Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**30 October 2019**		

Title of Report:	**Quality Report**
Status:	**For discussion**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery** **Bernie Marden, Medical Director**
Author:	**Sarah Merritt, Interim 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 2019 data.
The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2019/20 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 Report
    - Patient Advice and Liaison Report
- Part B – Patient Safety and Quality Improvement
    - Deteriorating patients:
    - Infection Prevention & Control : CDiff
    - Ward Accreditation
- Exception reports:
    - Serious Incidents (SI) monthly summary and Overdue SI 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.

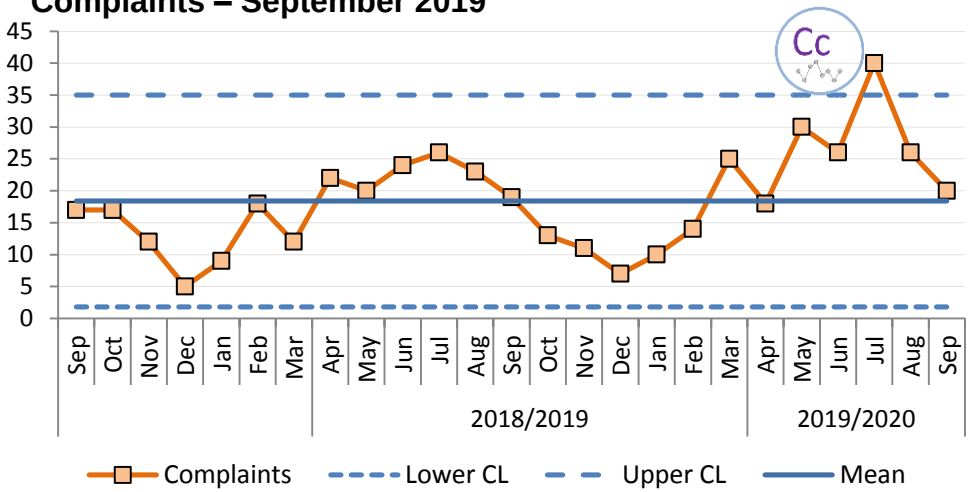
6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports to Management Board and Board of Directors	
8.	**Freedom of Information**
Public.	

QUALITY REPORT

PART A – Patient Experience

Patient Experience

Complaints – September 2019



Complaint response rate by Division	Division			Total
	Surgery	W&C	Medicine	
Closed within 35 day target	10 (83%)	0	8 (57%)	18 (67%)
Breached 35 Day target	2 (17%)	1 (100%)	6 (43%)	9 (33%
Total	12	1	14	27

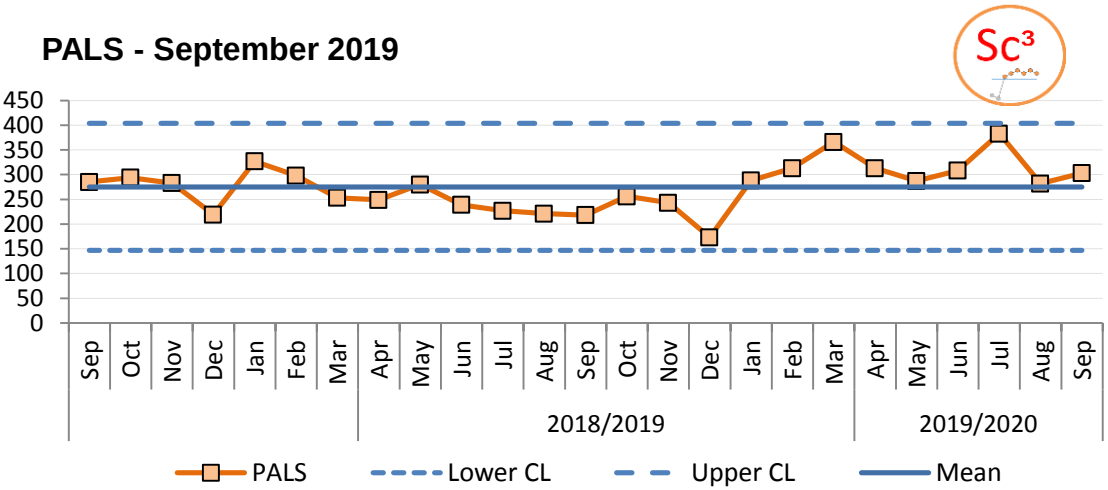
What the information tells us

- **20 formal complaints were received in September compared to 26 in August**. **11** for the **Medicine Division**, **8** for the **Surgical Division**, **1** for the **Women and Children's Division**. The **Medical Division** saw an increase in complaints from **8 in August to 11 in September**. Of the 11 complaints, Acute Medicine, Cardiology, the Emergency Department and Radiology all received 2 complaints. The complaints relate to clinical care concerns and one was a safeguarding . **The Surgical Division** saw a decrease in complaints from **13 in August to 8 in September**. 2 of the complaints relate to General Surgery, the rest were in Anaesthesia, Oral Surgery, Pathology and Urology. These relate to clinical care and communication. The **Women and Children's Division** received 3 complaints in September compared to 1 complaint in August, 2 related to Gynaecology and 1 in Oncology relating to clinical care and staff attitude.
- **There was an decline in the timeliness of complaint responses in September with 76% of complaints responded to within 35 working days compared to 88% in August**. **Medicine Division:** All 6 complainants requested a meeting to resolve their concerns. Delays occurred as a result of the co-ordination/availability of staff as well as the complainant (currently ranging from 8-24 days late) **Surgical Division:** 1 complaint had a meeting scheduled 2 days late and 1 complaint remains open due to delays in responses from key staff members. **W&C Division:** 1 remains open due to the co-ordination of a local resolution meeting.

Actions

The Corporate complaints team are currently developing a best practice toolkit which will be accessible on the intranet. One section will give guidance around the preparation of complaint meetings including early communication with complainants who have requested a meeting to check their availability and only inviting key staff to the meeting. Following this guidance should mean that complaint meetings are scheduled quickly and less likely to breach the target response date.

PALS - September 2019



There were **303 contacts with PALS** in September 2019. This is an **increase** of (6%) compared to the number of contacts in September 2018, and an **increase** of (7%) from August 2019.

