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

TRUST BOARD
29th September 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for August 2011.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience is occurring. Stakeholder views have been sought as part of the Quality Account development process.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's 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:	September 2011
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 2010/11 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 5 (August we divide 2011/12 Total by 2011/12 YTD at month 5 to give us the proportion of activity that has taken place as a guide to how much more activity will take place during the rest of 2011/12. This is then multiplied out by the YTD figure for 2011/12. To further account for recent up or downward trends we have divided the average monthly figure for 2011/12 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 5/(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 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 Commentary on Quality and Safety Balanced Scorecard

Table one: Quality Performance Dashboard

BALANCED SCORECARD — **Position as at: 31 Aug 2011**

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

	Patient Safety & Quality	Outturn 10/11	Annual Target 11/12	Annual Forecast 11/12	Aug Actual	Performance			YTD 11/12
						Jun	Jul	Aug	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	91.8	90.4(May)	▼	▼	▲	98.4*
1-02	Crude mortality	1.60%	1.60%	1.59%	1.37%	▲	▼	▲	1.58%
1-03	MRSA (Hospital only)	5	4	3	1	◄►	◄►	▼	1
1-04	C.Diff (Hospital only)	36	33	31	2	▲	▼	▼	11
1-05	Mortality from C.Diff (All cases)	10.3%	6.3%	10.7%	33.3%	▼	▲	▼	20.0%
1-06	Mortality from VTE	0.4%	0.35%	0.00%	0.0%	◄►	◄►	◄►	0.0%
1-07	Mortality from Hip fractures	4.8%	4.6%	4.6%	5.8%	▲	▼	▼	4.7%
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)	77.3%	90.0%	80.0%	80.4%	▼	▲	▼	79.9%
1-10	Formal complaints	360	320	342	42	◄►	◄►	▼	172
1-11	SUIs	14	14	19	2	◄►	▲	◄►	12
1-12	Falls - resulting in significant injury (grade 3)	16	14	14	2	◄►	▼	◄►	4
1-13	Hip fractures treated within 36 hrs	93.0%	85%	94%	96.8%	▲	▲	▼	93.9%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1583	130	▲	▼	▲	678
1-15	Average Bed Occupancy-Actual beds	94%	94%	94%	89%	▼	▲	▼	92%
1-16	Average Bed Occupancy-Planned beds	Work in progress							

Delivering or exceeding Target		Improvement Month on Month
Underachieving Target		Month in Line with Last Month
Failing Target		Deterioration Month on Month

The Trust's SMR has fallen to 90.4. This figure places the Trust at 108 in a ranking of 188 Trusts. A large number of Trusts are recording figures around this mark and a small improvement will see a dramatic improvement in the Trusts ranking. Dr Foster have also announced that they are about to add four more variables to the SMR calculation to improve its accuracy and discriminatory power. The Trust awaits this new calculation and ranking.

The Trust is currently reviewing mortality rates in neonatal medicine and complex bladder cancer surgery. Although the Trust has no specific concerns, it is felt important that we bench mark these highly specialist services against other specialist units. The Board will be updated on these reviews.

The Trust CMR has shown a return to the June figures which the Board will remember was a very the best CMR the Trust had recorded.

The Trust has to report 1 case of MRSA. This is the first report for over 1 year. The case is attributed to the Trust based on the timing of the discovery however the Root Cause Analysis has suggested that the patient was infected on admission and this does not represent a failure of care or procedure.

There have been 2 cases of *C.Difficile*. These cases are undergoing a Root Cause Analysis but early indicators are that these are isolated and unconnected cases with no obvious cause.

The Trust continues to show no cases of Venous Thrombo Embolism mortality associated with prior hospital admission and this coding has been reviewed. Although this is very encouraging the Divisions have been asked to check and confirm the robustness of this data at Divisional level. This will be reported at the Trust Clinical Governance Committee.

Hip fracture operative rates are consistently high and the orthopaedic department has been asked to respond to a request to demonstrate that patient data capture is complete and robust. The Trust has no concerns.

