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

TRUST BOARD
28 April 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for March 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. The Balanced Scorecard features no red ratings.
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.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to the equality on access taking into consideration disability, age and that 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 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:	17 April 2011
Decision:	For Noting

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

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indicator Definitions

1.2 Quality and Safety Balanced Scorecard and Commentary

2. Clinical Effectiveness

2.1 Mortality and Morbidity

2.2 Report on Sentinal Stroke Audit

3. Safety update

3.1 National Patient Safety Alerts (NPSA)

4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.2 National Patient Survey Results

4.3 Update – Action in Response to Parliamentary Ombudsman Report (Mr W)

4.4 Ward Quality Indicators (WQI) Commentary

5 Appendices

Appendix 1 Detailed Report National Sentinel Stroke Audit 2010

Appendix 2 WQI explanations

Appendix 3 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).

.

1.2 Quality and Safety Balanced Scorecard and Commentary

Ashford & St Peter's Hospitals NHS Trust
BALANCED SCORECARD **Position as at:** **31 Mar 2011**

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

Patient Safety & Quality	Annual Target	10/11 YTD	Actual	Change			YTD v Target var
Standardised mortality (Relative Risk)*	82	91.8**	94.3**	▼	▼	▲	12%
Crude mortality	2.6%	1.6%	1.7%	▲	▲	▼	-1.0%
MRSA (Hospital only)	5	5	0	◄►	◄►	◄►	0.0%
C.Diff	67	36	3	▲	▲	▼	-46.3%
Patient Satisfaction (Your Feedback)	90%	77.3%	80.6%	▼	▲	▲	-12.7%
Formal complaints	361	360	38	▼	▲	▼	-0.3%
SUIs	14	14	0	▼	◄►	◄►	0%
Falls - resulting in significant injury (grade 3)	29	16	1	◄►	◄►	◄►	-45%
Hip fractures treated within 36 hrs	85%****	93.0%	96.4%	▲	▼	▼	8.0%
Readmissions within 14 days	3.7%	3.5%	3.6%	▲	▲	▲	-0.2%
VTE Assessment	90%	85.2%	92%	▲	▲	▲	-4.8%
Summated Adverse Report Index (SARI)	1924	1799	218	▼	▼	▼	-6%

* Source data from Dr Foster ** Actual = Jan 2011 YTD =Apr-Jan 2010/11
*** Actual = Dec 2010/11 YTD =Apr-Dec 2010/11 ****Q2=70% Q3 = 85%

The March 2011 dashboard is shown above. This table represents the Trust's quality performance in March 2011 but also represents the end of year performance for 2010/2011.

To aid the overall assessment of quality performance the format of this dashboard has been changed for this report. A column comparing the year's performance variation against target has been included and the forecast column removed.

The Trust has performed well against its quality targets for 2011/2012.

1.01 and 1.02: The Trust's mortality data gives assurance to the Board of the Trust's overall outcome performance. The data and analysis is reinforced by the more detailed mortality report. The Trust's year end SMR data shows a figure of 91.8 which is 12% higher than the Trust's self imposed target of 82, and also higher than last year's figure of 83. The increase in SMR appears to relate to a period of high emergency activity, when the Trust saw an increase in the number of younger critically ill patients requiring critical care and respiratory support. This activity has returned to normal levels. The in-month mortality figures show a significant improvement from last month with the SMR of 107 recorded in February falling to a figure of 94 for March. As previously noted, there are no Dr Foster alerts or specific areas for concern. The Board's attention is also directed to the CMR data, which some authorities consider a more accurate, and sensitive, measure of hospital mortality. This figure is 1.6% which is 1% lower than the Trust target of 2.6%.

1.03 and 1.04: The Trust delivered the MRSA target of 5 cases for 2010/2011 and had recorded 9 months without a case of MRSA marking an excellent performance and reflecting the Trust's absolute commitment to reducing HAI. The Trust also delivered its C.Diff target with a year total of 36 cases marking a 46% improvement on the PCT imposed target value of 67 cases. This improved performance C.Diff infection rate is translated into the Trust's C.Diff mortality data. In 2009/2010 the C.Diff mortality at ASPH was 11%, the 2010/2011 performance is now recording a figure of 5%. This represents a 55% reduction in mortality. This important outcome measure will be tracked in the 2011/2012 dashboard.

1.08: The number of serious falls recorded within the Trust in 2010/2011 was 16 showing a 45% improvement on the Trust's own target of 29 and marks a significant improvement in performance over this year.

1.09: The number of hip fractures treated within 36 hrs of admissions has also shown a large and sustained improvement in performance in 2010/2011. The year figure of 93% is significantly better than the Q4 target set by the PCT of 85%. This performance also shows a great improvement over last year's outturn which showed 82% of patients were treated within 48 hrs of admission. This procedural performance metric is also translated into a low mortality rate for fractured hip of 5% which compares favourably against the national average of 7%. Mortality related to fractured neck of femur will tracked in the 2011/2012 dashboard.

1.11: VTE prophylaxis is recorded at 85% with a Q4 performance of over 90%. Although the year target is recorded as 90%, this is in fact the Q4 target, as there was a graded target imposed over the year. The Trust is reminded that the SEC SHA have quoted ASPH as an exemplar site with an excellent performance in this area.

1.12: The Trust's SARI, is a self designed index of avoidable harm. The Trust has recorded a value of 1799 events on this index which is a 6% improvement on the Trust's self imposed target of 1924. This improvement in performance is reinforced by the comparison with last year's outturn where a SARI value of 2690 was recorded. This represents an improvement of 34% or 891 less adverse events occurring in the Trust in 2011/2012.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table 2

CRUDE MORTALITY RATE BY DIRECTORATE

	CMR JAN 2011	ABSOLUTE NUMBERS	NOV 2010	DEC 2010	JAN 2011
ALL	1.95%	123	▼	▼	▲
MEDICINE	5.53%	102	▼	▼	▲
SURGERY	1.03%	11	▲	▼	▲
ORTHO	0.90%	4	▲	▼	▲
PAEDIATRICS	0.00%	0	▲	◄►	◄►

The overall Trust mortality has improved from 2.25 % to 1.95% from Dec to Jan showing a reduction from 141 deaths to 123. This represents a 13% improvement in performance and is shown in all divisions.

This improvement is most clearly demonstrated in medicine where the mortality rate has dropped from 6.34% to 5.53%, 119 to 102 deaths representing a 15% improvement in mortality.

In Surgery and Orthopaedics there is a fall in mortality from 1.23% and 1.11% respectively to 1.03% and 0.9%. This represents a reduction from 15 to 11 deaths in surgery and 6 to 4 in orthopaedics, this is a 27% reduction in mortality in surgery and 34% reduction in mortality in orthopaedics. Although the absolute numbers are small they demonstrate that there are no adverse mortality trends in either surgical specialty.

In considering the number of deaths in the Trust in 2009/2010 compared with 2010/2011, there were 1,972 more patients seen at the Trust in 2010/2011 vs 2009/2010 representing a 3% increase in activity. The number of deaths in these years was 1184 vs 1282 showing an increase of 100 deaths in 2010/2011. These figures represent a CMR of 1.7% for both years and indicates no adverse change in mortality between the 2 years. Although there have been improvement in mortality some areas e.g. C.Diff and Hip Fractures, these are not areas of sufficient activity to influence the Trust's overall mortality.

