Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**29 January 2020**		

Title of Report:	**Quality Report**
Status:	**For discussion**
Board Sponsor:	**Lisa Cheek, Director of Nursing and Midwifery, Bernie Marden, Medical Director**
Author:	**Sarah Merritt, 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 2019/2020 data.
The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2019/2020 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 Patient
    - Clostridium Difficile
    - Healthcare Associated Infections
- Exception reports:
    - Serious Incidents (SI) monthly summary and Overdue SI summary
    - Nursing Quality Indicators Exception report
    - Patient Experience

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	

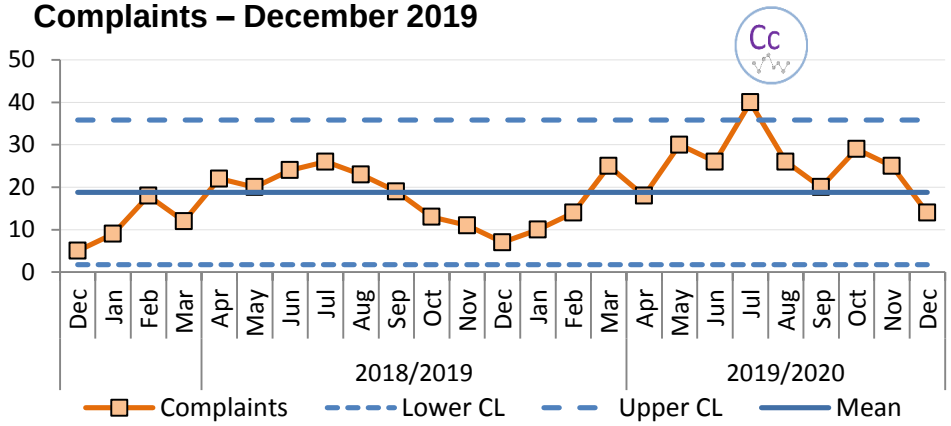
PART A – Patient Experience

Patient Experience – Complaints

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Complaints – December 2019



Complaint response rate by Division	Division			Total
	Surgery	W&C	Medicine	
Closed within 35 day target	7 (87%)	1 (33%)	4 (36)	12 (55%)
Breached 35 Day target	1 (13%)	2 (67%)	7 (64%)	10 (45%)
Total	8	3	11	22

What the information tells us

- **14 complaints were received in December**. **Medicine Division received 4 complaints** (Cardiology, Acute Medicine, OPU and ED). The complaints related to clinical concerns, communication, discharge concerns and patient property. **Surgical Division received 6 complaints** (3 for General Surgery, Bath Centre for Pain (1), Day Surgery (1) and Urology (1). The complaints related to clinical care, cancelled admission and staff attitude. **Women and Children's Division received 4 complaints,** all the complaints were for Oncology. 2 related to staff attitude/communication and 2 to the coordination of medical treatment.
- There was a further **decline in the timeliness of complaint responses in December** (55% of complaints were responded to within 35 working days compared to 60% in November). **Medicine Division**: one complaint had a delay in response from the speciality; 3 had requests for further information/clarity from the Directors Office; 1 complaint is awaiting a meeting and 2 complaints were waiting on the complaint response letter following a local resolution meeting. **Surgical Division**: complaint delayed due to delays in receiving a response. **Women and Children:** complaint delayed due to a key member of staff relating to investigation being off work and the other due to administrative delays.

Actions

Guidelines for staff in '**walking towards concerns**' and '**investigating and writing a complaint response'** are being launched on the intranet on 13th January 2020. The guidelines include facilitating an effective complaint meeting, investigating a complaint and writing a response letter.

There were 8 complaints in the last 3 months in General Surgery, 5 related to clinical care and concerns – waiting for surgery and aftercare/discharge. The Complaints Manager and Lead for Patient and Carer Experience are meeting with the Governance Lead for General Surgery on 15th January to discuss overall patient experience and themes and learning from complaints.

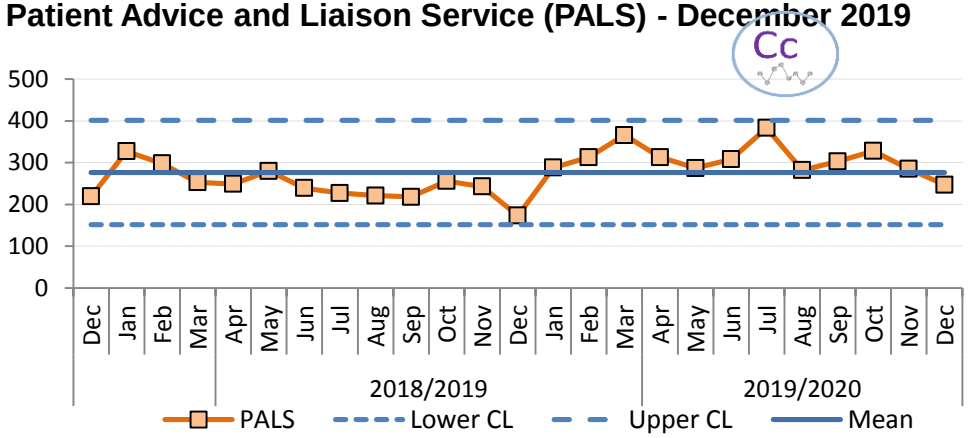
The Oncology complaints are currently under investigation. There has been an increase in recent months and the themes are varied – delays in treatment, follow-up and communication. We are awaiting the outcome of the investigations to understand what actions need to be taken to improve patient experience.

