Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
24th June 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary for exceptions • Ward Metrics, with associated commentary for exceptions The Quality Dashboard for June shows 3 areas which will require a concerted effort for improvement. • MRSA bacteraemia • Hip Fractures operated on within 36 hours • VTE assessment (Venous Thromboembolism assessment)
BOARD ASSURANCE (Risk) / IMPLICATIONS	There is an increased risk of non compliance with the MRSA target as 4 have already been identified. With a target of 5 for the full year it is disappointing to have 4 at this early stage.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Good quality services are essential. The quality metrics are benchmarked by the Strategic Health Authority and nationally. Poor quality services can affect the level of confidence the patients and commissioners place on our services, and affect the organisations reputation.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to the equality on access taking consideration into disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	None identified
The Trust Board is asked to:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter Medical Director & Caroline Becher Chief Nurse
Date:	16th June 2010
Decision:	For Noting

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard indicator definitions

1.2 Quality and Safety Balanced Scorecard and commentary

1.3 WQI (Ward Quality Indicators) commentary

2 Mortality and Morbidity

2.1 Dr Foster Summary report

2.2 Mortality and Morbidity Review Group

2.3 SUI update

3 Quality update

3.1 Safety Alerts

3.2 SHA adverse drug report

3.3 Trust Executive Committee Visibility & Assurance Visit

3.4 Learning Disabilities

3.5 PALS (Patient Advice Liaison Service)

3.6 Complaints Policy

3.7 Pilot on Visiting Hours at SPH

3.8 Privacy and Dignity Peer Review

3.9 Maternity Services

3.10 EQ Programme (Enhancing Quality)

4 Appendices

Appendix 1 WQI definitions

Appendix 2 WQI scorecard

1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2008/09 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

3. Forecast - the calculation is as follows:

    - For month 7 (Oct) we divide 2008/09 Total by 2008/09 YTD at month 7 to give us the proportion of activity that historically took place as a guide to how much more activity will take place during the rest of 2009/10. This is then multiplied out by the YTD figure for 2009/10. To further account for recent up or downward trends we have divided the average monthly figure for 2008/09 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 1/(SUM(2008_09 up to m7)/SUM(2008_09 Total)) x 2009_10 YTD x (2008_09 Ave/Last 12 Months Ave)

4. Actual - this is the actual achievement for the month.

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow.

6. Year to Date - The sum of the activity from the beginning of the financial year (April).

Line-by-line explanation of each Measure:

1-01 Standardised mortality (Relative Risk)
This measure is taken from Dr Foster for a limited set of diagnoses standardised across all NHS trusts so that mortality can be compared fairly with other trusts. The data is presented as a relative risk of mortality, a number below 100 means that the trust is better than the average for England, the lower the number the better performing the trust.

1-02 Crude Mortality
Number of deaths per month against number of admissions

1-03 MRSA
Number of hospital acquired MRSA identified, in the month they are identified.

1-04 C. Diff
Number of C.Difficile cases identified, in the month they are identified.

1.05 Patient satisfaction
Of the patients who completed a patient comment card in the reporting month, the percentage who expressed they were 'happy or very happy' with their experience.

1.06 Formal Complaints
Total complaints for the month - Data supplied from Datix by Complaints department

1.07 SUI's
Serious Untoward Incidents - Data supplied from Datix by Quality department

1-08 Falls – resulting in significant injury (grade 3)
Data supplied from Datix system by Quality department

1-09 Hip Fractures treated within 36 hours
The number of patients admitted for hip fractures that have been treated within 36 hours of admission. We specifically look for the time difference in hours between the admission date and the first procedure date

1-10 Readmissions within 14 days
The percentage of acute patients who have been re-admitted to hospital to the same specialty within 14 days, where the admission method is an emergency admission. We exclude patients who died in hospital, under 16's, maternity, planned and cancer patients

1-11 VTE assessment
Data based on a sample audit of where VTE risk assessment has been completed

1-12 Summated Adverse Report Index (SARI)
This measure is a sum of all the patients who were subject to an adverse event during the month. An adverse event in this case excludes mortality as that is reported 2 months in arrears and excludes VTE.