In 2010/2011 the Trust is focusing on improvement in outcome in a number of important areas of clinical care, with particularly emphasis on pneumonia, stoke, myocardial infarction and cardiac failure (Enhancing Quality Initiatives). The objectives of these interventions are to make a 10% reduction in overall mortality of the Trust in 2011/2012, representing a reduction of 128 deaths in the year (1 per month). This will be tracked in the 2010/2011 quality dashboard.

2.2 National Sentinel Stroke Audits 2010

A detailed report and analysis is at Appendix 1.

The National Sentinel Stroke Audit has taken place on a 2-year cycle since 1998. The audit is undertaken through retrospective analysis of patient records and compares delivery of care with the recognised best practice pathway of care.

The audit sample consisted of consecutive cases with primary diagnosis of stroke admitted to hospitals between 1st April and 30th June 2010.

In 2008 ASPH was rated in the middle range for the average score against key indicators and is now in 2010 recorded in the upper quartile against the same indicators.

Table 3 Comparison with National Performance on Key Indicators

Indicator	National 2010	ASPH 2010
Patients spending >90% of their stay on a stroke unit.	60%	**79%**
Screening for swallowing disorders within 24 hours of admission	83%	**99%**
Brain scan within 24 hours of stroke	70%	**96%**
Aspirin within 48 hours of admission	93%	**95%**
Physiotherapy within 72 hours of admission	91%	**100%**
Occupational therapy within 4 working days of admission	85%	**100%**
Patient weighed during admission	85%	**96%**
Mood assessed by discharge	80%	**63%**
Rehabilitation goals agreed by MDT	36%	**99%**
Patient initially admitted to SU	78%	**73%**
Rehabilitation goals agreed by the MDT within 5 days admission	94%	**100%**
Discussion about diagnosis	73%	**33%**

It is clear that when looking at the total number of patients who receive the best practice interventions at the right time the Trust performance is improved. In order to achieve the very best outcomes all patients should receive all the best practice interventions at the right time. On this analysis, however,

the Trust has more work to do; of patients who were eligible for all best practice interventions, 44% received them all (national value of 32%).

These results show that although great progress has been made in improving the delivery of individual elements of the best practice pathway there is still work to be done to consistently deliver the very best care.

Recommendations

Dr Bhaskar Mandal, Stroke Lead, will lead work going forward on increasing the numbers of patients experiencing all the best practice interventions as well as:

- screening and function assessment after admission
- promotion of continence
- communications with Patients and Carers, particularly regarding diagnosis and prognosis
- improved discharge through the Early Supportive Discharge Pilot with Surrey Community Health which is monitored by the Transformational Board.

3. Safety Update

3.1 NPSA Safety alerts

Table 4

Deadline	Description	Lead	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Jonathan Glover	Overdue
Andrew Davis an IT consultant has been working on an IT solution in liaison with two of the divisional directors. The system is called the code 5 tracker and will interface between PAS & CRIS to pick up any code 5 reports. The reports then need to be signed of by the referrer or clinician who is currently caring for the patient. The system has a full audit trail and will be monitored by Radiology. The prototype is near completion with a demonstration planned for the Friday the 6th May 2011. An action plan in place to ensure robust interim measures; Radiology Department has employed a clerical assistant and the new manual system is in place, clinicians are signing to acknowledge they have received the report, the test order sheet and subsequent process must be embedded and reviewed to ensure it is working before closure of alert.			
19-Sep-09	Risk to patient safety of not using the NHS Number as the National Identifier for all Patients	Donna Jarrett	No change in status. The iSOFT (PAS) new release (4.3) is required and not yet available. This will enable us to move forward with this alert. Other Trusts that use the same PAS software are in a similar position in that they have to wait for the IT software to be completed and implemented. In the meantime, and to mitigate the risk, the patients' hospital number and usual demographics are used in accordance with the patient identification policy.

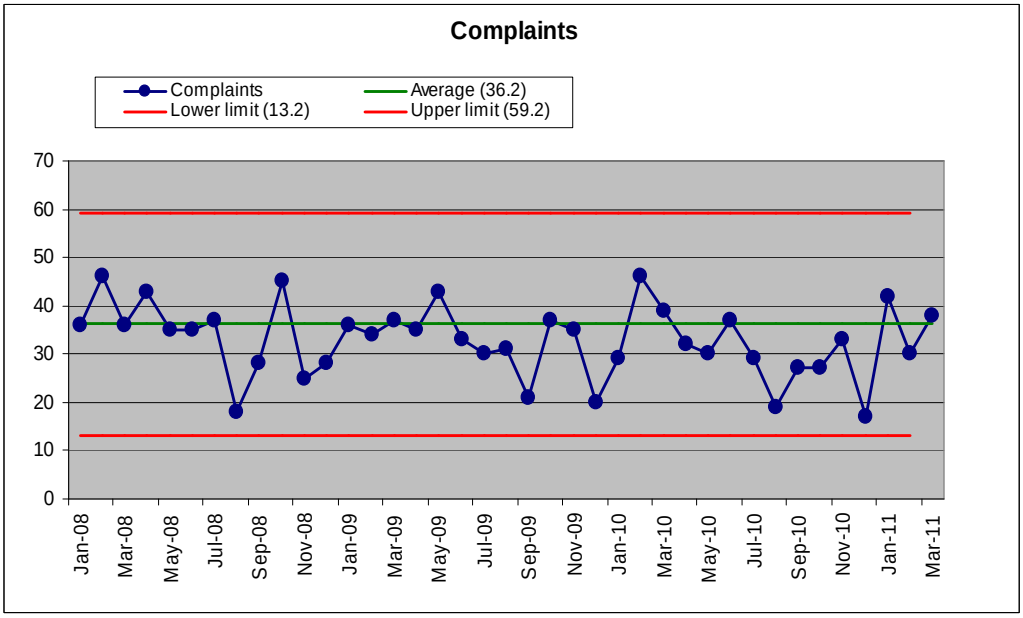
4. Patient Experience

4.1 Complaints/Ombudsman reports

There were thirty eight complaints received in March compared with thirty in February. The divisions with highest complaints were Surgery (twelve), Acute & Emergency Medicine (eight) and Trauma and Orthopedics (five).

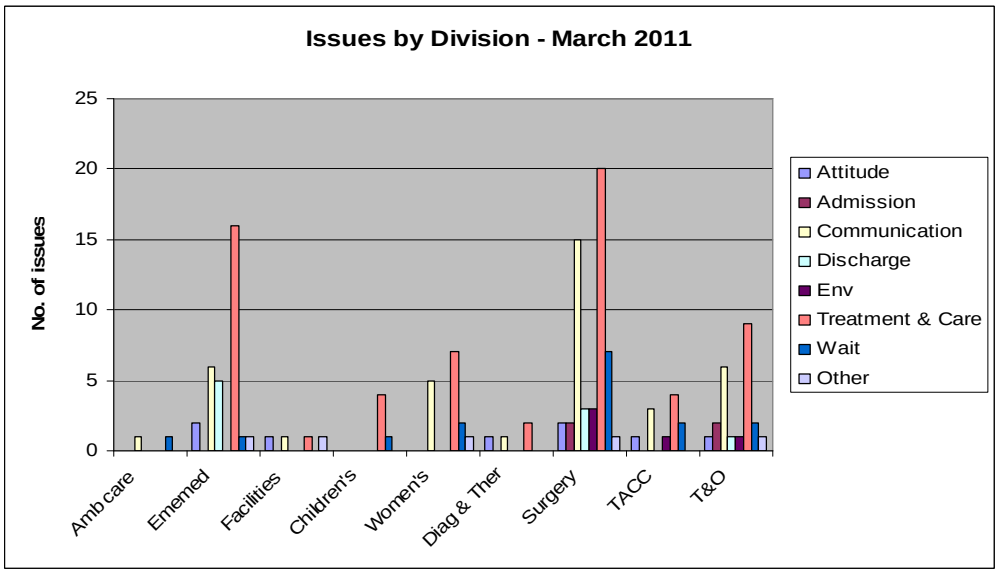
There were thirty seven responses due in March and thirty four (92%) were sent within the agreed timescale. Table 5 shows total number of complaints received each month and demonstrates that the average number of complaints received each month is 36.2.

