs.
- In maternity progress continues to be excellent with 100% of mothers with sepsis receiving antibiotics in 60 minutes since Aug 2017. Screening processes are still dependant on stickers and data is difficult to collect as there are different notes for the various parts of a mothers care (antenatal, birth and postnatal), although solutions are being sought to embed the process into routine documentation

Awareness and training

- 2259 (73%) of staff have received updated training since July 2016.
- The Sepsis team have identified the areas where training is under 50% of staff and have commenced focused training in these areas.
- However, one of the main challenges is releasing the staff to receive training due to staff shortages and the workload on the wards throughout January and February.
- A 'deteriorating patient' e learning training package to include AKI, Sepsis and NEWs is being developed.
- A deteriorating patient campaign is planned for April 2018, to align the work in these 3 areas.

Outcome data

The Sepsis team have reviewed outcome data for the patients identified in the sepsis data i.e those admitted on alternate days and inpatients identified who have deteriorated from sepsis . From that data , 30 day mortality rates of patients admitted with sepsis is on average 21%, and there appears to be a decrease over the second half of 2017. Inpatient 30 day mortality of the patients identified is 16%, with a median length of stay of 12 days .

Issues

- Data collection for the inpatient work remains a burden and difficult to sustain
- Implementation of electronic recording of observations is essential for further improvement in screening and management
- Accurate date trust wide for all patients will also then be available
- Time to release staff for training is difficult due to ward pressures
- ED data is delayed due to difficulties identifying patients from the first net system .

