Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**28 November 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery** **Francesca Thompson, Chief Operating Officer** **Bernie Marden, Medical Director**		
Author:	**Lisa Cheek, 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 October 2018 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2018/19 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:
  - Pressure Ulcers
  - Emergency Department 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.

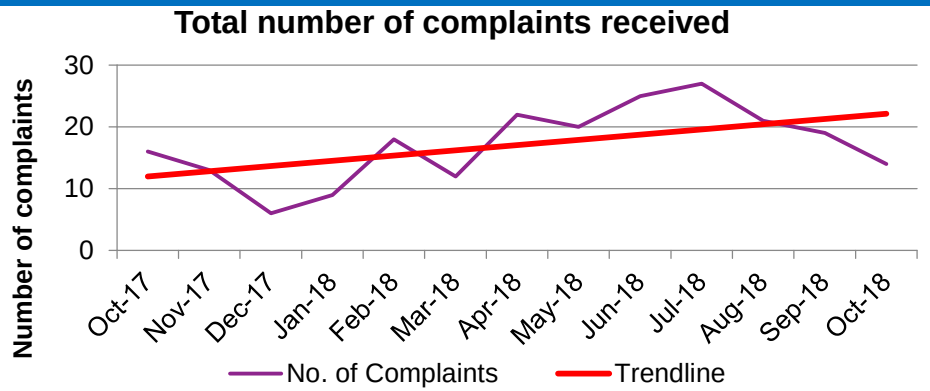
6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports to Management Board and Board of Directors	
8.	**Freedom of Information**
Public.	

QUALITY REPORT

PART A – Patient Experience

Complaints Report

Lisa Cheek



There were **14** formal complaints in September. **5** were for the Surgical Division; **6** for the Medical Division; **2** for Women & Children and **1** for Estates and Facilities. **9** complaints cited Clinical Care and Concerns; **4** related to appointments and **1** related to parking.

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	2 (50%)	0 (0%)	4(29%)	6 (33%)
Breached 35 Day target	2 (50%)	1 (100%)	10 (71%)	13 (67%)
Total	4	1	14	19

Of the complaints that breached the response dates:

- 1 was responded to within 50 days
- 1 was responded to within 45 days
- 11 currently have a response outstanding, these range from being 5 to 20 days over the 35 day target (as at 6th November)

Reasons for the breach of response dates:

Surgery Division

- Meeting with complainant within deadline, however awaiting the sign off of notes
- Awaiting responses from consultants

Medicine Division

- 4 are still awaiting for complaint meeting dates to being arranged
- 1 has a meeting date scheduled
- 1 requires meeting notes to be typed up
- Due to delay from Great Western Hospital for a joint response
- Awaiting a response from Consultant
- Further discussion to take place with Matron

Women's and Children's Division

- Complainant indicated that she was happy that the complaint had been dealt with on informal basis however later retracted this. This has delayed the completion of the response.

Currently the Trust is responding to the high levels of complaints that were received in August and September 2018. It is anticipated that the response performance will improve during November and December when we will be responding to a lower number of complaints.

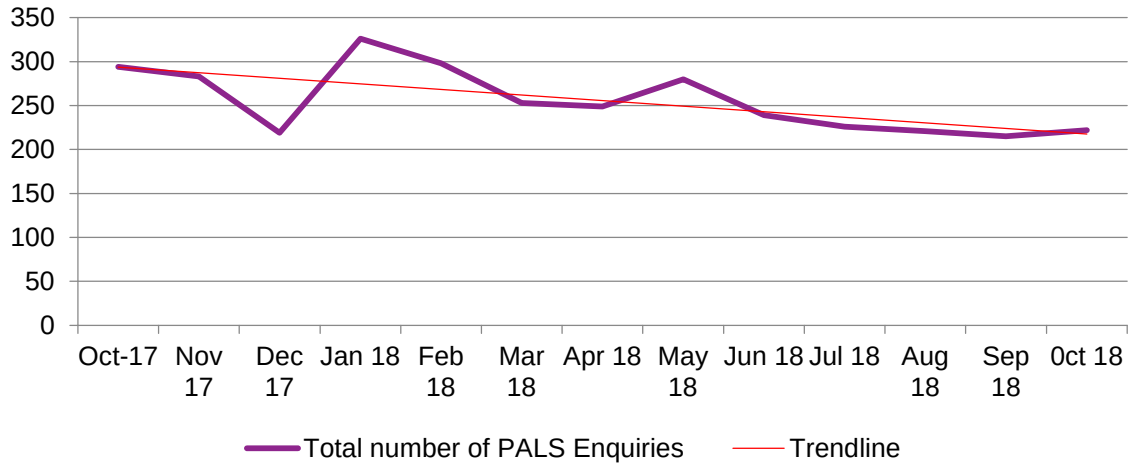
A high number of complainants are requesting a meeting to discuss their complaint. Complaint Coordinators are reporting difficulties arranging these meetings due to time demands on clinical staff who are required to attend. This will need to be addressed with the Heads of Division.

