Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**26 September, 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Lisa Cheek, Acting Director of Nursing and Midwifery** **Francesca Thompson, Chief Operating Officer** **Bernie Marden, Medical Director**		
Author:	**Lisa Cheek, Acting 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 August 2018 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:
  - Falls
  - National Safety Standards for Invasive Procedures (NatSSIPS)
  - Improving Insulin Safety
- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report summary
  - Nursing Quality Indicators Exception report

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)

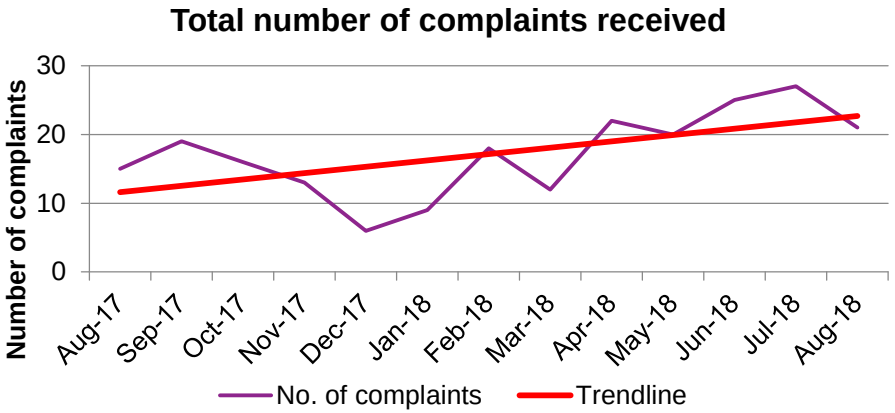
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.

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

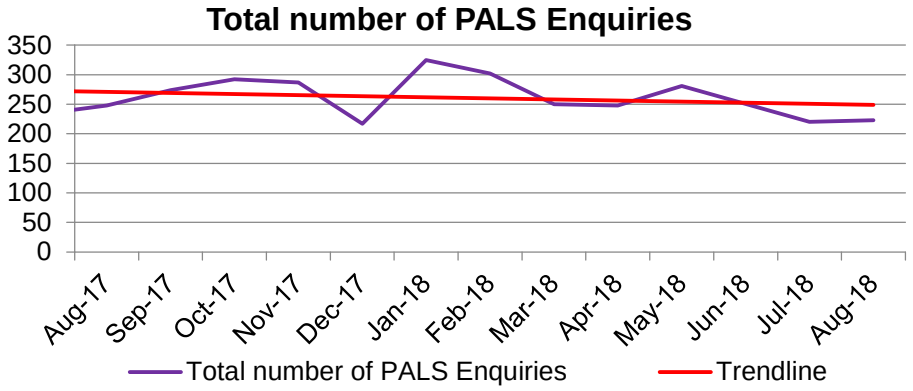


There were **21** formal complaints in August. **5** were for the Surgical Division; **15** for the Medical Division; **1** was for Women & Children.

13 complaints cited Clinical Care and Concerns; **3** related to appointments**, 2** Communication and Information**, 1** attitude of staff and **2** related to Discrimination and Safeguarding.

Complaint response rate by Division	Division			Total
	Surgery	W&C	Medicine	
Closed within 35 day target	2 (25%)		10(56%)	12 (44%)
Breached 35 Day target	6 (75%)	1 (100%)	8 (44%)	15 (56%)
Total	8	1	18	27

Reasons for Breaches: **5** meetings scheduled outside target, **5** delays in responses for requested information, **2** further information/ amendments requested by the Directors Office and **3** were delayed due to patients request to change from a meeting to a letter response



There were **223 contacts with PALS** in August 2018:

- 136 required resolution (61%)
- 54 requested information or advice (24%)
- 21 provided feedback (10%)
- 12 Were compliments (5%)

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

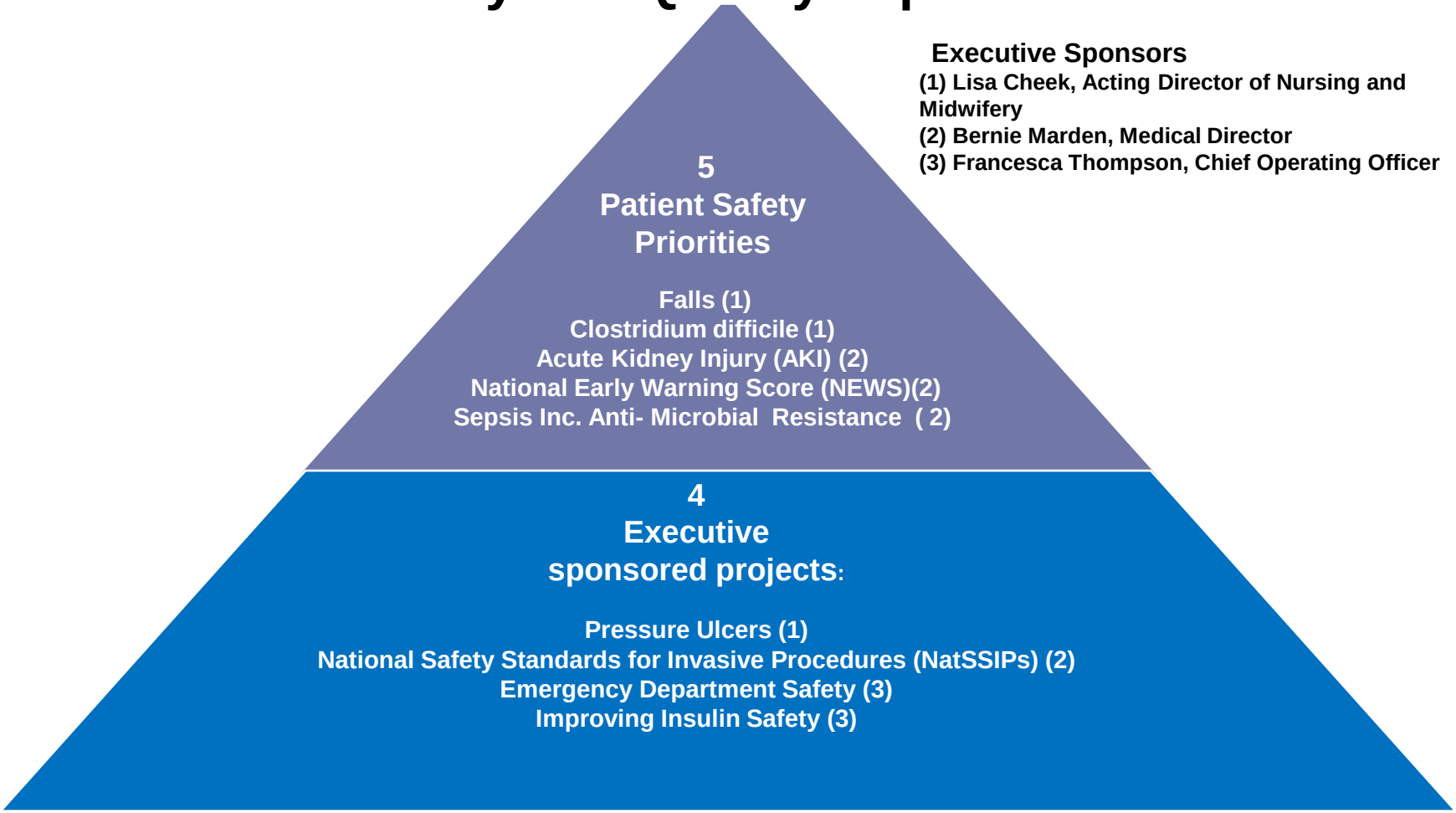
Communication & Information - there were **32** contacts relating to advice and communication. **12** of these were issues relating to telephones- issues ; **11** related to General Enquiries. There was no clear trend with the remaining contacts.