- 230 required resolution (76%)
- 42 requested advice or information (14%)
- 22 provided feedback (7%)
- 9 were compliments (3%)

What the information tells us

The top three subjects requiring resolution were:

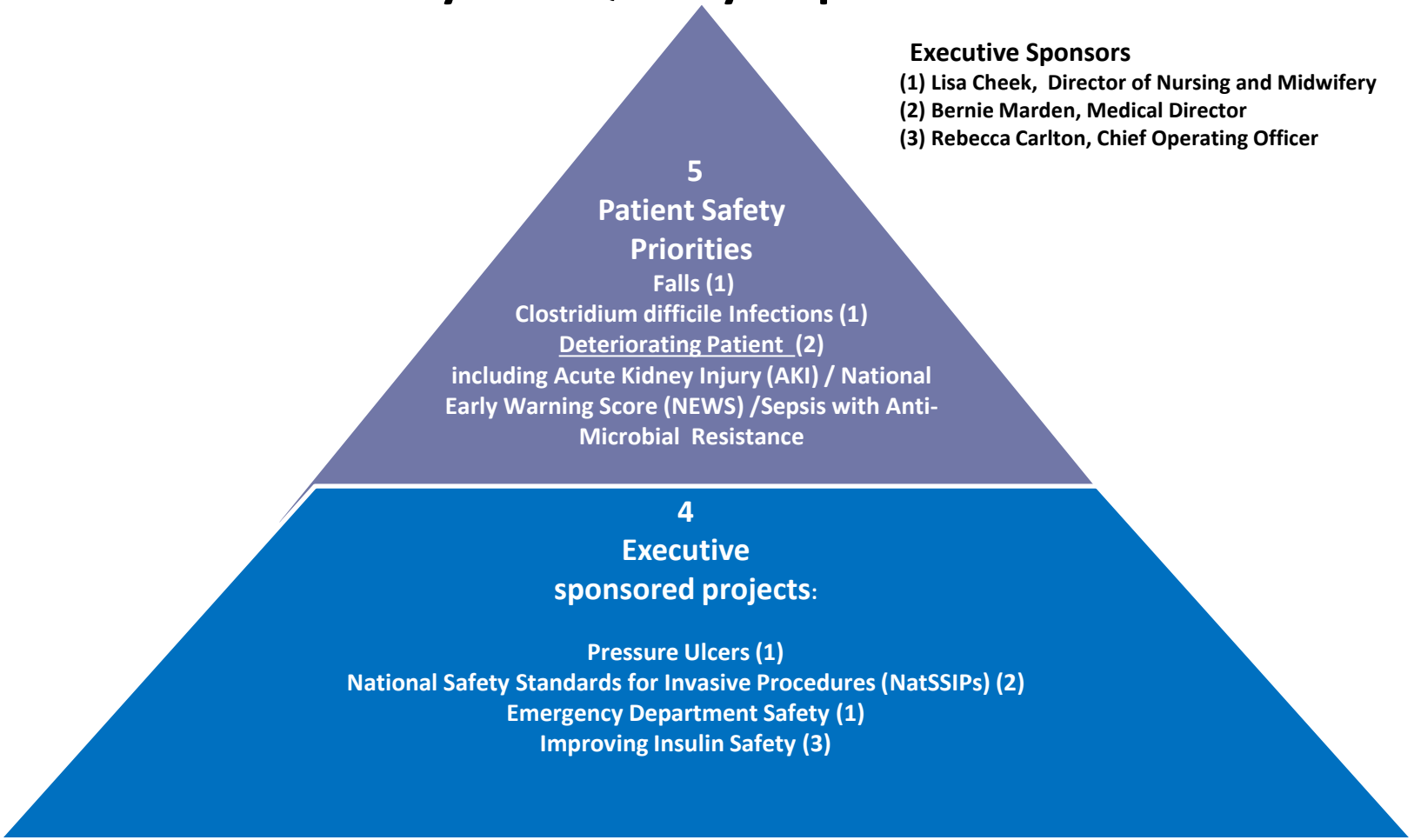
- **Appointments** - **53** – **10** of the contacts related to appointment changes by patients; **9** – were follow ups not given, **9** – concerned the length of time for a new appointment, **8** – related to the length of time for a follow up appointment, **5** – were appointment cancellations, **4** – related to appointment information (date/time/location). The remaining **8** contacts were spread across different subject areas with no trends.
- **Communication & Information** - **51** – **24** of the contacts related to general enquiries/communication; **11** – were telephone issues (phone not answered) out of the 11 contacts 4 were for the Brownsword Therapies Centre. **4** – related to test results not being acted upon. The remaining **12** contacts were spread across different subjects areas with no trends.
- **Clinical Care & Concerns - 39 – 7** of the contacts related to general enquiries/clinical care; **4** – concerned quality of nursing care, **4** were general enquiries/communication, **3** – related to medication error/timing/availability, **3** – concerned staff attitude. The remaining **18** contacts were spread across different subject areas with no trends.

Actions

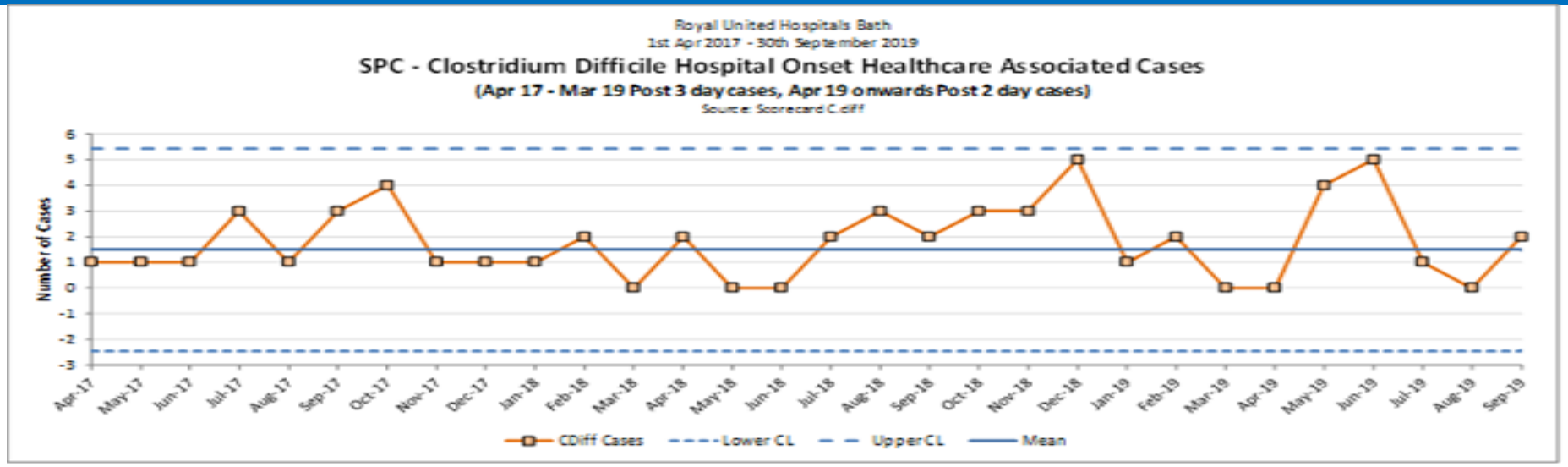
- During the relocation of the RNHRD some telephone lines were not redirected to the Brownsword Therapies Centre. All phone lines reported as not being answered have been checked and have now been properly transferred.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors
(1) Lisa Cheek, Director of Nursing and Midwifery
(2) Bernie Marden, Medical Director
(3) Rebecca Carlton, Chief Operating Officer