The Patient Experience Team is purchasing a meeting recording device. As a result Complaint Coordinators will spend less time writing up notes and having them checked, making this part more efficient.

Patient Advice and Liaison Report

Lisa Cheek

Total number of PALS Contacts



There were **222 contacts with PALS** in October:

- 136 required resolution (61%)
- 72 requested advice or information (32%)
- 7 provided feedback (3%)
- 7 were compliments (3%)

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

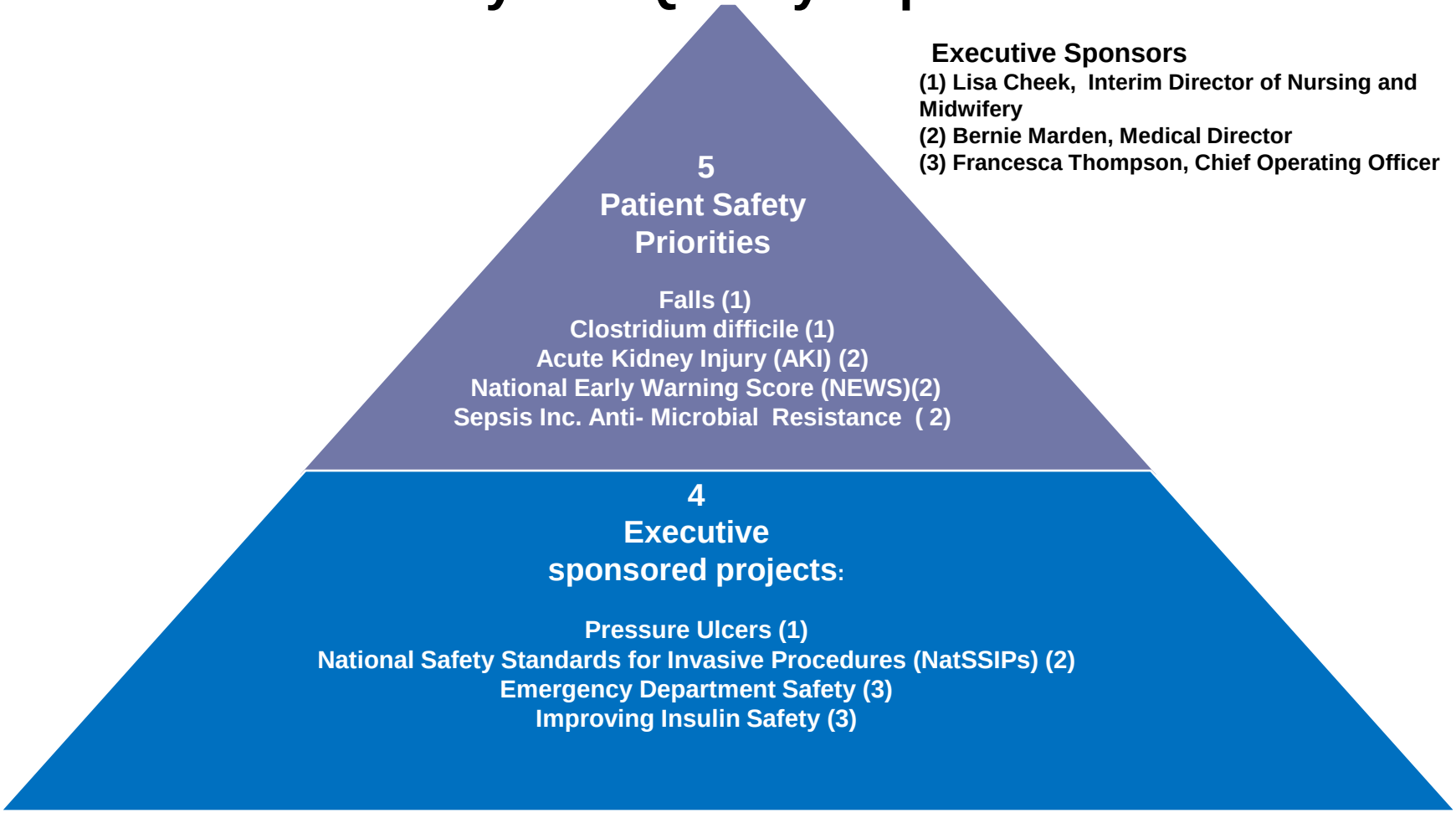
Clinical Care & Concerns - there were **35** contacts relating to clinical care & concerns. **22** of these were general enquiries; **3** related to quality/concerns regarding medical care; **2** concerned medication errors. There were no clear trends for the remaining **8** concerns.