Patient Experience – PALS

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Patient Advice and Liaison Service (PALS) - December 2019



There were 247 **contacts with PALS** in December 2019. This is a **decrease** of (13%) from November 2019 however an **increase** of (43%) compared to the number of contacts in December 2018. Of the contacts:

- 139 required resolution (56%)
- 56 requested advice or information (23%)
- 30 provided feedback (12%)
- 22 were compliments (9%)

What the information tells us

The top three subjects requiring resolution were:

- **Appointments - 28 - 13** of the contacts related to appointment changes by patients, **5** concerned the length of time for a follow up appointment, 2 of these contacts related to the Endoscopy department. **4** related to the length of time for a new appointment, **3** concerned appointment cancellations. The remaining **3** contacts were spread across different subjects with no trends.

- **Premises/Environment/Parking - 24 - 17** of the contacts related Parking fees/Penalty Charge Notices, **5** were general enquiries/parking. The remaining **2** contacts were spread across different subjects with no trends.

- **Communication & Information - 22 - 8** of the contacts related to general enquires/communication, **5** concerned telephones not answered these contacts were spread across different wards/departments, **5** were telephones not working, these contacts related to the Appointment Centre. The remaining 4 subjects were spread across different subjects with no trends.

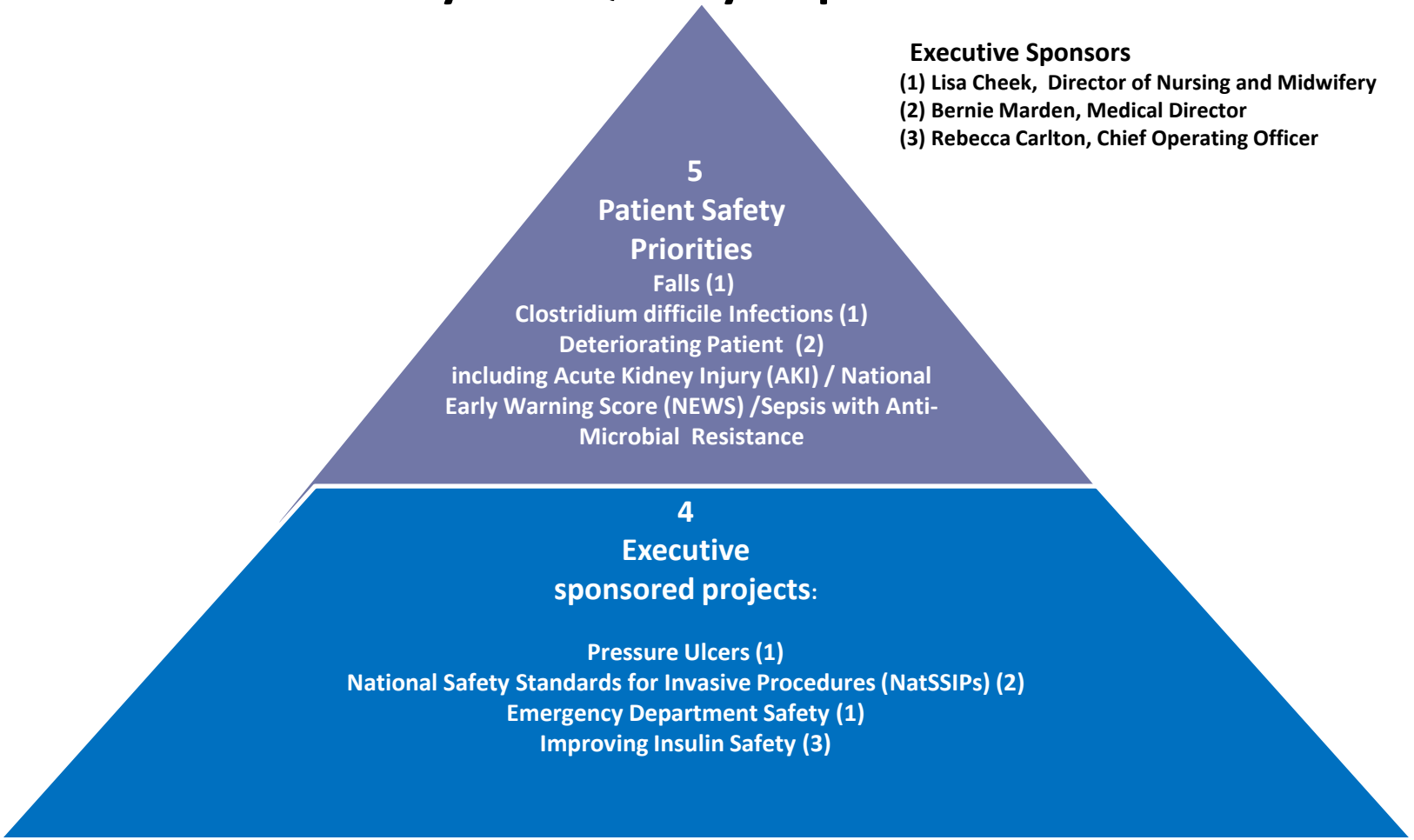
Actions

- The Appointment Centre phone lines went down on 30th and 31st December 2019. Issues were escalated. Patients have been informed of the technical issues and advised to use the contact form on the Trust website. An e-mail address has been created for Referral Management Services to use. The IT department are currently working on the technical issues with the appointment centre staff.