Royal United Hospitals Bath
NHS Foundation Trust

Patient Safety – Sepsis

Bernie Marden

Fig 1.1 Emergency Adult sepsis screening
- 50 patients per month

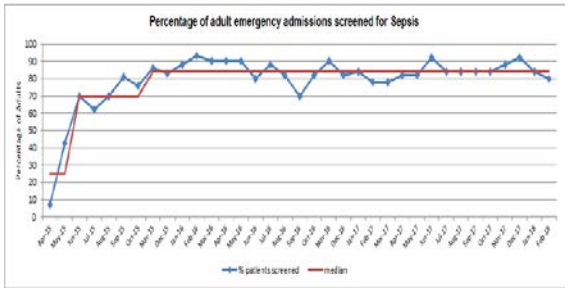


Fig 1.2 Emergency paeds sepsis screening
- 20 patients per month

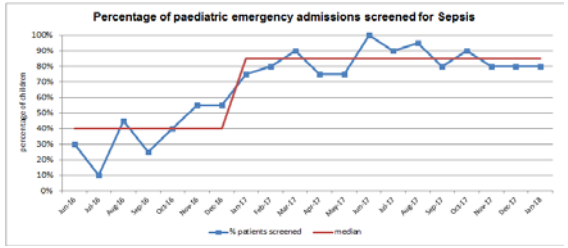


Fig 1.3 ED antibiotics in an hour for adults
– between 20-30 patients/month

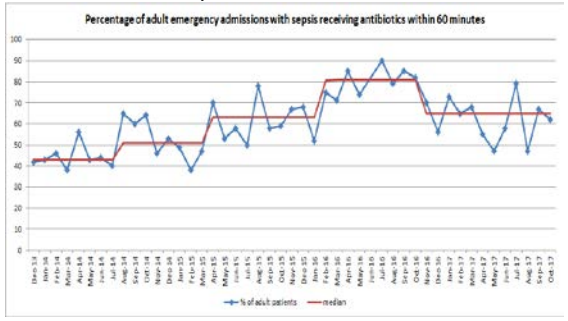


Fig 2.1. Inpatient adult screening-
between 80-100/month

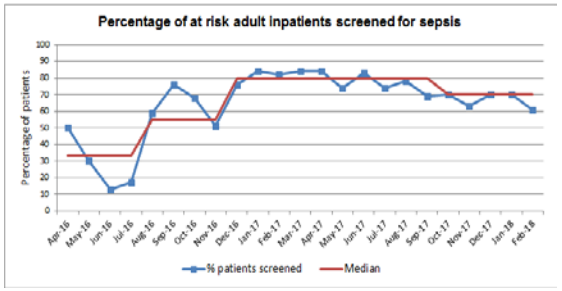


Fig 2.2: Inpatient paeds screening
– between 15-20/month

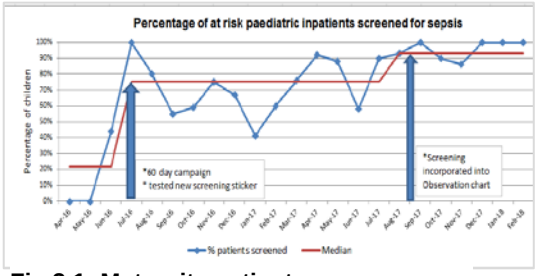


Fig 3.1: Maternity patients
- antibiotics in an hour

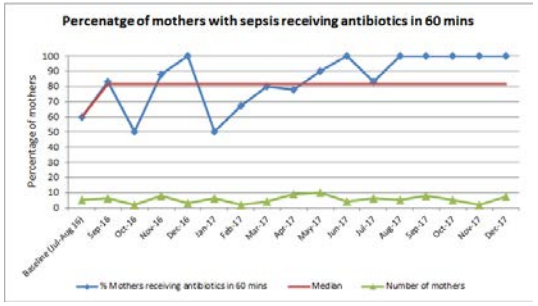
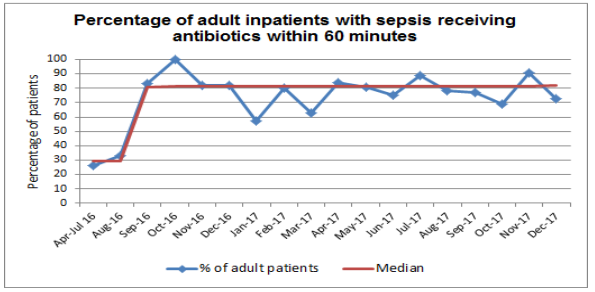
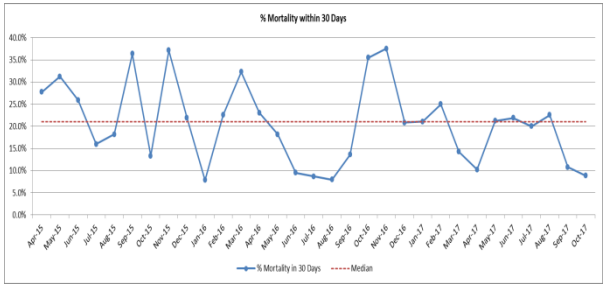


Fig 3.2; 1npatient Adult patients antibiotics in an hour



Outcome data
– Mortality patients admitted with Sepsis on alternate days



- Mortality patients inpatients deteriorating with Sepsis

Serious Incidents (SI) Summary

Helen Blanchard

Current Performance

During March 2018 two Serious Incidents were identified and reported to the CCG via STEIS.

Date of Incident	ID	Summary
10/03/2018	61448	Missed Diagnosis
18/03/2018	61548	Fall with fracture

Overdue Serious Incident Report

Helen Blanchard

The drive to reduce the number of overdue SI reports will continue this year, to a target of zero overdue reports.

As of 08th March 2018, there are 26 Serious Incidents that remain open. Of these, thirteen incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. The Head of Risk and Assurance has been in contact with the investigators regarding submission dates.

Delays in providing a final report is escalated to the relevant Divisional Management team, for the identification of what further support can be provided to the investigator to enable them to completing the investigation and draft the report.

The Operational Clinical Governance Committee (OCGC) monitors the progress against the action plans developed following the investigation and at the January OGC meeting, the status was reported as:

	Apr-17	May-17	Jun-17	July-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Outstanding Action Plans	8	9	17	21	22	15	19	19	30	23	28	32
Outstanding Actions	15	13	33	49	44	29	44	31	49	43	34	54

The Risk Management team continues to provide reminders and support to assist in the completion and closure of actions and the Heads of Nursing and Divisional governance leads are notified of the responsible managers who require support to complete their actions .

The review of outstanding actions is included in the Divisional Performance review.

Nursing Quality Indicators Exception Report Helen Blanchard

Areas of focus
The Nursing Quality Indicators chart is attached as Appendix A.
Two wards have flagged this month as having nursing quality indicators of note.

Combe ward (Older Persons)
This is the forth consecutive month that this ward has flagged.