Table 5



The main issues raised in complaints during March were 'Communication: Accuracy', 'Clinical Decisions and Treatment' and 'Communication: Sensitivity'. Table 6 provides a breakdown of issues by Division.

Table 6



The Trust received notification of two referrals to the Ombudsman for review during March. The first complaint was a Surgical complaint, investigated in 2009. The second was an Acute & Emergency Medicine Complaint investigated in 2008. A full copy of both complaint investigation files and relevant

medical records has been provided to the Ombudsman for initial assessment. The Trust awaits the outcome of this initial assessment as to whether these will proceed to further review.

"Your Feedback" Summary Results 2010-11

"Your Feedback" is a questionnaire approach to seeking views from patients on their experience of care and treatment within the Trust. The questionnaire is handed out to patients at the end of their stay and covers many aspects of care and experience, aligning with many of the questions within the National Patient Survey. The approach has been developed over the last 12 months and the inclusion of the Net Promoter Score (NPS) as an element within Your Feedback gives the Trust a view on patient "loyalty" by asking if they would recommend the Trust to others. Changes were made to the questionnaire in Q4 with minor changes to the wording of a few questions, inclusion of two extra questions; being treated with respect and courtesy by therapists and experience of mealtimes.

Net Promoter Score (NPS)

NPS is calculated by subtracting the % of patients scoring 0-6 (detractors) from the % of patients scoring 9-10 (promoters); values 7, 8 are neutral.

Table 7: Q4 results

Ward	Q4 Forms completed as % of Target	Q4 Score Trust Average 79.3%	Q4 NPS Trust Average 56%
Aspen	30%	83%	80%
Birch	120%	83%	73%
Holly	107%	83%	38%
Cedar	60%	87%	90%
May	44%	81%	67%
Maple	79%	67%	27%
MAU	95%	71%	27%
Chaucer	75%	53%	100%
Wordsworth	15%	76%	50%
Kestrel	6%	84%	67%
Fielding	65%	79%	67%
Dickens	41%	87%	82%
Elm	70%	77%	24%
Juniper	33%	81%	63%
Kingfisher	61%	76%	38%
Falcon	56%	78%	67%
Heron	37%	80%	79%
SAU	113%	79%	56%
All Wards	55%	79%	56%

- Wards where total score for "Your Feedback" and NPS are both high are: Aspen, Birch, Cedar, Dickens and Heron.
- In many cases the overall score for the questionnaire does not correlate to the NPS; Holly, Maple, MAU, Elm and Kingfisher. This is an interesting result; patients are scoring on Your Feedback relatively highly but would not recommend the Trust to others. Consideration is being given as to how the Trust can better understand these indicators.
- Note low numbers of forms returned for Chaucer (9), Wordsworth (11) and Kestrel (11). The Heads of Nursing will be tasked with increasing the rates of form completion.

Table 8: Overall Net Promoter Scores Q4

Trust	56%
Medicine	56%
T&O	62%
Surgery	52%

Table 9: Total "Your Feedback" (does not include NPS Scores) Q2 to Q4

Ward	Q2 Score	Q3 Score	Q4 Score
Aspen	79.7%	82.1%	83.0%
Birch	84.3%	80.1%	82.9%
Holly	70.5%	75.2%	83.3%
Cedar	77.8%	79.2%	86.7%
May	78.2%	71.0%	80.7%
Maple	69.9%	75.1%	66.6%
MAU	77.4%	72.0%	70.8%
Chaucer	85.5%	84.8%	53.1%
Wordsworth	65.8%	66.1%	76.1%
Kestrel	N/A	62.6%	84.0%
Fielding	75.3%	73.0%	79.4%
Dickens	85.3%	86.5%	87.3%
Elm	73.6%	72.9%	77.1%
Juniper	76.3%	73.6%	80.5%
Kingfisher	72.0%	74.6%	75.5%
Falcon	71.7%	81.7%	78.2%
Heron	79.7%	79.6%	80.4%
SAU	78.2%	78.6%	78.7%
All Wards	76.7%	76.70%	79.30%

- Wards with consistently high scores are: Aspen, Birch, Dickens, Heron, SAU.
- Wards where scores have improved are: Holly, Cedar, May, Kestrel (low numbers of forms), Fielding, Elm, Juniper.
- Wards where scores are in the middle range are: Maple, MAU, Kingfisher, Falcon, SAU.
- Wards where scores have decreased are: Chaucer (low numbers of forms).
- Overall score for the Trust has improved.
- Trust overall form completion rate has increased in Q4 to 55% of the target.

4.2 National Patient Survey Results 2010

Background

In accordance with national guidance, the Trust has recently completed the 8th mandatory Inpatient Survey. The Care Quality Commission (CQC) administers the survey programme, the results of which provide an important source of data for cross checking against Trust's self assessment of compliance with the CQC's Essential Standards of Quality and Safety. The surveys are expected to inform local improvement activity and are seen as an important source of information for both users of health services, to help them choose between providers, and for commissioners of service.

Following the completion, the CQC publish a nationally benchmarked Trust specific report to allow Trusts, and the population they serve, to make meaningful comparisons between organisations based on the reported experience of surveyed patients.

The survey of adult Inpatients involved 161 Acute and Specialist NHS Trusts with response received from more than 66,000 patients. People were eligible for the survey if they were aged over 16 years, had at least one overnight stay and were not admitted to a maternity or psychiatric unit during the

period of July 2010. The Trust surveyed 850 inpatients. The Trust survey response rate was 46% (the lowest over the eight year period) compared with a national average of 50%.

The Results

The Trust is scored on a scale of 0 –100. A score of 100 represents the best possible result (results are not percentages). Results also indicate whether the Trust is in the top 20% of performance, the lowest 20% of performance or, more average, with the remaining 60% of Trusts.