1.3 Quality Observatory Acute Trust Quality Dashboard

Appendix 3 presents the Quality Observatory Acute Trust Quality Dashboard. This dashboard provides an assessment of the Trust's quality across the five domains of the NHS Outcomes Framework against a national mean.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality rate by Specialty

	CMR AUG 2011	ABSOLUTE NUMBERS	JUNE 2011	JULY 2011	AUG 2011
ALL	1.36%	82	▲	▼	▲
MEDICINE	3.32%	63	▲	▼	▲
SURGERY	1.06%	13	▲	▼	▼
ORTHO	0.51%	3	▲	▼	▼
PAEDIATRICS	0.00%	0	◄►	◄►	◄►

The figures above demonstrate that the crude mortality rate has changed little this year – although small changes in numbers can make the numbers fluctuate. The mortality is contained predominantly in our non – elective population and comparing our data with Dr Foster data gives a better understanding of where the trust sits. In medicine the average mortality for medicine for April/May/June is 7.8% against a predicted rate of 8.5%. Emergency surgery rates are 2.3% against a predicted of 2.4% although in June the rate was 1.6% against a predicted of 2.4%. Non-elective orthopaedics has a mortality of 2.9% against an expected of 3.0% although for April and May the rate was higher at close to 4% with no deaths recorded so far in June and needs to be kept under review. The mortality for elective patients remains very low.

3. Safety Update

3.1 NPSA Safety Alerts

There are no new alerts.

Overdue Alerts

Two alerts remain overdue as follows:

Description	Deadline	Lead
Early identification of failure to act on radiological imaging reports	05-Feb-07	**Associate Director of Informatics**
STATUS		
A pilot is underway to test the effectiveness of the Code 5 Tracker. Specialties selected to be involved in the pilot were A&E ,Respiratory Medicine, Rheumatology Upper GI, Surgery, Vascular Surgery, Colorectal Surgery & Gastroenterology. Learning from the pilots will be shared with the Board in due course.		

Description	Deadline	Lead
Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	19-Sep-09	**Associate Director of Informatics**
STATUS		
The Trust is still awaiting the release of version 4.3 from iSOFT to resolve this issue. iSOFT has confirmed that this version is currently in testing but no confirmed date has been provided for this version to become available on general release. Other Trusts with the same CliniCom PAS are in the same position.		

3.2 Drug Storage and Fridge Temperature Audit

Introduction

As a result of concerns raised regarding medicines security and management by the recent incidents at Stepping Hill Hospital ASPH decided to undertake an audit to assess compliance with the Trust's Medicines' Management Policy. The audit focused on IV fluids, refrigerator storage and all other medicines on the wards. Controlled drugs were not included as they were comprehensively audited in March 2011.

Findings

The audit identified areas for improvement in staff awareness of and compliance with the Trusts Medicines' Management Policy. This was most notable on the St Peter's Hospital site.

The key areas of concern relate to

- the consistent locking of drug fridges
- inconsistent temperature recording
- inconsistent actions taken in response to fridges with temperatures recorded beyond the required parameters
- inappropriate storage of some fluids and medicines in unlocked clinic rooms.

Actions

Heads of Nursing are taking immediate action to address the concerns and are developing longer term plans with an emphasis on training and development in drug storage and security.

The purchase and introduction of standardised pre-calibrated recording devices for fridges in all clinical areas to support the correct monitoring of fridge temperatures.

The audit results and action plans will be formally considered and monitored by the Safety and Risk Committee.

3.3 The Munro Report

Introduction

In June 2010, the Government announced a national review of child protection to be led by Professor Eileen Munro. The Munro Review was presented to Ministers on 10 May 2011. The Report identified 4 separate themes, and contained 15 recommendations. In July 2011 the Government published their response to the review and recommendations; 9 recommendations were accepted in full, 5 accepted in principle and 1 required further consideration.

