Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
24th November 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for October 2011.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience is occurring. Stakeholder views have been sought as part of the Quality Account development process.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's CQC Registration and Monitor Licence.
The Trust Board is asked to:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	17th November 2011
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 7 columns namely:

1. Description of Measure - self explanatory.

2. Outturn 10/11 – this denotes the performance / outcome for last financial year 2010 /11 and is sourced from Dr Foster.

3. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2010/11 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

4. Forecast - the calculation is as follows:

   - For month 7 (September we divide 2011/12 Total by 2011/12 YTD at month 7 to give us the proportion of activity that has taken place as a guide to how much more activity will take place during the rest of 2011/12. This is then multiplied out by the YTD figure for 2011/12. To further account for recent up or downward trends we have divided the average monthly figure for 2011/12 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 7/(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 Ave/Last 12 Months Ave)

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

6. 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.

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

Table one: Quality Performance Dashboard

BALANCED SCORECARD

Position as at: **31 Oct 2011**

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.

	Patient Safety & Quality	Outturn 10/11	Annual Target 11/12	Annual Forecast 11/12	Oct Actual	Performance			YTD 11/12
						Aug	Sep	Oct	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	**90**	**85.7**	▲	▲	▲	**97.9***
1-02	Crude mortality	1.60%	1.60%	**1.55%**	**1.48%**	▲	▲	▼	**1.53%**
1-03	MRSA (Hospital only)	5	4	**4**	**0**	▼	◄►	▲	**2**
1-04	C.Diff (Hospital only)	36	33	**29**	**2**	▼	▲	▼	**14**
1-05	Mortality from C.Diff (All cases)	10.3%	6.3%	**9.0%**	**11.1%**	▼	▲	▼	**15.9%**
1-06	Mortality from VTE	0.4%	0.35%	**0.30%**	**0.0%**	◄►	◄►	◄►	**0.7%**
1-07	Mortality from Hip fractures	4.8%	4.6%	**6.0%**	**9.1%**	▼	▲	▼	**6.1%**
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			**60.0%**	**57.0%**	▼	▲	▲	**57.0%**
1-10	Formal complaints	360	320	**400**	**50**	▼	▼	▼	**269**
1-11	SUIs	14	14	**23**	**4**	◄►	▲	▼	**17**
1-12	Falls - resulting in significant injury (grade 3)	16	14	**13**	**1**	◄►	▲	◄►	**6**
1-13	Hip fractures treated within 36 hrs	93.0%	85%	**96%**	**100.0%**	▼	▲	◄►	**95.0%**
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	**1672**	**146**	▲	▼	▼	**957**
1-15	Average Bed Occupancy-Actual beds	94%	94%	**96%**	**98%**	▼	▲	▼	**97%**
1-16	Average Bed Occupancy-Planned beds				**105%**	New			

***Source from August Dr Foster**

1.2 Commentary on Quality and Safety Balanced Scorecard

1.01/1.02 The SMR has risen from last month's value of 76.6 to 85. CMR has also shown an increase from 1.36% to 1.48%. This 9% increase in mortality is reflected in a small increase in mortality in all divisions (table 1) but actually reflects a relatively small change in the absolute numbers of events recorded within the Trust (89 vs 83).

Although the data represents an overall good performance, work is underway to improve outcome (reduce mortality) in community acquired pneumonia, hospital acquired pneumonia, COPD and heart failure.

In addition, and in line with recommendations from a national report, the Trust is looking at improving the provision for emergency surgery and a report will be brought to the Board from the Division of Surgery in the New Year.

1.04/1.05 The Trust has no cases of MRSA, and only 2 cases of hospital acquired C.Diff. The Trust has had no deaths related to hospital acquired C.Diff.

1.07. Mortality for patients receiving hip fracture surgery has increased in month from a nationally low figure of 2.4% to a value of 9.1%. This figure represents 3 deaths in a cohort of 33 patients receiving treatment in October. These individual cases have been reviewed by the division of trauma and orthopaedics (and will be presented at the division's M&M meeting and to the Trust CGC). No concerns have been identified in these cases.

It is worth noting that for the second consecutive month 100% of # NOF were operated on within 36 hrs (**1.13).**

1.15/1.16 Are data points that relate to bed occupancy. These are important surrogate measures of patient flow, bed capacity and patient experience. It has also been suggested that there is a relationship between bed occupancy and HAI rates.

