Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**20 December 2017**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Lisa Cheek, Acting Director of Nursing and Midwifery**		
Author:	**Lisa Cheek, Acting Director of Nursing and Midwifery**		
Appendices	**Appendix A: Nursing Quality Indicators Chart**		

1. Executive Summary of the Report

This report provides an update on quality with a focus on patient experience and key patient safety and quality improvement priorities reviewing November 2017 data.

The Quality Report this month includes a quarterly update on the improvement priorities as highlighted in the 2017/18 Patient Safety and Quality Improvement Triangle. Other items will be reported on an exception basis.

This month the report focuses on:

- Part A - Patient Experience:
  - Complaints and PALS monthly activity data
- Part B – Patient Safety priorities:
  - Falls

    Executive sponsored projects:
  - NatSSips
  - Improving Insulin Safety
- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report summary
  - Nursing Quality Indicators Exception report

2. Recommendations (Note, Approve, Discuss)

To note progress to improve quality, patient safety and patient experience at the RUH.

3. Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)

A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.

5. Resources Implications (Financial / staffing)

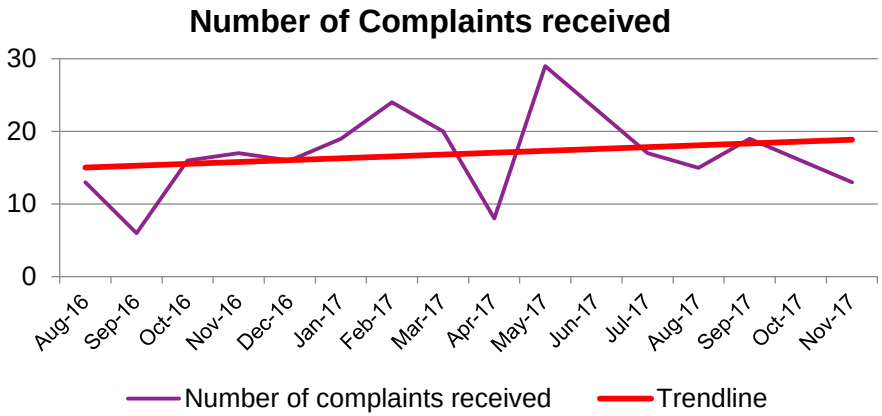
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.

6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports to Management Board and Board of Directors	
8.	**Freedom of Information**
Public.	

QUALITY REPORT

PART A – Patient Experience

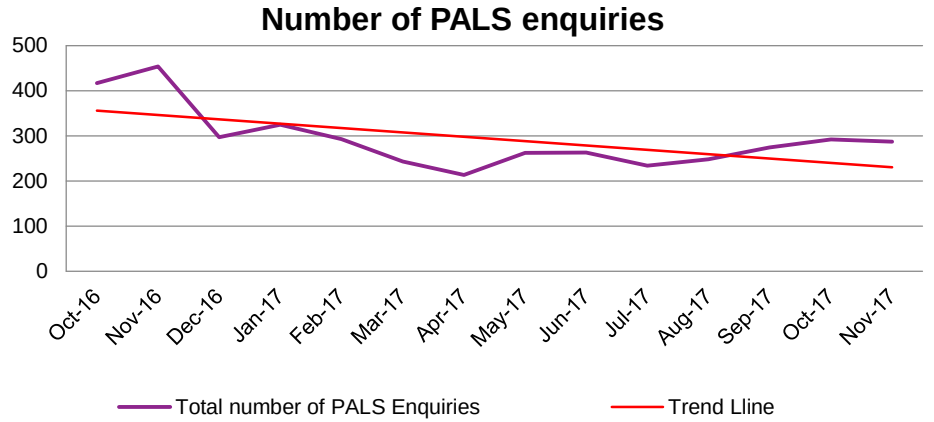
Complaints and Patient Advice and Liaison Report



There were **13 formal complaints** received in November. **5** were for Medicine; **7** for Surgery and **1** for Women and Children's. **8** related to Clinical Care and Concerns, **2** referred to issues with Communication, **1** was Staff Attitude and **2** Hospital Cleanliness (SAU and Robin Smith).