- Ongoing high demand on Endoscopy Service, patients continue to be made aware of waiting times and advice given regarding symptom changes.

QUALITY REPORT

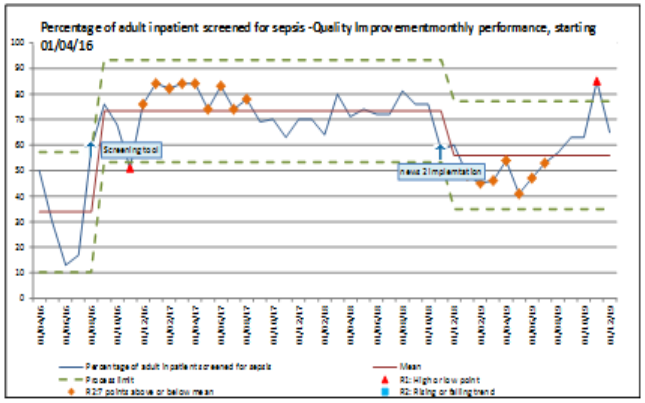
PART B – Patient Safety and Quality Improvement



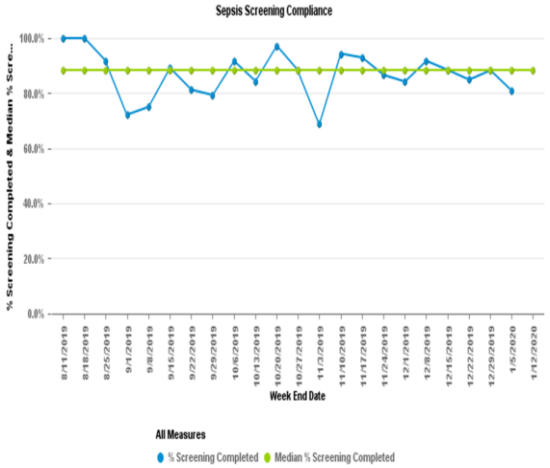
Executive Sponsors
(1) Lisa Cheek, Director of Nursing and Midwifery
(2) Bernie Marden, Medical Director
(3) Rebecca Carlton, Chief Operating Officer

Identification of deterioration : Inpatients

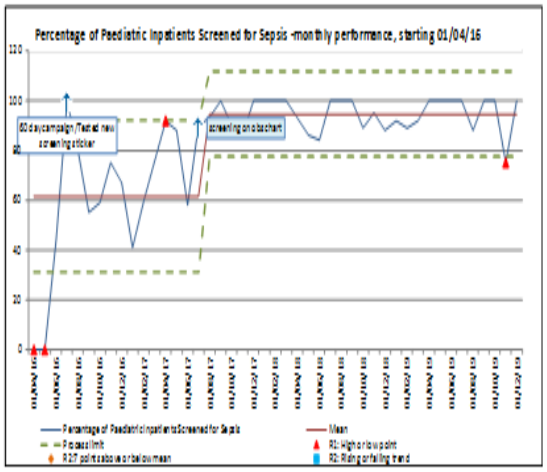
Adult Inpatient sepsis screening (monthly manual audits)



Weekly Sepsis screening from electronic observations wards



Inpatient Paediatric screening



What the information tells us

Inpatient adult sepsis screening from manual audits has shown an improvement since September following focused work by the SKIP team (graph on left).

Regular data is now available for sepsis screening on the 4 wards with electronic observations (Helena, William Budd, Phillip Yeomen and Robin Smith.(middle graph). Screening compliance is 89%.

Inpatient paediatric screening remains 90%

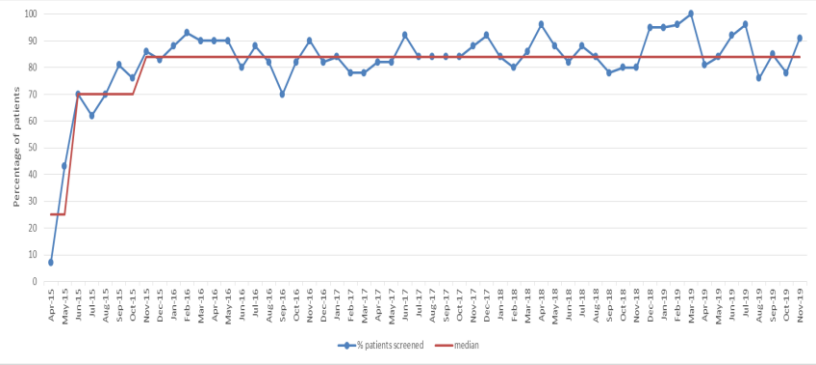
Actions

- The SKIP team are feeding back compliance weekly to E.obs. wards: theme for lack of screening being agency or bank staff.
- Combe ward is due to commence E.obs. on 8th January , with Cheseldon and Charlotte the following week, resulting in 1/3 all wards being converted to the electronic system. Manual audits have therefore been stopped from January enabling the SKIP team to focus on wards implementing E.obs. and provide ongoing frontline support to all teams to identify early deterioration and help timely sepsis management
- SKIP team are training the next wards for roll out of E.obs. to ensure all staff are familiar with sepsis and deteriorating patient pathways
- The new PEWS score and chart has been developed in line with the regional PEWS score and is being implemented in January
- The Paediatric , ED paediatric lead and SKIP team are continuing to collaborate and improve coordination between the teams