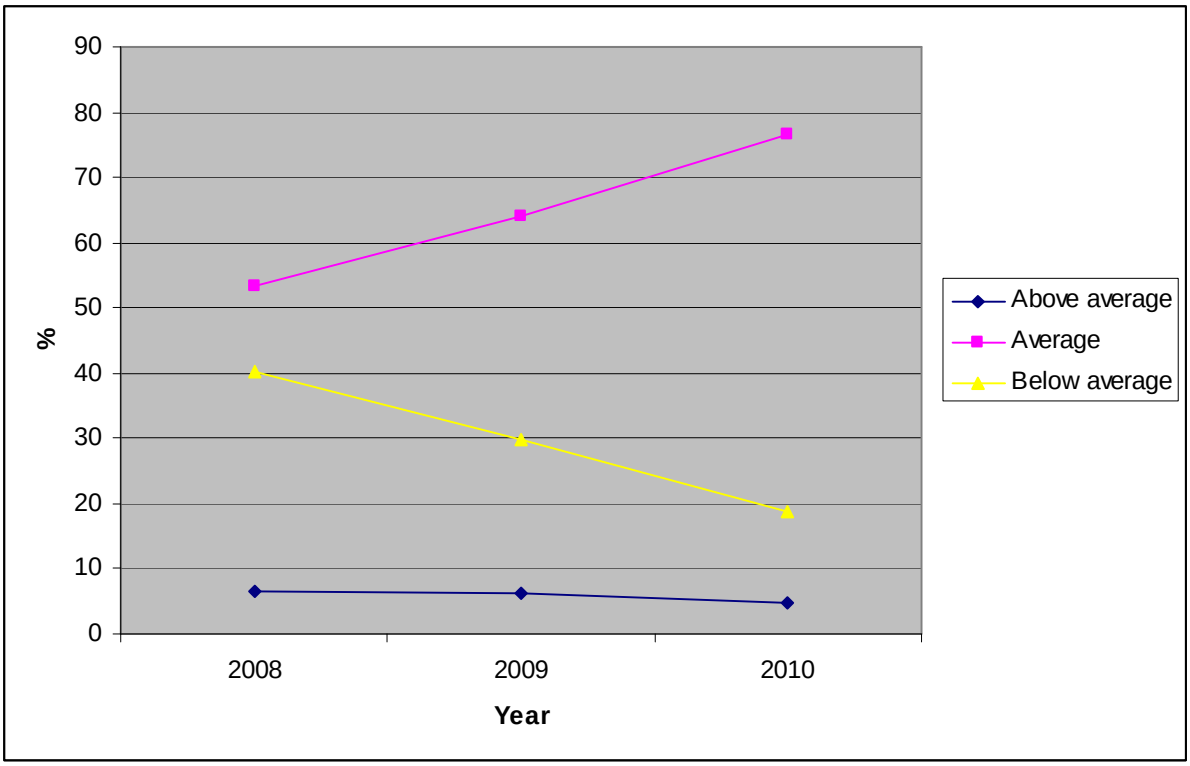
Overall, the CQC report indicates the Trust performance has continued to improve. The Trust demonstrated an 'above average' performance (highest 20% of Trusts) on 3 questions, an 'average' performance (60% of Trusts) on 49 questions and a 'below average' performance (lowest 20% of Trusts) on 23 questions.

Table 10 below presents the spread of Trust scores in comparison with the national average from 2008 to 2010. Information is also presented graphically in Graph 1. This analysis demonstrates that the Trust continues to make progress in improving the patient's perceptions of quality of care as measured through the National Inpatient Survey. Significantly, the Trust has progressed in moving a below average score to that of an average one. However, no progress has been made in moving average scores to one above average.

Table 10: The spread of Trust scores in comparison with the national average 2008 – 2010

	2010			**2009**			**2008**	
	Trust Score	**%**	% change 2009-10	Trust Score	**%**	% change 2008-09	Trust Score	**%**
Above Average	3	4.7	-1.6	4	6.3	-0.3	4	6.5
Average	49	76.6	+12.6	41	64	+10	33	53.2
Below Average	12	18.7	-11	19	29.7	-10.6	25	40.3
	64			64			62	

Graph 1: Graphical presentation of the % spread of Trust Scores by year: 2008 - 2010



Analysis of questions indicating below and above average response are presented in tables 11 and 12 below (questions in italics indicate an ongoing trend). It is positive to note a small increase in the number of responses in the top 20% and a bigger reduction in the responses in the bottom 20% but clearly a more significant shift in responses into the top 20% is desirable.

Direct comparison between questionnaires is not fully possible as, year on year, there is some variation in the questions.

Table 11: Above Average Responses (where the Trust is in the top 20%) 2010, 2009 & 2008

2010	2009	2008
Did you have somewhere to keep your personal belongings whilst on the ward?	*Did you have somewhere to keep your personal belongings whilst on the ward?*	*Did you have somewhere to keep your personal belongings whilst on the ward?*
Did you receive copies of letters sent between hospital doctors and your family doctor?	Did the anaesthetist explain how he or she would put you to sleep or control your pain?	*Did you receive copies of letters sent between hospital doctors and your family doctor?*
While in hospital, were you every asked to give your views on the quality of your care?	*Did you receive copies of letters sent between hospital doctors and your family doctor?*	*While in hospital, were you every asked to give your views on the quality of your care?*
	Were the letters written in a way that you could understand?	Did you see any posters or leaflets explaining how to complain about the care you received?

Table 12: Below Average Responses (where the Trust is in the bottom 20%) – Comparison 2010 & 2009

2010	2009
Were you given enough privacy when being examined or treated in the A & E Department? Overall, how long did you wait from being referred to hospital to be admitted? *Were you ever bothered by noise at night from other patients?* Did you feel threatened during your stay in hospital by other patients or visitors? As far as you know, did doctors wash or clean their hands between touching patients? *When you had important questions to ask a nurse, did you get answers that you could understand?* *Did you find someone on the hospital stall to talk to about your worries and fears?* *Were you given enough privacy when discussing your condition or treatment?* Were you given enough privacy when being examined or treated? Did a member of staff explain the risk and benefits of the operation or procedure? Did hospital staff explain the purpose of the medicines you were to take home? *Were you told how to take your medication in a way you could understand?*	How much information about your condition did you get in the A & E Department? *Were you given enough privacy when being examined or treated in the A & E Department?* Were you given a choice of admission dates? Were you ever bothered by noise at night from other patients? Were you every bothered by noise at night from hospital staff? Were hand-wash gels available for patients and visitors to use? Were you offered a choice of food? When you had important questions to ask a doctor, did you get answers that you could understand? *When you had important questions to ask a nurse, did you get answers that you could understand?* Did you have confidence and trust in the nurses treating you? Were you involved as much as you wanted to be in decisions about your care? *Did you find someone on the hospital staff to talk to about your worries and fears?* *Were you given enough privacy when discussing your condition or treatment?* Did a member of staff explain what would be done during the operation or procedure? Did a member of staff answer your questions about the operation or procedure? How long was the delay to discharge? Did a member of staff tell you about medication side effects to watch for? *Were you told how to take your medication in a way you could understand?*

Review of below average responses indicates the following ongoing themes:

- Privacy & Dignity in A & E
- Noise at night; particularly from other patients
- Communications with Nurses
- Hand Hygiene
- Privacy & Dignity in discussion, examination & treatment
- Information about medications.

The Way Forward

The Trust plans a feedback afternoon for Senior Managers and Clinicians on 3 May 2011. At this time, Divisional General Managers will be asked to present their Divisional plans for developing the patient experience over the coming year. In addition, a corporate plan will be drafted aimed at promoting the survey and taking further action prior to the 2011 sampling period; July 2011.

Patient Experience Summary

Overall the results indicate an improving picture with some notable exceptions to the trend. The rate of improvement, however, should be accelerated and a number of key initiatives should support more rapid improvement:

- **Programme 1 Improving the Patient Experience**: the programme aims to integrate work across a variety of dimensions that together aim to improve the patient experience of care and has improvement work underway in the areas of:
  - leadership, strategy and campaign development
  - strengthening effective communication
  - environmental improvements
  - safety, privacy and dignity
  - monitoring and identifying good and poor practice to enable reward and intervention.

  In the forthcoming year the programme will initiate three further areas of work:

  - Living our Values
  - Best Care Program
  - Streamlining Discharge Project.