Appointments - there were **29** contacts. **6** of these were queries relating to new appointments, **5** relating to appointment information. There was no clear trend for the remaining contacts.

Clinical Care & Concerns – there were **28** contacts. **8** relating to general enquiries , **4** relating to Quality Care & Concerns , **3** relating to Unsafe Discharge .

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors

(1) Lisa Cheek, Acting Director of Nursing and Midwifery
(2) Bernie Marden, Medical Director
(3) Francesca Thompson, Chief Operating Officer

Patient Safety – Falls

Lisa Cheek

Background

Reduction in falls is one of the Trust's safety priorities. Figure 1 shows performance for the total number of inpatient falls. Analysis of falls data shows an increase in falls across the trust in August (n = 112). Additional analysis including times of falls and correlation with staffing is taking place.

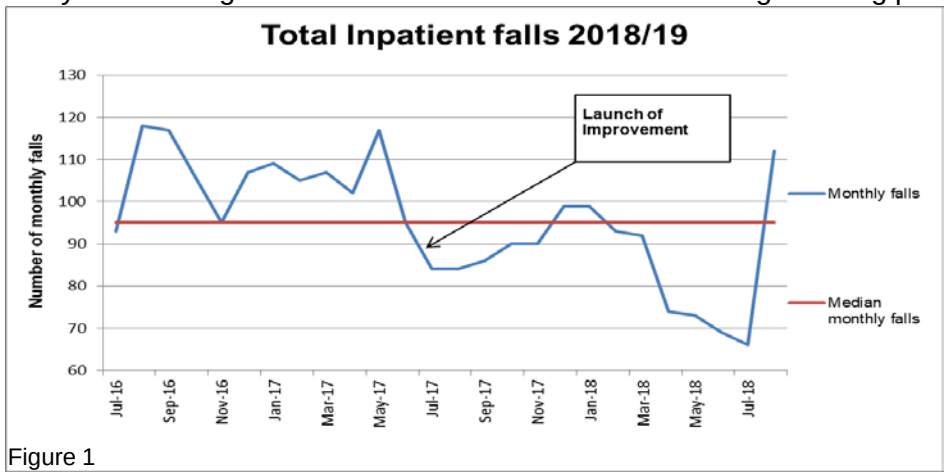


Figure 1

Figures 2 and 3 show comparison with national data.

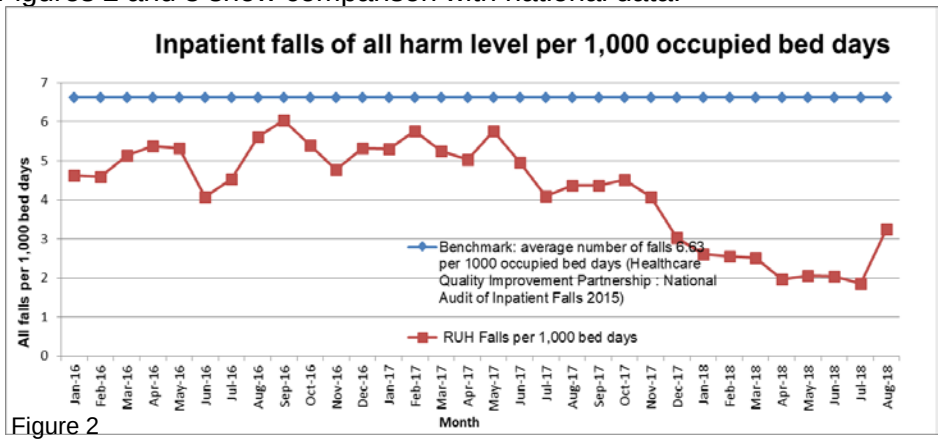


Figure 2

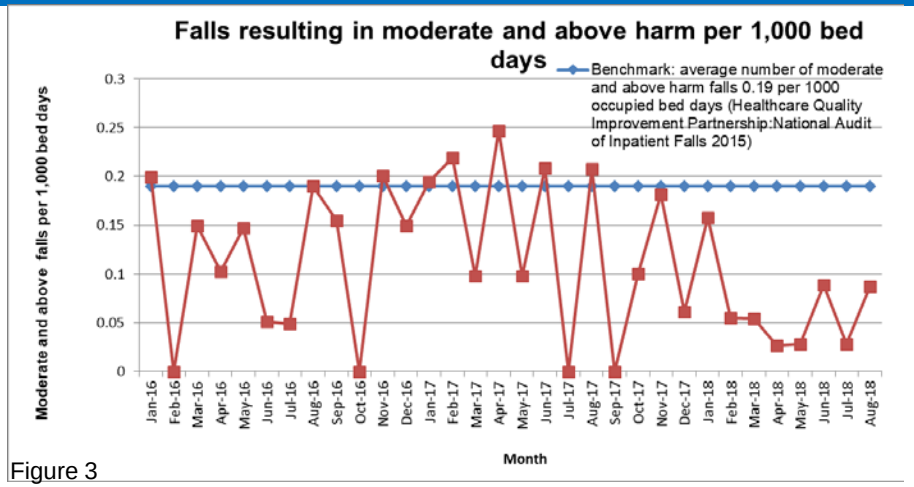


Figure 3

All moderate harm and above harm falls are investigated through the Serious Incident (SI) process and learning incorporated into the Falls Steering group work plan.