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	1 (33%)	2 (50%)	7 (85%)	10 (66%)
Breached 35 Day target	2 (66%)	2 (50%)	1 (15%)	5 (33%)
Total	3	4	8	15

The breaches in Surgery were due to meetings taking place resulting in a delay to the final written response. The breach in Medicine was due to delays in managing the complaint informally initially. The 2 breaches in W & C were due to arranging a meeting and changes to the final response letter.



There were **287 contacts with the PALS** service in November:

- 155 required resolution (54%)
- 100 requested information or advice (35%)
- 21 were compliments (7%)
- 11 provided feedback (4%)

The **top three subjects requiring resolution** were:

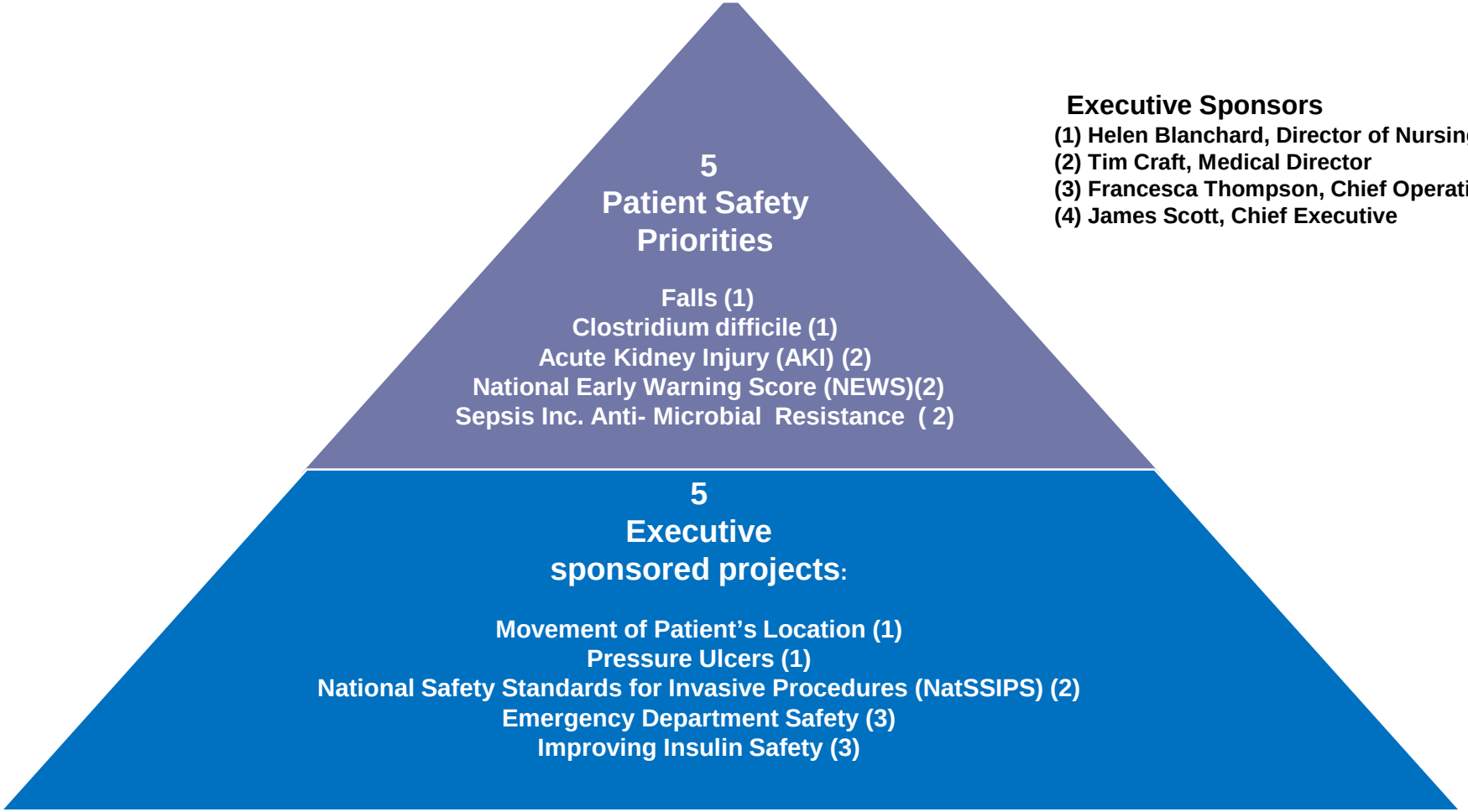
Communication and Information - 25 contacts related to requests for information about services provided by the Trust. There are no trends or themes in relation to these contacts.