Clostridium difficile infections (hospital onset only)

What the information tells us

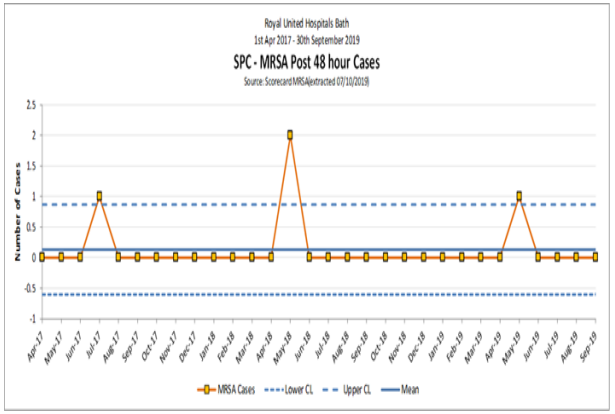
- Reporting criteria changed in April 2019: prior to this hospital onset cases were defined as those where the positive sample was taken 3 or more days after admission. From April 2019 this changed to 2 or more days after admission. There have been 12 cases year to date.
- Community onset healthcare associated cases are also apportioned to the Trust. These cases are defined as those where the sample is taken in the community or less than 2 days after admission. These cases are not shown in the chart above. There have been 10 cases year to date.
- The Trust's *Clostridium difficile* objective is 59 cases for 2019/20. There have been a total of 22 cases year to date. 3 of these cases have been successfully appealed: 2 hospital onset and 1 community onset healthcare associated case.
- Performance remains variable with a spike in the number of cases in June 2019

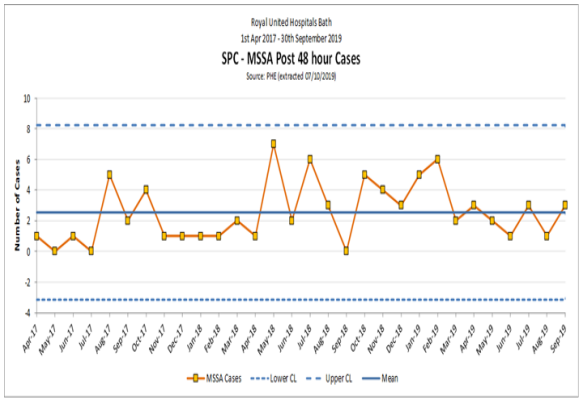
Actions

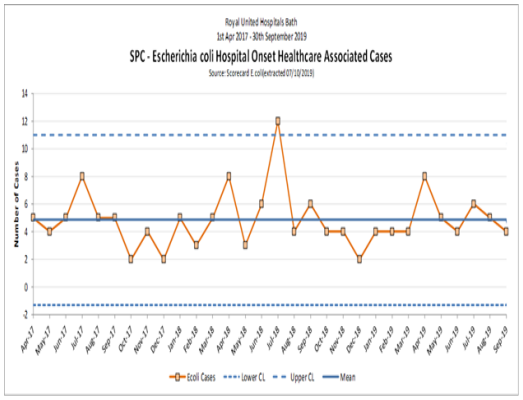
The IPC performance improvement plan was developed following the visit from NHSE/NHSI in July 2019. The improvement plan is based on recommendations made as a result of the visit and also on improvement work that had commenced prior to the visit. Progress on these actions include:

- Established fortnightly senior sisters meetings. Sisters are leading on improvement projects within their own areas and ideas are being shared at the meetings. Small changes have been introduced within the clinical areas that are contributing to improving patient safety and reducing infection.
- Compliance against the Hygiene Code is being monitored at each IPCC meeting to provide assurance that the Trust meets the requirements of each criterion.
- Weekly walkabouts with the Director of Infection Prevention and Control, Infection Prevention & Control Team, Estates and Facilities to clinical areas have continued. Findings are reported after each walkabout and followed up by the relevant leads.
- An infection prevention and control campaign is being planned by the IPCT and the Head of Communications.
- Policies have been amended in line with NHSI recommendations.
- A robust escalation process is now in place for cleaning of the environment and equipment.

MRSA, MSSA and E coli blood stream infections







What the information tells us

- MRSA blood stream infections: there is a target of zero for preventable MRSA infections. There has been one Trust attributed cases year to date; this was an unpreventable infection.
- MSSA blood stream infections: there is no current reduction target. The number of hospital onset MSSA blood stream infections has decreased in comparison with the same time period during 2018 however the number of MSSA infections that are line associated has increased. Actions are in place to address this.
- E coli blood stream infections: there is a 10% year on year reduction target which is shared with the CCGs. There has been a decrease of 20% in the number of hospital onset cases in comparison with the same time period in 2018. The main source of these infections is the urinary tract and there tends to be a spike in the number of cases during the warmer months of the year.