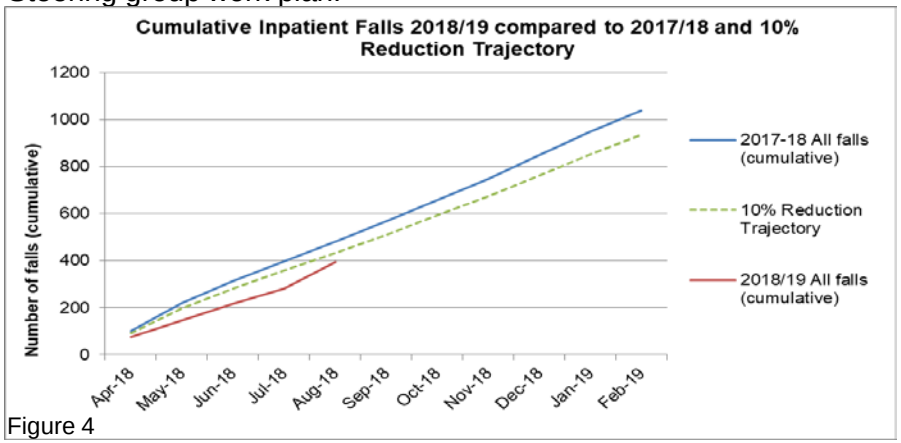


Figure 4

Figure 4 shows the cumulative number of falls for June 2018-2019 plotted against the 10% reduction target agreed as the outcome measure for the Falls Improvement programme.

Patient Safety – Falls

Lisa Cheek

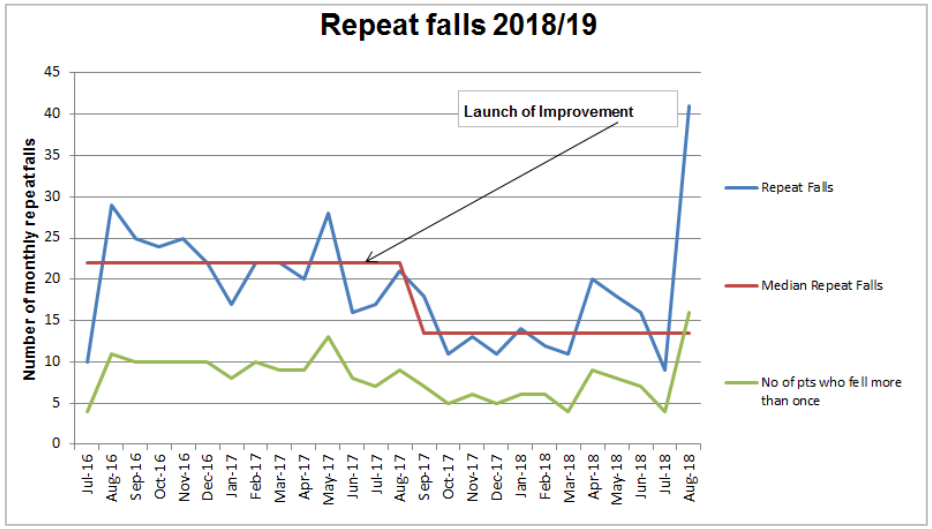


Figure 5

Figure 5 shows the number of repeat falls and the number of patients who have fallen more than once. As demonstrated in Figure 5 the number of repeat falls and number of patients who fall more than once has increased in August. There were 8 wards across the Trust where repeat falls occurred. This data has been shared at ward and divisional level and support from the Quality Improvement team is being given to wards where there has been a notable increase.

Next steps:

- The Falls steering group has reviewed the Falls prevention pathway (originally launched June 2017). Representatives from each ward have been invited to attend a relaunch of the pathway on September 12. Work stations for falls prevention documentation, enhanced observations process, medical interventions, environmental risks, spot the hazards bed space and post falls care will be delivered by members of the Falls Steering group. A resource folder will also be provided with key messages for all wards.
- An improvement project is underway on Midford to review the process of enhanced observation (a multidisciplinary team approach to the supervision of patients at high risk of falls).
- The Falls simulation training project (funded by to Health Education England South West Simulation Network (HEESWSN) commenced in April. The aim of the project is to improve the knowledge of the multidisciplinary teams with a view to reducing in-patient falls. Over 60 staff have been trained on 5 wards the focus being within OPU.
- The development of a Falls eLearning programme has been agreed and the subject matter experts identified. The first meeting is scheduled for October 12 at the availability of the eLearning lead.
- The Falls policy and webpage are in the process of being updated (aim for completion by the end of September).
- To support the awareness in the use and training of the Falls retrieval kit a trolley dash to all wards is planned for September 17.
- The review of the SI process for moderate and above harm falls is being tested on a fall of moderate harm on CCU. The revised approach to falls investigation is to support a focus on prevention and learning rather than investigation. The approach will be tested in June on any falls of moderate or above harm.

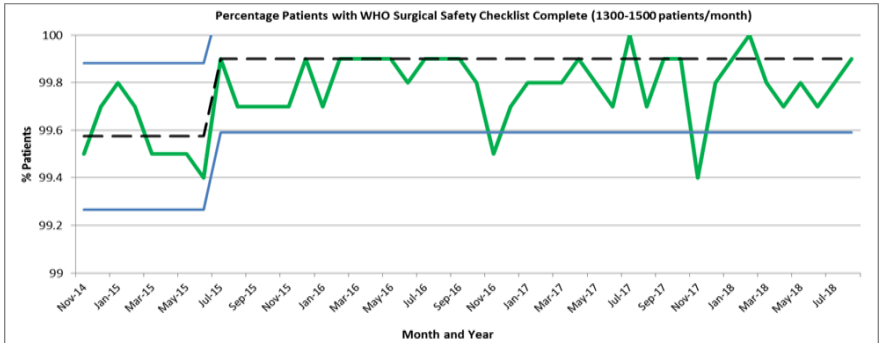
National Safety Standards Invasive Procedure (NatSSIPs) Bernie Marden

National Safety Standards for Invasive Procedures(NatSSIPs)

Operating Theatres:

Compliance with WHO Surgical Safety checklist in Theatres

Compliance remains high with 100% patients undergoing surgery having a WHO checklist performed, 99.9 % of which are fully complete (1300-1600 patients). There have been no never events since march 2012, over 6 years.