Appointments - there were **37** contacts. **9** of these were appointments changed by patients; **8** related to the cancellation of an appointment; **6** were for appointment information; **6** related to the length of time waiting for a new appointment; **3** related to the length of time for a follow up**.** There were no clear trends for the remaining **5** concerns.

Communication & Information – there were **84** contacts. **60** were general enquiries/communication; **5** general enquiries/clinical care; **3** related to telephone issues; **3** were test results not acted upon; **3** related to translation services. There were no clear trends for the remaining **10** concerns.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors

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

Patient Safety – Pressure Ulcers

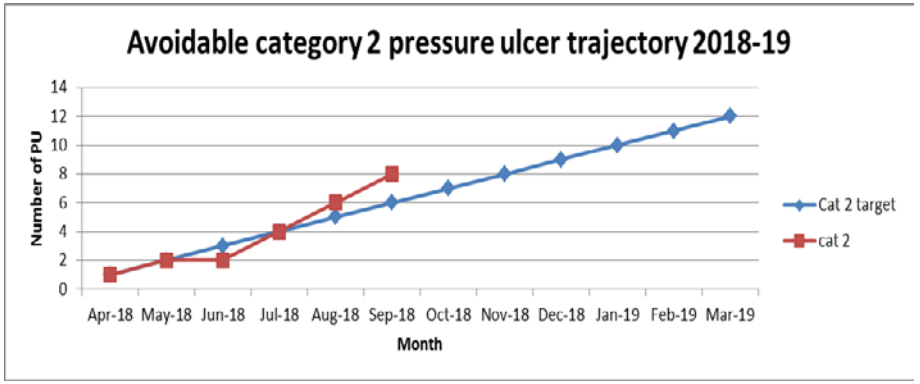
Lisa Cheek

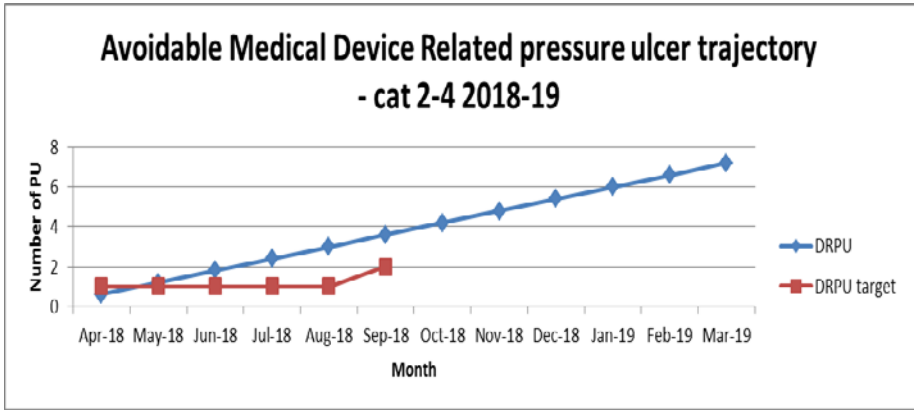
The ambition for 2018/19 is a 20% reduction of category 2 pressure ulcers and the elimination of all category 3 and 4 pressure ulcers, plus a 25% reduction in Medical Device Related pressure ulcers.

Avoidable Category 2 and medical device related Pressure Ulcers performance

- Quarter 2 reported 6 avoidable category 2 pressure ulcers, 2 on sacrum and 4 on heels, this positions us 2 over trajectory
- Quarter 2 reported 0 category 2 Medical Device related pressure ulcers.
- **Avoidable Category 3 & 4 Pressure Ulcers performance**
- Quarter 2 reported 1 category 3 Medical Device related pressure ulcer on a heel under a cast, an outpatient of the fracture clinic.
- Quarter 2 reported 1 category 3 pressure ulcer 9the first in over 200 days) and 1 category 4 pressure ulcer, (the first in over 650 days).

Key ward issues identified:
Long lapses in documented repositioning
Heels not offloaded from the surface of the bed
Poor categorisation
Lack of escalation to senior staff when deterioration noticed
Poor uptake of clinical media for photography





Patient Safety – Pressure Ulcers

Lisa Cheek

Actions already taken

- Presentation of patient cases to Matrons Forum to galvanise actions
- Patient cases sent to all senior sisters and available on the shared drive for dissemination through out teams
- Key focus of Matrons with a plan for recovery to include daily ward rounds to identify vulnerable patients and ensure all preventative measures are in place.
- STOP the pressure week 12-16th November; a week of activities and awareness to include all wards
- A funded central store for Repose foot protectors for easy access, particularly at the front door for ED and MAU – opened October 25th 2018 – review one month.
- TVNs targeted teaching new to care HCAs.
- Improve e-learning compliance across the Trust to 95% via support from the senior sisters and matrons – monitor at the Tissue Viability Steering group
- NHSI National prevalence audit undertaken on October 17th – sample audit only due to pressures.
- More clinical media training for staff to access