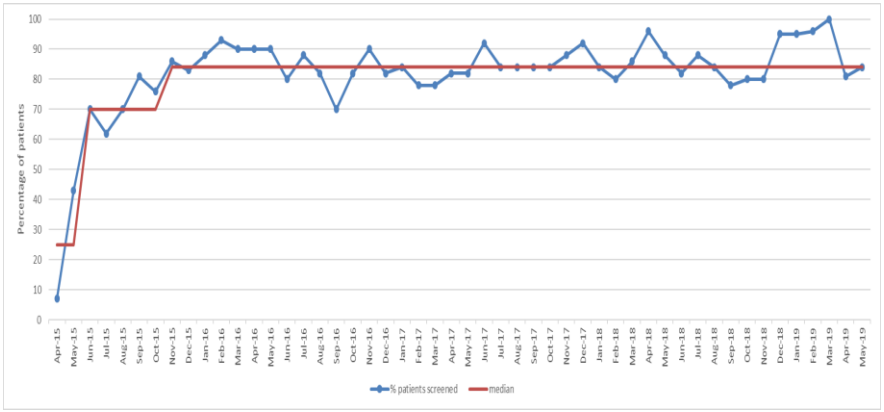
Actions

An overarching plan has been implemented to identify actions to reduce these infections.
A new structure for infection prevention and control meetings will commence by December 2019, ensuring that there are both strategic and operational committees to gain assurance that plans are being taken forward and to monitor outcomes.

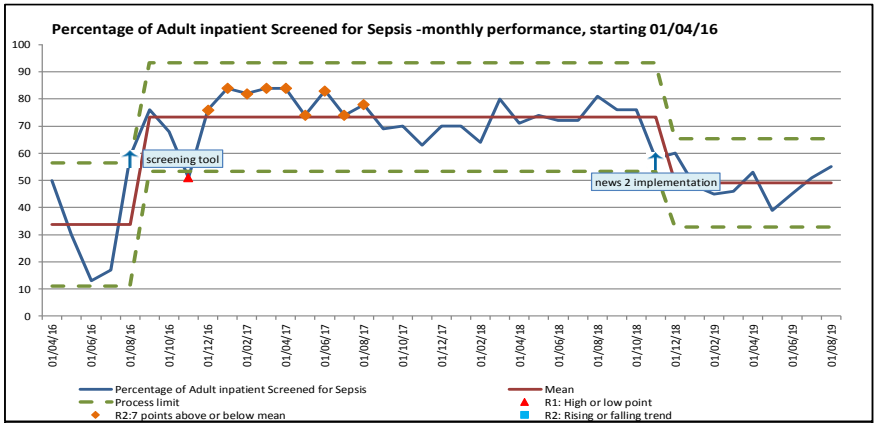
Patient Safety – Deteriorating Patient Bernie Marden

Identification

Percentage adult emergency patients screened for sepsis



Inpatient sepsis screening



What the information tells us

Compliance with sepsis screening for emergency adult patients is only available up to end of May due to changes in the Sepsis project support team. Compliance remains at 84%, despite increasing to >95% Jan – March 2019. More recent data is awaited which will inform us as to whether further improvement has occurred.

Inpatient screening had achieved a compliance of 80% following initial implementation but this has been hard to sustain with the introduction of NEWS 2 and changes in the team. There has resulted in a significant decrease to 50% since November 2018, but recent data is showing a small upward trend. Contributory factors include numbers of bank staff, high acuity of patients. The new SKIP team have also been very focused on emergency admissions and have given considerable support to the front door due to increased demand, resulting in less time available for ward training and support.

Actions

- The SKIP team have focussed on some key wards providing frontline training to improve compliance, although this as been limited by front door activity . Areas supported have shown some improvement. The future focus is to concentrate on those wards due to have electronic observations implemented , to ensure all staff are compliant with sepsis and deteriorating patient training which will support successful implementation of electronic observations which includes automatic screening.
- Electronic observations have been implemented on Helena and Philip Yeomen and screening compliance is 100%. The next step is to confirm alert is completed in a timely fashion from when alert identified. Further learning continues before spreading further.
- The SKIP team will continue to focus on specific wards and provide individual ward feedback
- Ward specific compliance will also be shared with the divisional teams to promote ownership by each team and support from senior leads to promote' NEWS up /What's up' and be curious about change in vital signs and document accordingly , escalating if required.

Identification Paediatrics

Fig 3.0 Paediatric ED sepsis screening:

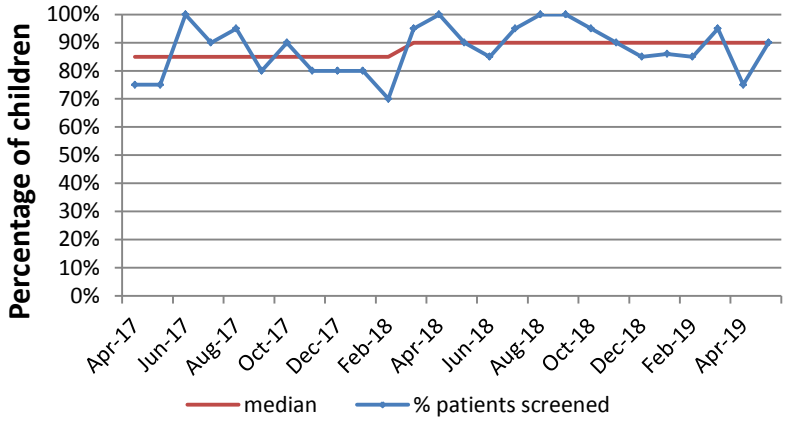
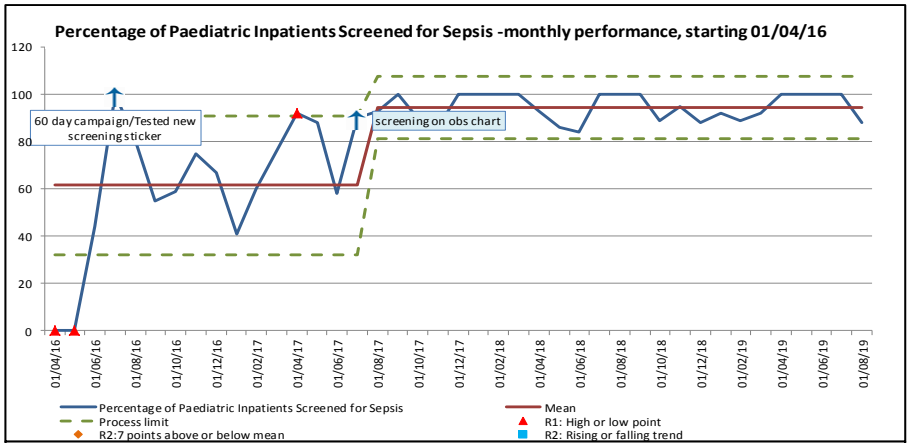