Munro Themes

- Valuing professional expertise

- Sharing responsibility for the provision of early help
- Developing social work expertise and supporting effective practice
- Strengthening accountabilities and creating a learning system.

Implications for ASPH

The Trust Safeguarding Children Team has reviwed the Munro Report and identified a number of implications for the Trust. The Trust will need to:

- revise policy and procedures
- improve data collection to demonstrate early intervention and multi-agency working
- develop a rigorous audit programme
- continue close working and information sharing processes with community health colleagues
- strengthen and develop Safeguarding Team to deliver sustained training and supervision
- scope role in early intervention and prevention
- undertake a local community needs analysis and map service to meet identified gaps
- improve identification of those children who are vulnerable, particularly by adult services
- review Trust access to child protection social work expertise for those professionals providing early help and who are operating at the boundary of statutory social care services
- review capacity within the Safeguarding Team.

Conclusion

Recommendations and actions will be integrated into the existing Child Safeguarding Action Plan and monitored for delivery via the Child Safeguarding Steering Group.

4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.1.1 Complaints

There were 42 complaints received in August compared with 35 in July. The Trust aims to reduce the number of formal complaints by 30% during 2011/12 with an overall target of 320. A total of 172 complaints have been received year to date (+29% over target (133)).

Chart 1 shows a breakdown of complaints received by month (series 1), the monthly target (series 2) and the trend line.

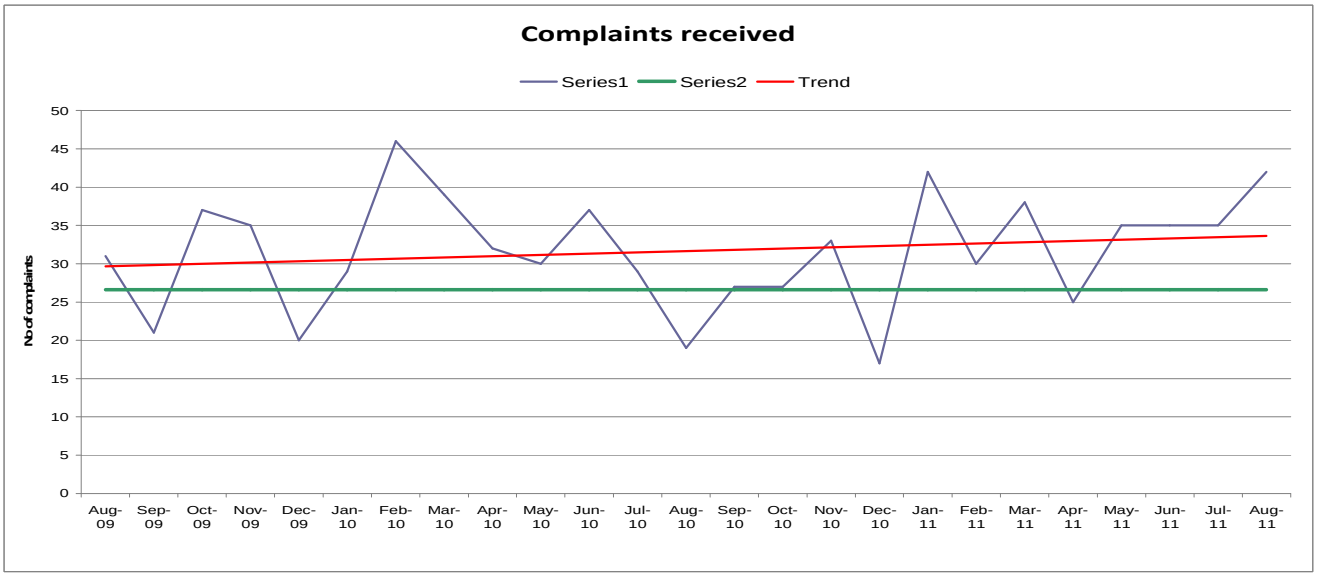

Chart One

Response Management Performance

There were 37 responses due in August, of these, 16 responses were sent within the agreed timescale, this equates to a monthly performance of 43% with agreed timescales for response in comparison to 25% performance in July. An action plan to address the recent decline in response rate has been implemented which includes weekly and monthly performance reporting by Division. This has brought about an increase in performance compared with the previous two months.