1.2 Balanced Scorecard

Balanced Scorecard

Quality Section

Table 1

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.							
Patient Safety & Quality	**Annual Target**	**Forecast**	**Actual**	**Change**			**YTD**
Standardised mortality (Relative Risk)	82	**80**	**65**	▼	▲	▲	**78**
Crude mortality	2.6%	**2.7%**	**2.8%**	▲	▼	▼	**2.5%**
MRSA (Hospital only)	5		**2**	▼	▼	◄►	**4**
C.Diff	90	**50**	**3**	▼	▼	◄►	**6**
Patient Satisfaction	100%	**97.7%**	**97.8%**	▲	▼	▲	**97.4%**
Formal complaints	361	**365**	**30**	▲	▲	▲	**62**
SUIs	14	**16**	**1**	▲	▼	▲	**3**
Falls - resulting in significant injury (grade 3)	29	**27**	**1**	▼	▲	◄►	**2**
Hip fractures treated within 36 hrs	85%	**65.9%**	**61.9%**	▲	▲	◄►	**61.9%**
Readmissions within 14 days	2.6%	**2.6%**	**2.3%**	▲	◄►	▼	**2.1%**
VTE Assessment	90.0%	N/A	68.0%	Based on sample audit			
Summated Adverse Report Index (SARI)	tbc		**231**	▲			**558**

The Dr Foster mortality data is for March, due to problems with the Dr Foster site. We are recording an excellent SMR at this point which is below our forecast end point.

Crude mortality has increased slightly but still remains around 2.6-2.8%. I am trying to reach an agreement to exchange this data with Frimley and the Royal Surrey so we can offer a benchmark figure. These figures do not give any cause for concern. See Trust Mortality report.

MRSA shows a further 2 cases this month. These cases have been discussed with the board. The Trust had put in a request for mitigation of 2 of these cases; although the Health Protection Agency considered the application and conceded they were complex cases they felt that attribution should remain with the Trust. There is no route of appeal as this decision is final . In Root Cause Analysis (RCA) analysis only 1 of the MRSA cases is clearly related to an MRSA infection contracted in the hospital, and this was in a high risk patient. Actions have been put in place and Medical Director and Chief Nurse are assured that the hospital has taken appropriate actions.

The good general performance of the Trust in infection control is indicated by the low C.Diff rate with a projected outturn which is 48% lower than the target value.

There has been 1 SUI which relates to an MRSA case. The requirement is that a SUI report needs to be filed only if there is an adverse outcome related to an MRSA infection.

Patient satisfaction remains at just under 98%. The ten high impact changes have been implemented at the end of May and should become apparent in the July figures.

Formal complaints continue to show a small but consistent decline over the last 3 consecutive months, which is mapping the patient satisfaction data.

The number of falls show a dramatic improvement with only 1 fall recorded last month and a trajectory to deliver our target reduction in the incidence of falls.

Treatment of hip fractures within 36 hours remains at 62% and there is a requirement to make a significant impact on this number if the 85% target is to be delivered. The newly appointed CD to trauma and orthopaedics is a Trauma surgeon and is committed to, and confident that, this target can be delivered.

Readmission rates at 14 days remain at just over 2%. The Secretary of State for Health has introduced an incentive for Acute Trusts that any readmission of a patient within 30 days of discharge (for the same clinical reason) will not receive a payment for this episode. I have asked for data on the rates, and absolute numbers of the Trust's 30 day readmission rates and this will be available for the Board meeting.

The figure for VTE represents the previously presented audit data. Our automated system for the collection of this data goes live in the middle of June, and "real time" data will be available for the July Board.

The SARI has shown a small improvement and we will be able to adjust this figure for VTE uptake (and set a target) for the July meeting.

1.3 WQI (Ward Quality Indicators) commentary

The WQI definitions can be found at Appendix 1

The WQI scorecard can be found at Appendix 2

The May WQI shows red ratings with regard to two MRSA bacteraemia. There are also three C diff cases but these were contained within the ward environment and did not spread to other patients.

At the May Trust Board it was agreed to track the last six months ward quality indicators and to see if there were any wards that were regularly flagging amber on red on crucial indicators.

Wards that represent the greatest challenge in terms of their WQI are the medical wards in particular Maple, May, Holly and Birch. The clinical challenge here is related to the specialty of these patients many who have multi-pathology, are elderly and often confused on admission and in some cases have neglected to maintain a healthy nutritional diet for weeks in advance of admission. These cases represent a risk in terms of pressure sores, falls and general vulnerability. This current month shows Maple with 13 falls and 9 prescribing errors, Holly with 9 falls. In looking over a period of months these wards do have a record of problems in reducing these occurrences. Patients that represent a falls risk are cohort and 'Specials' are booked to supervise and minimise further risks. The Matrons are all working with front line staff to improve these indicators

2 MORTALITY AND MORBIDITY

2.1 Dr Foster Summary report

Data download from Dr Foster from 10/06/10 showed that there were no adverse mortality reports for ASPH.

