Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
26th August 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 • Quality overview The Quality Dashboard for July shows 2 areas which will require a concerted effort for improvement. • MRSA, there has been one case notified for July taking the total to 5 cases • VTE Assessment (Venous Thromboembolism assessment not on target Some areas worthy of noting • Formal complaints is the lowest months total recorded this year • No recorded falls for July resulting in harm to patients' • Dramatic improvement in performance of hip fractures being operated on within 36hrs
BOARD ASSURANCE (Risk) / IMPLICATIONS	MRSA is a key risk as the Trust has now reached its trajectory for the year
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 & Susan Osborne Interim Chief Nurse
Date:	26th August 2010
Decision:	For Noting

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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).

Ashford & St Peter's Hospitals NHS Trust

BALANCED SCORECARD

Position as at: **31 Jul 2010**

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
1-01	Standardised mortality (Relative Risk)*	82	81	89**	▲	▲	▼	76**
1-02	Crude mortality	2.6%	1.6%	1.4%	▼	▲	▲	1.3%
1-03	MRSA (Hospital only)	5		1	◄►	▲	▼	5
1-04	C.Diff	90	55	9	◄►	▲	▼	16
1-05	Patient Satisfaction (Your Feedback)	90%	76.7%	76.7%	New Survey			76.7%
1-06	Formal complaints	361	367	29	▲	▼	▲	128
1-07	SUIs	14	17	1	▲	◄►	◄►	5
1-08	Falls - resulting in significant injury (grade 3)	29	27	0	◄►	▼	▲	4
1-09	Hip fractures treated within 36 hrs	70%****	85.0%	86.2%	◄►	▼	▲	65.5%
1-10	Readmissions within 14 days	2.6%	2.5%	2.4%	▼	▼	▲	2.3%
1-11	VTE Assessment*****	90.0%	N/A	86.4%	New System			86.4%
1-12	Summated Adverse Report Index (SARI)	tbc			▲	▲	▲	1068

***** Based on wards where full VTE assessment data is available

1.2 <u>Commentary on Quality and Safety Balanced Scorecard</u> (Table 1)

Line by line explanation of each measure

1-01 -1-02: The reported SMR appears to have increases in July. The Board will remember last month the figure was 55. This month the reported figure is 89. However, the crude mortality for the organisation remains low at 1.4% and continues to show month on month improvement. Details of the Mortality and Morbidity meeting (section 3), show that the pattern for mortality in the Trust is as predicted and that there are no areas for specific concern.

1-03 – 1-04: These figures relate to hospital acquired infection in the Trust. Line 1.4 shows the excellent performance on C.Diff. The Trust continues to show low levels of C.Diff infections. It is worth noting that cases are now isolated and contained and there is good compliance to the policy of patients with C.Diff (or suspected of having it) being placed in side rooms with 2 hours of notification. Similarly, the compliance with the drug formulary (avoiding C.Diff sensitizing antibiotics) is over 93%, and improving.

1-03: Relates to MRSA. It shows that we have a further case of MRSA bringing our year total to 5. Details of the case are reported elsewhere in the Board papers. The actions from this case which have been implemented immediately are: MRSA screening for inter-hospital transfers, a strict policy on urinary catheter screening (and protocol for changing if infected) and a phlebotomy delivered Blood Culture Taking Service. Theses action have been approved by the PCT. Fig 2 shows the Trust performance for hospital acquired MRSA by quarters since 2007.

1-05: Relates to a patients satisfaction rating based on a composite mark from the new patient survey information. This is the first report in this form and the Trust will need to review several months' data to access trends and set targets. On the previous measures, the Trust was performing well but it was felt this was not sensitive enough to give the Board a sense of the trends and variations in this metric, or a true feel for the effect of improvements and changes that were being made. It is hoped this composite measure may be more helpful.

1-06: Relates to formal complaints and is the lowest months total recorded this year. There is a consistent theme around discharge and this has been picked up as a specific action by the MD and CN. A formal report and action plan will be presented to the Board.

1-07: The Trust has declared one SUI during July. This is reported elsewhere in the Board papers, but the Trust's process has been activated and the SHA and PCT notified.

1-08: There have been no falls, resulting in a grade 3 incident, in the Trust in July, and 4 cases in the whole of the first quarter. This is a very dramatic improvement and has been lead by the roll out of work done on the medical and orthopaedic wards.