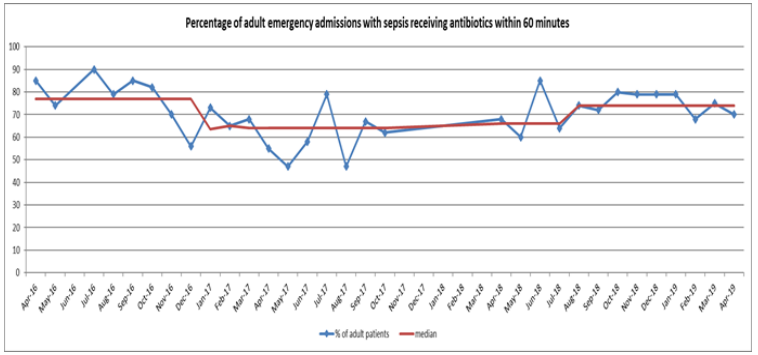
Patient Safety – Deteriorating Patient. Bernie Marden

Identification of deterioration : Emergency admissions: screening and management of sepsis

% emergency patients screened for sepsis on admission



% emergency patients' with sepsis receiving antibiotics in an hour



What the information tells us

- ED sepsis screening remains a median of 85% with several months being >90% but this is not yet consistent Left hand graph)

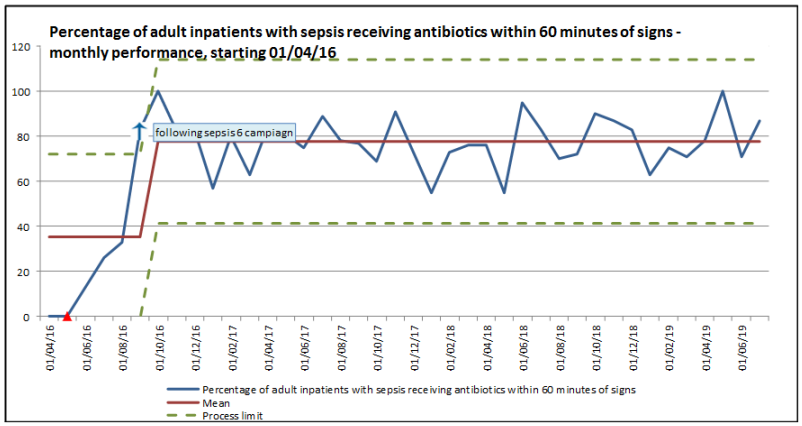
- Compliance with antibiotics for emergency patients is only available up to April 2019 due to changes in the sepsis support team. (right hand graph). This was sustained at 77% patients receiving antibiotics within 60 minutes since April 2018. The SKIP team has supported management of multiple patients in ED over the last 6 months and it is expected that this performance will have improved. Discussions with ED regarding identification of patients with sepsis to obtain antibiotic compliance data is ongoing

Actions

- Further discussions with ED to determine methods for reliable data collection whilst awaiting E.obs. implementation are ongoing

Management of Inpatients with Sepsis

antibiotics within 60 mins of signs of sepsis for inpatients



What the information tells us

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

Antibiotic times from the first **signs** of sepsis are also recorded aiming to deliver treatment as soon as possible and the graphs above show compliance with this is 78 % for inpatients, (right hand graph).

86% patients receive antibiotics within 90 minutes. Compliance data is available up to July 2019 for inpatients and shows sustained improvement. More recent data is still being validated and should be available up to December 2020 in near future, but is awaiting note retrieval.

Actions

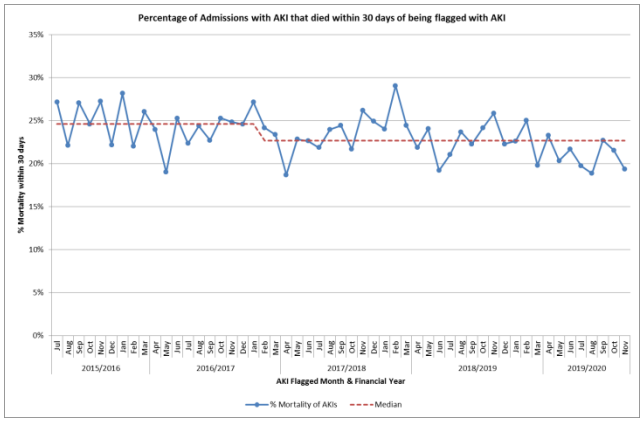
- The SKIP team is currently available 6 days a week. Development of the service is essential for further improvements and a business case for a second band 6 SKIP nurse is being submitted to enable availability 7 days/week week.
- The SKIP and Outreach team will develop coordinated working to improve pathways for early identification of deteriorating patients. A deteriorating patient working group is being re-established to further develop robust processes with the implementation of E.obs.
- Outreach service has been expanded and new team members appointed to enable 24/7 service from April 2020.
- A new sepsis 6 power plan has been implemented as part of the E.obs. implementation to enable easier prescription antibiotics with sepsis
- Plans for development of the SKIP team to prescribe IV fluid bolus and first dose antibiotics for sepsis are being progressed in 2020
- .Implementation of the sepsis 6 power plan may enable identification of these patients and this is being investigated with BIU.