Divisional View

Chart 2 details complaints received monthly by Division. The chart demonstrates a significant increase in the number of complaints received in Women's Health and Paediatrics and Ambulatory Medicine. In Women's Health and Paediatrics, 4 complaints related to Gynecological Treatment and Care and 2 of the 3 Paediatric complaints related to queried Treatment and Diagnosis immediately following birth**.** Of the 4 complaints received by Ambulatory Medicine, 2 related to Consultant Attitude and 2 to clinic process. Investigations are underway but initial analysis reveals no clear links between the complaints. Divisions will formulate improvement actions as per the routine on completion of the investigations.

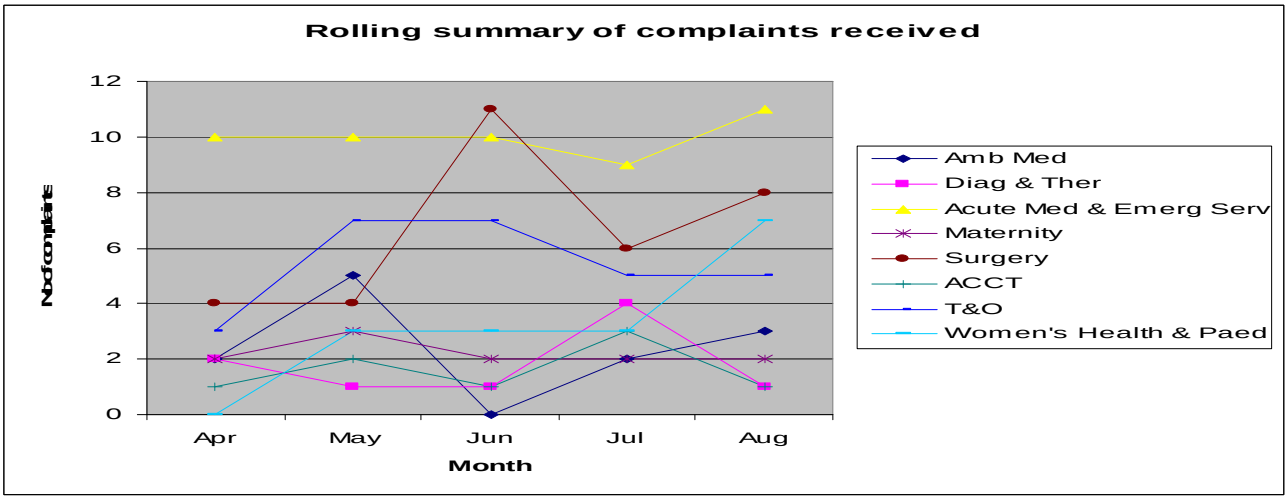

Chart 2

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

Chart 3 provides a breakdown of the types of issues raised, by Division, in August. Within Acute & Emergency Care 11 issues related to Treatment and Care, of which 4 related to 'clinical decisions and treatment'. Within Surgery, 11 issues related to Treatment and Care, of which 3 related to 'clinical decisions and treatment'.