Line 1.15 shows the bed occupancy rate of the beds in use within the Trust. The current in month figure of 98% reflects a very high occupancy rate and is higher than the target set on the dashboard of 94% (reflecting 10/11 outturn)

1.16 Indicates that the Trust has bed capacity, over and above its core bed stock, currently open. If the patients currently in the Trust were accommodated within the "core bed allocation" the bed occupancy would be 105%. The Trust target, in line with national best practice, would be to have a bed occupancy rate (within the core bed stock) of 85%.

2 Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality rate by Specialty

	CMR Oct-11	ABSOLUTE NUMBERS	Aug-11	Sep-11	Oct-11
ALL	1.48%	89	▲	▲	▼
MEDICINE	8.92%	71	▲	▼	▼
SURGERY	3.83%	13	▼	▼	▼
ORTHO	0.63%	2	▼	▲	▼
PAEDIATRICS	0.44%	3	◄►	◄►	▼

3.0 Safety Update

31 NPSA Safety Alerts

There has been one new alert reported by the NPSA in October 2011, the details are described below:

Description	Deadline	Lead
Keeping newborn babies with a family history of Medium-chain Acyl-CoA dehydrogenase deficiency (MCADD) safe in the first hours & days of life.	April 2012	**Head of Maternity**

Overdue Alerts

Two alerts remain overdue as follows:

Description	Deadline	Lead
Early identification of failure to act on radiological imaging reports	05-Feb-07	**Associate Director of Informatics**
STATUS		
A&E, Respiratory Medicine, Rheumatology, Diabetes/Endocrinology & Gastroenterology specialties have agreed to participate in piloting our new Code 5 Tracker system. Staff have been trained. The pilot is progressing and will end mid-December. The Project Team is scheduled to undertake mid-pilot review of the functionality with staff week commencing 21st November 2011 to determine if any modifications are required. At the end of the pilot the approval of the Medical Director will be sought to authorise a Trust-wide deployment. It is recommended that the status for this alert be revised to amber until such time that the Code 5 Tracker is deployed across the Trust.		

Description	Deadline	Lead
Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	19-Sep-09	**Associate Director of Informatics**
STATUS		
The Health Informatics Team met with CSC iSOFT on 24th October 2011 to discuss the unacceptable lack of progress with the availability and installation of version 4.2 of CliniCom PAS. Since that meeting, significant progress has been made. We are now scheduled to implement version 4.2 on Tuesday 22 November 2011. The original Data Set Change Notice (32/2008) that triggered the NPSA alert requiring specific treatment of the NHS number was amended by the NHS Information Standards Board (ISB) in May 2011. The ISB is expecting to publish these amendments before Christmas. These amendments coupled with the implementation of version 4.2 of our CliniCom PAS means that the Trust is now compliant. Consequently, the status of the alert can now be revised. It is recommended that this alert has a green status and can now be closed.		

4.0 Patient Experience

4.1 Outpatient Department Survey 2011: Initial results

Introduction
In accordance with national guidance, the Trust has recently completed a mandatory Outpatient Survey. The survey was carried out on behalf of the Trust by Picker Institute Europe and formed part of a series of annual patient surveys carried out by the Care Quality Commission (CQC). The Trust will receive the CQC Survey Report early in 2012.

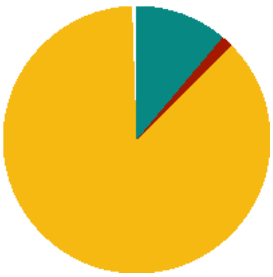
The results presented to the Trust by Picker represent the Trust's 'raw' results. These results have been submitted to the CQC who will undertake a weighting exercise to enable a national benchmarking of results as a uniform sample.

This report summarises the **Trust's 'Picker' results**. Picker results are benchmarked against all 74 'Picker' Trusts. In addition, historical analysis of Trust performance is presented. The last nationally mandated survey of Outpatients was carried out in 2009.

Survey methodology
The survey was based on a random sample of 850 patients who attended for an Outpatient appointment in May 2011.

The Results
429 patients returned their questionnaire; giving an overall response rate of 51%. This compared with a response rate for the 74 'Picker Trusts' of 49%.