Patient Safety – Deteriorating Patient. Bernie Marden

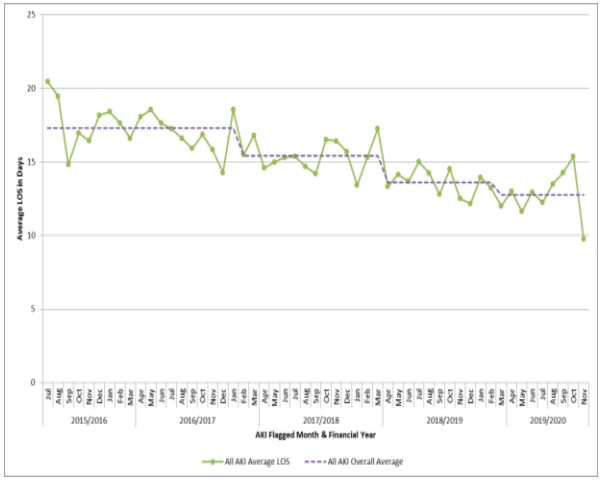
Royal United Hospitals Bath NHS Foundation Trust

Outcomes

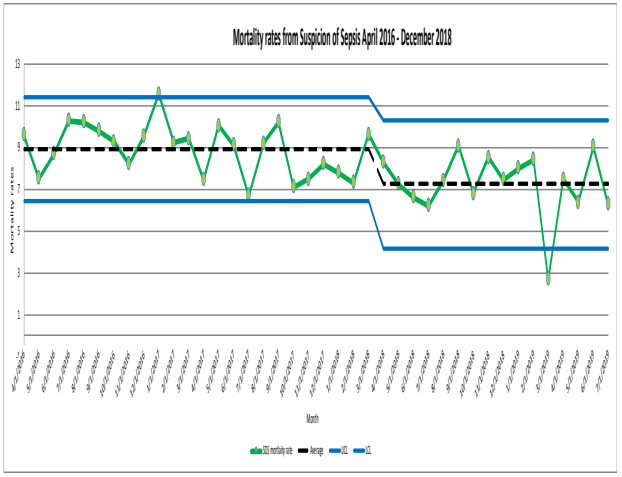
1. Mortality rate patients with AKI admissions



2.Length of stay all patients with AKI



3.Suspicion of Sepsis (SOS) Mortality



What the information tells us

Graph one shows a decrease in mortality for patients with AKI from March 2019 to November 2019.

Graph 2 shows Length of stay for all patients with an Acute kidney Injury remains stable and the improvement is sustained

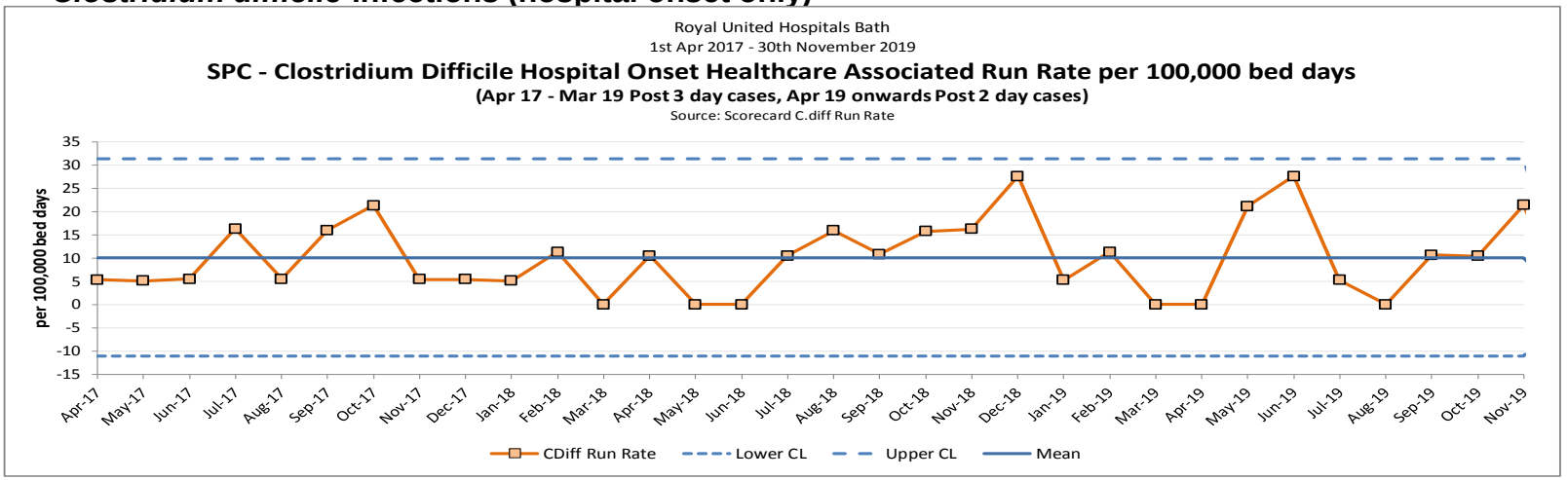
Graph 3: Data from the National SOS diagnoses dashboard shows a sustained decrease in mortality from SOS at RUH since march 2018 to July 2019 from 8.9% to 7.2%. National data is available up to July 2019

Actions

- Continue to spread News Up what's Up campaign and embed as routine practice owned by ward teams.
- Continue to spread awareness of importance accurate urine output monitoring and AKI bundle
- Spread implementation of electronic observations trust wide by July 2020
- E learning for sepsis and NEWs established. E learning for AKI in development. To be completed by March 2020
- Junior doctor project reviewing management AKI and developing further improvement to processes
- Electronic recording of urine output being investigated as part of roll out of E Obs.
- SKIP team routinely reviewing patients with AKI grade 3 for learning and ensuring patient information leaflets received.