Quality audits continue, including out of hours procedures and demonstrate excellent quality in 98% of audits. Themes are used to further increase quality of the checklist.

Prelist Briefing

Pre-list briefing is well established, average compliance being 99%.

Debriefing

Routine Debrief at the end of the list has been tested in 2 theatres and is being rolled to a 3rd theatre in September. This has been progressing well and the aim is to spread all theatres by end 2018. This is part of the NHS Quest theatre safety community which RUH hosted the last workshop in June, led by Suzette Woodward from NHSE, with excellent feedback

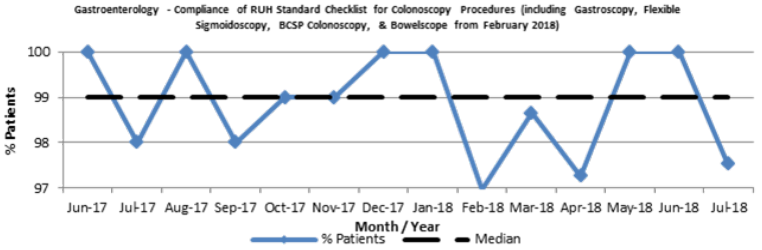
Checklist implementation for procedures outside theatres

Compliance for procedures outside of the operating theatres continues from random note review and is available for the majority of procedures. IT support is required to establish electronic recording.

Compliance for areas is shown in following run charts.

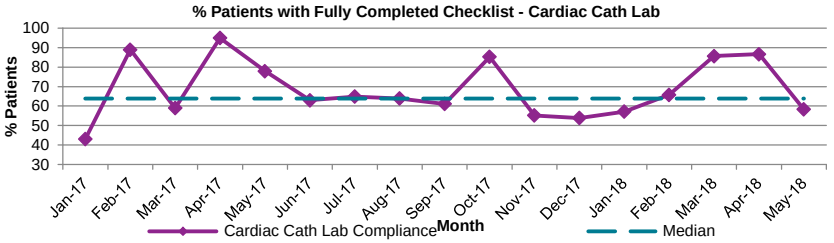
Gastroenterology:

Electronic recording established. June 2018 compliance is 100%



Cardiology

Compliance recorded from random note reviews:



Compliance with use of checklist is high (92%) but overall compliance is decreased as the sign out is often omitted, resulting in overall compliance of 64%.

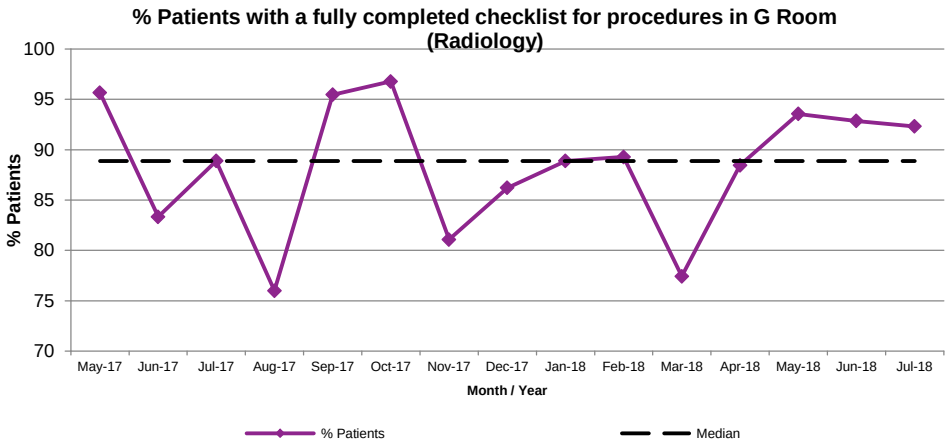
Cardiac Pacemaker procedures

A new pacemaker checklist has been implemented. The sign out is the commonest uncompleted section, which is being addressed. Compliance is 59% for June 2018.

National Safety Standards Invasive Procedure (NatSSIPs) Bernie Marden

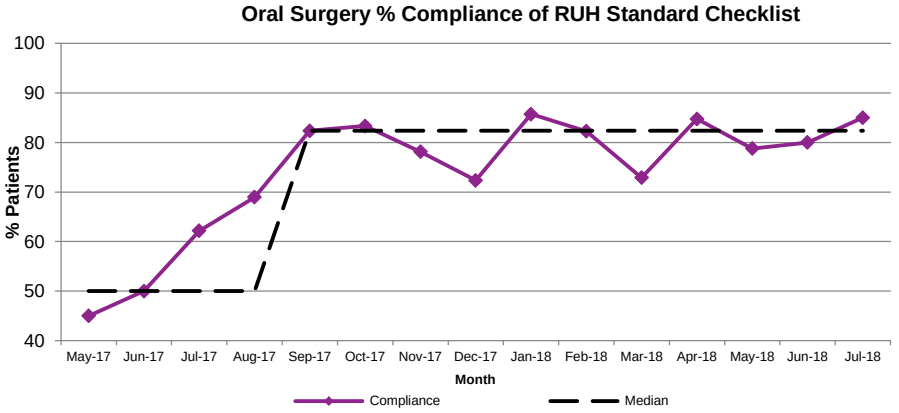
Radiology

Compliance 90% in G Room .



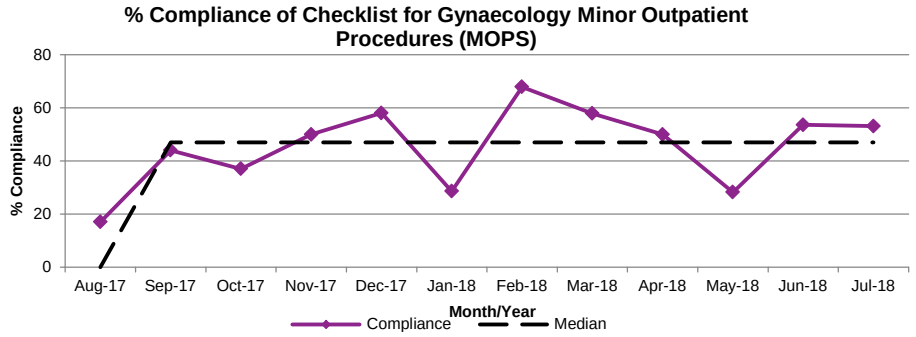
Oral Surgery

80% compliance. Started to record electronically.