1-09: Demonstrates a dramatic improvement in performance of the Hip Fracture Surgery rates within 36 hrs. Last month the Trust reported figures of around 60% but in July the figures reported are 86% illustrating an improvement in performance of approaching 50%. The figure of 86% is far in excess of the graded trajectory of 70% and is actually in line with the year end target of 85%. This improved performance has been attributed to improved process and increased dedicated theatre capacity.

In absolute terms, there were 29 admissions with fracture neck femur, 25 were operated on within 24hrs (4 patients missed the 36 hr target).

1-10: Readmission rates at 14 days remain low and within target.

Table 2 illustrates the numbers of patients either readmitted with 30 days of discharge or for the fourth time (or more) in the last 12 months.

The 30 day readmission data relates to the new measure, with financial implications, which is discussed in the recent White Paper and may well become a very important issue for the Trust, as well as a metric of patient experience (Quality).

The 4 plus admission data relates to the Trust's 501 project on readmission (Programme 2) in the NWS Transformational Programme which ASPH is leading.

30 day readmissions are running at around 12% with absolute numbers of 250-300 admissions per month. Although 74% of these relate to medical patients (circa 200 per month), 23% are surgical and 3% orthopaedic. This data will now be reported monthly. A strategy to address this issue is being devised, and actions to affect this will be monitored against this data.

The 4 plus readmission data shows a figure of 30-40 per month, circa 2 admissions per day.

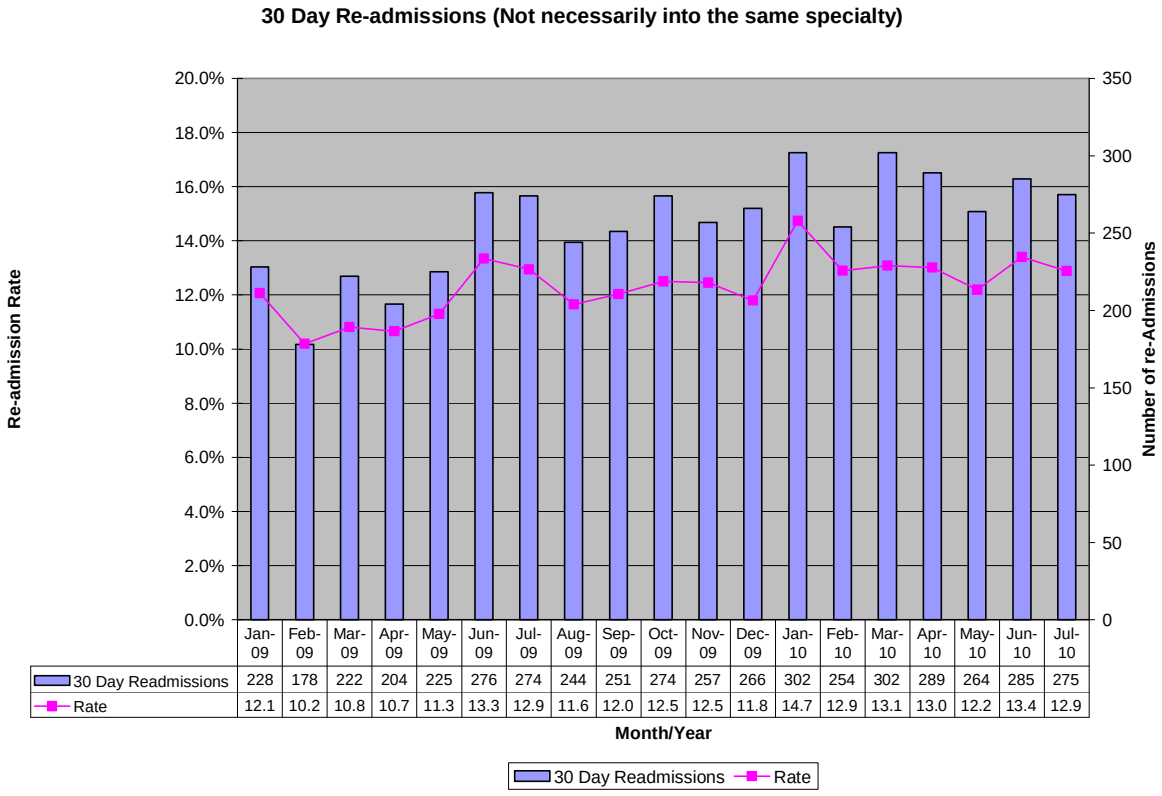
The final column shows the percentage that these multi attendee admissions are of the 30 day readmitted cohort.