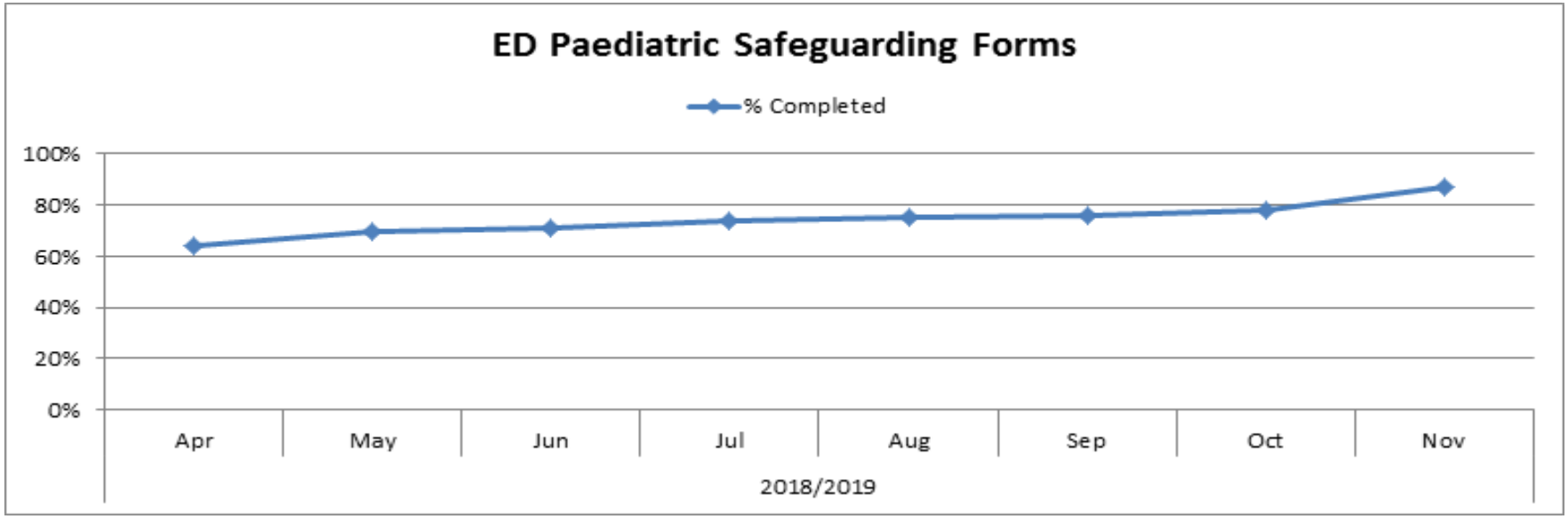
Actions planned

- New guidance for pressure ulcer definition and measurement from NHSI for implementation by the end of January 2019 this includes a rebranding of the SSKIN bundle to bring the RUH in line with all NHSI guidance. This will raised awareness throughout the Trust.
- New branding for the Tissue Viability Team – new stand out uniforms to bring in line with the Infection Control Team
- Develop a work plan for the reduction and management of Incontinence Associated Dermatitis which can be a precursor for pressure ulcer development.
- All band 2-4 to complete the Skin Care Pack and workbook which includes categorisation and skin checking
- Registered Nurses will document and check the Comfort record every 12 hours (every shift) as a minimum
- Matrons to review the accuracy of the pressure ulcer documentation on comfort round as part of their daily ward visit / matron walk round, providing real time feedback to the SSR and the wider team.

Emergency Department Safety

Francesca Thompson

Emergency Dept. Only	2018/2019							
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Safeguarding Forms Completed	666	753	814	875	638	865	907	300
Total Paeds Attendances	1040	1084	1150	1181	846	1138	1164	345
% Completed	64.04%	69.46%	70.78%	74.09%	75.41%	76.01%	77.92%	86.96%



Emergency Department Safety

Francesca Thompson

Summary
The Emergency Department is required to complete a paediatric safe-guarding screening tool on all paediatric attendances. Following the introduction of our new IT system (FirstNet) we experienced a decrease in compliance. Work was already underway prior to the last CQC inspection to improve this compliance, but this has also now been recorded as a CQC “must do” action.

Improvements

- An icon was added to FirstNet to indicate where the Paediatric safeguarding screening is required in June 2018.
- Weekly audits have been undertaken and imbedded since September – target is 85% by the end of January.
- A weekly report is generated about the timeliness of the paediatric reviewing nurses overview of the safe-guarding screening tool and consequent referral or actions form this. This information is fed into the Children and Young People’s Safeguarding Committee. At the time of the CQC inspection the safeguarding reviewing nurses were 17 days behind schedule – this has been decreased to 2 days.
- As can be seen from the graph above the compliance with completing the safeguarding screening tool has increased to 86.9%

Areas of Focus
Sustainable progress needs to be maintained.