Clinical Care and Concerns - 23 contacts, 5 of which related to general enquiries regarding clinical care and concerns and 5 referred to concerns regarding medical care (doctors).

Appointments – 23 clients contacted the service regarding their appointment specifically appointment cancellations (by patient & hospital), length of time waiting for follow up appointment and information regarding appointment date and time.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors

(1) Helen Blanchard, Director of Nursing and Midwifery
(2) Tim Craft, Medical Director
(3) Francesca Thompson, Chief Operating Officer
(4) James Scott, Chief Executive

Patient Safety – Falls work stream report

Helen Blanchard

Background

Reduction in falls is one of the Trust's safety priorities. A trust wide Falls Improvement programme was launched 19 June 2017. Figure 1 shows performance for the total number of inpatient falls. Analysis of falls data since the launch in June shows falls remain consistently below the median.

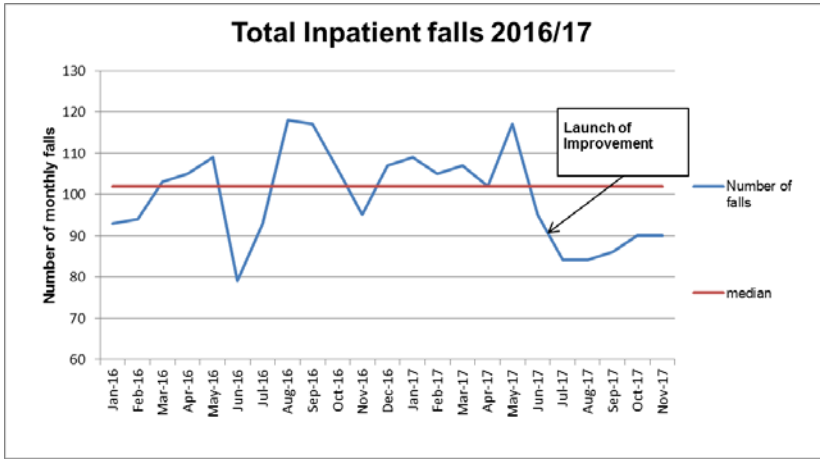


Figure 1

Figures 2 and 3 show comparison with national data.

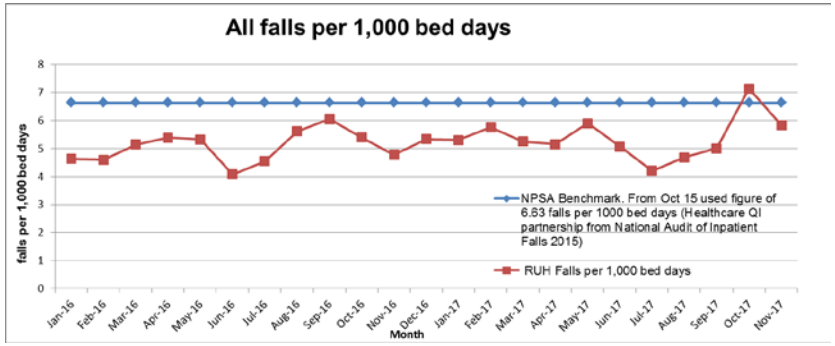


Figure 2 N.B. The spike in October is due to a reduced number of Occupied Bed Days – this number is being investigated by BIU.

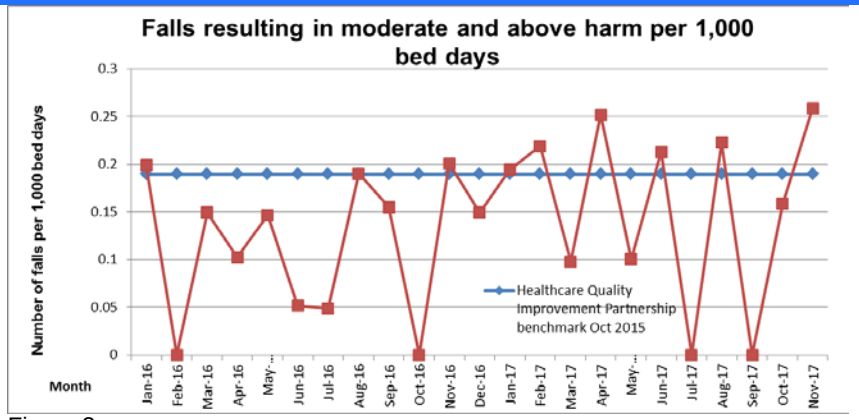


Figure 3

Figure 3: In November it should be noted there were 3 Moderate and 1 Major harm reported. The Falls steering group will undertake a review of all Moderate and above harms for the last 6 months to review any emerging themes for inclusion in the Falls prevention work plan .