Living our Values is an initiative which seeks to expose the whole organisation (all 3,200 staff) to real patient stories which provide a narrative describing their experience and emphasising how the attitude of staff made them feel. This will be delivered to ward and speciality groups by trained facilitators. The initial sessions will hear the patient stories and experience and feel the emotions generated. The energy created will then be harnessed to motivate and sustain staff to build upon our organisational values and behaviours and to resolve to deliver service and care tangibly and empathetically focused on the individual needs of patients – “compassion in action”.

The **Best Care Programme** focuses on improving the provision of essential and specialist care to the vulnerable, elderly and those with dementia and at end of life and will initiate a variety of activities that aim to deliver and monitor the “best care” and identify areas for targeted improvement support. Activity such as “Care Rounding” and ward to ward peer review will be included. Essential care will focus on dignity, hydration and nutrition, safety and comfort ensuring all staff give basic but essential elements of care. Specialist care will focus on more sophisticated care including administering of drugs and therapeutic interventions such as catheterisation and intravenous line insertion as well as meeting the specialist needs of specific patient groups such as those with dementia.

The **Discharge Project** will reinforce the learning from investigations concerning poor discharge practice. All staff involved in discharge planning will undergo specific training and understand their

responsibility to the patient in arranging discharge. There will be multidisciplinary approach and the role and responsibility of the ward sister will be emphasised.

4.3 Update – Action in Response to Parliamentary Healthcare Ombudsman Report (Mr W)

Summary of Case

Mr W was 79 years old and suffered from dementia, depression and was frail and was admitted to St Peter's Hospital with recurrent dehydration and pneumonia in 2007. His daughter complained about Mr W's care and treatment to the PHSO who upheld her complaint finding that:

- the Trust did not follow the discharge policy or national guidance which state that patients should be fit for discharge
- the Trust did not meet Mr W's nutritional and fluid intake needs and this continued until his discharge
- the doctor caring for Mr W was no longer actively treating him; the implication being that he would develop another chest infection from which he would die
- the lack of treatment given to Mr W put his life at risk.

The full report can be read at:

http://www.ombudsman.org.uk/care-and-compassion/home

Trust Response

Development of Action Plan

A detailed action plan has been developed and was submitted to the Trust Board for approval in August 2010. The action plan was shared with the complainant, the Care Quality Commission, South East Coast Strategic Health Authority and the PHSO. The PHSO has subsequently agreed that the action plan is appropriate in both content and delivery focus and commended the comprehensive nature of the plan. Work to deliver the action plan and thus improve the care of patients is focused in three key areas:

1. Improvement of and compliance with Discharge Policy.
2. Achieving safe and timely discharge.
3. Achieving a behavioural shift within the organisation that creates an enabling culture that promotes patient centred decision making and action at all times and advocacy.

Progress

Detailed actions and response have formerly been reported to Board but key recent actions are detailed below:

1. **Discharge Road Shows** that raise awareness and enable frontline clinicians and staff to share their practice and concerns have been undertaken across the Trust in March and will be repeated on a rolling basis to co-ordinate with junior doctor rotations.
2. A **Discharge Follow-up Call** initiative has been modelled and developed by the Day Surgery Team. A member of nursing staff calls every patient the day following their discharge to check on the patient's progress, answer any queries or concerns and direct to the appropriate level of service as necessary. The initiative has been well received by patients. The model is now being trialled in MAU prior to refinement and implementation across the Trust.
3. Implementation of the **new nursing establishment and leadership structure** which enables; stronger divisional leadership and "holding to account, frees the Matrons from operational service delivery to focus on quality, valuing and role modelling Essential Care, identification of Band 6 (Junior Sister) ward level discharge liaison nurses.

4. Completion of Essence of Care Nutritional Audit of St. Peters site with Ashford site to be completed as part of **Nutrition Focus Month in June**. The audit gave rise to an action plan that includes a re-launch of protected mealtimes and a focus on improved MUST skills and competence. The monthly Registered Nurse Development Days now include a session on the use of MUST Nutritional Risk Assessment. Nutrition Focus Month will provide an opportunity for all staff in the Trust to consider the importance of nutritional assessment and support and to reflect on their practice. The dieticians are reporting a strong increase in the numbers of referrals received requesting nutritional a support and therapy which indicates a wider improvement in nutritional awareness and practice.
5. **Care Rounds** have been introduced across the Trust in a way that enables ward areas to tailor the approach to meet individual patient needs. The Heads of Nursing and Ward Managers are designing the audit approach.
6. The **Essential Care Spot Checks** are now well embedded across the Trust and routinely report positive findings. The key focus now is to ensure follow through on those aspects checked found to be below the desired standard.
7. The **Best Care Programme** is almost fully defined. Essential Care and Specialist Care workstreams have been agreed using the Essence Care Toolkit as a framework. The Programme will be led by the Deputy Chief Nurse, each project by a Head of Nursing and each workstream by a Matron.

External Peer Review

The Board previously agreed that an external Peer Review be sought to review the effectiveness of the action plan and to examine the extent to which best practice had been embedded across the organisation.

Professor David Oliver has agreed to work with the Trust on developing and implementing the Peer Review. David Oliver is the National Clinical Director for Older People. He is a consultant physician and clinical director at the Royal Berkshire NHS Foundation Trust, visiting professor of medicine for older people at City University, London and a recent secretary of the British Geriatrics Society. He has enjoyed a wide variety of leadership and national advisory roles and is an active researcher and teacher.

The Chief Nurse and Medical Director have arranged to meet David Oliver and agree the terms of reference and design for the Peer Review in May.

4.4 Ward Quality Indicators (WQI)

Ward Quality Indicators (WQI)

The ward Quality Indicators are found at Appendix 3.

Action to implement the Essential Care Spot Checks and Care Rounds has been taken. The checks have demonstrated some very positive observations, the opportunity to address patient and staff issues in real-time as well as emphasising the role modelling and visible leadership role for senior clinical, non-clinical and nursing staff across the Trust. Ward Sister will champion these initiatives and work with the Heads of Nursing to develop the appropriate audit methods over the coming months.

For the month of March 2011, the WQI indicate that the main themes, by Division, are:

Medicine and Emergency Services:

Falls – Aspen, Kestrel and MAU remain high but the trend analysis indicates these are now decreasing. The Trusts falls group are developing a falls strategy and the Division have set a target of 15% reduction in falls for 2011-12. High impact interventions for nursing and midwifery and the

development and implementation of the Best Care Programme will focus on addressing this as a first priority.

Medication Errors- there have been a number of medication errors on Aspen ward, a root cause analysis has been completed and the matrons are using this information as a learning tool. Within the Division the Clinical Governance Manager has developed a "medication error points system" for keeping a record of staff that has been involved in any medication errors - they are awarded points depending on the severity of the error. This is an excellent idea and will be used to develop a Trust wide model.

Discharge Checklists- the restructure and development of ward establishments have now identified two Band 6 Registered Nurses per ward who will have responsibility for discharge practices within the ward area. Implementation of the Discharge Project will support training and development and best practice as well as identify metrics for effectiveness.

As the new nursing structure embeds one of the key matron roles will be to monitor the quality of care given within the ward areas working with the Ward Managers to address areas of concern and facilitating Ward Manager ownership and accountability of all action plans.

Wards identified for action based on the WQIs are: Kestrel, Aspen, May, ED, MHDU, CCU. Examples of action noted are: discharge training, introduction of the new single assessment process document and training and development of medication practices.

Surgery & Orthopaedics:

Discharge Checklist- actions identified as (above) within the Division of Medicine & Emergency Services.