Emergency Department Safety

Francesca Thompson

50% Complete - Out of applicable fields only

				Month 14	Month 15	Month 16	Month 17	Month 18	Month 19	Month 19	Month 20	Month 21	Month 22
				Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
		Total Notes Pulled		249	187	241	206	171	211	192	169	113	47
		Total Applicable Notes		125	96	104	100	95	123	100	93	60	23
		% Compliance		50%	51%	43%	49%	56%	58%	52%	55%	53%	49%
			Red	Green									
HOUR 1	Vital Signs measured + News recorded + Pain recorded		49%	80%	100%	100%	100%	100%	100%	98%	100%	100%	100%
	Triage completed on Patient First		49%	80%	98%	99%	100%	98%	99%	100%	89%	97%	98%	100%
	ECG recorded + Checked (If appropriate)		49%	80%	86%	86%	91%	86%	94%	98%	89%	98%	100%	87%
	Analgesia administered (if appropriate)		49%	80%	52%	87%	77%	50%	75%	98%	86%	90%	100%	91%
	Investigations Initiated (as appropriate):													
	IV access and / or Blood tests		49%	80%	80%	87%	83%	85%	89%	98%	80%	89%	91%	91%
	Hydration Chart / Fluid Chart		49%	80%	57%	64%	65%	36%	78%	98%	79%	87%	94%	82%
	Meds on time		49%	80%	15%	59%	59%	19%	69%	100%	86%	93%	92%	86%
	Specific Pathway Triggered:													
	NoF/Cath Lab/Sepsis/Trauma/Self Harm		49%	80%	41%	85%	80%	27%	76%	96%	83%	76%	88%	82%
	Hour Compliance:				78%	87%	86%	72%	88%	99%	0%	91%	95%	89%
HOUR 2	Vital Signs measured + News recorded + Pain recorded		49%	80%	96%	94%	98%	96%	99%	97%	83%	79%	88%	80%
	Analgesia administered (if appropriate)		49%	80%	56%	86%	81%	61%	81%	97%	76%	78%	82%	75%
	Next of kin aware		49%	80%	93%	89%	97%	93%	100%	98%	93%	98%	96%	85%
	Safety magnet (if appropriate)		49%	80%	40%	69%	74%	35%	89%	97%	90%	95%	88%	85%
	Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart		49%	80%	85%	98%	89%	72%	90%	97%	84%	84%	84%	75%
	Pressure Area Care Assessment undertaken		49%	80%	89%	78%	97%	94%	99%	97%	97%	96%	92%	80%
	Hour Compliance:				85%	87%	92%	83%	94%	97%	0%	87%	88%	79%
HOUR 3	Vital Signs measured + News recorded + Pain recorded		49%	80%	92%	100%	95%	96%	88%	100%	98%	78%	96%	67%
	Pain score re-assessed		49%	80%	94%	88%	87%	96%	89%	100%	93%	75%	92%	65%
	Analgesia administered (if appropriate)		49%	80%	50%	76%	67%	52%	76%	100%	93%	73%	88%	65%
	Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart		49%	80%	91%	73%	73%	93%	86%	100%	93%	75%	96%	65%
	Hour Compliance:				85%	86%	83%	89%	86%	100%	0%	75%	93%	65%
HOUR 4	Vital Signs measured + News recorded + Pain recorded		49%	80%	89%	100%	100%	96%	78%	100%	100%	50%	100%	64%
	Analgesia administered (if appropriate)		49%	80%	30%	100%	67%	69%	59%	100%	100%	48%	83%	64%
	Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart		49%	80%	88%	82%	70%	80%	78%	100%	100%	46%	100%	64%
	Regular medication administered (if appropriate)		49%	80%	33%	88%	71%	44%	68%	100%	100%	48%	92%	64%
	Hour Compliance:				68%	94%	81%	81%	70%	100%	100%	48%	89%	60%

Emergency Department Safety — Francesca Thompson

Summary
Hour 1 continues to shows consistent completion.
Hour 2 shows some continued improvement except on “refreshments and analgesia”. It should be noted that this audit shows compliance with checklist completion rather than whether actions have been undertaken. There are some staff in the Emergency Department (eg: volunteers) that offer refreshments who currently may not complete the checklist.

The performance improvement in October does not appear to have been sustained in November – however it should be noted that the audit sample size is only about a third of the normal size and this is being addressed through the expansion of the data collection group.

Improvements
Performance has been embedded in hour 1.

Areas of focus
The documentation leads will continue to use the brief 5 minute intervention at nursing handover to remind and encourage staff about completion of the safety checklist.

This audit is a standing agenda item on the ED Senior Nurse Forum and in addition forms part of the CQC improvement plan.