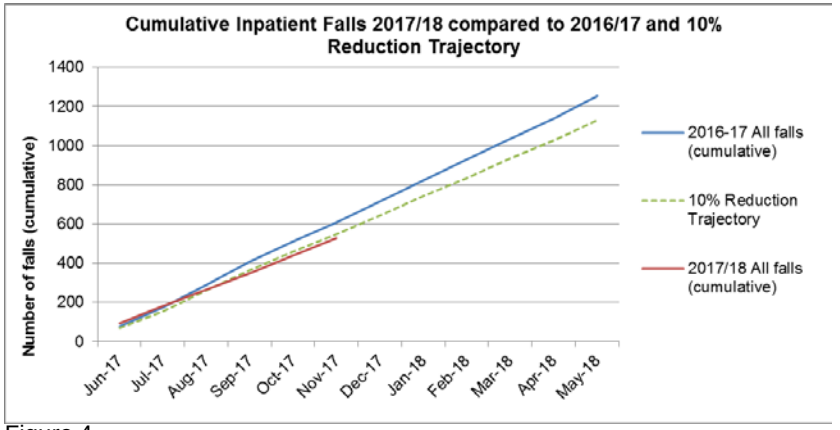


Figure 4

Figure 4 shows the cumulative number of falls for June 2017-2018 plotted against the 10% reduction target agreed as the outcome measure for the Falls Improvement programme.

Patient Safety – Falls work stream report

Helen Blanchard

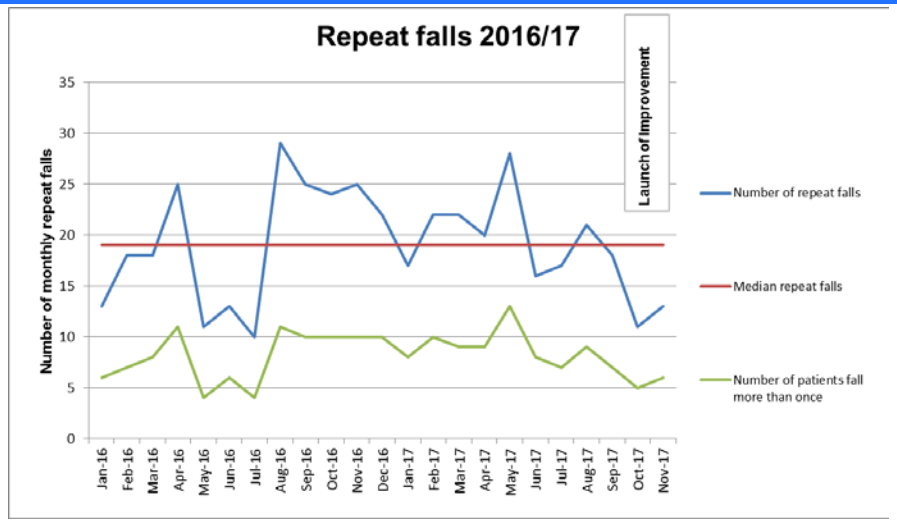


Figure 5

Figure 5 shows the number of repeat falls and the number of patients who have fallen more than once. Reduction in the number of repeat falls is a high focus for the Falls Improvement programme.

Falls Improvement programme

The aim of the Falls Improvement programme "It takes us all to stop a fall" is to provide assurance that the falls prevention pathway is robust and staff have access to the most appropriate interventions to prevent wherever possible patients falling and experiencing harm. The Improvement programme is multidisciplinary (MDT) and includes:

- Enhanced Observation - an MDT approach to the supervision of patients at high risk of falls aiming to ensure that appropriate observation is provided at all times. A revised tool was launched October as part of a trust wide launch of new Nursing plans of care.
- A revised electronic falls risk assessment to meet NICE guidance
- Post Falls Assessment documentation and SWARM process – an immediate post falls review of every fall by the MDT.