Elm Ward – quality indicators highlighted this ward as needing support to address falls and hospital acquired pressure ulcers. The matron for this area is working to strengthen and support the ward leadership using weekly monitoring and feedback sessions. Action plans have been developed and are owned by the Ward and Ward Manager.

SAU - Saving Lives quality indicators highlight concern around peripheral cannula insertion. Root Cause Analysis (RCA) identified that Visual Infusion Phlebitis (VIP) Scores should be closely need monitored and included with the Care Rounding Checklist for this area.

The tables below outline quarterly trends for the number of non-compliant recordings (breaches) against the WQI targets.

It can be seen that improving trends (reducing numbers of breaches) are emerging for:

- Maple, Holly, Heron, Cedar, Birch, Heron, and Falcon wards

Equivocal trends are apparent for:

- Fielding, Wordsworth, Kingfisher and Chaucer wards

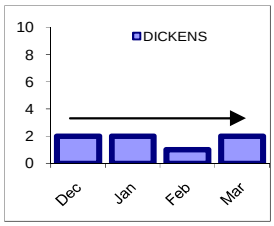
Declining trends are apparent for:

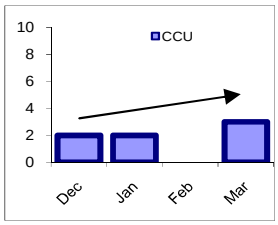
- Aspen, May, kestrel, Elm, Dickens, CCU, MHDU, SDU, SAU wards and ED.

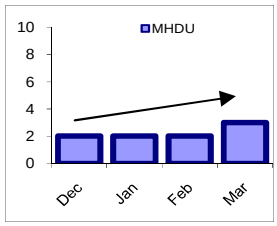
Focused review of these ward areas will be undertaken by the Deputy Chief Nurse in conjunction with the Heads of Nursing and the relevant Matrons and Ward Sisters to both understand these trends and take responsive action.

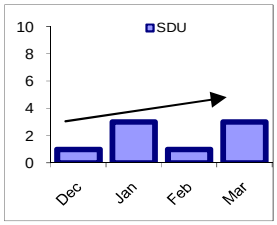
Head of Nursing for Medicine and Emergency Survives together with the relevant Matrons will conduct a Deep Dive Review of the ward areas on Ashford site early in May.

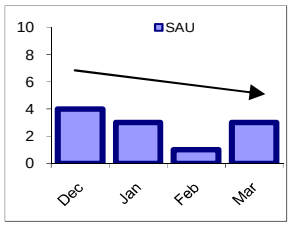
It is positive to note that significant reversals of trend are noted for Kingfisher and Falcon Wards and the Heads of Nursing will be tasked with acknowledging this achievement with the ward teams and ensuring sustained improvement.