Emergency Department Safety

Francesca Thompson

NEWS Audit	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Patient name recorded?	100%	100%	100%	100%	100%	100%	100%
Date of birth recorded?	97%	100%	100%	100%	100%	100%	100%
MRN recorded?	97%	100%	100%	100%	100%	100%	100%
Ward recorded?	93%	95%	98%	90%	95%	100%	90%
Target O_2 sats range recorded?	86%	90%	100%	95%	95%	95%	90%
Frequency of assessment (ED) met?	59%	85%	73%	85%	78%	60%	80%
Pain score in use recorded?	93%	85%	100%	95%	90%	90%	90%

Standards	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Extreme Units	100%	100%	100%	100%	100%	100%	100%
Total NEWS	92%	98%	97%	94%	98%	100%	100%
Total NEWS, Rec + Acc	97%	97%	95%	98%	93%	97%	100%
Pain Score	73%	95%	79%	96%	83%	89%	100%

Emergency Department Safety — Francesca Thompson

Summary

The CQC inspection identified that documentation was not always completed to a good standard. A "must do" from the inspection is that the ED should ensure patients are checked regularly whilst waiting in the department and that this is recorded on the observation chart.

The tables above show the last NEWS audit information using NEWS(1) – NEWS 2 was implemented on the 7th November. Trust wide and local ED data is collected to ensure that the focus remains on timings and accuracy of NEWS recording.

Improvements

- There is continuing improvement in the recording of "target oxygen saturation" . Target oxygen compliance measures are part of the changes in the NEWS2 documentation.

- Frequency of assessment has shown an improvement on the previous month although it remains an amber rating. The ED NEWS lead is re-focusing on the assessment standard, particularly given some of the extended length of stay in the Emergency Department. This focus is planned for December.

Areas for focus

Pain scoring has improved but needs to be sustained. NEWS2 implementation is being led by the ED NEWS lead with regular "5 minute brief intervention training" to ensure accuracy about recording.

Serious Incidents (SI) Summary

Lisa Cheek

Current Performance

Five serious incidents were reported to STEIS in October. All incidents continue to be under investigation.

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

Date of Incident	ID	Summary
26/09/2018	**66645**	Pressure Ulcer
29/09/2018	**66733**	Treatment/procedure
29/09/2018	**66741**	Pressure Ulcer
20/10/2018	**67374**	Pressure Ulcer
10/09/2018	**67100**	Treatment/procedure

Overdue Serious Incident Report

Lisa Cheek

The drive to reduce the number of overdue SI reports continues this year and the result is the SI reports are being reviewed at OGC in a timely manner with the aim for the SI's to be ready for submission to the CCG within the required time.
As of 7th November 2018, there are 24 Serious Incidents that are open and under investigation. In agreement with the CCG all SI's presented at OGC meetings or the Falls Steering Group will be updated on STEIS following the meeting to advise of those that are approved, awaiting amendment or need to be returned to OGC for further discussion. All RCA's are on track and extensions have been granted or requested for those that may breach the original submission time.

Actions outstanding continue to fluctuate. The Heads of Nursing for each Clinical Division have been advised of the actions outstanding related to their Divisions and asked to update the risk team on progress of closure. Recent recruitment within the risk team will see SI's assigned to the team members case loads going forwards enabling consistent follow up and support throughout the SI Investigation process.

	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Outstanding Action Plans	22	15	19	19	30	23	28	32	25	19	14	21	29	32	26
Outstanding Actions	44	29	44	31	49	43	34	54	42	46	22	30	54	54	66

Nursing Quality Indicators Exception Report — Lisa Cheek

Neonatal Intensive Care Unit
This ward has flagged for the fourth month consecutively.
Quality Matrices to note are:
- RN appraisal 70.5%
- HCA appraisal rate 78.6%
- RN hours percentage night/day fill rate <85%
- HCA night fill rate 43.9%

There is a workforce appraisal plan in progress which is overseen by the Matron and new band 7. All outstanding appraisals are being actively managed by the senior sister.
There are 3.0 WTE vacancies on NICU which are being actively recruited to, this is in addition to staff being on maternity leave. There are two full time care staff on maternity leave. Staff are relocated between Paediatrics and NICU dependant on workload requirement. The Matron is supporting the unit by undertaking the band seven appraisals. The Practice Development Sister who helps support the appraisal process is on leave following bereavement. On her return appraisals of all grades will be prioritised. Although the RN and HCA staff fill rate is less than 85% the unit is able to flexibly move staff around in order to minimise any risk to patients.