Table 1 shows performance for completion of the Post Falls Assessment and SWARM for a sample of patients who have fallen each month.

Measure	Target	Aug-17	Sep-17	Oct-17	Nov-17
Was a Post Falls Assessment and SWARM form in place?	95%	96%	100%	100%	94%
Overall Compliance for completion of the Post Falls Assessment and SWARM form	95%	89%	94%	78%	73%

Table 1

Next steps:

Measurement of compliance of the enhanced Observation tool and Post falls form is being included in the schedule of audits as part of the Nursing and Midwifery peer audit programme, which commences 13 December.

Members of the Falls Steering group were successful in a bid to Health Education England South West Simulation Network (HEESWSN) for £25,000 to support Falls simulation training. The team are in the process of recruiting to a band 6 part time post to lead the Falls Simulation project.

The Falls group are revisiting a proposal to be implemented in January whereby all patients who have a repeat fall, in a ward outside of OPU, will be reviewed by an Elderly Care Registrar. In addition from 1 January the team will be testing on Respiratory ward a process whereby all patients who have a fall on will be reviewed by an Elderly Care Registrar. The effectiveness of this process in preventing repeat falls will be measured.

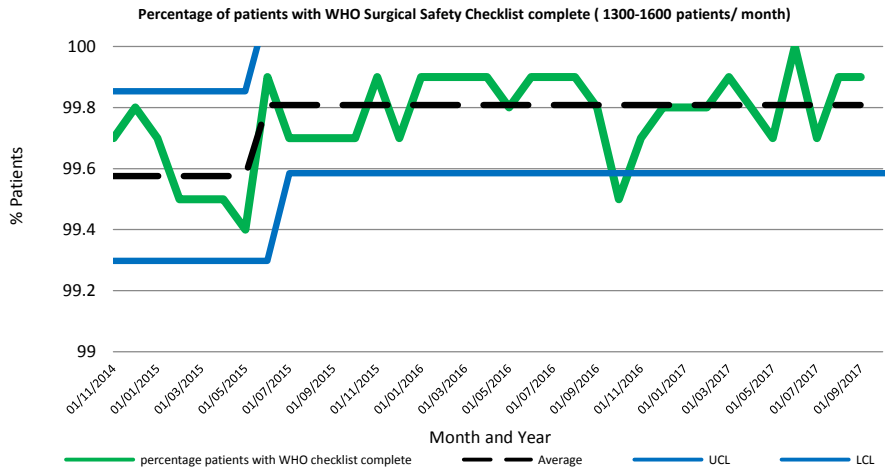
Patient Safety – National Safety Standards Invasive Procedure (NatSSIPs) Tim Craft

National Safety Standards for Invasive Procedures (NatSSIPs)

- Local policy for all procedures (LocSSIPs) has been approved.
- Checklist are being used and tested for procedures included in the LocSSIPs.
- Data for compliance for procedures outside of the operating theatres is being obtained from random note review whilst awaiting IT support for electronic recording, which is required trust wide to obtain accurate data
  for assurance .

Operating Theatres: Compliance with WHO Surgical Safety checklist

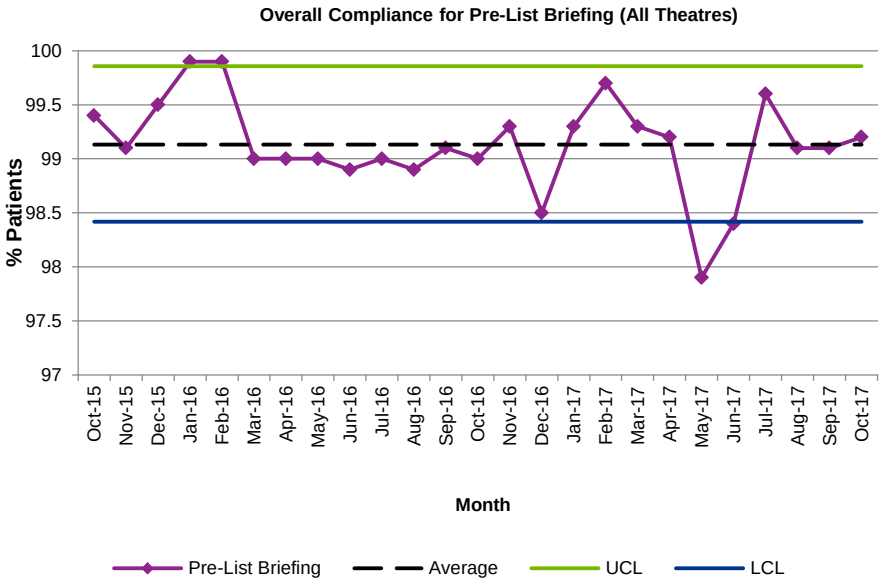
100% patients undergoing surgery in the operating theatres have a WHO checklist performed, 99.8 % of which are fully complete.(1300-1600 patients).