As previously described, the value of 12-15% suggests, that there are 2 separate patient populations, and that reducing the multiple admissions will not dramatically influence the 30 day readmission rates, and these issues may require different interventions.

To date, our interventions in the multiple admission cohort have not influenced these admission rates for these patients. Work continues to understand and influence this data and to fully implement the programmes.

Table 2 Readmission with 30 days of discharge and admissions for the 4th or more time in the last calendar year

Month	30 Day Re-admissions NOT necessarily into same specialty	Non- Re-Admits	Total	Rate	Re-Admissions with 4 or more emerg adms within the last 12 months	Re-admission % 4 or more emerg adms within the last 12 months
Jan-09	228	1661	1889	**12.1%**	29	12.7%
Feb-09	178	1568	1746	**10.2%**	27	15.2%
Mar-09	222	1830	2052	**10.8%**	25	11.3%
Apr-09	204	1710	1914	**10.7%**	29	14.2%
May-09	225	1767	1992	**11.3%**	24	10.7%
Jun-09	276	1792	2068	**13.3%**	36	13.0%
Jul-09	274	1843	2117	**12.9%**	21	7.7%
Aug-09	244	1851	2095	**11.6%**	26	10.7%
Sep-09	251	1836	2087	**12.0%**	33	13.1%
Oct-09	274	1918	2192	**12.5%**	38	13.9%
Nov-09	257	1807	2064	**12.5%**	33	12.8%
Dec-09	266	1990	2256	**11.8%**	29	10.9%
Jan-10	302	1747	2049	**14.7%**	39	12.9%
Feb-10	254	1716	1970	**12.9%**	28	11.0%
Mar-10	302	2006	2308	**13.1%**	46	15.2%
Apr-10	289	1932	2221	**13.0%**	36	12.5%
May-10	264	1902	2166	**12.2%**	35	13.3%
Jun-10	285	1842	2127	**13.4%**	40	14.0%
Jul-10	275	1859	2134	**12.9%**	40	14.5%



	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10
30 Day Readmissions	228	178	222	204	225	276	274	244	251	274	257	266	302	254	302	289	264	285	275
Rate	12.1	10.2	10.8	10.7	11.3	13.3	12.9	11.6	12.0	12.5	12.5	11.8	14.7	12.9	13.1	13.0	12.2	13.4	12.9

1-11: Reports VTE compliance. The figure quoted of 86.4% shows a very large improvement in the Trust's performance. This is the first report using data from the automated reporting system. Data is only reported from area where the system has been fully adopted. This high figure is, however, fully supported by a manual audit of the whole hospital where 77% compliance was reported. The new system has given us a powerful tool to focus our attention on areas that require improvement. The Trust is confident it will achieve the 90% required compliance rates.

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

2 Mortality and Morbidity

2.1 Dr Foster Reports

There are no Dr Foster alerts

2.2 Mortality and Morbidity Review Group

This was the first meeting using the new process. There was good clinical involvement and consultants were happy to review their own cases and responded well to the data sharing.

108 deaths were recorded in the Trust in May.

The demographic data showed a picture consistent with previous reviews with 82% deaths being in medicine (89 deaths, CMR 4.08%), 11% in emergency surgery (12 deaths, CMR 0.4%), 3.7% Orthopaedics (4 deaths, CMR 0.33%) and 1.8% in paediatrics (2 deaths, CMR 0.85%).

Trends since Jan show a progressive improvement in Emergency Surgery CMR (0.87% to 0.4%) and in Orthopaedics CMR (0.69% to 0.33%). Medicine and Paediatrics are less dramatic but show a modest improvement in CMR (5.64% to 4.08%) for Medicine and (0.88% to 0.85%) for Paediatrics.

The highest HRG for the Trust remains pneumonia (10 deaths in May) and the Respiratory physicians have been asked to look at these specific cases and also review the clinical pathways used in the Trust and on the respiratory ward, to assess if there are any consistent themes or new learning. The Board is, however, reminded that the Trust's pneumonia mortality compares very well with the rest of the SHA. A local comparison with RSCH and ASPH (from Dr Foster) clearly shows our CMR at 15.5% is lower than Frimley at 17.3% and RSCH at 19.3% and this translation to an SMR of 67.3 vs 70.3 and 87.6 respectively.