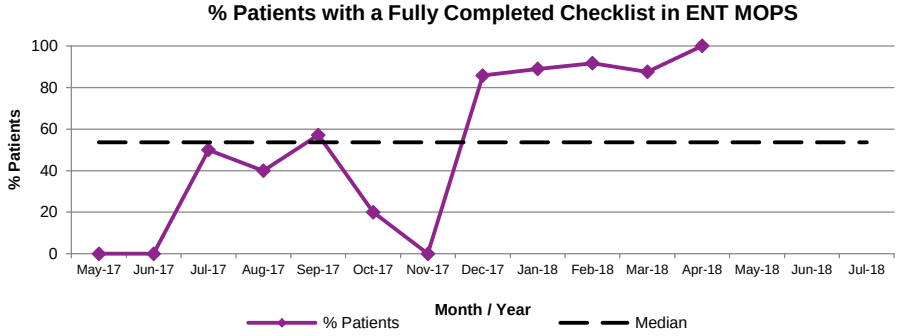
Gynaecology

Compliance is inconsistent (53% for July 2018), depending on clinician, which is being addressed.



ENT

No data since April 2018



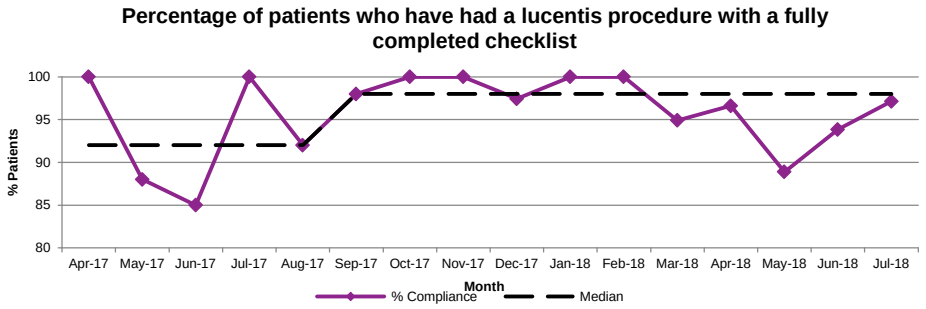
Dermatology, ED, Chest procedures on ward & Outpatients

Natsips lead met with Dermatology clinical governance team and agreed recording plan. Data will be available from September

National Safety Standards Invasive Procedure (NatSSIPs) Bernie Marden

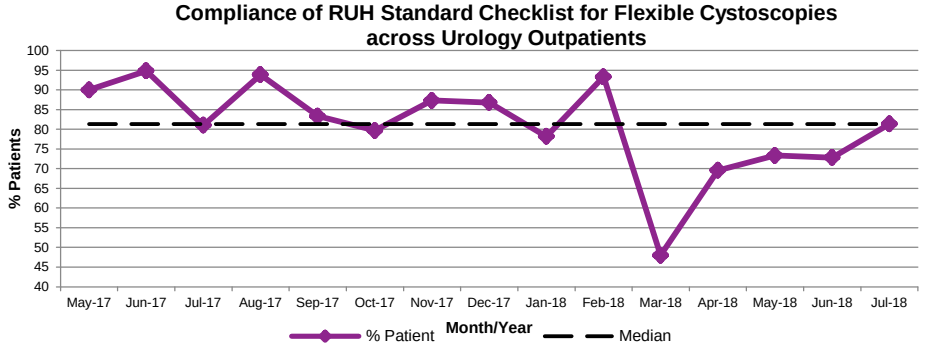
Ophthalmology

Lucentis injections –compliance 97%. Electronic recording has declined and is reverting back to paper recording in the notes.

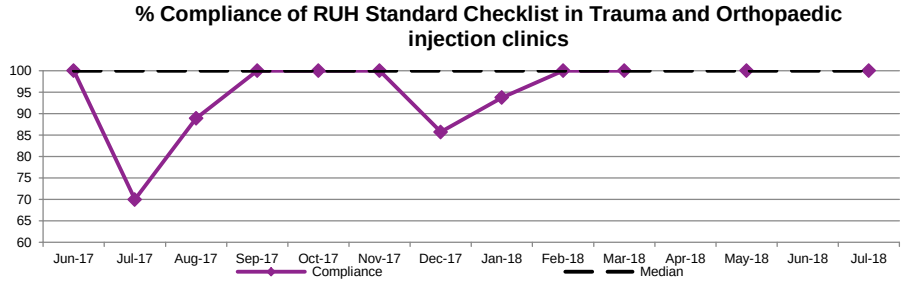


Urology

Decreased compliance in march was a recording issue rather than lack of compliance .Recording had been manual rather than electronic , which is being addressed.

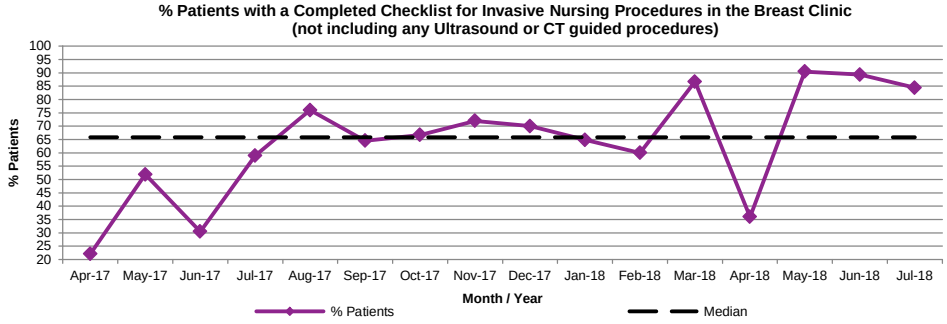


Orthopaedics Outpatients



Breast Clinic

Median compliance is 65% but has improved since may 2018.