Below is a tabulation of the comparative mortalities (SMR and CMR) for all emergency admissions in March 2010. The data is broken down by medicine, surgery and trauma.

Trust	ASPH		Frimley Park		RSCH	
Category	**CMR%**	**SMR%**	**CMR%**	**SMR%**	**CMR%**	**SMR%**
Emergency Medicine	2.6	68	2.9	62	3.80	95.4
Emergency Surgery	2.3	68	1.2	47	1.4	56.0
Emergency Trauma	3.1	57	2.6	74	2.4	64.0
Total Emergency	2.4	67	2.3	58	3.30	77

It is clear that ASPH performance in all emergency care is good with SMR in the 57-68 range and with an overall rate of 67.

The Trust performs particularly well in Trauma (SMR 57) although medicine and surgery also record the very commendable figures of 68.

In comparison with Frimley and Royal Surrey County Hospital (RSCH) the Trust performs comparable to Frimley in medicine and trauma, and both trusts perform better than RSCH in these specialities.

The most marked comparative difference being in medicine (ASPH 68 vs RSCH 95). There has been no Dr Foster update since Feb 2010.The Trust is awaiting the next report.

2.2 <u>Trust Mortality Review Meeting (TMRM)</u>

The group meet in May to review deaths in March.

We now have reported general demographic information to accompany our note review. The data for March showed that:

There were 91 deaths in the Trust in this month, 89 were related to emergency admissions. 74 deaths occurred in acute medical admissions (3 cardiology, 1 gastroenterology), 6 patients in surgery and 4 in the trauma service. Of these patients 80 were of white ethnic origin and there was a 49/52 male, female split and the age range was 34 to 104. This is consistent with the Trust demographics and service activity.

There were no signals for concern re excessive mortality related to wards, individual consultants or day of the week.

The note review was performed on 50 sets of notes. Sample of 55%.

In this note review there were NO unexpected deaths under the criteria agreed.

We did identify 3 cases in which the patient journey could have been improved; 2 in medicine and 1 in surgery and these cases have been referred to the directorates for review and presentation at the directorate M&M (Mortality and Morbidity) and governance meeting to ensure shared learning.

The group felt that we had made significant progress and our aim is to review over 70% of notes at the next meeting. These results are very encouraging.

2.3 SUI update

There were 2 SUIs in May 2010, both MRSA cases. (For future reference changes to the requirement that all MRSA infections must be recorded as an SUI will mean a revised figure for the dashboard. For the month of June current reporting has been maintained, meeting with the PCT will clarify change date.)

Both cases have had RCA completed and actions implemented – full details are in the closed part of the Board.

3 Quality update

3.1 Safety alerts

There are 5 alerts currently over the deadline for closure. Three alerts are waiting on August DTC to ratify policies and forms. This will be discussed with Chief Pharmacist and Tanya Bernard Chair of DTC to consider whether taking chairman's action is appropriate in order to speed up process.

05-Feb-07 No change	Early identification of failure to act on radiological imaging reports	There is an early alert pilot in place currently, prior to implementation of electronic software later in the year. This pilot will be reviewed in July at Clinical Governance Committee, and then closed if review is positive.
31-Mar-08	Actions that make anti-coagulation therapy safer	Heparin policy requires minor amendments and then ratification post May DTC. Warfarin discharge policy now in draft to be ratified at next DTC which is August 2010
09 June 09	Reducing risk of overdose with midazolam injection in adults	The sedation policy requiring amendments was not received in time for DTC meeting. To be ratified at next DTC meeting in August 2010
07-Sep-09	Reducing risk of harm from oral bowel cleansing solutions	Proposed changes and process has not been taken up by pharmacy, further review has been required. Agreement has now been reached between pharmacy, clinical team and GP's. Required documentation has been produced and forms awaiting ratification at August DTC
19-Sep-09 No change	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Our planned solution is to use iSOFT (PAS) there is a new release (4.3) due in Sept 2010 that will enable us to validate the correct NHS number with the correct patient. This will enable us to move forward with this alert. Other Trusts are in a similar position in that they are having to wait for the IT software to be completed and implemented.