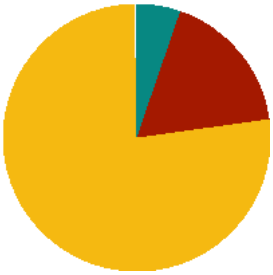
Have we improved since the 2009 survey?



.
Compared to the 2009 survey, the Trust is:

- Significantly BETTER on 7 questions
- Significantly WORSE on 1 question
- The scores show no significant difference on 54 questions

How do we compare to other Trusts in the 2011 survey?



The survey showed that the Trust is:

- Significantly BETTER than average on 4 questions
- Significantly WORSE than average on 13 questions
- The scores were average on 57 questions

The Trust has improved significantly (against 2009 Trust performance) on the following questions:

Lower scores are better

	2009	2011
Not fully aware what would happen during appointment	68 %	57 %
Could not find a convenient place to park	42 %	29 %
Not easy to find way to Outpatients Department	31 %	24 %
Appointment started more than 15 minutes after stated time	49 %	39 %
Other member of staff did not listen fully to what patient had to say	26 %	18 %
Did not completely discuss worries or fears with other health professional	47 %	34 %
Do not always see the same doctor or member of staff	61 %	50 %

The Trust has worsened significantly (against 2009 Trust performance) on the following questions:

Lower scores are better

	2009	2011
Appointment changed to later date by hospital	21 %	27 %

Trust results were significantly better than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Not given name of person that appointment would be with	22 %	28 %
Could not find a convenient place to park	29 %	35 %
Do not always see the same doctor or member of staff	50 %	59 %
Did not receive copies of all letters sent between hospital doctors and family doctor (GP)	20 %	41 %

Trust results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
Appointment changed to later date by hospital	27 %	23 %
Not easy to find way to Outpatients Department	24 %	17 %
Patient waited for longer than they were told, or were not told how long the wait would be	76 %	69 %
Doctor did not fully listen to what patient had to say	23 %	18 %
Did not have full confidence and trust in doctor	22 %	17 %
Other member of staff did not know enough about medical history	21 %	15 %
Not all staff introduced themselves	36 %	28 %
Not given complete privacy when discussing condition / treatment	17 %	13 %
Not fully involved in decisions about care or treatment	32 %	27 %
Patient not given information on who to contact	38 %	32 %
Reason for visit not dealt with completely to patients satisfaction	31 %	25 %
Overall - Outpatients Department not at all/fairly organised	44 %	38 %
Overall - not always treated with respect or dignity	15 %	12 %

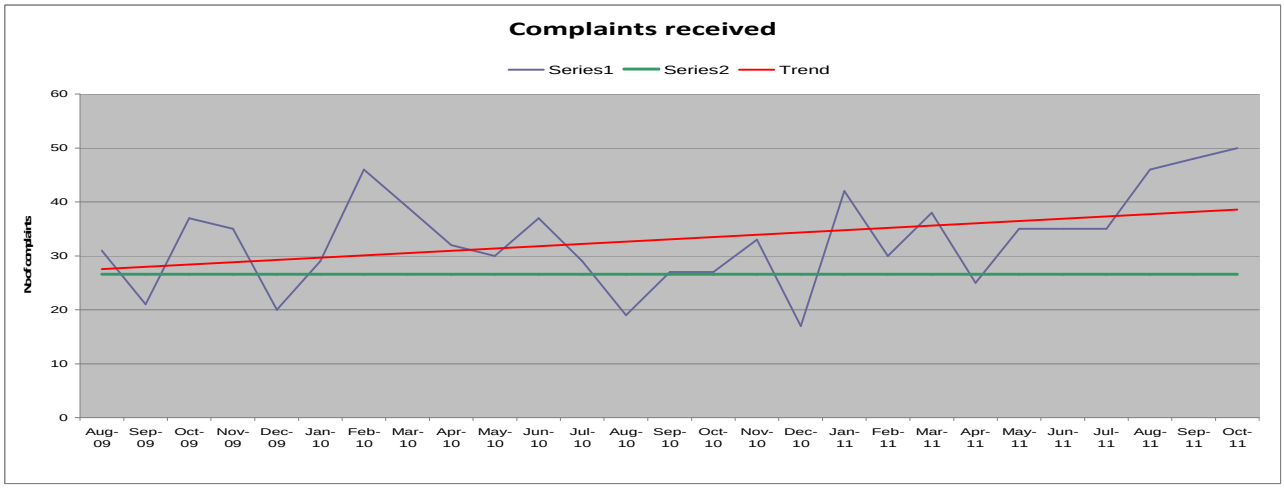
Conclusion

The Picker results suggest that although the Trust has made some good progress continued improvement is required. Current Trust initiatives such as Living our Values and the Improving the Patient Choice and Control programmes will support continued improvement. In addition, detailed plans to address specific issues are being developed by the Outpatient Team.