Improving Insulin Safety

Francesca Thompson

Background
Improving Insulin safety is one of the Safer Six Patient Safety priorities. Due to the high risk with insulin therapy and despite the significant improvement in 2017 safety work will continue and a work plan is monitored by the Insulin taskforce to identify other key areas for improvement.

Workplan Progress

Self-Administration
There has been a significant reduction in insulin administration errors (> 50%) on the wards **self-administration** of insulin since it's introduction in March 2018, see graphs A &B.

Training
The mandatory safe use of insulin e-learning has been updated with ePMA features and other improvements following feedback.

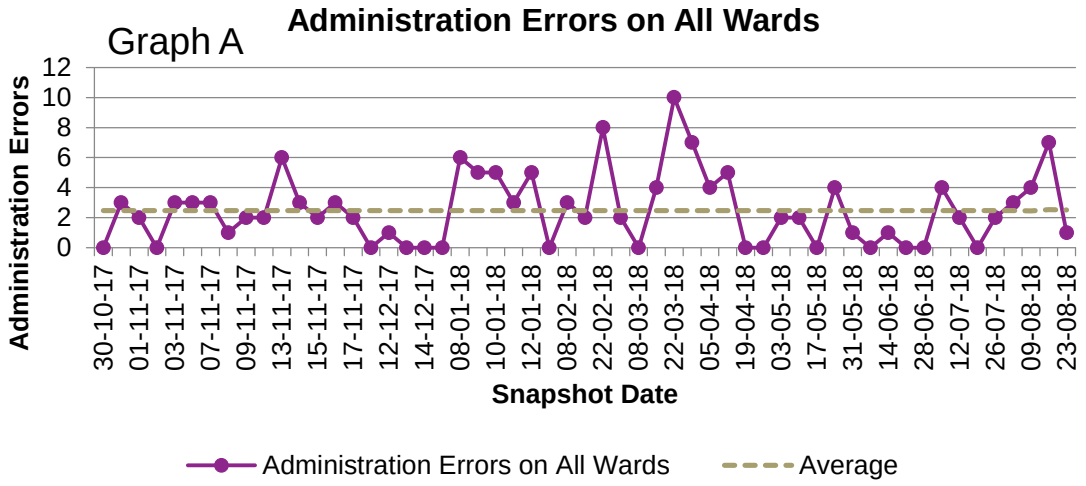
Hyperglycaemia
A new policy for the management of hyperglycaemia has been ratified and now on the intranet.

IT Development
IT have recently converted Blood Glucose (BG) monitors to wireless connectivity enabling remote checking. It is planned to take advantage of this to target severe hypos in future.

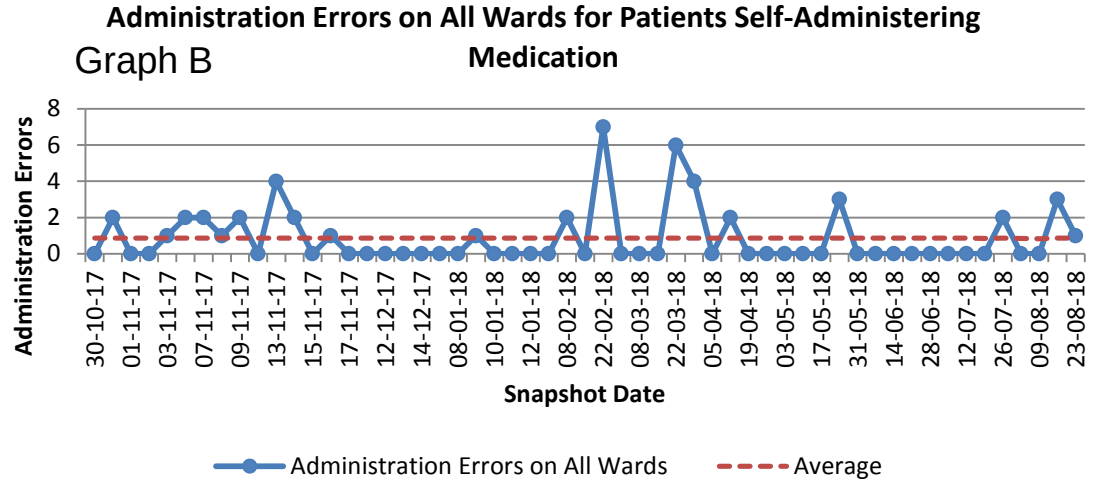
Barriers
The pressure on ward staff continues to have an impact on ability to engage with some of the projects.

Future Plan
Expansion of self-administration of insulin Trust-wide will be a priority.

Graph A



Graph B



Serious Incidents (SI) Summary

Lisa Cheek

Current Performance

Eight serious incidents were reported to STEIS in August. One incident involved four patients over a period of time up to April 2018. One incident occurred as a consequence of surgery in October 2017, three Serious incidents occurred in July and three in August. Each incident was agreed to be investigated as an SI following the Professional Review Meeting.

Serious Incidents Reported to STEIS July 2017 to August 2018												
Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	July-18	Aug-18
7	0	5	6	6	10	5	0	3	13	2	5	8

Date of Incident	ID	Summary
27/07/2018	**65024**	Baby born in poor condition
27/07/2018	**65088**	Misplaced Central Line
01/04/2018	**65561**	Complication following cardiac procedure
08/08/2018	**65451**	Fall resulting in injury
23/07/2018	**65470**	Incorrect pre-op diagnosis
02/10/2017	**65709**	Post-op injury to finger
17/08/2018	**65552**	Fall with fracture
30/08/2018	**65898**	Fall with injury

Overdue Serious Incident Report

Lisa Cheek

The drive to reduce the number of overdue SI reports continues this year has resulted in the Trust being on target with SI reports being reviewed at OGC in a timely manner. Serious Falls Investigations now get reviewed at the Falls steering group with an agreement for a quarterly report to be presented at OGC going forward. As of 12th September 2018, there are 18 Serious Incidents that remain open. Of these, 4 have been discussed at OGC but are overdue for submission to the Clinical Commissioning Group by the agreed due date for the following reasons:

- 1 has an extension request agreed,
- 2 are to be returned to OGC for sign off following amendments
- 1 requires the Medical Director amendments to be made prior to submission to the CCG

The CCG are aware of the delays.