Medical Assessment Unit (MAU)
The last time MAU flagged was July 2018.
Quality Matrices to note are:
- 1 complaint received
- 2 negative PALS contacts
- 5 patients fell with no harm sustained
- HCA sickness 16.8%
- RN appraisal rate 78.7%
- RN and HCA staffing <86%

HCA sickness has increased and sickness is being managed in line with trust policy. 2 HCA's are currently on long term sick.
RN appraisals have reduced this month and this has been reviewed with the senior sister and her band 6 team and progress has already been made in completing these.
There were 5 falls with no harm this month and 3 of these were repeat falls. Enhanced observation and the need to observe those patients at risk of falls has been discussed at the unit safety briefings.
Registered nurse fill rate is below % , the unit has recently recruited to external band 6 sisters and also 2 further band 5 staff nurses with 2 newly qualified staff starting in October/November. The unit has used HCA staff to support the RN vacancy to support patient flow and safety. Mau has welcomed 2 nurses from overseas who have started their inductions on MAU.
Complaints/ PALS during October resulted in poor attitude and communication from nursing and medical staff, the Matron has spoken to the PALS contacts and feedback to those staff involved.

Nursing Quality Indicators Exception Report — Lisa Cheek

Pierce Ward
Pierce ward have flagged for the second consecutive month
Quality Matrices to note are:

- FFT 19%
- 1 negative PALS contact
- 1 patient contracted clostridium difficile
- 1 catergory 3 pressure ulcer
- HCA appraisal rate 78.6%
- RN night fill <85%

Pressure ulcer, grade 3 – action plan put in place following the incident across orthopaedics to include increased awareness, recognition and escalation processes to minimise future similar events.
FFT tests – discharge facilitator has taken up post during October and is actively encouraging completion, facilitating the distribution and collection of FFT cards going forward.
PALS – this has been closed down locally through a telephone call and letter from the matron
Clostridium difficile – RCA has taken place and action plan put in place.
Appraisals- dates booked for all staff to comply
RN cover at night – From March 2019 there will be a full RN nursing establishment – all current vacancies have been offered and awaiting starters.

Cardiac Ward
Cardiac ward last flagged in August 2018
Quality Matrices to note are:

- 1 patient contracted clostridium difficile
- There were 7 falls which did not sustain any harm
- HCA sickness 6.2%
- RN appraisal rate 75%
- RN day and night fill <85%

New matron taken over post at beginning of November.
1 Patient contracted clostridium difficile in the month, this RCA is underway and sampling and care of the patients met all the expected parameters and should go to appeal when discussed at the IPC meeting.
Re-focus on falls this month and review being undertaken of use of staff within the constraints of the ward. Re-look at use of cohort bays and enhanced observations.
There is 1 HCA on long term sickness and the rest is being managed in line with trust policy.
Appraisal rates have dropped. This is due to some sickness and also maternity leave. There has been an emphasis placed with the Senior Charge Nurse to raise these levels as soon as possible with appropriate support offered.
Cardiac ward has recruited 3 senior nurses and this should improve their fill rate.

Nursing Quality Indicators Exception Report

Lisa Cheek

Pulteney Ward:
This is the second consecutive month that Pulteney have flagged on the nursing quality indicators.
Quality Matrices to note are:

- 1 patient contracted clostridium difficile
- HCA sickness 7.7%
- RN appraisal rate 45.8%
- HCA appraisal rate 26.7%
- The RN night fill rate <82.4%
- FFT results 29%

The clostridium difficile case is being investigated as in line with Trust policy.
The RN and HCA appraisal rate have slightly improved since previous month. The ward team continue to prioritise this as an urgent action. HCA sickness has risen but is being actively managed in line with Trust policy. The FFT % return results are disappointing. The ward manager will continue to encourage the multidisciplinary team in asking patients to complete .