The mortality data also suggested that there had been 8 deaths related to acute renal failure. As we do not currently have a renal unit, I have investigated these cases and was reassured that the clinical coding was appropriate and that the renal failure recorded was part of a more complex medical presentation and that the cases were managed appropriately.

There were no outlying consultants, teams or wards and no obvious trends related to ethnicity or days of the week admitted.

54 cases were reviewed by our audit procedure (50%). There were no unexpected deaths and no cause for concerns were identified. 1 case was referred to Medicine for local M&M review as it was felt there was good process learning to be shared.

Ongoing action includes - All deaths in patients under 60 should be flagged and requiring specific review and comment.

It was also agreed that a junior doctor should be on the review group to allow feedback to junior staff and also raise the importance of this group amongst medical staff encouraging incident report as appropriate.

Table 3 Dr Foster Derived Data for Mortality Review to a Diagnosis of Pneumonia

	CMR	**SMR**
ASPH	15.5%	67.3
FRIMLEY	17.3%	70.3
SURREY	19.30%	87.6

Quality Update

3.1 Safety Alerts

Overdue alerts
Two of the overdue alerts have been closed following the Drugs and Therapies group meeting in August. This leaves two alerts remaining overdue as follows.

Deadline	Description	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Software is currently being tested and it is expected that this alert will be closed imminently.
19-Sep-09	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 Oct 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 have to wait for the IT software to be completed and implemented.

Current Alerts
There are currently 11other alerts open. Work is underway to ensure these are completed before the deadline.

Date of Issue	Description	Deadline	Lead	Status
30 July 2010	Reducing treatment dose errors with low molecular weight heparins	26 January 2011	Heidi Galang	On target
16 June 2010	Safer administration of Insulin	16 December 2010	Debbie Hindson	On target
26 May 2010	Reducing the risk of retained swabs after vaginal birth and perineal suturing	26 November 2010	Jacqui Rees	On target
28 April 2010	Checking pregnancy before surgery	28 October 2010	Kate Eidens	On target
31 March 2010	Early detection of complications after gastrostomy	30 September 2010	Peter Finch	On target
24 February 2010	Reducing harm from omitted and delayed medicines in hospital	24 February 2010	Victoria Griffiths	On target
9 February 2010	Safer use of intravenous gentamicin for neonates	9 February 2011	Audrey Elmore	On target
1 December 2009	Safer lithium	31 December	Victoria Griffiths	On target

	therapy	2010		
24 November 2009	Safer spinal (intrathecal), epidural and regional devices – Part B	1 April 2013	Andrew Laurie	On target
24 November 2009	Safer spinal (intrathecal), epidural and regional devices – Part A	1 April 2011	Andrew Laurie	On target
19 November 2009	Being open: Communicating with patients, their families and carers following a patient safety incident	23 November 2010	Marty Williams	On target

3.2 Complaints

On 5 July 2010 the Trust received a final report from the Health Service Ombudsman following review of complaint ref 07/346. The report has identified service failures with regard to discharge planning, nutritional care and timeliness and completeness of medical assessments. Having had an opportunity to previously review the draft report, the Trust fully accepted the findings. On receipt of the final report, the Chief Executive immediately wrote to the complainant to acknowledge and apologise for the service failures.

The PHSO have made a number of recommendations to the Trust and an action plan to address the required actions is being led by the Deputy Chief Nurse, supported by
Clinical Director for Medicine, Complaints Manager, Head of Capacity Management Head of Dietetics, Head of Nursing and Matron

The complainant has been invited to meet with Chief Nurse, Medical Director and Head of Dietetics in order to share action plan once it has been approved by Trust Board and the Ombudsman. In addition, once fully agreed the action plan will also be shared with Strategic Health Authority and the Care Quality Commission.

Actions and learning from this case will be disseminated through regular staff forums including Junior Doctors forum, Matrons and Ward Sister's meetings and a dedicated Nursing training day to review. The action plan will also be monitored by the Complaints Monitoring Group on a quarterly basis until completion.