The Operational Governance Committee monitors the progress against the action plans developed following the investigation and at the August OGC meeting, the status was reported as:

	July-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May - 18	Jun - 18	Jul - 18
Outstanding Action Plans	21	22	15	19	19	30	23	28	32	25	19	14	29
Outstanding Actions	49	44	29	44	31	49	43	34	54	42	46	22	54

The Divisional leads have been pro-active in supporting staff to manage the action plans generated from SI investigations. Matrons meet on a weekly basis to review action plans and update progress accordingly. However, the drive to reduce the number of SI's breaching submission dates has resulted in an increased number of actions for managers to implement and review.

Nursing Quality Indicators Exception Report Lisa Cheek

Areas of Focus
The Nursing Quality Indicators chart is attached as Appendix A. Seven areas have flagged this month as having nursing quality indicators of note.

Haygarth Ward
This ward last flagged in April 2018. Haygarth currently do not have a band 7 Senior Sister/Charge Nurse.
Quality Matrices to note are:
2 Complaints
11 falls
1 grade 2 pressure area
RGN Sickness 10.9%
HCA Sickness 6.3%
RGN % hours day and night < 85%

The complaints have been managed and resolved by the Matron and the band 6 Junior Sister.
All falls are being reviewed by the matron and support being given to implement any necessary changes. The ward will be involved in the relaunch of the falls pathway event.
The pressure area was a category 2 on a patients heel, and an RCA has been undertaken. As a result of this the Junior Sister is providing additional teaching for the ward staff in conjunction with the Tissue Viability team and the Tissue viability ward Link Nurse.
The RGN and HCA sickness is being proactively managed in line with Trust policy. The Matron is overseeing this process.

Cardiac Ward (Acute Medicine)
This ward has flagged May, June, July and August. The ward underwent a NIST in April and are awaiting the final report.
Quality matrices to note are:
- There has been 6 falls but no harm.
- HCA sickness 7.8%
- RN appraisals 64%
- HCA appraisals 64.3%
- RN hours % day and night fill rate <85%
- CHPPPD = 5.2

The Senior Charge Nurse is working to a recovery plan to address the out of date appraisals. This is on target for recovery.
The night and day fill registered nurse fill rate is consistently lower, this is partly to do with 4.12 WTE vacancies and also due to staff then being moved from cardiac wards to support wards in greater need of registered nurses throughout the Trust.
There is some long term sickness with the Health Care Assistants which is being proactively managed via Occupational Health and Human Resources.

Nursing Quality Indicators Exception Report Lisa Cheek

Combe (Older Peoples)
This ward has flagged for the second consecutive month.
Quality matrices to note are:

- 1 negative PALS contact
- 7 patient falls, 6 no harm and 1 minor harm
- RN sickness is 8.2%
- HCA sickness is 13%
- RN appraisals 50%
- HCA appraisals 73.3%
- RN hours % night/day fill rate <85%

The negative PALS contact was proactively managed by the Matron A meeting with the complainant has been set up with the Consultant and Senior Sister.
There are two staff on maternity leave and a further two on long term sickness which impacts on the percentage completion rate for appraisals. Plans are being put in place to address the remainder of the other appraisals due.

The Senior Sister is currently actively recruiting to the vacancies. I WTE RGN commencing in September. 1 job offer made for a further WTE RGN has been made this month.
There is an open day specifically targeted for vacancies in Older Peoples Unit taking place on Tuesday 2nd October.

Staff are deployed where possible into enhanced bays for observation to minimise the risk of falls. HCA 's continue to be requested to help provide the enhanced observation.

ACE (Older Peoples)
This ward has flagged for the second consecutive month.
Quality matrices to note are:

- 1 negative PALS contact
- 10 falls with no harm
- 1 category 2 pressure ulcer
- HCA sickness 8.9%
- RN sickness 7.2%
- RN appraisals 68.4%
- RN hours % night/day fill rate <85%

PALS contact dealt with appropriately by the Senior Sister.
One person fell more than once. Additional HCA's are requested to support enhanced observations.
Staff have recently returned from long term sickness and the short term sickness is being proactively managed in line with Trust policy.
The appraisals are being managed with a recovery plan for the members of staff who are out of date, one of whom has recently completed their appraisal and the other being the Senior Sisters, who has a date booked.
All vacancies are being managed locally and divisional / trust wide. There is an open day specifically targeted for vacancies in Older Peoples Unit taking place on Tuesday 2nd October.

Nursing Quality Indicators Exception Report Lisa Cheek

Forrester Brown (Trauma & Orthopaedics)
This ward has flagged for the second month.

Quality matrices to note are:
- 1 negative PALS contact
- RN sickness 6.5%
- HCA sickness 5.5%
- RN hours % night/day fill rate <85%

One PALS negative contact was received : This has been dealt with by the Matron via a telephone call. The Matron has sent a follow up letter and this has been resolved.

All sickness is being managed in line with Trust policy. Only one member of staff is currently on long term sick leave at present. The HCA long term sickness will be resolved from September.

Vacancies are being actively recruited to, 0.6 WTE registered nurses to start in September, 1.0 WTE registered nurses in October.. Staffing is reviewed regularly by the Senior Sister and matron.

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Neonatal Intensive Care Unit
This ward has flagged for the second month consecutively.

Quality matrices to note are:
- FFT response rate 25%
- RN appraisal 73.2%
- RN hours % night/day fill rate <85%

The Senior Sister has allocated the FFT recovery plan as a project to a band 4 nurse. There has been a slight increase in response rate from last month.

All outstanding appraisals are being actively managed by the senior sisters.

There are 3.0 WTE vacancies on NICU which are being actively recruited to, this is in addition to two full time care staff on maternity leave. Staff are re allocated between Paediatrics and NICU dependant on workload requirement.

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Nursing Quality Indicators Exception Report Lisa Cheek

Midford ward (Older Peoples)

This ward last flagged in June 2018.
Quality matrices to note are:

- 7 falls no harm
- HCA sickness 11.3%
- RN sickness 10%
- RN appraisal rate 77.8%
- RN hours % night/day fill rate <85%

Staff are deployed where possible into enhanced bays for observation to minimise the risk of falls. HCA 's continue to be requested to help provide the enhanced observation. The ward therapist is utilised to support with enhanced observations.

Sickness is being closely managed in line with Trust Policy and with support from HR where required. Long term sickness among the staff is now resolved and staff are back undergoing a phased return.

The vacancy level for RN remains high. 5 beds remain closed to support the reduced staffing levels. Midford are continuously proactively recruiting. There is an open day specifically targeted RGN's for return to acute care in Older Peoples Unit taking place on Tuesday 2nd October.