4.2 Complaints/Ombudsman reports

There were 50 complaints received in October compared with 48 in September and 46 in August. A total of 275 complaints have been received year to date, +36% compared with the same period 2010-11. Chart one shows a breakdown of complaints received by month (Series 1), the monthly target (Series 2) and the overall trend line.

Chart one:

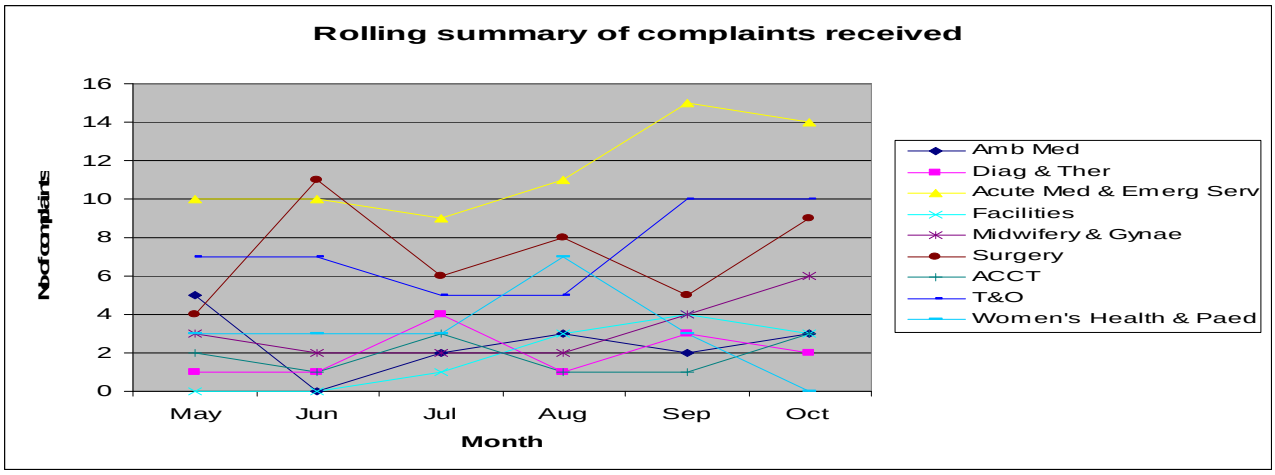


There complaint response performance for October was 23% in comparison to 18% performance in September. A further 31 overdue complaints responses were completed during October.

An improvement plan has been developed in order to support the sustained recovery of complaints performance. The proposed trajectory to clear all outstanding complaints responses is mid-December and all Clinical Divisions have fully committed to the recovery plan.

Chart two details complaints received monthly by Division and demonstrate that all Divisions saw a reduction in the number of complaints received with the exception of Surgery and Women's Health - Midwifery and Gynaecology.