In addition the Chief Nurse asked that the action plan from this case revert to the Trust Board accompanied by a high level executive review of all aspects of the complaint and actions taken and future actions planned this work is being led by the Deputy Chief Nurse.

The Trust has also been notified that a case referred for review during the previous quarter has now been assessed and the request of review declined. The case is now closed with no further action for the Trust.

There are no other cases currently under consideration by the Ombudsman.

3.3 Falls
The number of Patient falls has remained fairly consistent across the Trust but has fallen substantially in Orthopaedics and Trauma. There is no indication of falls having resulted in injury for July.

3.4 Agency Nursing
Temporary staffing has reduced considerably due to the implementation of the Decision Tree resulting in tighter controls

3.5 Blood Traceability Tag Returns
This has been an improvement on return of tags this month from 8 areas receiving 100% compliance in June to 13 areas achieving 100% compliance in July. This is encouraging but will need to continue being monitored to drive up compliance across all areas.

3.6 Complaints
The number of complaints across the clinical departments has reduced in the month of July

3.7 Patient Feedback
'Your feedback' initially demonstrates patient dissatisfaction regarding Noise at Night. Although work has been undertaken to improve this, further attention and focus is required to improve this part of the patient experience and this is being actioned. Consideration of the reporting of your feedback data is currently under discussion.

3.8 Peripheral Cannula Care
This month highlights some under performing areas which is due in the main to lack of documentation for the submission although labour wards demonstrate an issue regarding poor skin cleansing prior to cannula insertion. This has been actioned by the Associate Director of Midwifery. All nurses are undertaking competency assessment for aseptic technique.

3.9 Quality Indicators
Three further indicators are to be included from August, those being MUST (Malnutrition Universal Screening Tool), VTE and Discharge checklists.

3.10 Independent Inquires
The Airedale and Colin Norris independent inquiries report highlights numerous findings and recommendations regarding the misuse of drugs, resulting in patient deaths. The Trust has reviewed both reports and steps have been taken to minimize the risks identified in the report and in particular to the medicines management of controlled drugs. The Authorized Officer for controlled drugs with the Lead Pharmacist has compiled an action plan following the recommendations and this provides assurance that Ashford and St Peters Hospitals are able to demonstrate safe policy and practice. The action plan will be sent to the PCT Accountable Officer for controlled drugs by the 30th September.

Submitted by: Susan Osborne, Interim Chief Nurse and Dr Mike Baxter, Medical Director