Nursing Quality Indicators - Monthly Template August 2018

APPENDIX A

Ward Name	Report for May 2018 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																													
	Accreditation Status	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				Care Hours Per Patient Day (CHPPD) overall	Number of times parameters outside of KPI metrics					
																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		Aug 18 No:	Jul 18 No:	Jun 18 No:	May 18 No:	Apr 18 No:	Mar 18 No:
A&E	Foundation	98	2.5%	2	5				1	0	0	0				3.7	3.9	88.6	95.2							2	4	2	1	2	2
SAU	Bronze	100	6.5%		2				3	0	0	0				2.8	3.7	84.2	83.3	4	76.4%	105.9%	81.7%	129.4%	9.8	3	3	1	0	3	3
MAU	Bronze	78	4.5%		1				3	0	0	0				2.6	12.8	88.6	85.7	2	74.1%	133.4%	77.4%	140.2%	9.1	5	8	6	6	3	2
Helena	Bronze	100	65.9%						2	0	1	0				4.6	3.2	100.0	73.3		90.9%	162.1%	86.7%	175.0%	9.2	1	3	3	4	5	4
Medical Short Stay Unit	Foundation	98	33.3%		1				3	0	0	0				2.2	2.7	84.6	88.9		64.6%	138.4%	98.7%	193.8%	6.5	2	5	3	2	5	5
Charlotte	Bronze	96	34.5%						0	0	0	0				0.0	0.5	61.5	83.3	3	81.5%	92.0%	99.8%	95.2%	7.2	3	2	0	1	1	1
Cheselden	Bronze	97	86.0%						2	1	0	0				11.6	0.0	71.4	92.9		70.7%	119.4%	97.4%	100.0%	5.5	3	2	1	2	0	0
Surgical Short Stay Unit	Bronze	97	51.9%		1	1			0	1	0	0				3.1	9.6	100.0	100.0	1	84.8%	108.2%	74.1%	164.5%	6.8	3	2	4	1	2	1
Violet Prince (RNHRD)	Bronze	100	80.0%						0	0	0	0				0.0	13.0	100.0	66.7		76.2%	102.0%	98.4%	90.3%	4.9	3	3	3	2	3	4
Phillip Yeoman	Bronze	98	74.6%						3	0	0	0				0.6	2.1	83.3	100.0		92.9%	70.1%	69.4%	81.5%	6.7	3	3	3	3	3	4
CCU	Bronze	100	52.0%						0	0	0	1				1.9	23.4	87.5	50.0		79.5%	94.7%	98.1%	93.5%	9.2	3	3	4	3	4	4
Mary Ward	Bronze	100	21.8%						0	0	0	0				2.4	3.1	80.5	36.4		98.1%	82.6%	90.8%	91.0%	13.3	3	4	5	1	3	4
Robin Smith	Foundation	97	41.8%	1					2	1	0	0				3.4	6.7	90.0	88.2		84.9%	107.2%	78.2%	142.9%	6.4	4	1	2	3	3	2
Acute Stroke Unit	Bronze	94	52.9%				1		5	2	0	0				0.5	2.6	87.5	100.0	7	68.8%	91.1%	81.8%	138.1%	7.3	4	4	4	5	6	5
Waterhouse	Bronze	100	15.2%						16	2	0	0				10.2	4.7	100.0	87.5	2	69.2%	98.3%	102.3%	109.0%	6.3	4	4	5	4	3	5
Critical Care Services	Bronze	N/A	N/A						0	0	0	0				9.8	0.0	87.0	100.0		82.1%	86.8%	78.3%	45.2%	29.2	4	4	7	5	5	4
Pierce	Bronze	100	7.0%						2	2	0	0				1.6	0.9	76.5	75.0	2	66.5%	146.7%	77.8%	208.1%	7.3	5	3	1	3	2	1
Parry	Bronze	98	38.3%	2		1		1	4	1	0	0				1.0	19.1	90.9	84.6		74.7%	104.4%	92.7%	110.0%	5.9	5	3	1	5	5	2
Children's Ward	Bronze	100	25.1%		1	1	1		1	0	0	0				4.2	0.7	76.3	100.0	5	75.4%	94.4%	73.2%	157.8%	8.0	5	3	4	4	5	4
Respiratory	Bronze	98	59.6%	1	1				7	0	0	0				1.8	5.2	88.2	86.7		63.7%	143.9%	71.2%	117.4%	5.8	5	4	5	3	4	4
William Budd	Bronze	94	45.9%				1		2	0	0	0				0.5	0.0	76.9	62.5	1	61.5%	127.3%	71.2%	146.0%	7.6	5	4	6	4	5	7
Pulteney	Bronze	97	45.0%						2	0	0	0				10.6	4.7	45.8	25.0	1	81.1%	87.5%	81.4%	109.5%	6.8	5	5	5	1	7	4
Midford	Bronze	97	93.9%						7	0	0	0				10.0	11.3	77.8	100.0	1	51.2%	137.5%	69.1%	180.6%	7.3	6	4	6	4	3	5
Forrester Brown	Bronze	91	47.9%		2		1	2	1	0	0	0				6.5	5.5	100.0	100.0	1	80.7%	105.1%	77.0%	126.2%	7.0	6	6	3	3	4	3
NICU	Not assessed	100	25.0%						0	0	0	0				3.7	0.3	73.2	92.9		84.5%	38.2%	76.0%	37.1%	11.0	6	6	5	4	5	5
Cardiac	Foundation	94	40.9%						6	0	0	0				3.2	7.8	64.0	64.3		78.9%	113.7%	81.0%	169.6%	5.2	6	6	6	6	5	4
Haygarth	Foundation	96	38.1%				2		9	1	1	0	1			10.9	6.3	87.5	88.9		62.9%	97.6%	68.5%	184.2%	5.8	7	4	5	4	6	5
ACE OPU	Bronze	98	70.9%				1		10	0	0	0	1			7.2	8.9	68.4	94.1	1	57.9%	106.1%	60.3%	141.3%	6.8	8	6	5	4	3	4
Combe	Foundation	97	66.7%				1		6	1	0	0				8.2	13.0	50.0	73.3	12	62.1%	109.3%	72.2%	203.2%	6.6	8	6	5	7	5	7
		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 (falls and staffing levels)					

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