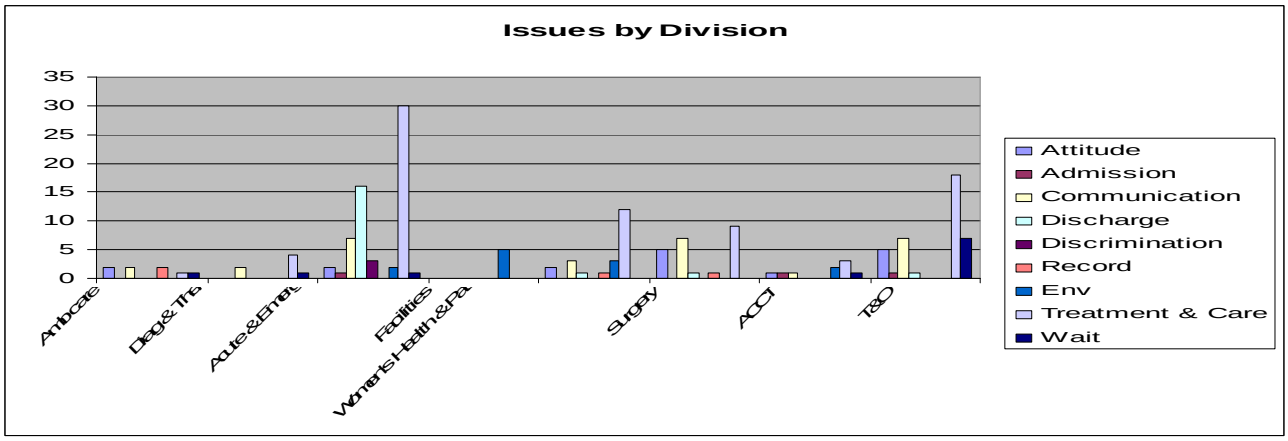
Chart two



Each separate issue raised via a complaint is logged onto the Trust's risk management database (Datix) to enable analysis of emerging trends.

Chart three provides further breakdown of the types of issues raised by Division in September. Within Acute & Emergency Care 30 issues related to 'Treatment and Care' and 16 issues related to Discharge. Similarly Trauma & Orthopaedics also saw high levels of issues relating to Treatment and Care.

Chart three



Ombudsman cases

4.3 Ombudsman Cases

The Trust has received two notification of complaints referred to the Ombudsman.
Copy papers have been provided for each case and the cases are currently under initial assessment.

The first case was investigated in 2009 and was previously assessed by the Ombudsman and referred back to the Trust for further work. The Trust provided a detailed further response to the complainant explaining what action had been taken as a result of the complaint. The complainant

remained dissatisfied and has asked the Ombudsman to re-assess the case. A detailed action plan is in place to address the issues arising from this complaint.

The second case was investigated in 2011 and the complainant was dissatisfied with the way in which the complaint was handled. Both cases relate to the Acute Medicine and Emergency Division.

4.4 Best Care Dashbaord (replacing Ward Quality Indicators)

The Best Care Dashboard Definitions are found at Appendix 1 and the Best Care results are found at Appendix 2. This is the first publication of this new ward quality dashboard and is based on a rigorous set of audits and observations. Some indicators appear to have significantly declined since last reported to Board but the new audit process is more detailed and reduces the reliance on individual judgment thus scores are more sensitive and accurate. The approach aims to identify with a high degree of accuracy the key areas for improvement. In addition, the dashboard measures both process and associated outcome, indicating the quality of the process as well as compliance. The dashboard is, and should be, an iterative piece of work – indicators will continue to be added and tested for data quality and robustness.

The following narrative is provided by the relevant Head of Nursing for the month of October 2011.

Division of Women's Health and Paediatrics Service

Paediatrics

Scores for October are overall encouraging.

Medication Errors

There has been 1 administration error reported. An improvement plan will be implemented to ensure that all nurses and doctors comply with the policy for administrating medication correctly and safely. Additional training on safe administration of medicines will be included in the paediatric bonus study days the next one due to be held in December. This matter will also be raised in the monthly ward meetings and junior doctors training.

Medicine and Emergency Services

Patient Observations scores require focused improvement. The Clinical Practice Educators are supporting wards with their improvement plans.

Nursing documentation requires attention. The Head of Nursing is reviewing the issue with the Ward Sisters and development support is being provided by the Clinical Practice Educators.

Net Promoter Score in some areas is very impressive and areas where scores are lower will be encouraged to engage and share the learning and best practice.

Surgery & Orthopaedics

Trauma & Orthopaedics

Nursing documentation requires attention. The Head of Nursing is reviewing the issue with the Ward Sisters and development support is being provided by the Clinical Practice Educators.

Net Promoter Score remains below the Trust average.

Surgery

A number of key indicators reveal some clear areas for improvement in Falcon and Heron wards. Improvement plans are being drawn up with targeted support from the Corporate Nursing Team, Clinical Practice Educators and the Quality Team.

ACCT, Ambulatory Care, Diagnostics & Therapeutics

We are currently adapting the new Essential Care indicators for the Division which have been piloted in some areas. As these are in the process of being adapted they are not currently reported on the dashboard but results are as follows:

Documentation/Communication

The documentation score for DSU & Theatres was 85% - this is a high comparative score.