Patient safety: *Clostridium difficile* infections (CDI). Lisa Cheek

Clostridium difficile infections (hospital onset only)



What the information tells us

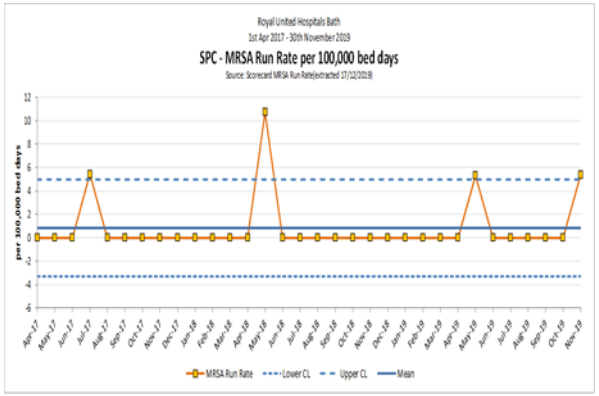
- Reporting criteria changed in April 2019: prior to this hospital onset cases were defined as those where the positive sample was taken 3 or more days after admission. From April 2019 this changed to 2 or more days after admission. There have been 19 cases year to date.
- Community onset healthcare 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 14 cases year to date.
- The Trust's *Clostridium difficile* objective is 59 cases for 2019/20. There have been a total of 33 cases year to date. 5 of these cases have been successfully appealed: 3 hospital onset and 2 community onset healthcare associated case.
- There were 7 Trust attributed cases in November 2019: 4 hospital onset and 3 community onset healthcare associated cases.

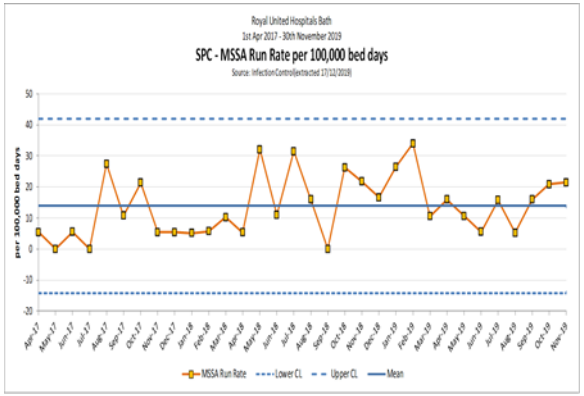
Actions

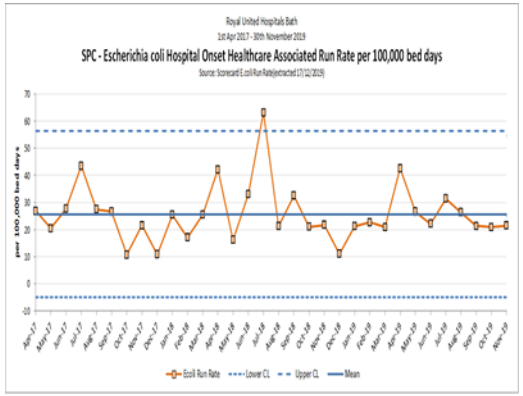
The IPC performance improvement plan was developed following the visit from NHSE/NHSI in July 2019. The improvement plan is based on recommendations made as a result of the visit and also on improvement work that had commenced prior to the visit. Progress on these actions include:

- Continued engagement at fortnightly senior sisters meetings. Successful improvement strategies are being shared and the sisters are reporting on progress within their individual areas at each meeting.
- A new Operational Infection Prevention and Control Working Group has been implemented. The group meet monthly and report into the Strategic Infection Prevention and Control Committee. All *C difficile* RCAs are reviewed at this meeting and improvement actions agreed.
- A number of cleaning trials have been undertaken with varying results. The most successful trial was the introduction of 7 day cleaning with a full complement of staff every day of the week. Increased staffing along with supervisory support has improved the level of cleanliness in the two trial areas. New equipment has also been introduced which has reduced the amount of dust in clinical areas. An review of cleaning staffing will be required to meet the new cleaning standards that will be launched nationally in early 2020.
- An infection prevention and control awareness campaign is planned for early 2020. The IPC and Communications teams will be leading on this.

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. At the end of November 2019 there had been 2 Trust attributed cases year to date; both were unpreventable infections in patients who are intravenous drug users.
- MSSA blood stream infections: there is no reduction target currently. There was an increase in the number of infections in November 2019 and 6 were potentially line associated.
- E coli blood stream infections: there is a 10% year on year reduction target which is shared with the CCGs. The number of infections reported in November 2019 have decreased by 6 cases in comparison with the same time period in 2018. Urinary tract infections remain the main source of these blood stream infections. In November 2019 the were 4 E coli blood stream infections that were urinary catheter associated however none of the affected patients had been in hospital in the 28 days preceding infection onset.