3.2 SHA Adverse Drug report

The Board will remember that we had identified that the Trust were recording a high rate of Adverse Drug responses when compared to other Trusts in the SEC on the SHA observatory data.

Although our internal reporting had not recorded high levels of drug errors or drug related incidence, this SHA figure placed the Trust as an outlier.

Investigation showed that this figure quoted by the SHA observatory was in fact extracted from the HES data and represented our coders recording adverse medical events related to the use of therapeutic agents. This is not the same category as a drug error, and usually

the recording of a known adverse side effect of a medication, e.g. a rash on penicillin or vomiting on an antibiotic.

The Medical Director performed a 20 note audit. The notes were coded correctly, in accord with national guidelines. The audit demonstrated that in none of these cases was there a prescription or drug error. In all cases patients were suffering from known side effects of appropriate instigated therapeutic interventions. Furthermore there was no evidence of harm in any of these 20 cases.

This analysis has been shared with the SHA and offers assurance that the Trust is shown as an outlier only because it has a robust and accurate coding department.

3.3 Trust Executive Committee Visibility & Assurance Visit

Members of the Trust Executive Committee used the scheduled meeting on the 11th of June to split into small groups and visit clinical areas. Eight groups visited wards across the St Peter's site with the intention of increasing visibility, seeing the environment through fresh eyes and talking to patients and staff about their experiences. There were some very positive accounts from the patients regarding nursing care. The unannounced visits were unanimously agreed to be very informative and a group reflection at the end of the visits culminated in some corporate decisions on standards. Drink rounds to include visitors, de-cluttering generally, and proactive status updates to the next of kin after surgery.

3.4 Learning Disability

In June ASPH were delighted to be the host for the Launch of the Surrey Wide Nursing Liaison Acute Services for People with Learning Disability. This is an exciting new initiative which is intended to drive nest practice for access to healthcare and inclusion for people with a learning disability and to also meet National Policy requirements. The Acute Liaison service will work across the five acute Trusts in Surrey and share best practice. The introduction of a "Hospital Passport" was extremely well received at the launch and has already been introduced in many health care environments.

3.5 PALS (Patient Advice Liaison Service)

A revised PALs Standards and Operational Policy was ratified by the Trust Executive Committee on the 28th of May 2010. The changes to this Policy was a review and update undertaken in the light of changes and clarification on the National Regulations and had been recommended by the complaints monitoring group (CMG). (See 3.6 below Complaint).

3.6 Complaints Policy

The Complaints Policy had been fully reviewed and ratified by TEC on the 22nd June 2009. The changes were in light of the National Health Services Complaints Regulations (England): Statutory Instrument No 309 came into force 1st April 2009. The Trust's Complaints Procedure and approach to managing patients' complaints reflects the requirements of this legislation as does the PALs Standards & Operational policy referred to above.

3.7 Pilot on Visiting Hours at St Peter's Hospital

The pilot and consultation period on revised visiting hours commenced as planned on the 1st of June. Press releases advising the public as well as three local radio announcements were made by the Chief Nurse. To date we have had a mixed response from patients and staff. Some patients are truly delighted to have that uninterrupted "lights off" time in the

afternoon when they can have additional sleep/rest. Some relatives and public have complained and feel this is a harsh proposal which they are against. Staff in general were extremely supportive but have recognised the importance of a flexible and accommodating interpretation of the guidance.

3.8 Privacy & Dignity Peer Review (P&D)

The Peer review on P&D that was due to be conducted on the 15th of June at ASPH by staff from Dartford and Gravesham NHS Trust (who the SHA have designated as 'buddy' for peer review) was cancelled at late notice; this visit needs to be rescheduled. ASPH's review of Dartford and Gravesham NHS Trust is still scheduled to go ahead on the 22nd of June as planned. Surrey University Lecturer Ann Gallagher gave a presentation to the ward sisters meeting on the 15th of June on the collaborative approach to promoting dignity in care and highlighted important research linked to privacy and dignity as well as underlining the University commitment to address this with the pre-registration student nurses.

3.9 Maternity Services

THE CNST assessor visited the Trust on the 25th of May as a pre meet before the CNST assessment due to take place on the 28th & 29th of September 2010. All work is scheduled and on plan for this important assessment.