Quality matrices to note are:
- FFT responses Nil returns
- 11 falls (9 no harm and 2 minor harm)
- RN sickness 9.7%
- HCA sickness 15.3%
- HCA appraisals 68.8%
- RN hours % day and night fill rate <85%

The Matron covering this ward has discussed with the ward Sister the importance of FFT feedback and will be closely monitoring the response rate to improve FFT returns. The ward presently has a Senior Sister vacancy which is likely to have contributed to the FFT response performance, however a Senior Sister has been successfully appointed and will start in post on 30th April.

The ward Sister has made some progress with appraisals and RN appraisal completion has improved this month. There is an improvement trajectory in place and the Sister is now focussing on HCA appraisals.

Recruitment is being proactively managed and to address the shortfall of RN hours and additional HCA hours were provided to ensure there are sufficient staffing levels each shift.

Combe ward (Older Persons) cont:
Sickness levels for HCAs improved slightly since last month due to staff returning from short term sickness. RN sickness levels however have increased slightly again this month and this is mainly due to long term sickness. Sickness continues to be closely managed as per Policy with monthly review meetings with HR and Matron support.

The Matron is closely supporting the ward and taking the actions as identified within the nursing quality indicators Escalation Support Framework

William Budd ward
The previous occasion that this ward flagged was in December 2017.

Quality matrices to note are:
- FFT response rate 20%
- Five falls (5 no harm)
- RN sickness 7.3%
- HCA sickness 5.6%
- RN appraisals 80.0%
- RN hours % day and night fill rate <85%

The poor response rate for completed FFT cards was mostly due to the staff sickness of a few staff who usually support these being completed. The Senior Sister will monitor responses more closely and discuss this with relevant staff to improve the response rate for next month.

There are several staff who have been on long term sickness, however they are returning to work this month. Sickness is being closely managed with support from HR and the Matron.

Nursing Quality Indicators Exception Report Helen Blanchard

William Budd ward cont;
There is a plan in place to address appraisal completion and they are being completed. The Senior Sister has noted several staff on the appraisal list from HR workforce who have resigned and left the ward, therefore she will ensure that HR workforce have an accurate list of staff on the ward and an up to date list of when staff have had appraisals undertaken.

Recruitment is being proactively managed and two Pool nurses have been assigned to the ward. To support shortfalls in RN hours, additional HCA hours have been provided to ensure there are sufficient staffing levels each shift. The Matron and Head of Nursing are reviewing staffing levels each day to ensure that staffing levels meet the patient's acuity and dependency.

To note:
Cardiac, Haygarth, Medical Short Stay, and Philip Yeoman wards flagged last month but their quality indicators have improved.
These wards will continue to be closely monitored and supported to maintain/improve performance as per the nursing quality indicators Escalation Support Framework.

Areas which have not flagged since March 2017
To note that over the last twelve months10 wards and departments have not flagged, these being:

- Emergency Department
- Charlotte ward (Gynaecology and older persons)
- Cheselden ward (Step down older persons)
- Violet Prince ward (Rheumatology)
- Helena ward (Neurology)
- Forrester Brown ward (Trauma orthopaedics)
- Children's ward
- Mary ward (Maternity)

On reviewing these areas for reasons why they have consistently not flagged, it is likely that there are several reasons for this, for example:

- Four of the six wards are smaller bedded wards i.e. 16 – 22 beds, (except Forrester Brown 28 beds, and Children's 31 beds)
- Nursing Quality Indicators are less applicable to these areas

With this in mind the Head of Nursing and Midwifery is currently reviewing the quality indicators within the Women and Children's Division to identify more appropriate indicators to their areas.

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Nursing Quality Indicators Exception Report — Helen Blanchard

Other Quality Indicators of note:

Falls: There were a total of 92 falls this month of which the majority 81 resulted in no harm. There were 9 falls which resulted in minor harm,1 fall which resulted in moderate harm and 1 fall which resulted in a major harm. This fall has been recorded as a Serious Incident and a Root Cause Analysis (RCA) investigation is being undertaken.

Pressure Ulcers: There was 1 hospital acquired Category 2 pressure ulcer this month.

Pressure ulcer performance 2017/18
The Trust's ambition for 2017/18 was a **25%** reduction of category 2 pressure ulcers, a **50%** reduction of Medical Device related pressure ulcers and the elimination of all category 3 and 4 pressure ulcers.

The Trust has performed well this year and the year end performance as at 31 March 2018, resulted in reductions of **57%** of category 2 pressure ulcers and **47%** reduction of Medical Device related pressure ulcers. There was one avoidable category 3 pressure ulcer however there have been no category 4 pressure ulcers.