Actions

- An overarching plan has been implemented to identify actions to reduce these infections.
- There are a number of key actions to reduce these infections underway:
- The IPC Team are working with the local Drug and Alcohol Services to provide education and patient information for IV drug users to help them to look after their skin,
- Senior sisters are undertaking spot audits of cannula documentation with a focus on improving documentation and education of their staff
- Further training on use of cannula dressings has been provided and this is being disseminated to their teams
- The screening of all IV drug users for MRSA on admission
- A Trust wide hydration audit has been completed and areas for improvement identified.

All actions are being followed up at the fortnightly senior sisters meetings.

Serious Incident (SI) Summary

Lisa Cheek

Royal United Hospitals Bath NHS Foundation Trust

Serious Incidents Reported to StEIS/registered with CCG in 12 month period												
Dec 18	Jan 19	Feb19	Mar 19	Apr19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19
6	4	8	7	4	6	9	4	4	8	9	13	6

O/S Actions	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep t 19	Oct 19	Nov 19	Dec 19
Action Plans	8	9	12	7	6	10	8	3	6	10	15	17
Actions	17	17	25	19	30	24	34	6	24	29	32	29

Date of incident	ID	Serious Incidents for November 2019	Date of incident	ID	Serious Incidents for November 2019
02/12/2019	79684	Unexpected admission to NICU	07/12/2019	79872	Treatment/procedure – Delayed thrombolysis
04/12/2019	79732	Slip/Trip/Fall– Head injury	08/12/2019	79889	Cardiac Arrest
04/12/2019	79821	Pressure Ulcer – Unstageable	07/12/2019	79887	Slip/Trip/Fall - Fracture

What the information tells us

- **6** SIs reported to StEIS/registered with the CCG in December 2019
- **33** SIs remain open and under investigation as of 30/12/2019
- **3** of these are being investigated by Healthcare Safety Investigation Branch
- **7** of the SI's open are overdue according to the agreed deadline date
- **17** open SIs with overdue actions

Actions

- The Quality Assurance & Risk Business Analyst has developed a Key Performance Indicator dashboard which allows an overview of the Specialties and Divisions performance data relating to incidents management specific to their areas.
- The revised Serious Incident process, which commenced in November 2019, is intended to facilitate a prompt review of incidents assessed as significant harm and determine the level of investigation required thus enabling investigations to commence in a timely manner. All the incidents reported to StEIS in December had occurred in December. This indicates that the new 72 hour report process is significantly reducing the time taken to make a decision on whether an incident meets the Serious Incident criteria.
- The overdue actions for December were 29 out of a total of 17 SI's. The overdue action data continues to be sent to the Divisional Heads of Nursing to enable dissemination of concerns through the Division.
- Of the overdue SI's three have since been submitted. Three have extension dates agreed with the CCG. One was a falls part C investigation that was delayed over the holiday period. The Risk team has liaised with the author to offer support with completing the report. A representative from the falls steering group will be attending the Operational Clinical Governance Committee in February 2020 to discuss the impact of the current process for investigating serious falls and identify areas for further review.

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	Complaints	PU	Sickness		Appraisal		Day Fill rate		Night Fill Rate	
								HCA %	RN %	HCA %	RN %	HCA %	RN %	HCA %	RN %
Haygarth	Dec 19	29%	1		6			11.2	13.5		54.5		66.3		
NICU	Aug 19	34%						5.9	5.7	75		54.1	81.8	43.1	80.5
MSSU	Feb 19	22%						11.5	9.8	71.4	66.7	65.1			
Pulteney	Dec 19	34	1					8.5	11.6	20	50		82.9		
Parry	Nov 19	11	1					6.2	7.6				82.1		83.7

What the information tells us

- 5 wards have flagged with 6 or more quality indicators. Pulteney Ward and Haygarth has flagged for the second consecutive month.
- For all wards:
  - There were 7 negative contacts to PALS for nursing related issues . The issues raised were primarily regarding communications between the nurses and significant others. 9 complimentary contacts, 4 were regarding ED.
  - There were 2 formal complaints relating to nursing on wards that did not flag this month.
  - There were 4 grade 2 pressure ulcers and 1 grade 3 pressure ulcer this month, this was considered unavoidable following investigation.
  - There were 90 falls this month, There was 1 with moderate harm and 2 with major harm occurring on wards that did not flag this month.
  - There was1 case of Healthcare Associated *Clostridium Difficile* this month on a ward that did not flag.

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 team to ensure resolution and action lessons learned.
- All no harm or minor harm falls have been investigated via Datix. A thematic review of no harm falls is planned for February with the completed report available in March. .
- The fall with a moderate harm and 2 major falls reported above are being investigated and lesson learnt will be circulated.
- The grade 2 pressure ulcers occurred on two patients on the same ward. This ward will be undertaking a ‘mini immersion’ event to increase education and awareness among its staff regarding pressure ulcer prevention and will be supported by the tissue viability team. In addition the ward are actively recruiting to HCA vacancies to support continuity of care for patients.
- All sickness has been managed in line with the Trust Supporting Attendance Policy with support from the matrons, HR and OH.
- The wards with lower appraisal rates meet regularly with HRBP deputies and matrons to discuss how to improve their performance.
- Recruitment remains ongoing. 104 overseas have joined the Trust, 82 of which have gained registration with the NMC.