3.10 Enhancing Quality Programme

Enhancing Quality (EQ) is an innovative PCT Alliance quality programme focused on enhancing standards in patient care. It aims to give patients a better experience of health services, and ultimately, a better quality of life. It covers five high frequency clinical areas, heart failure (acute), acute myocardial infarction, hip and knee surgery, community acquired pneumonia and dementia. The programme incentivises improvement in quality through the commissioning for Quality and Innovation (CQUIN) initiatives. A Programme Manager has been seconded for six months to lead the establishment of the programme. For each of the areas of clinical practice, a series of process measures and outcomes have been identified. Doctors and nurses are responsible for ensuring the clinical process measures are followed and that data is collected (manually and/or through existing electronic systems) and outcomes monitored. This helps them to identify where improvements can be made in care pathways and processes.

- End -

Submitted by: Caroline Becher, Chief Nurse and Dr Mike Baxter, Medical Director

Date: 16th June 2010

Appendix 2 WQI definitions

1 Hand Hygiene Compliance
Audits of members of staff cleaning/decontaminating their hands between procedures

2 Number of MRSA bacteraemia
MRSA isolated in a blood culture therefore present in the patient's blood stream

3 Number of C Diff cases (Hospital post 72 hours)
Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

Saving Lives is the compliance measurements that indicate the use of High Impact Interventions in key clinical procedures which aims to decrease the risk of infection

4 Central Lines
Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections

5 Urinary Catheter
Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections

6 Peripheral Cannula care
Ensures peripheral cannula insertion and after care undertaken in line with good practice to reduce cannula infections

7 Cleanliness
Audit undertaken by facilities on a monthly basis related to cleaning standards

8 Matrons Environmental Audit
Matrons environmental audit undertaken weekly of the ward and department and the mean taken for the month

9 Blood Traceability
Numbers of labels returned against number of blood bags used.

10 Pressure Ulcer Prevention
2 areas are audited: Compliance with the monitoring return, and Actual Grade of Pressure Ulcer

11 Mixed Sex Wards
Number of patients that were in a mixed sex environment for more than 2 hours

12 Total number of falls

13 Number of falls resulting in significant injury,
Falls graded 3, 4 or 5 which indicates harm as reported via incident reporting