Nursing Quality Indicators - Monthly Template October 2018

APPENDIX A

Ward Name	Report for May 2018 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					
	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					Oct 18 No:	Sep 18 No:	Aug 18 No:	Jul 18 No:	Jun 18 No:	May 18 No:
						Positive	Negative		No Harm	Minor Harm	Mod Harm	Major Harm	Cat: 2	Cat: 3	Cat: 4	Sickness %		Appraisal %			Day		Night								
																RN/RM	HCA	RN/RM	HCA		Reg Nurses/ Midwives	Care Staff	Reg Nurses/ Midwives	Care Staff						
SAU	Bronze	97	16%						3	1	0	0				5.2	3.3	66.7	63.2	3	70.6%	95.0%	82.6%	125.6%	10.7	5	4	3	3	1	0
A&E	Foundation	95	3%		2	2	2		1	0	0	0				6.2	8.7	83.1	90.9							5	5	2	4	2	1
MAU	Bronze	100	18%	1			2		5	2	0	0				3.6	16.8	78.7	81.0		79.7%	134.0%	84.8%	141.4%	9.3	7	5	5	8	6	6
Forrester Brown	Bronze	96	47%						0	1	0	0				1.8	0.7	100.0	94.1		85.9%	98.2%	71.2%	129.3%	6.6	1	4	6	6	3	3
Cheselden	Bronze	100	96%						0	0	0	0				9.5	1.3	92.9	92.3		76.2%	126.4%	99.9%	115.9%	6.0	2	2	3	2	1	2
Acute Stroke Unit	Bronze	95	56%						4	0	0	0				1.8	1.5	84.6	100.0	2	73.4%	73.5%	89.9%	142.7%	7.3	2	2	4	4	4	5
Helena	Bronze	97	58%						2	0	0	0				0.2	3.5	100.0	93.3		80.8%	139.9%	67.7%	187.0%	8.9	2	3	1	3	3	4
CCU	Bronze	100	61%						0	0	0	0				0.1	0.0	93.3	50.0		71.1%	89.2%	95.2%	96.6%	9.5	2	3	3	3	4	3
Phillip Yeoman	Bronze	97	66%		1				1	0	0	0				0.0	0.6	100.0	100.0		93.9%	58.3%	66.1%	75.9%	9.1	3	3	3	3	3	3
Medical Short Stay Unit	Foundation	96	44%						3	1	0	0				1.4	1.5	71.4	77.8		70.9%	106.9%	99.9%	149.1%	5.5	3	4	2	5	3	2
Violet Prince (RNHRD)	Bronze	100	64%						0	0	0	0				1.1	28.4	90.9	50.0		86.7%	84.7%	100.1%	93.5%	5.4	3	4	3	3	3	2
Robin Smith	Foundation	95	33%						0	0	0	0				5.1	1.1	100.0	93.8	1	91.3%	96.3%	83.9%	143.9%	6.4	3	4	4	1	2	3
Waterhouse	Bronze	N/A	N/A						9	0	0	0				3.6	6.9	91.7	100.0	6	69.5%	94.2%	110.2%	114.2%	6.1	3	5	4	4	5	4
Haygarth	Foundation	97	51%						2	0	0	0				0.6	5.7	87.5	100.0	1	59.8%	96.8%	71.7%	172.6%	5.7	3	7	7	4	5	4
Respiratory	Bronze	92	54%					1	2	0	0	0				3.5	6.2	94.7	88.2		73.6%	119.5%	76.4%	107.3%	5.6	4	4	5	4	5	3
Midford	Bronze	100	55%						3	1	0	0				5.5	12.3	90.0	92.9	2	54.5%	119.0%	64.0%	163.9%	5.8	4	7	6	4	6	4
Surgical Short Stay Unit	Bronze	98	58%	2	1				0	0	0	0				4.3	19.8	60.0	83.3		82.4%	93.9%	66.6%	203.2%	6.8	5	4	3	2	4	1
Critical Care Services	Bronze	N/a	N/a						0	0	0	0				5.3	5.6	81.8	100.0		83.5%	92.2%	81.0%	51.6%	27.5	5	4	4	4	7	5
Charlotte	Bronze	94	33%	1		1			0	0	0	0				1.5	7.1	84.6	75.0	3	88.5%	88.3%	98.1%	102.2%	6.9	5	5	3	2	0	1
Mary Ward	Bronze	23	100%		1	1			0	0	0	0				3.9	7.9	83.5	75.0	2	101.8%	95.1%	91.2%	65.7%	11.2	5	5	3	4	5	1
Children's Ward	Bronze	100	17%			1			0	0	0	0				2.4	3.2	80.0	100.0		78.1%	112.6%	84.5%	122.0%	7.0	5	5	5	3	4	4
Parry	Bronze	96	21%				1		8	0	1	0				2.0	13.4	91.7	76.9		90.6%	103.5%	104.4%	126.2%	6.2	5	6	5	3	1	5
William Budd	Bronze	100	28%	1					0	0	0	0				1.7	1.4	66.7	85.7		69.9%	92.6%	76.8%	133.9%	12.8	5	6	5	4	6	4
ACE OPU	Bronze	94	65%				1		5	4	0	0				7.8	1.0	85.0	94.4		59.1%	97.4%	66.5%	127.3%	6.7	5	7	8	6	5	4
Combe	Foundation	84	59%						5	1	0	0				6.5	3.2	90.9	71.4	3	64.8%	112.8%	67.5%	217.3%	6.8	5	7	8	6	5	7
Cardiac	Foundation	94	40%					1	7	0	0	0				0.7	6.2	75.0	86.7		76.3%	122.9%	76.4%	190.7%	5.4	6	5	6	6	6	6
Pierce	Bronze	94	19%				1	1	2	2	0	0		1		0.6	3.5	93.3	78.6	2	88.1%	146.1%	80.0%	193.5%	7.7	6	6	5	3	1	3
Pulteney	Bronze	88	29%		1			1	0	2	0	0				0.9	7.7	45.8	26.7	1	89.8%	95.4%	82.4%	124.2%	6.6	6	7	5	5	5	1
NICU	Not assessed	90	38%													2.2	1.0	70.5	78.6		82.5%	42.3%	73.1%	43.9%	9.8	6	7	6	6	5	4
		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