Nursing Quality Indicators - Monthly Template Jan 2020 [from Dec data]

APPENDIX A

Ward Name	Report 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 overall	Dec 19 No:	Nov 19 No:	Oct 19 No:	Sept 19 No:	Aug 19 No:
																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					
Cheselden	Bronze	97	85%	1					1	0	0	0				5.5	2.8	100.0	100.0		73.8%	105.0%	100.0%	100.8%		3	2	2	1	1
Charlotte	Silver	96	34%		2				0	0	0	0				13.1	9.2	68.8	63.6		76.4%	89.7%	100.0%	98.4%		5	6	2	2	2
Surgical Short Stay Unit	Bronze	100	19%			2			0	0	0	1				4.8	1.9	95.2	76.9		76.2%	97.7%	83.6%	200.0%		3	4	5	2	2
Pierce	Bronze	87	41%						5	0	1	0				5.6	7.6	100.0	94.1		80.9%	107.1%	83.7%	112.9%		5	5	3	3	2
CCU	Bronze	100	50%						0	0	0	0				4.5	1.1	75.0	50.0							2	2	2	2	3
Helena	Silver	100	75%				1		3	0	0	0				4.0	11.9	71.4	80.0		85.8%	112.1%	75.2%	121.0%		5	4	2	3	3
Midford	Bronze	97	65%						2	2	0	0				1.5	14.9	84.6	86.7		84.7%	99.8%	94.3%	132.3%		2	4	4	3	5
ACE OPU	Bronze	97	43%				1		3	2	0	0				7.9	5.3	89.5	94.4		66.0%	101.7%	75.7%	107.3%		5	3	4	4	2
Children's Ward	Bronze	100	9%				1		0	0	0	0				1.6	0.7	85.7	100.0		89.3%	77.0%	88.0%	148.4%		3	4	4	4	2
Combe	Bronze	100	53%						3	2	0	0				1.7	7.6	93.3	64.7		80.5%	97.7%	72.0%	179.0%		4	4	4	4	5
A&E	Foundation	91	4%		4	4			2	0	0	0				8.3	10.1	68.1	65.4							5	5	7	4	5
Waterhouse	Bronze								8	1	0	0	1	1		0.0	7.9	93.3	93.3		103.9%	82.3%	143.4%	100.0%		3	5	4	5	1
Forrester Brown	Bronze	100	22%				1		4	1	0	0				8.4	6.4	95.2	94.7		94.3%	94.5%	101.2%	125.8%		4	2	3	5	2
Robin Smith	Bronze	94	30%				1		2	0	0	0				1.7	0.7	87.5	93.3		92.8%	97.6%	102.8%	150.0%		1	2	2	5	2
Violet Prince (RNHRD)	Bronze															0.0	0.0	-	-		95.0%	85.9%	78.2%	128.2%		1	0	4	5	3
Respiratory	Bronze	88	46%					1	7	3	0	0	3			9.4	6.3	91.3	86.7		66.7%	106.9%	80.4%	104.3%		4	5	4	5	3
SAU	Bronze	96	7%						0	1	0	0				6.0	5.5	57.1	78.6		91.9%	92.6%	93.3%	116.1%		5	5	3	5	3
Phillip Yeoman	Bronze	99	54%						4	0	0	0				1.2	8.4	90.0	91.7		92.6%	63.2%	67.2%	66.1%		4	4	3	5	4
Medical Short Stay Unit	Bronze	100	22%						1	0	0	0				9.8	11.5	66.7	71.4		65.1%	97.1%	101.5%	119.4%		6	4	4	5	4
Mary Ward PAW	Bronze	100	17%		2				0	0	0	0				2.3	5.2	81.0	66.7		107.7%	81.2%	95.2%	86.6%		4	4	5	5	4
Acute Stroke Unit	Silver	97	46%		1	1			4	2	0	0				6.8	10.3	86.7	100.0		72.4%	97.4%	99.1%	105.5%		2	5	4	5	5
MAU	Bronze	86	12%						2	3	0	1				3.6	4.4	81.6	76.2		84.1%	205.8%	105.3%	130.2%		4	3	5	5	5
NICU	N/A	100	34%													5.7	5.9	88.6	75.0		81.8%	54.1%	80.5%	43.1%		7	4	4	5	6
Haygarth	Foundation	95	29%				1		6	2	0	0				13.5	11.2	54.5	95.0		66.3%	107.5%	72.8%	175.8%		6	7	7	6	5
Intensive Care Unit [ITU / CCS]	Bronze															3.2	0.0	77.8	100.0		81.6%	127.9%	86.3%			1	3	5	6	6
Pulteney	Bronze	88	34%				1		4	0	0	0				11.6	8.5	50.0	20.0		82.9%	88.9%	94.6%	110.8%		6	9	4	7	3
Cardiac	Bronze	93	19%						2	0	0	0				6.2	2.2	86.4	100.0		65.4%	120.1%	76.5%	153.2%		4	7	4	7	6
Parry	Bronze	100	11%						2	1	0	0				7.6	6.2	100.0	81.3		82.1%	93.9%	83.7%	93.3%		6	6	8	8	5
William Budd	Bronze	100	14%						2	0	0	0				14.5	5.2	64.7	100.0		95.0%	85.9%	78.2%	128.2%		5	2	2	8	6
		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)