14 Complaints
Actual number of complaints registered to the clinical area in reporting month.

15 Medicine administration errors
Number of errors reported via incident reporting

16 Medication prescribing errors.
Number of errors reported via incident reporting

Ashford and St Peter's Ward Quality Scorecard - May 2010

N/S: No submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives						Cleanliness	Matron Environment Audit	Blood Traceability	Pressure Ulcer Prevention	Mixed Sex Wards Compliance	Patient Falls		Complaints	Medication Errors	
					Central Lines Insertion	Central Lines After Care	Urinary Catheter Insertion	Urinary Catheter After Care	Peripheral Cannula	Peripheral Cannula After Care				Compliance with monitoring of Pressure Ulcer		Number of falls	Resulting in Injury		Administration	Prescribing
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	=100%	=100%	=0	=0	=0	=0	=0	=0
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%		99% - 76%						
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<100%	<=75%	>=1	>=1	>=1	>=1	>=1	>=1
Medicine 1, 2, 3	ASPEN	99 %	0	0	N/A	N/A	100 %	100 %	67 %	100 %	94 %	95 %	12/13	N/A	0	3	0	N/A	0	3
	CCU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	88 %	98 %	6/6	N/A	N/A	0	0	N/A	0	2
	BIRCH	97 %	0	0	N/A	N/A	100 %	100 %	70 %	80 %	88 %	98 %	7/7	N/A	0	2	0	N/A	0	0
	MHDU	99 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	95 %	16/17	N/A	0	0	0	N/A	0	0
	HOLLY	100 %	0	0	N/A	N/A	100 %	75 %	100 %	100 %	91 %	95 %	16/18	N/A	0	9	0	N/A	0	2
	CEDAR	100 %	0	0	N/A	N/A	100 %	100 %	80 %	100 %	91 %	95 %	7/7	N/A	0	2	0	N/A	0	1
	MAY	96 %	0	1	N/A	N/A	100 %	100 %	60 %	100 %	96 %	95 %	9/10	N/A	0	2	0	N/A	0	0
	MAPLE	97 %	0	1	N/A	N/A	100 %	100 %	100 %	90 %	91 %	95 %	20/20	N/A	0	13	0	1	1	8
	COLPOSCOPY	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	N/A	0	0
	ANGIO SUITE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	RHEUMATOLOGY	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ashford	CHAUCER	100 %	0	0	N/A	N/A	N/A	100 %	100 %	100 %	96 %	97 %	0/1	N/A	0	1	0	N/A	0	0
	WORDSWORTH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	95 %	3/3	N/A	0	5	0	N/A	0	0
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	93 %	N/A	N/A	0	2	0	N/A	0	0
	DICKENS	100 %	0	0	N/A	N/A	100 %	N/A	100 %	N/A	99 %	95 %	8/8	100 %	0	1	1	1	0	0
Orthopaedics	ELM	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	97 %	93 %	26/26	100 %	0	1	0	1	0	0
	JUNIPER	90 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	89 %	93 %	35/35	100 %	0	2	0	N/A	1	0
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93 %	N/A	N/A	N/A	0	0	1	0	0
Surgery	KINGFISHER	96 %	1	1	N/A	100 %	100 %	100 %	100 %	100 %	91 %	93 %	35/37	100 %	0	0	0	2	0	1
	FALCON	100 %	1	0	N/A	100 %	100 %	100 %	70 %	100 %	96 %	91 %	30/32	100 %	0	0	0	N/A	0	0
	KESTREL	N/S	0	0	N/A	N/A	N/A	N/A	N/A	N/A	93 %	90 %	38/40	N/A	0	6	0	N/A	0	0
	SDU	96 %	0	0	N/A	N/A	N/A	100 %	90 %	100 %	96 %	91 %	23/29	100 %	0	0	0	N/A	0	0
	ADMISSIONS LOUNGE	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	N/A	N/A	N/A	N/A	0	0	N/A	0	0
	HERON	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	86 %	13/13	100 %	0	2	0	1	0	0
	MAXFACS CLINICS ASH	98 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	89 %	N/A	N/A	N/A	0	0	0	N/A	0	0
Emergency Services	MAU	98 %	0	0	N/A	N/A	100 %	N/A	100 %	100 %	N/A	89 %	119/124	N/A	0	4	0	1	0	2
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	93 %	26/26	N/A	0	0	0	3	0	0
	A&E	93 %	0	0	N/A	N/A	N/A	N/A	90 %	N/A	20 %	92 %	63/63	N/A	0	1	0	4	0	0
Paediatrics	OAK	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	99 %	93 %	6/6	N/A	0	0	0	N/A	0	0
	ASH	98 %	0	0	N/A	100 %	N/A	N/A	100 %	N/A	97 %	93 %	26/26	N/A	0	0	0	N/A	0	1
	PAED A/E	98 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	92 %	N/A	3/4	N/A	0	0	0	1	0	0
	NICU	97 %	0	0	N/A	100 %	N/A	N/A	N/A	100 %	93 %	89 %	22/23	N/A	0	0	0	1	0	0
Theatres	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	95 %	N/A	31/33	N/A	0	0	0	2	0	0
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	60 %	100 %	N/A	97 %	N/A	N/A	0	0	0	N/A	0	0
	DSU SPH	100 %	0	0	N/A	N/A	N/A	100 %	100 %	100 %	98 %	N/A	N/A	N/A	0	1	0	N/A	0	0
	DSU ASH	98 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	97 %	88 %	N/A	N/A	0	0	0	2	0	0
Imaging / Endoscopy	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	96 %	94 %	N/A	N/A	0	0	0	N/A	0	0
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	99 %	91 %	N/A	N/A	0	0	0	N/A	0	0
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94 %	N/A	N/A	0	0	0	N/A	0	0
Critical Care	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	N/A	84/84	N/A	N/A	0	0	N/A	0	0
Maternity	JOAN BOOKER	99 %	0	0	N/A	N/A	N/A	90 %	N/A	90 %	N/A	93 %	17/18	N/A	N/A	0	0	N/A	1	0
	LABOUR	91 %	0	0	N/A	N/A	100 %	N/A	90 %	N/A	N/A	90 %	50/56	N/A	N/A	0	0	2	0	0
	LABOUR THEATRES	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	N/A	0	0
	MATERNITY TRIAGE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	N/A	N/A	N/A	N/A	0	0	N/A	0	0
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	2	0	0
Ophthalmology	EYE CLINIC ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	N/A	N/A	N/A	0	0	0	N/A	0	0
	EYE CLINIC SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	N/A	0	0
	EYE WARD ASH	N/S	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	N/A	0	0