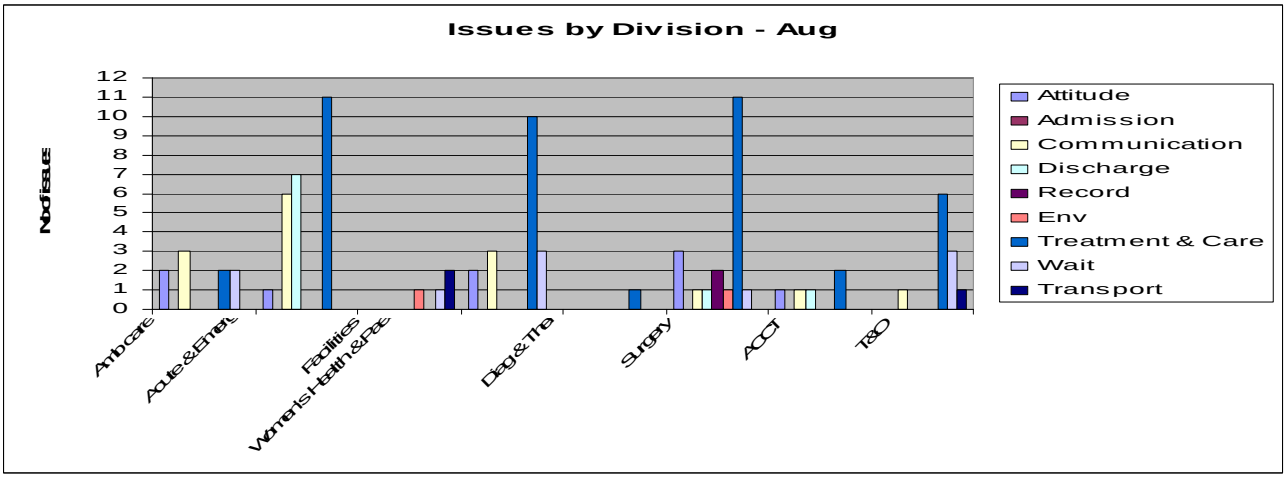

Chart 3

Ongoing analysis of complaints shows a continuing high number of issues raised relating to Clinical Decisions and Treatment. This is indicative of inadequate communication with patients around their treatment and/or a lack of shared decision making. The recent Kings Fund paper, '*Making shared decision-making a reality: No decision about me, without me*', outlines the importance of communication skills in shared decision making. Project 2 of the Enhancing Patient Choice and Control Programme will aim to embed these principles in practice across the Trust. Early discussion with the Divisional Director for Ambulatory Medicine has identified the potential for the Outpatient Department to be used as a pilot for this project since many discussions with patients about clinical decisions and treatment occur there.

4.2 Ombudsman cases

The Trust has received no notifications of new cases referred to the Ombudsman.

There is currently one case under initial assessment, papers were provided to the Ombudsman in Quarter 4, 2010/11 and we await the outcome of this assessment.

4.3 Quality Governance in the NHS: A Guide for Provider Boards

The Trust Board was updated in June on the work of the National Quality Board (NQB) and publication of the paper *'Quality Governance in the NHS: A Guide for Provider Boards'.* (March 2011).

It was agreed that an initial analysis of the Trust current position against the principles set out in the Quality Governance Framework, detailed in the NQB Guide for Provider Boards, should be undertaken.

Analysis

The gap analysis has been completed. The Trust approach to quality governance is well aligned to the Quality Governance Framework and the detail it covers. Some areas for further work have been identified, although on the whole this refers to work requiring refresh or review rather than clear gaps in the ASPH approach.

Areas for Continued Development

- review and refresh the Clinical Quality Strategy to ensure it is a live document that can be measured and reported upon; align with Quality Account
- continue dashboard development work. This is now well underway and includes the development of:
    - the **Best Care Dashboard** to replace the existing WQI. This dashboard will review all elements of essential and specialist nursing care quality, measuring both process and outcome. The Informatics Team is now working on a second iteration of the dashboard. The Best Care Nursing Audit Programme which will provide the data for the dashboard is now well defined and has been tested within the Acute and Emergency Medicine Division. Trust wide roll-out and data stream integrity testing will commence 1 October. Once the data streams can be assured the Dashboard will be shred with Trust Board for comment.
    - the **Predictor Dashboard**. This is a new dashboard that aims to use clinical, performance and workforce data to enable triangulation and identification of areas "under pressure" so that early intervention can be initiated and harmful outcomes to patients and/or staff averted. This work is developing with the support of the Informatics Team and once the data streams are validated will be presented to Board on a monthly basis.
    - the **Quality Account Dashboard**. This dashboard is now formulated and populated. The current view requires further analysis. The fully populated and analysed QA Dashboard will be reported to the October Board and quarterly thereafter.