Privacy & Dignity

Privacy and dignity complaints have reduced in the DSU at St Peters Hospital due to the new changing room facilities on the unit.

Submitted by: Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse

Date: November 2011

Appendix 1 Best Care Audit definitions

Documentation

1. Patient Observations: documentation of patient observations includes MEWS score, 24 h cumulative fluid balance, pain assessment on admission and referral / escalation for "at risk" patients
2. Nutrition: BMI / weight recorded on admission; MUST assessment on admission and reassessment with a care plan in place for “at risk” patients; the care plan shows evidence of progression and referral as appropriate to dietician
3. Skin Integrity: Waterlow risk assessment on admission and further reassessment with a care plan in place for “at risk” patients; the care plan shows evidence of progression with interventions as appropriate and the care rounding chart completed; where required there is referral to tissue viability nurse,
4. Falls / Manual Handling Assessment: assessments carried out on admission with care plan in place for “at risk” patients; the care plan shows evidence of progression; where appropriate the post fall protocol is implemented
5. Medication Assessment: documentation is legible and completed appropriately, omission codes are utilized and allergies identified
6. Nursing documentation: bed side folders are up to date and tidy; there is clear, contemporaneous documentation which is dated, printed and signed; property disclaimer and discharge sections are completed

Observational

7. Privacy & dignity: there are strategies in place to prevent disturbing, personal boundaries are not compromised; modesty is maintained within the ward and on patient transfer; there is appropriate communication with patients; the white board maintains confidentiality and there are no breeches of single sex accommodation.
8. Communication: handover quality, co-ordinating care-plans are maintained; there is good interpersonal skills of staff with medications being clearly explained and resources to aid communication being used where appropriate; Your feedback target is achieved and ward rounds commencing appropriately.
9. Environment & Infection control: results for hand hygiene audits, saving lives compliance, MRSA, Cdiff and environmental audit

Notes:

- MEWS: Modified Early Warning Score
- Saving Lives are the compliance measurements that indicate the use of High Impact Interventions in key clinical procedures which aim to decrease the risk of infection
- Hand Hygiene Compliance: audits of members of staff cleaning/decontaminating their hands between procedures
- MRSA isolated in a blood culture therefore present in the patient’s blood stream
- Cdiff: Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.
- Environmental audit of the ward / department undertaken weekly.

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Best Care Dashboard - October 2011