Fig 3.1 Paediatric Inpatient sepsis screening:



What the information tells us

Compliance with paediatric screening for both inpatients and emergency admission remains high being 95 % and 90% respectively

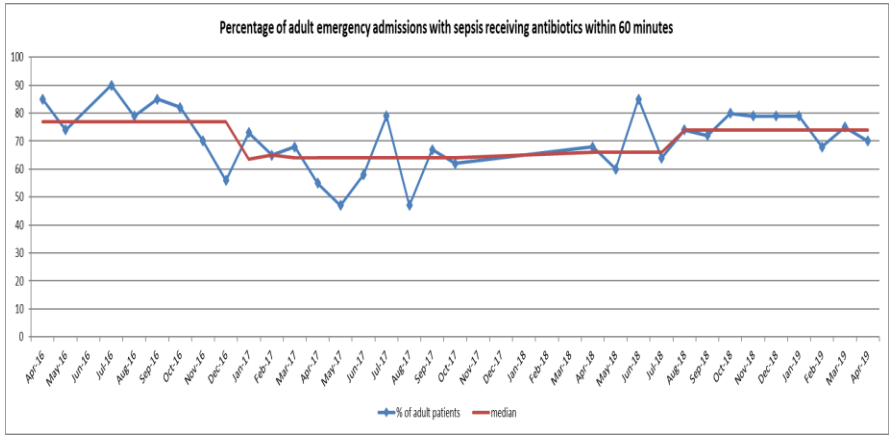
Data for ED paediatric screening is only available up to May – further data required to confirm improvements are sustained .

Actions

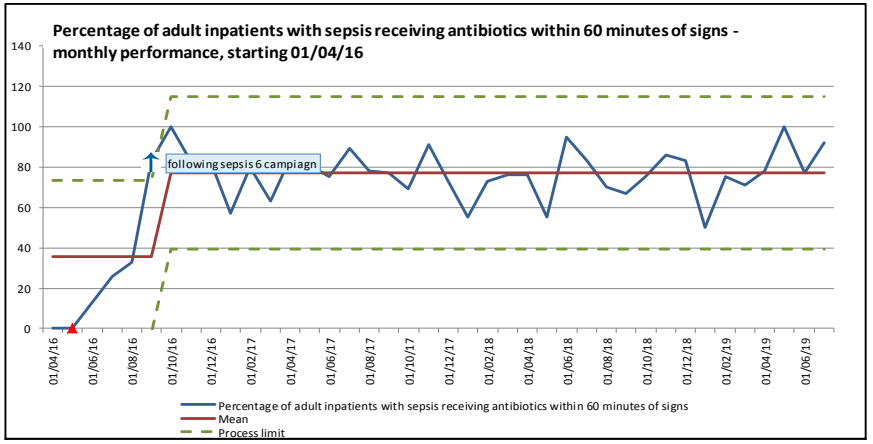
- Development of new PEWS score and chart is ongoing and due to be finalised by end of October, to comply with regional PEWS score.
- This will then be tested and implemented into electronic system for implementation early in 2020.
- The Paediatric team , ED paediatric lead and SKIP team are continuing to collaborate on all paediatric sepsis work and developments to improve coordination between the teams
- Simulation training has been developed by the paediatric team and some nursing paediatric tools by the ED paediatric sepsis team, which have been very successful

Management of Sepsis

Percentage of emergency patients receiving Antibiotics within 60 mins of signs of sepsis



Percentage of adult Inpatients receiving antibiotics within 60 mins of signs of sepsis



What the information tells us

Antibiotics delivered within an hour of diagnosis of sepsis remains high at 93% of all patients.

We specifically also record antibiotic times from the first signs of sepsis aiming to deliver treatment as soon as possible. This is shown above. Compliance with antibiotics within 60 minutes of first signs remains at 78 % for inpatients with sepsis, with 86% receiving antibiotics within 90 minutes. Compliance data is available up to June for inpatients and shows sustained improvement with signs of further improvement.

Compliance with antibiotics for emergency patients is only available up to April 2019 due to changes in the sepsis support team.

This has been sustained at 77% patients receiving antibiotics within 60 minutes since April 2018. More recent data is awaited to see if the impact of the SKIP team at the front door has resulted in improvement .

Compliance with antibiotics within 90 minutes for maternity patients with sepsis remains 100% since December 2017 (graph not shown)

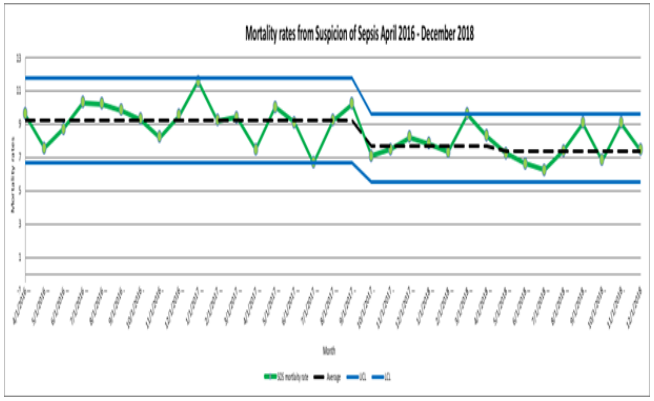
Actions

- Improved identification of deterioration from change in the NEWS score from focused ward training is aimed to increase delivery antibiotics from sign of sepsis. It is also aimed to improve deterioration from all conditions as well as promote early decision making.
- This is the focus of the SKIP team
- The SKIP team is currently only available 6 days a week. Development of a robust nursing service to support identification of deteriorating patients is essential for further improvements . To achieve this, a business case for a second band 6 SKIP nurse is being developed to enable to service to be available 8am – 8pm 7 days a week.
- The SKIP and Outreach team will also develop more coordinated working to coordinate work on early identification of deteriorating patients. A business case has recently been approved for Outreach service to be available 24/ 7.