C.Difficile: There was 1 case of C.Difficile this month.

The Board has been provided with a more detailed update report regarding C.Difficile within this month's quality report.

It is pleasing to note that the Trust was within its target for 'Trust apportioned' *Clostridium difficile* during 2017/18 and no more than 22 cases.
The Trust has reported 21 cases by 31 March 2018 and this number may be further reduced as 2 cases are presently being appealed and reviewed by the CCG.

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Appendix A: Nursing Quality Indicators - Monthly Template March 2018

APPENDIX A

Ward Group	Ward Name	Report for July 2017 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																						Care Hours Per Patient Day (CHPPD) overall	Number of times parameters outside of KPI metrics					
		FFT % Recomd:	FFT Response Rate %	Number of complaints received	Number of compliments received	Number of PALS contacts		Number of patients with Cdiff	Number of patients who fell				Number of Pressure Ulcers			Human Resources (1 month lag)				Nurse Staffing Datix Report	Safer Staffing % Fill rate									
																Sickness %		Appraisal %			Day		Night							
						Positive	Negative		No Harm	Minor Harm	Mod Harm	Major Harm	Cat: 2	Cat: 3	Cat: 4	RN/RM	HCA	RN/RM	HCA		Reg Nurses/ Midwives	Care Staff	Reg Nurses/ Midwives	Care Staff			Mar 18 No:	Feb 18 No:	Jan 18 No:	Dec 17 No:	Nov 17 No:	Oct 17 No:
Emergency Dept	A&E	99	6%		3	3	9		0	0	0	0				2.4	5.7	85.4	83.3		N/A	N/A	N/A	N/A	N/A			2	2	1	2	3	3
	MAU	95	24%				4		0	0	1	0	1			3.0	4.0	88.6	75.0	1	88.4%	130.2%	87.7%	139.6%	9.5		2	2	2	6	6	2
	SAU	100	12%						1	0	0	0				3.3	7.2	76.2	92.9	1	85.2%	113.2%	91.6%	124.6%	10.2		3	1	5	5	4	5
Inpatient Wards	Cheselden	100	100%						0	0	0	0				1.4	0.2	100.0	100.0		85.3%	104.3%	99.9%	100.0%	5.7		0	0	2	2	3	2
	Charlotte	97	30%				1		0	0	0	0				0.0	0.0	86.7	83.3	1	95.7%	106.5%	99.9%	117.7%	6.9		1	2	1	1	0	0
	Pierce	100	42%						3	1	0	0				4.6	2.6	94.4	100.0		82.9%	125.3%	89.0%	176.5%	7.8		1	2	6	5	4	4
	Surgical Short Stay Unit	100	33%	1			1		1	0	0	0				4.0	0.6	92.3	91.7		104.2%	156.9%	95.1%	185.8%	6.2		1	3	1	2	1	3
	Parry	100	36%				6		3	2	0	0				3.7	4.2	100.0	100.0		83.7%	91.6%	111.4%	105.6%	5.9		2	2	5	3	4	5
	Robin Smith	100	42%						3	0	0	0				6.9	6.5	85.0	87.5	1	91.0%	116.7%	93.1%	114.8%	6.6		2	4	5	5	5	5
	Forrester Brown	97	50%		1				6	1	0	0				4.9	10.4	84.2	86.7	2	88.4%	109.3%	79.9%	121.2%	7.1		3	3	3	2	1	3
	Helena	100	89%						5	0	0	0				2.4	14.4	80.0	92.3		94.0%	117.6%	77.4%	128.6%	7.9		4	2	3	2	0	1
	ACE OPU	97	87%						0	1	0	0				1.2	7.3	80.0	94.1		71.5%	93.2%	67.1%	119.6%	6.9		4	2	7	5	2	4
	Critical Care Services	N/A	N/A						1	0	0	0				3.6	0.0	73.7	75.0		93.1%	68.2%	88.3%	35.5%	26.6		4	3	2	2	5	3