Essential Care Indicators

Patient Safety

		Process: Patient Observations	Outcome: Outcome to be defined	Process: Matrons Environment Audit	Process: Hand Hygiene Audits	Process: Saving Lives	Outcome: MRSA	Outcome: C-Diff	Outcome: CAUTI	Outcome: Catheter > 29days (aftercare)	Process: Skin Integrity	Outcome: Hospital Aquired PU	Process: VTE Assessment	Outcome: VTE Mortality	Outcome: Number of Falls	Outcome: Number of Falls resulting in injury	Process: Post Fall Protocol	Process: Nutrion	Process: Referrals to Dietician	Process: Nursing Documentation	Outcome: No of Incidents of poor documentation	Process: Medication	Outcome: No of Administration Errors
Acute Medicine & Emergency Services	Aspen	92%		98%	100%	100%	0	0	-		68%	0	100%	0%	0	0	78%	81%	100%	48%	Data Unavailable	100%	3
	Aspen HDU	-		-	-	-	0	0	100%	100%	-	0	-	-	2	0	-	-	-	-		-	0
	CCU	100%		97%	100%	100%	0	0	100%	100%	100%	0	95%	0%	1	0	100%	100%	-	72%		95%	0
	Birch	78%		97%	100%	100%	0	0	-	-	100%	0	100%	0%	3	0	100%	100%	100%	90%		88%	0
	Cedar	72%		93%	100%	100%	0	1	-	-	84%	2	100%	0%	5	0	89%	100%	100%	72%		100%	1
	Holly	77%		95%	100%	100%	0	0	-	-	96%	2	100%	0%	4	0	91%	100%	100%	96%		95%	1
	May	83%		94%	98%	100%	0	0	-	-	95%	0	96%	0%	6	0	98%	68%	50%	72%		100%	0
	MAU	97%		98%	100%	100%	0	0	-	-	48%	0	58%	0%	6	0	-	68%	-	80%		-	0
	Maple	83%		98%	97%	100%	0	0	-	-	94%	0	100%	0%	2	0	85%	100%	100%	92%		100%	0
	Fielding	72%		90%	87%	100%	0	0	-	-	87%	1	100%	0%	0	0	73%	92%	100%	56%		100%	0
	Chaucer	65%		94%	100%	100%	0	0	-	-	75%	0	100%	0%	4	0	93%	100%	100%	98%		100%	0
	ED	-		-	-	-	0	0	-	-	-	0	-	-	0	0	-	-	-	-		-	0
	Swift	-		-	-	-	0	0	-	-	-	0	-	-	0	0	-	-	-	-		-	0
	Wordsworth	95%		97%	100%	100%	0	0	-	-	97%	2	100%	0%	3	0	97%	98%	100%	94%		98%	0
Surgery	Kingfisher	100%		-	98%	100%	0	0	-	100%	99%	0	100%	0%	2	0	97%	100%	100%	98%	Data Unavailable	93%	0
	Falcon	94%		-	0%	98%	0	0	-	100%	58%	0	100%	0%	0	0	56%	68%	25%	66%		80%	0
	SDU	100%		-	100%	100%	0	0	-	100%	100%	0	100%	0%	0	0	75%	100%	100%	100%		94%	0
	Heron	98%		-	100%	100%	0	0	-	100%	58%	0	69%	0%	1	0	40%	51%	50%	78%		95%	0
	SAU	100%		-	100%	100%	0	0	-	-	100%	0	50%	0%	1	0	98%	60%	0%	100%		95%	0
T & O	RBE	85%		96%	100%	98%	0	0	-	-	100%	1	100%	0%	2	0	98%	92%	100%	56%		90%	0
	RBW	86%		96%	97%	100%	0	0	-	-	99%	1	100%	0%	5	0	98%	96%	-	86%		88%	0
ACCT	ITU	-		-	100%	100%	0	0	-	100%	-	0	-	-	0	0	-	-	-	-		-	0
Women's health & Paediatrics	Oak	-		-	97%	100%	0	0	-	100%	-	0	-	-	0	0	-	-	-	-	Data Unavailable	-	0
	Ash	100%		100%	99%	100%	0	0	-	100%	100%	0	-	-	0	0	-	50%	-	100%		100%	1
	NICU	100%		50%	97%	100%	0	0	-	100%	100%	0	-	-	0	0	-	100%	100%	100%		100%	0
	Paeds ED	-		-	98%	100%	0	0	-	-	-	0	-	-	0	0	-	-	-	-		-	0

Patient Experience

		Communication	Complaints	Discharge	Nurse Facilitated Discharge	Privacy & Dignity	SSA Breaches	Net Promoter	Number of Ward transfers
Acute Medicine & Emergency Services	Aspen	50%	3	Data Unavailable	Data Unavailable	50%	0	100%	Data Unavailable
	Aspen HDU	-	1			-	0		
	CCU	100%	0			93%	0		
	Birch	100%	0			100%	0	65%	
	Cedar	50%	0			57%	0	48%	
	Holly	50%	0			64%	0	63%	
	May	0%	0			0%	0	69%	
	MAU	100%	3			100%	0		
	Maple	58%	2			86%	0	59%	
	Fielding	40%	0			57%	0	33%	
	Chaucer	0%	0			57%	0	100%	
	ED	-	0			-	0		
	Swift	-	0			-	0		
	Wordsworth	60%	0			57%	0	73%	
Surgery	Kingfisher	86%	2	Data Unavailable	Data Unavailable	100%	0	56%	Data Unavailable
	Falcon	64%	1			100%	0	72%	
	SDU	100%	0			100%	0		
	Heron	71%	1			93%	0	57%	
	SAU	86%	4			86%	0	32%	
T & O	RBE	79%	2			100%	0	44%	
	RBW	79%	1			100%	0	52%	
ACCT	ITU	-	0			-	0		
Women's health & Paediatrics	Oak	-	0	Data Unavailable	Data Unavailable	-	0		Data Unavailable
	Ash	100%	0			100%	0		
	NICU	50%	0			50%	0		
	Paeds ED	-	0			-	0		

Action Plan

** The Patient Experience measures are calculated from the results of observational audits.

Prepared by Information Services