Date: 26th August 2010

Appendix 1 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 - July 2010

N/S: No submission

		Saving Lives										Pressure Ulcer Prevention						Patient Falls			Medication Errors	
		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Central Lines Insertion if applicable	Central Lines After Care if applicable	Urinary Catheter Insertion if applicable	Urinary Catheter After Care if applicable	Peripheral Cannula if applicable	Peripheral Cannula After Care if applicable	Cleanliness	Matron Environment Audit	Blood Traceability	Compliance with monitoring of Pressure Ulcer	Hospital Acquired Grade 1	Hospital Acquired Grade 2	Hospital Acquired Grade 3	Hospital Acquired Grade 4	Mixed Sex Wards Compliance	Number of falls	Resulting in Injury	Complaints	Administration	Prescribing
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	=100%	=100%	<=3	<1	<1	<1	=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%	1- 2	1- 2	1- 2	1- 2							
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<100%	<=75%	>3	>=3	>=3	>=3	>=1	>=1	>=1	>=1	>=1	>=1
MEDICINE 1,2,3	ASPEN	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	95 %	95 %	13/13	100 %	1	1	0	0	0	1	0	0	2	0
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	90 %	100 %	95 %	95 %	5/7	100 %	0	0	0	0	0	1	0	1	0	0
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	100 %	95 %	15/19	100 %	0	0	0	0	0	0	0	0	0	0
	HOLLY	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	94 %	95 %	5/5	100 %	2	1	0	0	0	1	0	0	0	2
	CEDAR	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	94 %	95 %	4/4	100 %	3	0	0	0	0	9	0	0	0	0
	MAY	100 %	0	3	N/A	N/A	100 %	100 %	50 %	100 %	96 %	90 %	11/11	N/A	0	0	0	0	0	10	0	0	0	1
	MAPLE	99 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	96 %	95 %	21/25	100 %	0	0	0	0	0	6	0	1	0	0
ASHFORD	CHAUCER	99 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	95 %	94 %	N/A	100 %	0	0	0	0	0	8	0	0	0	0
	WORDSWORTH	100 %	1	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	96 %	N/A	100 %	1	0	0	0	0	4	0	0	0	0
	FIELDING	99 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	94 %	4/4	100 %	2	0	0	0	0	5	0	0	0	0
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	N/A	100 %	100 %	98 %	95 %	4/4	100 %	0	0	0	0	0	1	0	0	0	0
	ELM	99 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	90 %	95 %	20/22	100 %	1	1	0	0	0	0	0	0	0	0
	JUNIPER	98 %	0	1	N/A	N/A	100 %	100 %	90 %	90 %	93 %	97 %	42/42	100 %	0	1	0	0	0	1	0	2	0	0
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	91 %	95 %	N/A	N/A	0	0	0	0	0	0	0	4	0	0
SURGERY	KINGFISHER	96 %	0	1	N/A	100 %	100 %	100 %	80 %	100 %	96 %	98 %	25/34	100 %	0	0	0	0	0	3	0	2	0	0
	FALCON	100 %	0	0	N/A	100 %	100 %	100 %	90 %	100 %	94 %	95 %	17/21	100 %	0	0	0	0	0	0	0	0	0	0
	SDU	99 %	0	0	N/A	100 %	N/A	100 %	100 %	100 %	94 %	98 %	40/41	100 %	1	0	0	0	0	0	0	0	0	0
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	94 %	95 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
	HERON	100 %	0	1	N/A	100 %	100 %	100 %	100 %	100 %	94 %	95 %	25/28	N/A	0	0	0	0	0	4	0	0	0	0
	KESTREL	Closed	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	93 %	24/31	100 %	3	0	0	0	0	0	0	0	0	0
EMERGENCY SERVICES	MAU	95 %	0	0	N/A	N/A	100 %	N/A	100 %	100 %	95 %	90 %	169/180	100 %	0	0	0	0	0	6	0	3	0	0
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	94 %	25/28	100 %	0	0	0	0	0	0	0	0	0	0
	A&E	93 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	95 %	39/42	100 %	0	0	0	0	0	1	0	5	0	0
PAEDIATRICS	OAK	93 %	0	0	N/A	N/A	N/A	N/A	40 %	N/A	97 %	92 %	15/17	N/A	0	0	0	0	0	0	0	0	0	0
	ASH	99 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	95 %	92 %	24/24	N/A	0	0	0	0	0	0	0	0	0	1
	PAED A/E	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	91 %	N/A	N/A	0	0	0	0	0	0	0	1	0	0
	NICU	100 %	0	0	N/A	100 %	N/A	N/A	N/A	100 %	90 %	92 %	15/15	N/A	0	0	0	0	0	0	0	0	0	0
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	90 %	97 %	41/82	N/A	0	0	0	0	0	0	0	1	0	0
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	96 %	97 %	2/2	N/A	0	0	0	0	0	0	0	0	0	0
	DSU SPH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	95 %	100 %	1/1	N/A	0	0	0	0	0	0	0	0	0	0
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	97 %	2/2	N/A	0	0	0	0	0	0	0	0	0	0
IMAGING/ENDOSCOPY	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	N/A	92 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	94 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	88 %	93 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	N/A	100 %	100 %	100 %	95 %	93 %	40/45	N/A	0	0	0	0	0	0	0	0	0	0
MATERNITY	JOAN BOOKER	100 %	0	0	N/A	N/A	N/A	90 %	N/A	90 %	93 %	96 %	13/13	N/A	0	0	0	0	0	0	0	1	1	0
	LABOUR THEATRES	92%	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	96 %	N/A	N/A	0	0	0	0	0	0	0	1	0	0
	LABOUR WARDS	92%	0	0	N/A	N/A	100 %	N/A	80 %	N/A	100 %	93 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	96 %	N/A	N/A	0	0	0	0	0	0	0	1	0	0
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	89 %	96 %	N/A	N/A	0	0	0	0	0	0	0	2	0	0
OPHTHALMOLOGY	EYE CLINIC ASH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	100 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0
	EYE CLINIC SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	89 %	N/S	N/A	N/A	0	0	0	0	0	0	0	0	0	0
	EYE WARD ASH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	100 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0