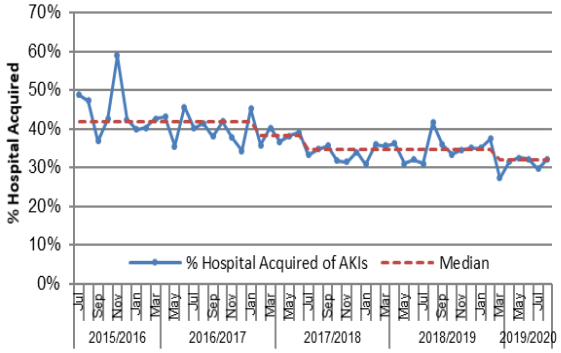
Patient Safety – Deteriorating Patient Bernie Marden

Outcomes:

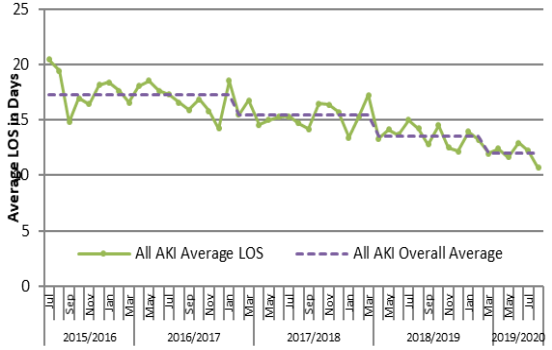
Suspicion of Sepsis diagnoses Mortality Rate.



Incidence inpatient –acquired AKI .



Length of stay all patients with AKI



What the information tells us

The National Suspicion of Sepsis diagnoses dashboard shows a 19% decrease in mortality from SOS at RUH from 8.9% to 7.2 % since April 2018. Data is available up to March 2019 on the national dashboard

Inpatient acquired AKI shows an overall 24% decrease in incidence since February 2017 with a further 9% decrease since March 2019. Length of stay for all patients with an Acute kidney Injury has continued to decrease by a further 1.5 days since March 2019.

Actions

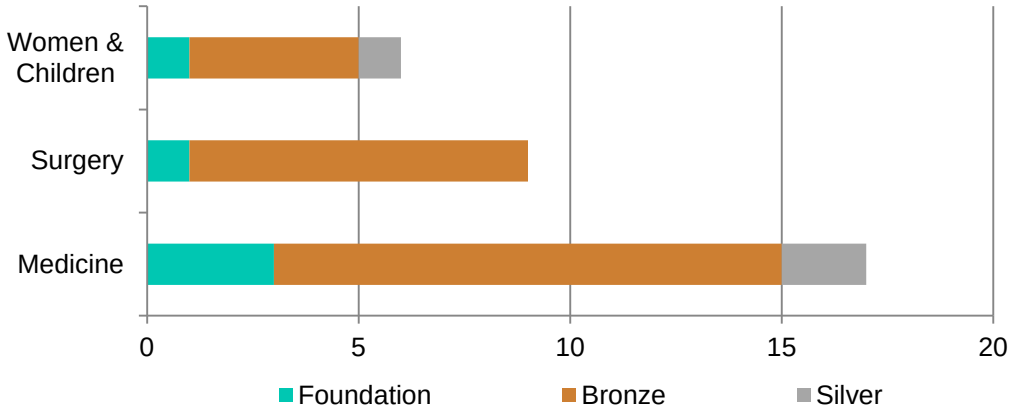
- Continue to spread News Up what's Up campaign and embed as routine practice owned by ward teams. Collaborative method suggested to run alongside spread of electronic observations and to include strengthening of handover processes
- Continue to spread awareness of importance accurate urine output monitoring and AKI bundle
- Spread implementation of electronic observations trust wide by March 2020
- E learning for sepsis already in place. E learning for AKI to be developed by March 2020
- Develop routine case based update training for all staff.

Nursing and Midwifery Ward Accreditation

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Number of wards achieving Accreditation (by level)



Plans for next assessments

Month	Ward	Level
October 2019	Robin Smith	Silver
	ED	Bronze
	ED Obs	Bronze
November 2019	Combe	Silver
December 2019	Cheselden	Silver
	Waterhouse	Silver
January 2019	SAU	Silver
February 2019	Mary	Silver
TBC	Haygarth	Bronze

What the information tells us

- 32 areas are included in the Accreditation Programme – 25 adult wards, Maternity ward (Mary), Bath Birthing Centre, NICU, Admission Suite, Children's ward, Critical Care Services and Emergency Department
- 3 wards have achieved Silver: Acute Stroke Unit, Helena, Charlotte
- Since the last update:
  - NICU and Admission Suite achieved Foundation in October 2019
  - Acute Stroke Unit and Charlotte achieved Silver in September 2019

Actions

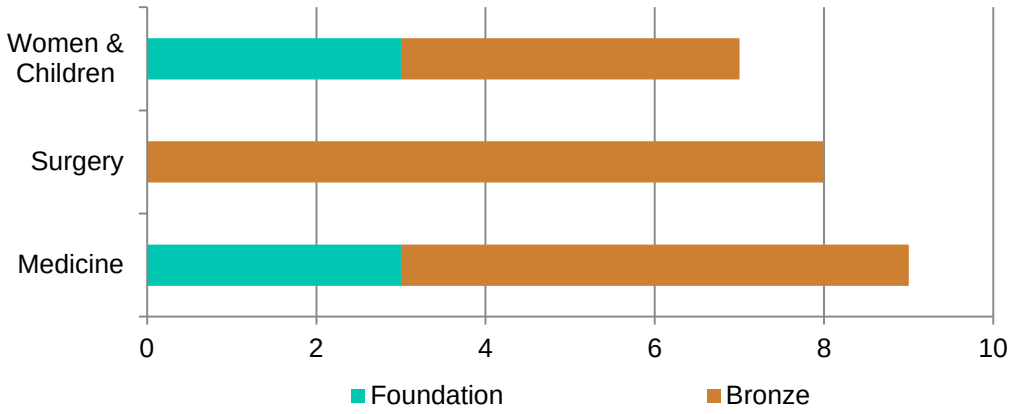
- Areas that have not achieved on the first assessment at Bronze level have a supportive programme and timeframe for reassessment agreed with the Senior Sister
- Areas for assessment at Silver level are agreed with the Divisions and a timeframe agreed with the ward team
- Silver is the highest level currently developed and includes unannounced observations, Dementia and End of Life charter marks and a Portfolio of evidence designed to showcase achievements and evidence of improvements by the team
- Recognition for areas achieving Silver level is being developed - ideas sought from staff include trophy ,silver badge or plaque displaying the level achieved
- The draft for an article for the British Journal of Nursing will be submitted end of October