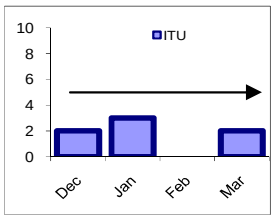

DICKENS
10
8
6
4
2
0
Dec
Jan
Feb
Mar

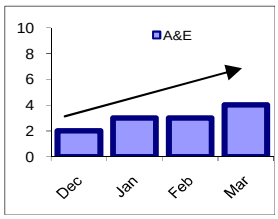

CCU
10
8
6
4
2
0
Dec
Jan
Feb
Mar

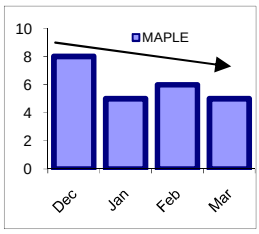

MHDU
10
8
6
4
2
0
Dec
Jan
Feb
Mar

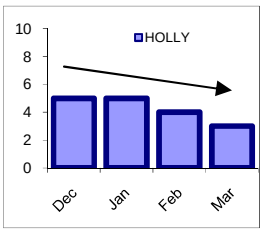

SDU
10
8
6
4
2
0
Dec
Jan
Feb
Mar

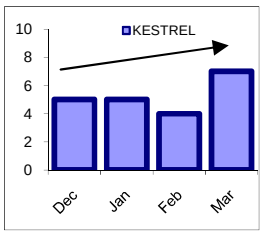

SAU
10
8
6
4
2
0
Dec
Jan
Feb
Mar

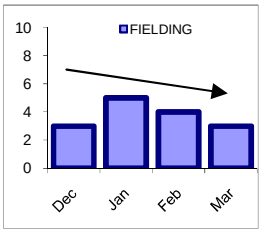

ITU
10
8
6
4
2
0
Dec
Jan
Feb
Mar

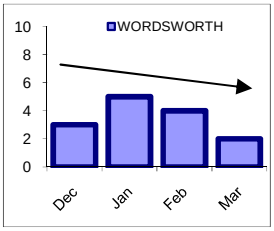

A&E
10
8
6
4
2
0
Dec
Jan
Feb
Mar

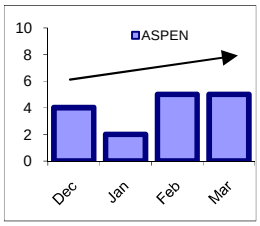

MAPLE
10
8
6
4
2
0
Dec
Jan
Feb
Mar

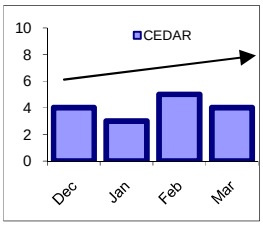

HOLLY
10
8
6
4
2
0
Dec
Jan
Feb
Mar

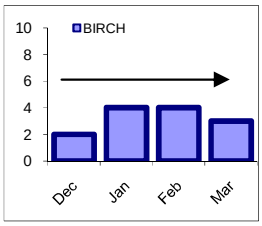

KESTREL
10
8
6
4
2
0
Dec
Jan
Feb
Mar

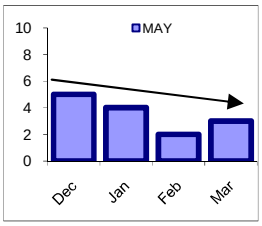

FIELDING
10
8
6
4
2
0
Dec
Jan
Feb
Mar

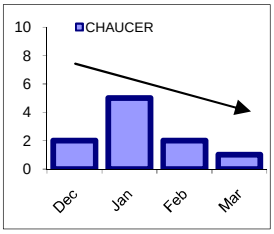

WORDSWORTH
10
8
6
4
2
0
Dec
Jan
Feb
Mar

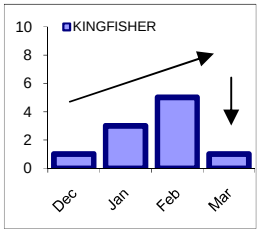

ASPEN
10
8
6
4
2
0
Dec
Jan
Feb
Mar

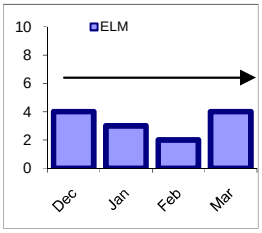

CEDAR
10
8
6
4
2
0
Dec
Jan
Feb
Mar

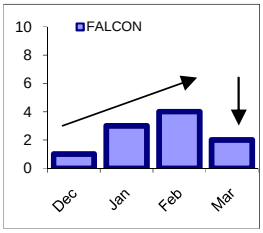

BIRCH
10
8
6
4
2
0
Dec
Jan
Feb
Mar

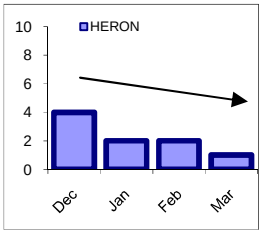

MAY
10
8
6
4
2
0
Dec
Jan
Feb
Mar

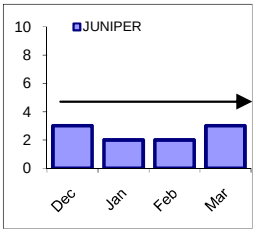

CHAUCER
10
8
6
4
2
0
Dec
Jan
Feb
Mar


KINGFISHER
10
8
6
4
2
0
Dec
Jan
Feb
Mar


ELM
10
8
6
4
2
0
Dec
Jan
Feb
Mar


FALCON
10
8
6
4
2
0
Dec
Jan
Feb
Mar


HERON
10
8
6
4
2
0
Dec
Jan
Feb
Mar


JUNIPER
10
8
6
4
2
0
Dec
Jan
Feb
Mar

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

Date: 20th April 2011

National Sentinel Stroke Audit 2010

1.0 Background

The National Sentinel Stroke Audit has taken place on a 2-year cycle since 1998 and is now it it's seventh round. The audit was funded by the Healthcare Quality Improvement Partnership (HQIP) and run by the Clinical Standards Department of the Royal College of Physicians. Data was collected within trusts using a standardised method. This audit was overseen at trust level by a lead clinician for stroke who is responsible for the quality of data supplied. At ASPH this was Dr Bhaskar Mandal, Stroke Lead.

The results from this audit are based on information obtained retrospectively from patient records. They compare delivery of care with standards derived from systematically retrieved and critically appraised research evidence and agreed by experts in all disciplines involved in the management of Stroke.

The audit sample consisted of consecutive cases with primary diagnosis of stroke (ICD 10 codes: 161, I63 and I64) admitted to hospitals between 1st April and 30th June 2010. ASPH were required to submit 60 cases but actually 70 cases were returned and included in the audit.

2.0 Patient Demographics

The findings for ASPH using the data collected from the 70 cases submitted showed 65 of these patients were admitted to the Stroke Unit the remaining 5 were cared for in areas more appropriate to their needs, this included ITU and MHDU (4%) or were already an inpatient at the time of their stroke (3%). Of the 70 patients 50% were male and 50% female, against a national average of 49% and 51% respectively. Our female patients were slightly older than the national average (median 81.4yrs versus 82.2yrs).

Our patients presented mainly with ischaemic strokes (87%), 13% of our patients were haemorrhagic strokes 1% more than the national average. Of these 16% presented unconscious against a national average of 9% this may mean the dependency level for our patients at admission is greater. Past medical history indicated our patients were more likely to have significant co-morbidities prior to admission. For example 30% of our patients had atrial fibrillation (AF) versus the national average of 21%. Similarly 29% of patients had a previous diagnosis of diabetes versus the national average of 18% and 24% of patients had had an MI or angina against the national average of 18%. This is reflected in the patient's pre-admission medication, 47% were on lipid lowering drugs and 46% on anti-platelet medication (national average 41% and 43% respectively). 28% of the patients had three risk factors for stroke compared to the national average of 23%, only 14% of patients admitted to ASPH had no known risk factors, nationally this figure is 27%. Risk factors identified showed less ASPH patients were smokers but alcohol excess greater than 14 units for women and 21 units for men was higher in the ASPH patients (11%) than the national average of 8%.

6% of our patients were entered onto a research trial.

3.0 Patient Outcomes

Fifty five patients were discharged alive, of these 6% were transferred to residential or care homes for the first time, nationally the figure is 10%. Discharge disability measured using Barthel score suggests more of our patient are independent at discharge 55% compared to 42% nationally. Just 7% have a function level at discharge of very severe against 12% nationally.

The length of stay for a stroke patient at ASPH who were discharged a live was 8 days (median) compared to 10 days (median) nationally. Just 36% of our patients stayed more than 14 days compared to 41%.

At the time of the audit we did not have an Early Supportive Discharge service. The current pilot has proved favourable and the intention with the support of the Transformational board is to extend the project for a further three months. For follow up with a member of the stroke team at six weeks and for rehabilitation planned prior to discharge we were within 1% of the national average.

21% against the national average of 19% died in hospital, this could be a consequence of the severity of the strokes suffered with 16% presenting unconscious.

4.0 Multidisciplinary Assessment

Overall our patients received the recommended average daily amount of therapy input – 45 minutes – where applicable from physiotherapy, OT and Speech and Language. There may be a link to independence at discharge with 55% compared to 42% nationally being independent. Speech and Language therapy were able to provide 45 minutes to 35% of patients against a national average of 18%. Although this is an achievement it is recognised by the Local Implementation Team for Stroke at ASPH more resource is required to build on this success. This is reflected in the initial assessment of communication problems by speech and language therapist within seven days of admission where ASPH scored 65% against a national average of 82%.

Screening and function assessment after admission showed a gap in evidence patients mood had been assessed, just 63% compared to the national average of 80%. This could be due to poor documentation it is however recognised ASPH stroke patients do not have direct access to a clinical psychologist.

Patients had been weighed during admission and screened for malnutrition using MUST but only 95% received fluids within 24 hours of admission compared to nationally 99% with 90% of patients receiving nutrition within 72 hours of admission compared to nationally 95%. Remembering 16% of ASPH stroke patients presented unconscious.

Social worker assessment within seven days of referral was 19% compared to 67% nationally,

5.0 Promotion of Continence

ASPH patients were 3% more likely to have a urinary catheter the most documented reason was for retention. Pre-existing catheters accounted for 6% and urinary incontinence as a rationale for catheterisation accounted for 13%. Nationally urinary incontinence as a reason for catheterisation was 10%. Disappointingly only 20% of ASPH patients had a documented plan to promote urinary continence.

Interestingly 11% of ASPH patients had developed a urinary tract infection in the first seven days compared to 6 % nationally. Our patients were also more likely to develop pneumonia after admission 19% compared to 13% nationally. This may be linked to the number of patients presenting as unconscious.

6.0 Communications with Patients and Carers

The results for this section are significantly below the national average. Discussion with patients about diagnosis 57% (80%), prognosis 33% (73%), advice given on driving 32% (65%), carers needs for support assessed separately 53% (76%), skills taught to care for patients at home 62% (80%). Since the audit the Trust has introduced seven day stroke nursing service this may address some of the issues with communication. A further survey and more education and support for the stroke team on communication and documentation of communication id required.

7.0 Nine Key Performance Indicators summary

Nine Key Indicator Stroke Care	National	Our Hospital
Patients spending >90% of their stay on a stroke unit.	70%	**91%**
Screening for swallowing disorders within 24 hours of admission	83%	**99%**
Brain scan within 24 hours of stroke	93%	**95%**
Physiotherapy within 72 hours of admission	91%	**100%**
Occupational therapy within 4 working days of admission	83%	**100%**
Patient weighed during admission	85%	**96%**
Mood assessed by discharge	80%	**63%**
Rehabilitation goals agreed by MDT	78%	**99%**
Patient initially admitted to SU	36%	**73%**
Rehabilitation goals agreed by the MDT within 5 days admission	78%	**99%**
Discussion about diagnosis	80%	**57%**

7.0 Recommendations

7.1 Screening and function assessment after admission a review of the following areas:

- 7.1.1 Provision of Speech and Language requirements specific to communication
- 7.1.2 Provision of access to clinical psychologist and / or access to assessment of patient cognitive and perceptive problems (mood). Work to be linked to the requirements identified for patients with Dementia.
- 7.1.3 Nutritional guidelines
- 7.1.4 Provision of social worker assessment within seven days of referral

7.2 Promotion of continence

- 7.2.1 A review of services to promote continence should be conducted across the Trust using the National Audit of Continence Care Healthcare Quality Improvement Partnership report September 2010

7.3 Communications with Patients and Carers

- 7.3.1 Training and education for the Multidisciplinary team, including doctors on communication and documentation of communication
- 7.3.2 Internal notes audit
- 7.3.3 Audit and review of Integrated Care Pathway documentation
- 7.3.4 Survey Patients and Carers to determine the understanding of the issues

7.4 Outcomes

- 7.4.1 Continue to actively participate in the Early Supportive Discharge Pilot with Surrey Community Health. The Pilot is monitored by the Transformational Board

Appendix 2 WQI definitions

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

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.