- review of clinical quality structures and committees, alongside formulated reporting mechanisms and measures of effectiveness.
- review of patient engagement and involvement strategies to ensure alignment and where possible integration.

This work will be progressed under the leadership of the new Associate Director for Quality who joins the Trust in early October. A refreshed Clinical Quality Strategy will be presented to Board towards the end of the financial year for implementation from April 2012.

4.4 Ward Quality Indicators (WQI)

The Ward Quality Definitions are found at Appendix 1 and the Ward Quality Indicators are found at Appendix 2.

The following narrative is provided by the relevant Head of Nursing.

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

Division of Women's Health and Paediatrics Service

Scores for August 2011 have, overall, been very encouraging and have improved since last month. However, it would be ideal to achieve 100% in all areas. The launch of the Essence of Care document should have a huge impact of the quality metrics for the future.

Paediatrics

Complaints
Ash Ward
Ash Ward had one complaint in August. The Consultant has answered the complaint and the family is happy with the response.

Maternity

Antenatal Clinic, Joan Booker Ward and Labour Ward
The scores for the infection control audits in August for all three areas were good this month. However, the Hand Hygiene Audit from Antenatal Clinic shows as non-submission as it was sent from the Clinic but did not get to the Infection Control Team. The audit has been checked, was 100% and we will ensure that it is in on time next month.

The VTE Assessment on Labour Ward has fallen this month but has remained at 98% on Joan Booker Ward. The results for the Labour Ward will be monitored on a daily basis. A random notes audit shows they are being completed. This has been addressed with clinical staff to ensure recording is not left to clerical staff.

There were two complaints for August relating to Joan Booker Ward, one relating to post natal care which has been addressed and the other relating to post delivery assessment of the child.

Medicine and Emergency Services:

Falls- the division has set a target to reduce the number of falls by 18% month on month which has revealed encouraging results. The Division is meeting this target. The trend analysis of the following wards: Birch, May, Maple, Chaucer, Wordsworth and Fielding is now starting to indicate a decrease in falls with 2 patients sustaining injury from the 20 falls reported. The Falls Prevention Nurse has now implemented a protocol to follow when a patient falls, this is in line with best practice and we are one of the first Trusts within the region to have implemented this fully.
Medication Errors- there has been a decrease in the number of medication errors. A total of 5 administration errors and 6 prescribing errors have been noted. Aspen has seen an increase. Work has been actioned through the Corporate Governance route to look into junior doctor's prescribing

errors. Most administration errors have occurred as a result of the prescription errors. A draft tool kit has been developed to look at trends and will be used to create a passport of errors per registered nurse. This is now being considered to be developed as part of the junior doctors development programme.

Discharge Checklists- CCU and May Wards have been identified as non compliant with the discharge documentation. Action plans have been developed for both wards. However, CCU has been consistently low. This is due to the transferring of patients stepping down from critical care to the general ward setting and the current audit has not reflected this practice.

Saving Lives- There has been 1 MRSA bacteraemia this month. The findings from the RCA showed the contributory factors for this are communication and teamwork, care pathway and patient-derived risk factors. The main conclusion was that the patient was high risk due his frail skin and multiple sores and could have become infected at any time. There have been 2 cases of C Difficile on separate wards. This was not an outbreak and both cases were related to antibiotic use.

Non-Submissions- there is an error on the ward quality indicator dashboard this month for Chaucer Ward. This has now been corrected and should read as follows: *Hand hygiene – 100% Urinary catheter ongoing – 100% everything else is N/A.*

The Division has completed the new essential care quality dashboard (part of the Best Care Dashboard) which encompasses the elements from the Essence of Care Programme- based on best practice as set out by the Department of Health. Early indications suggest that nutritional care, skin integrity and documentation practices need improvement. A full report and presentation will be available for the next Trust Board meeting.