Nursing and Midwifery Outpatient Accreditation

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Number of outpatient areas achieving Accreditation (by level)



Plans for next assessments

Month	Ward	Level
October 2019	Respiratory	Bronze
	Oncology Day Care	Bronze
	Sexual Health	Bronze
November 2019		
December 2019		
January 2019	Cardiology	Bronze
	Diabetes	Bronze

What the information tells us

- A total of 24 areas including Children's unit are included in the Outpatient Accreditation programme
- All areas have achieved at least Foundation Level
- All outpatient areas in Surgery Division have achieved Bronze Level

Actions

- The inclusion of the 4 birthing centres has been paused awaiting for the outcome of the Maternity transformation programme in order to determine appropriate indicators
- Areas that have not achieved on the first assessment at Bronze level have met with staff from the Quality Improvement centre to discuss the assessment findings and identify any further support needed to achieve the required standard. A timeframe for reassessment has been agreed with the Senior Sister
- Silver indicators for outpatient areas are being developed and will be agreed at the Outpatient Steering Group with the first area to be tested planned for December 2019

Serious Incident (SI) Summary

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Serious Incidents Reported to STEIS in 12 month period												
Sept 18	Oct 18	Nov 18	Dec-18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19
5	5	4	6	4	8	7	4	6	9	4	4	8

O/S Actions	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19
Action Plans	26	24	18	8	9	12	7	6	10	8	3	6
Actions	66	43	38	17	17	25	19	30	24	34	6	24

Date of incident	ID	Serious Incidents for September 2019	Date of incident	ID	Serious Incidents for September 2019
25/07/2019	75546	Category 4 Pressure Ulcer (Hospital Acquired)	19/08/2019	76329	Slip/Trip/Fall
15/08/2019	76210	Documentation (failure to follow up)	30/08/2019	76656	Medical Device / Equipment
15/08/2019	76216	Hospital Acquired Unstageable Pressure Ulcer	04/09/2019	76795	Infection Control issues (MSSA)
19/08/2019	76303	Slip/Trip/Fall	15/09/2019	77176	Slip/Trip/Fall

What the information tells us

- 8 SIs were reported to StEIS in September 2019
- As of 11th October 2019 there are 27 SIs that remain open and under investigation. 8 of these are overdue according to the agreed deadline date for disseminating the final RCA report to the Clinical Commissioning Group
- There are 6 open SIs with overdue actions. This amounts to 24 SI actions that are overdue for closure

Actions

- The SI Task and Finish Group has developed a new process for reviewing whether incidents that resulted in moderate harm or above meet the criteria of a Serious Incident. This includes a revision to the templates used for the 72 hour report and Root Cause Analysis (RCA) investigations. These changes will enable investigations to commence in a more timely manner which will reduce the number of overdue investigations. The RCA template also includes an overall action plan owner, responsible for confirming and evidencing the actions taken. The new process is being submitted to the Operational Clinical Governance Committee for approval in October 2019
- The SI Task and Finish Group is reviewing the process for sign off of completed RCAs. It is proposed that a separate panel will be established to review completed RCAs
- The Risk Applications Manager sends out weekly updates to the Heads of Nursing and Patient Safety Leads for each Clinical Division with details of overdue open actions and requests updates for these. KPIs have been developed for the SI process which will be monitored through the quarterly incident report

Nursing Quality Indicators Exception Report Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

As provided by individual Ward	Date Last flagged	FFT Response rate	Negative PALS contact	*C diff*	Falls	Compl-aint	PU	Sickness		Appraisal		Day Fill rate		Night Fill Rate	
								HCA %	RN %	HCA %	RN %	HCA %	RN %	HCA %	RN %
William Budd	August 2019	28%		1	7		1	7.9	7.3			75.2	83.5		82.5
ITU	August 2019								7.1	66.7	76.8		73	13.3	74.5
Haygarth	July 2019		1		5				17.2		66.7	78.3	83.4		
Parry	July 2019	12			6	1		7.2		73.3		82.1	84.6		77.8
Pulteney	October 2018	26			9	1		7.0		31.3	65.2	78.5			
Cardiac Ward	August 2019		2				1	7.8	10	68.8	75	84.8	71.2		74.4

What the information tells us

- 6 wards have flagged with 6 or more quality indicators. William Budd and Cardiac ward have flagged for the second consecutive month and critical care have flagged for the third consecutive month. For all wards:
  - There were 15 negative contacts to PALS for nursing related issues and 6 complimentary contacts.
  - There were 4 formal complaints.
  - There were 4 pressure ulcers this month.
  - There were 95 falls this month, 2 with moderate harm.
  - There were 3 cases of *Clostridium difficile* this month, 1 in Respiratory, 1 in William Budd and 1 community onset healthcare associated case

Actions

- Heads of Nursing, Matrons and Senior Sisters are aware of the wards that have flagged.
- The formal complaints will be investigated in line with Trust policy. The negative PALS contacts have been addressed by a senior member of the nursing teams to ensure resolution and action lessons learned.
- All no harm or minor harm falls have been investigated via Datix.
- There have been 2 falls with moderate harm on wards that have not flagged. These are being investigated and lesson learnt will be circulated.
- All sickness managed in line with the Trust Supporting Attendance Policy with support from the matrons, HR and occupational health.
- The wards with lower appraisal rates have discussed and agreed plans with their matrons on how they will increase appraisal rates.
- 1 clostridium difficile case on Respiratory Ward has been attributed to lapses in care following investigation. The ward have an action plan that they are working to following the investigation. The remaining 2 cases have not yet been investigated.
- Recruitment remains ongoing. 86 overseas have joined the Trust, 57 of which have gained registration with the NMC. Business case approved for further ongoing overseas recruitment

Nursing Quality Indicators - Monthly Template October 2019 [Sept data]