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 - March 2011

N/S: No submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives: Central Lines Insertion	Saving Lives: Central Lines After Care	Saving Lives: Urinary Catheter Insertion	Saving Lives: Urinary Catheter After Care	Saving Lives: Peripheral Cannula	Saving Lives: Peripheral Cannula After Care	Cleanliness	Matron Environment Audit	MalNutrition Universal Screening Tool	Discharge Check List	Mixed Sex Wards Compliance	Pressure Ulcer Prevention: Compliance with monitoring of Pressure Ulcer	Pressure Ulcer Prevention: Hospital Acquired Grade 1	Pressure Ulcer Prevention: Hospital Acquired Grade 2	Pressure Ulcer Prevention: Hospital Acquired Grade 3	Pressure Ulcer Prevention: Hospital Acquired Grade 4	Mixed Sex Wards Compliance	Patient Falls: Number of falls	Patient Falls: Resulting in Injury	Complaints	Medication Errors: Administration	Medication Errors: Prescribing	VTE Assessment Compliance	Your Feedback
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	>=85%	>=85%	0	=100%	<1	<1	<1	<1	=0	=0	=0	=0	=0	=0	>=90%	>=90%
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%	84% - 70%	84% - 70%		99% - 76%	1- 2	1- 2	1- 2	1- 2								89%-75%
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<70%	<70%	>=1	<=75%	>=3	>=3	>=3	>=3	>=1	>=1	>=1	>=1	>=1	>=1	<90%	<75%
MEDICINE 1,2,3	ASPEN	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	90 %	95 %	94 %	87 %	0	100 %	3	0	0	0	0	5	0	0	2	1		68.6 %
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	80 %	100 %	97 %	95 %	100 %	31 %	0	100 %	0	0	0	0	0	0	0	0	1	1		N/A
	BIRCH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	95 %	100 %	100 %	0	100 %	1	0	0	0	0	0	0	0	1	0		76.7 %
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	95 %	100 %	N/A	0	100 %	0	0	0	0	0	1	0	1	0	1		N/A
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	92 %	97 %	98 %	100 %	0	100 %	0	0	0	0	0	1	0	0	0	1		85.8 %
	CEDAR	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	93 %	97 %	98 %	93 %	0	100 %	0	0	0	0	0	1	0	1	0	0		79.2 %
	MAY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	95 %	87 %	N/A	0	100 %	0	0	0	0	0	2	0	0	0	1		85.5 %
	MAPLE	98 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	94 %	93 %	100 %	87 %	0	100 %	0	1	0	0	0	3	0	0	0	5		74.3 %
	SHORT STAY UNIT	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	93 %	92 %	N/A	0	N/A	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A		N/A
ASHFORD	CHAUCER	98 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	97 %	87 %	27 %	0	100 %	0	1	0	0	0	3	0	0	0	0		N/A
	WORDSWORTH	100 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	96 %	97 %	87 %	75 %	0	100 %	0	1	0	0	0	3	0	0	0	0		N/A
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	97 %	92 %	55 %	0	100 %	0	1	1	0	0	1	0	1	0	0		98.9 %
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	98 %	N/A	77 %	0	100 %	0	0	0	0	0	0	0	1	0	0		88.2 %
	ELM	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	90 %	95 %	93 %	28 %	0	100 %	0	2	0	0	0	5	0	1	0	0		66.9 %
	JUNIPER	100 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	95 %	97 %	83 %	37 %	0	100 %	0	0	0	0	0	8	0	0	0	0		96.4 %
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	85 %	96 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0		N/A
SURGERY	KINGFISHER	100 %	0	0	N/A	100 %	100 %	100 %	100 %	80 %	100 %	95 %	88 %	95 %	0	100 %	0	0	0	0	0	0	0	1	0	0		73.3 %
	FALCON	100 %	0	1	N/A	100 %	100 %	100 %	100 %	100 %	96 %	92 %	87 %	62 %	0	100 %	0	0	0	0	0	0	0	0	0	0		73.9 %
	SDU	99 %	0	0	N/A	N/A	100 %	100 %	90 %	90 %	99 %	100 %	100 %	N/A	0	100 %	0	0	0	0	0	0	0	1	0	0		N/A
	ADMISSIONS LOUNGE	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	96 %	94 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	2	0	0		N/A
	HERON	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	90 %	92 %	35 %	0	100 %	0	0	0	0	0	0	0	0	0	1		94.7 %
	KESTREL	95 %	0	0	N/A	N/A	100 %	70 %	80 %	70 %	94 %	93 %	78 %	91 %	0	100 %	1	1	0	0	0	7	0	0	0	0		N/A
EMERGENCY SERVICES	MAU	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	92 %	98%	N/A	57 %	0	N/A	0	0	0	0	0	5	0	1	0	0		86.1 %
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	80 %	100 %	96 %	90 %	100 %	64 %	0	100 %	0	0	0	0	0	0	0	2	0	0		86.6 %
	A&E	96%	0	0	N/A	N/A	N/A	N/A	80 %	N/A	96 %	96 %	N/A	N/A	0	N/A	0	0	0	0	0	3	0	3	0	1		N/A
PAEDIATRICS	OAK	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	98 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	ASH	98 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	98 %	96 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	2		N/A
	PAED A/E	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	92 %	94 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	2	0	0		N/A
	NICU	100 %	0	0	N/A	100 %	N/A	N/A	N/A	100 %	99 %	95 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	1	1		N/A
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	96 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	THEATRES ASH	98 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	97 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	DSU SPH	100 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	95 %	97 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	1	0	0		N/A
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	94 %	96 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
IMAGING/ENDOSCOPY	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	97 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	98 %	99 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	83 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	98 %	100 %	N/A	N/A	0	100 %	0	2	0	0	N/A	0	0	0	3	0		N/A
MATERNITY	JOAN BOOKER	100 %	0	0	N/A	100 %	100 %	100 %	N/A	100 %	97 %	95 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0		N/A
	LABOUR WARDS	100 %	0	0	100 %	N/A	100 %	N/A	100 %	100 %	97 %	93 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	2	0	1	1	0		N/A
	MATERNITY ULTRASOUND/ANC	100%	0	0	N/A	N/A	N/A	N/A	N/A	N/A	88 %	94 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0		N/A
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	98 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0		N/A
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	91 %	98 %	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0		N/A
OTHERS	EYE CLINIC SPH	96 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	2	0	0		N/A
	EYE CLINIC/UNIT AH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	98 %	N/A	N/A	0	N/A	0	0	0	0	0	0	0	0	0	0		N/A