Surgery & Orthopaedics:

Peripheral Line After Care- Kingfisher Ward scored red for this indicator which is due to poor documentation post insertion of the intravenous cannula. Both SDU and Heron Wards scored 80% this month, an improvement from 75% from May.

Discharge Check List- Heron ward scored 38%, which has been a decrease from the previous month. The Head of Nursing is to conduct a review of practice on the ward to understand the issue and failure to improve.

Falls- the division has set a target to reduce the number of falls by 18% month on month. The Falls Prevention Nurse has been working closely with the wards that have a higher risk of patients falling. Despite Dickens, Falcon and Heron Wards reporting a number of falls none have resulted in injury to the patient.

VTE Assessments- the number of assessments carried out on Dickens Ward have fallen. This has resulted in an audit being undertaken to identify which team have not completed the correct documentation. Matron is to ensure Consultant Teams are aware of the importance of timely assessment and will monitor compliance daily.

ACCT, Ambulatory Care, Diagnostics & Therapeutics

Complaints

There has been one complaint for the Day Surgery Unit at St Peters Hospital this month, which involved several issues regarding the patients' treatment plan and referrals to the general surgeons, urologists and orthopaedic doctors.

Patient capacity issues have improved this month with the unit managing to close on several occasions at nights and two weekends. There has been a noticeable difference by not having to use the reception area as the admission lounge, which has resulted in no complaints this month for patients' privacy & dignity. The new patients changing rooms are also nearing completion.

VTE Assessment Compliance

Day surgery at SPH score for VTE assessment is up compared to the previous month at 90%, this will be discussed at the staff meeting with a request for the staff to ensure the doctors are completing this important document. Ashford Day Surgery's compliance remains at 100%

Hand Hygiene

Imaging scored at only 90% this month for hand hygiene, this will be followed up with the Team to ensure staff are challenged on there poor practice. To be discussed with the Infection Control Team. Eye Clinics Hand Hygiene score has improved at 94%.

Matrons Environment Audits

The Matrons environment audits were not submitted on time for Imaging and Endoscopy, although scores of 97% for Imaging at SPH, 96% for Imaging at AH and 98% for Endoscopy were achieved.

Pressure Ulcers

ITU has had 4 patients acquiring pressure ulcers this month. Two patients were long stay, 1 patient immuno-supressed and one patient on Isotopes. The Matron along with the Team Leaders and Clinical Practice Educator are carrying out an RCA. This will be monitored by the Head of Nursing and the Chief Nurse to ensure appropriate actions are taken.