APPENDIX A

Ward Name	Report for June 2019 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																								Flagged Areas:					
	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 overall						
																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		Sept 19 No:	Aug 19 No:	Jul 19 No:	Jun19 No:	May 19 No:	Apr19 No:
Cheselden	Bronze	95%	79%						1	0	0	0				0.0	0.0	100.0	100.0		64.2%	104.5%	98.3%	105.0%	5.6	1	1	2	2	2	2
Charlotte	Silver	98%	50%				1		0	0	0	0				0.0	11.9	87.5	90.0		97.7%	86.7%	99.4%	95.0%	6.8	2	2	2	2	1	1
Surgical Short Stay Unit	Bronze	99%	52%						1	0	0	0				0.6	1.3	95.7	92.3	1	81.1%	65.2%	73.7%	170.0%	5.7	2	2	2	4	3	3
Pierce	Bronze	95%	40%						2	0	0	0		1		3.5	6.3	80.0	68.4	3	87.4%	86.6%	99.3%	198.5%	8.0	3	2	1	3	4	8
CCU	Bronze	100%	48%						1	0	0	0				0.0	20.2	93.8	100.0		86.4%	66.1%	100.1%	103.3%	11.3	3	3	3	2	3	1
Helena	Silver	100%	52%						1	0	0	0				0.4	10.1	66.7	60.0	1	104.2%	102.2%	98.7%	140.0%	9.1	3	3	3	5	3	3
Midford	Bronze	98%	96%						11	1	0	0				4.4	0.2	90.9	93.3	8	66.2%	88.2%	74.0%	185.0%	5.7	3	5	5	5	4	7
ACE OPU	Bronze	98%	85%						5	1	0	0				4.9	4.4	94.1	93.8		70.7%	83.9%	73.3%	122.4%	7.3	4	2	3	5	2	5
Children's Ward	Bronze	99%	24%				1		0	0	0	0				3.6	0.0	94.3	100.0	2	78.8%	103.1%	75.8%	163.5%	10.0	4	2	5	6	4	5
Combe	Bronze	100%	38%				1		2	5	1	0				12.0	3.9	78.6	87.5	5	70.6%	98.1%	85.1%	165.5%	6.6	4	5	3	3	4	7
A&E	Foundation	95%	19%	1		2	4									5.1	5.0	66.7	64.0							4	5	7	4	4	4
Waterhouse	Bronze	100%	2%						7	0	0	0		1		4.1	8.5	93.8	80.0		93.9%	71.8%	104.9%	103.3%	6.8	5	1	3	2	3	3
Forrester Brown	Bronze	100%	39%				1		1	0	0	0				6.1	5.4	100.0	100.0	4	87.2%	84.8%	84.9%	114.0%	6.7	5	2	3	3	2	1
Robin Smith	Bronze	98%	40%						5	0	0	0				0.2	1.1	81.3	68.8	1	80.1%	77.5%	79.0%	133.3%	6.0	5	2	3	3	2	2
Violet Prince (RNHRD)	Bronze	89%	45%													0.0	0.0	100.0	60.0		56.5%	37.8%	43.3%	41.7%	2.8	5	3	1	1	1	1
Respiratory	Bronze	99%	56%					1	0	2	1	0				11.2	8.8	87.0	94.1	1	64.0%	91.8%	82.2%	107.3%	5.6	5	3	6	7	4	6
SAU	Bronze	97%	8%						0	3	0	0				4.5	3.7	76.5	75.0	3	81.6%	75.0%	88.6%	114.9%	11.6	5	3	7	5	2	3
Phillip Yeoman	Bronze	100%	73%			1	1		1	0	0	0				0.6	8.8	75.0	90.0		100.1%	52.2%	81.5%	67.1%	8.9	5	4	4	1	1	5
Medical Short Stay Unit	Bronze	100%	22%			1			2	0	0	0				8.9	13.1	84.6	100.0	2	63.6%	65.4%	98.1%	125.0%	5.1	5	4	4	2	4	3
Mary Ward PAW	Bronze	100%	22%						0	0	0	0				5.3	17.2	69.8	94.7		106.0%	77.6%	91.0%	85.3%	15.4	5	4	5	4	3	3
Acute Stroke Unit	Silver	100%	53%	1			2		3	1	0	0				1.4	10.6	91.7	85.7		58.5%	72.3%	95.7%	102.2%	7.4	5	5	3	3	5	4
MAU	Bronze	100%	12%				1		6	1	0	0	1			4.0	8.2	58.3	70.0	1	75.7%	142.4%	96.4%	125.1%	10.5	5	5	5	7	6	6
NICU	N/A	100%	40%													1.7	0.2	81.8	75.0		77.6%	55.9%	73.6%	38.3%	7.6	5	6	5	5	5	6
Haygarth	Foundation	93%	54%				1		4	1	0	0				0.8	17.2	66.7	100.0	4	83.4%	78.3%	88.0%	163.5%	6.5	6	5	6	8	3	5
Intensive Care Unit	Bronze					1			0	1	0	0	1			7.1	2.7	76.8	66.7		73.0%	102.5%	74.5%	13.3%	24.6	6	6	6	5	3	4
Pulteney	Bronze	95%	26%	1					9	2	0	0				2.4	7.0	65.2	31.3	1	85.9%	78.5%	87.0%	117.8%	6.4	7	3	3	3	5	5
Cardiac	Bronze	93%	51%				2		0	0	0	0				10.0	7.8	75.0	68.8	1	71.2%	84.8%	74.4%	170.0%	4.9	7	6	5	4	4	5
Parry	Bronze	93%	12%	1		1			5	1	0	0				2.2	7.2	100.0	73.3		84.6%	82.1%	77.8%	101.0%	5.7	8	5	8	5	7	5
William Budd	Bronze	100%	28%					1	6	1	0	0				7.3	7.9	92.9	100.0	8	83.5%	75.2%	82.5%	141.7%		8	6	5	4	6	3
		80% or less	< 30% (< 15% ED, MAU & SAU)	Nursing / Midwifery related	non PALS from Datix	Neg N/M related only		C. Diff (per patient)	5 plus total Falls or a major harm				> cat2 PUs			above 5%		Below 80%			Below 85%						above 5					

C.Diff 4x Trust apportioned (community onset healthcare associated) not assigned to a single ward as multiple factors involved

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