	Mary Ward	100	17%		3				0	0	0	0				6.5	12.1	83.3	78.9		115.0%	93.9%	96.7%	91.4%	10.9		4	3	3	5	4	4
	Violet Prince (RNHRD)	92	40%						2	0	0	0				1.9	5.0	76.9	50.0		94.5%	82.3%	100.0%	122.6%	5.5		4	4	4	3	2	3
	Respiratory	99	67%						2	0	0	0				2.8	18.4	68.8	93.8		69.7%	137.3%	73.0%	103.2%	5.5		4	4	4	3	4	5
	Children's Ward	100	15%			1			0	0	0	0				6.9	1.4	83.8	100.0	3	75.0%	99.3%	80.6%	148.4%	7.5		4	4	4	5	2	4
	CCU	100	71%						0	1	0	0				5.2	0.9	72.2	75.0		72.1%	125.2%	99.1%	96.8%	10.6		4	4	5	3	4	4
	Pulteney	95	46%		1	1			1	0	0	0				5.2	16.3	75.0	57.9		91.2%	88.7%	92.4%	115.4%	6.5		4	5	7	4	6	3
	Phillip Yeoman	100	30%				1		1	1	0	0				6.6	11.3	92.9	84.6	1	94.8%	77.6%	92.3%	110.5%	5.1		4	6	3	4	3	4
	Cardiac	95	40%	1	1		4		5	0	0	0				2.7	11.9	86.4	61.5		88.2%	128.7%	74.1%	195.2%	5.6		4	6	6	6	4	3
	Acute Stroke Unit	96	74%				2		12	0	0	0				13.3	9.9	87.5	63.2	2	76.7%	89.9%	91.9%	120.5%	7.5		5	4	4	4	4	6
	NICU	100	18%		1				0	0	0	0				2.2	3.2	75.6	85.7		95.6%	66.2%	84.3%	61.2%	8.4		5	5	6	5	3	5
	Waterhouse	100	31%				1		8	0	0	0				10.8	6.6	100.0	93.8		81.7%	96.7%	98.1%	109.4%	6.2		5	5	6	5	6	7
	Midford	100	53%				1	1	7	0	0	0				3.5	11.6	92.3	88.2	2	68.0%	123.9%	75.7%	180.3%	5.8		5	5	9	8	7	5
	Medical Short Stay Unit	89	9%						4	0	0	1				11.2	2.5	78.6	88.9		68.8%	115.8%	98.3%	173.3%	6.2		5	6	5	4	4	5
	Haygarth	98	83%				1		2	0	0	0				5.9	6.5	80.0	81.3		64.7%	99.8%	68.6%	170.2%	5.9		5	6	5	7	3	5
	William Budd	100	20%		1		2		5	0	0	0				7.3	5.6	80.0	100.0	5	74.7%	119.1%	70.6%	129.6%	6.5		7	5	5	6	2	3
	Combe	Nil responses	Nil responses						9	2	0	0				9.7	15.3	85.7	68.8	9	73.4%	117.9%	70.9%	210.0%	7.1		7	7	6	8	4	5
* FFT data taken from Maternity FFT touchpoint 2- Post natal Ward		80% or less	< 35% (< 15% ED, MAU & SAU)	Nursing / Midwifery related		Neg N/M related only		C. Diff (per patient)	5 Falls or more, or a major harm				Avoidable harms any PUs			5% or more		80% or less			85% or less						More than 5 Amended metrics for Feb 2018					

Please note: Chart includes amended metrics for Staffing level fill rates and CHPPD (Feb 2018)

A&E	ED Nursing
SAU	SAU
MAU	MAU

Acute Stroke Unit	Acute Stroke Unit
NICU	Newborn Intensive C U
Pulteney	Pulteney Ward
Medical Short Stay Unit	Med Short Stay
Cheselden	Cheselden Ward
Robin Smith	Robin Smith Ward
CCU	Coronary Care Unit
Helena	Helena Ward
Phillip Yeoman	P.Yeoman/Recovery
Surgical Short Stay Unit	Short Stay Surgical Ward
Children	Paediatric Inpats & Outpats (Pay Only)
ACE OPU	ACE OPU
Cardiac	Cardiology Ward
Parry	Parry Ward
Forrester Brown A	Forrester Brown
Haygarth	Haygarth Ward
Charlotte	Charlotte Ward
Waterhouse	Waterhouse Ward
Combe	Combe Ward (3)
Midford	Midford Ward (9)
Respiratory	Respiratory Unit
William Budd	W Budd Cancer Unit
ITU	Critical Care Unit
Mary Ward *	PAW Mary Ward
Violet Prince (RNHRD)	Rheumatology Inpats