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

Date: 19th September 2011

Appendix 1 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

Appendix 2 WQI scorecard

Paper 5.2

Ashford and St Peter's Ward Quality Scorecard - August 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	Discharge Check List	Malnutrition Universal Screening Tool	Pressure Ulcer Prevention: Compliance with monitoring of Pressure	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%	=100%	<=3	<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%	<=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 %	80 %	100 %	92 %	88 %	94 %	94 %	N/A	N/A	N/A	N/A	N/A	0	0	0	0	4	4	100 %	75.2 %
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	95 %	56 %	100 %	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	1	89 %	N/A
	BIRCH	100 %	1	0	N/A	100 %	100 %	100 %	100 %	100 %	91 %	95 %	100 %	100 %	N/A	N/A	N/A	N/A	N/A	0	1	0	0	0	0	100 %	86.0 %
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	88 %	N/A	100 %	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	1	100 %	N/A
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	92 %	95 %	100 %	97 %	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	100 %	89.2 %
	CEDAR	98 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	97 %	97 %	100 %	100 %	N/A	N/A	N/A	N/A	N/A	0	4	0	1	1	0	100 %	81.2 %
	MAY	100 %	0	0	N/A	N/A	N/A	100 %	90 %	100 %	97 %	88 %	67 %	99 %	N/A	N/A	N/A	N/A	N/A	0	3	0	0	0	0	79 %	75.8 %
	MAPLE	98 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	94 %	95 %	100 %	98 %	N/A	N/A	N/A	N/A	N/A	0	6	1	0	0	0	100 %	81.2 %
	SHORT STAY UNIT	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100 %	N/A	100 %	N/A	N/A	N/A	N/A	N/A	0	2	0	0	N/A	0	N/A	N/A
ASHFORD	CHAUCER	90%	0	1	N/A	N/A	N/A	N/A	N/A	N/A	94 %	98 %	89 %	97 %	N/A	N/A	N/A	N/A	N/A	0	1	0	0	0	0	100 %	90.9 %
	WORDSWORTH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	98 %	90 %	93 %	N/A	N/A	N/A	N/A	N/A	0	2	1	0	0	0	100 %	72.9 %
	FIELDING	99 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	95 %	100 %	100 %	N/A	N/A	N/A	N/A	N/A	0	1	0	0	0	0	100 %	73.7 %
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	97 %	100 %	100 %	100 %	0	0	0	0	0	0	0	3	0	0	86 %	90.1 %
	ELM	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	92 %	96 %	65 %	99 %	100 %	0	0	0	0	0	2	0	0	0	0	100 %	76.0 %
	JUNIPER	97 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	96 %	87 %	90 %	100 %	0	1	0	0	0	1	0	0	0	0	100 %	79.2 %
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	94 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	3	0	0	N/A	N/A
SURGERY	KINGFISHER	97 %	0	0	N/A	100 %	100 %	100 %	80 %	100 %	95 %	100 %	97 %	99 %	100 %	N/A	N/A	N/A	N/A	0	0	0	2	0	0	100 %	78.0 %
	FALCON	100 %	0	0	N/A	100 %	100 %	100 %	100 %	90 %	94 %	94 %	82 %	88 %	100 %	0	0	1	0	0	2	0	1	0	0	100 %	77.5 %
	KESTREL	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	88.5 %
	SDU	99 %	0	0	N/A	100 %	N/A	100 %	90 %	100 %	94 %	100 %	N/A	N/A	100 %	0	0	0	0	0	0	0	0	0	0	100 %	N/A
	HERON	100 %	0	0	N/A	100 %	100 %	100 %	90 %	100 %	97 %	95 %	38 %	92 %	100 %	0	0	0	0	0	1	0	0	0	0	89 %	80.6 %
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	96 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
	MAXFACS AHSPH	98 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EMERGENCY SERVICES	MAU	100 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	93 %	N/S	N/A	100 %	N/A	N/A	N/A	N/A	N/A	0	1	0	2	2	0	90 %	89.5 %
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	92 %	50 %	100 %	100 %	0	0	0	0	0	1	0	1	0	0	58 %	75.7 %
	A&E	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	96 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	1	0	4	0	1	N/A	N/A
PAEDIATRICS	NICU	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	95 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	OAK	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	98 %	100 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	ASH	99 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	99 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
	PAED A/E	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	94 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	93 %	100 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	100 %	N/A
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	99 %	100 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	DSU SPH	100 %	0	0	N/A	N/A	N/A	100 %	100 %	100 %	96 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	90 %	N/A
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	N/A	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	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	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	100 %	N/A
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	91 %	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	96 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
OTHERS	EYE CLINIC SPH	94 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	94 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
	EYE CLINIC/UNIT AH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	100 %	N/A
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	94 %	100 %	N/A	N/A	100 %	0	4	0	0	0	0	0	0	0	0	100 %	N/A
MATERNITY	JOAN BOOKER	100 %	0	0	N/A	N/A	N/A	N/A	N/A	100 %	93 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	2	0	0	98 %	N/A
	LABOUR WARDS	100 %	0	0	N/A	N/A	100 %	N/A	100 %	N/A	95 %	93 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	80 %	N/A
	MATERNITY ULTRASOUND/ANC	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A