Two observational quality audits continue to be performed in each theatre per week, including out of hours procedures. These demonstrate excellent quality in 98% of audits and any themes are used to continue with improvements.

Prelist Briefing

Pre-list briefing occurs in 99.2% of elective cases.

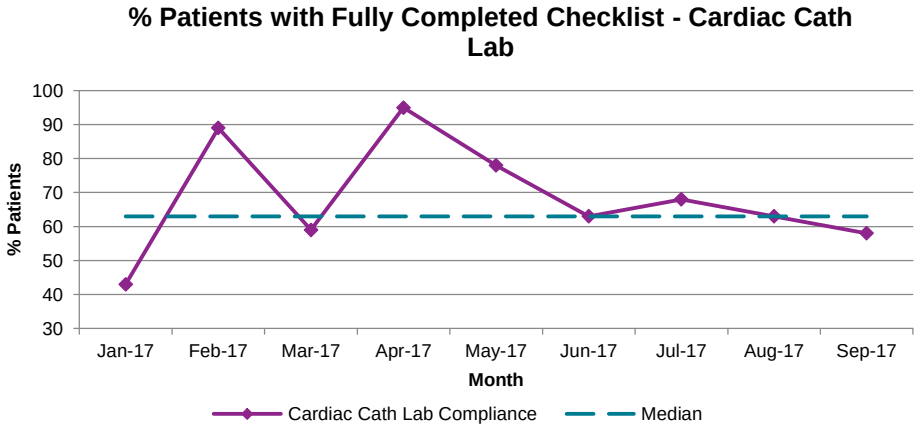


Patient Safety – National Safety Standards Invasive Procedure (NatSSIPs) Tim Craft

Progress with Checklist implementation for procedures outside theatres:

Gastroenterology:
Electronic recording has been established on Endobase for all procedures and data is awaited. 83% compliance for February 2017.

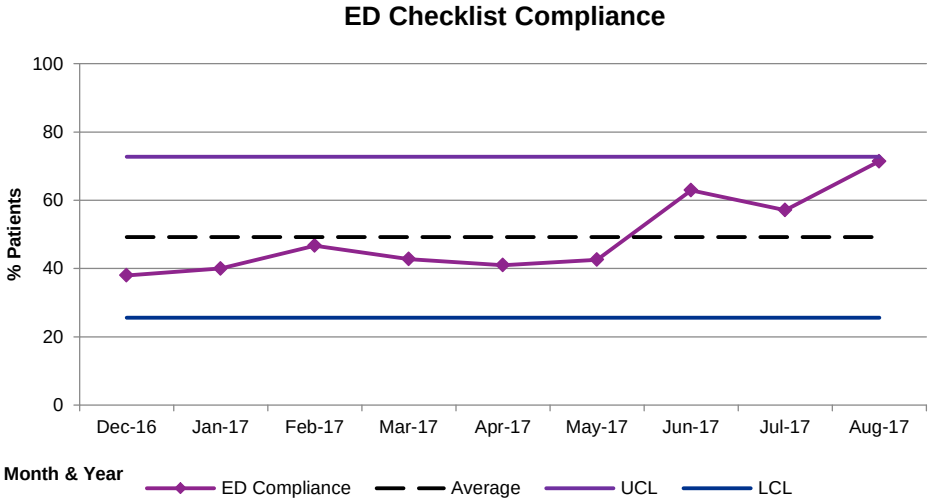
Cardiac Cath Lab:
Compliance recorded from random note reviews (shown below):



Compliance with fully completed checklist has decreased. Although 94% of patients had a checklist performed, only 58% were fully completed, the sign out being the commonest part omitted. This has been fed back and is being addressed.

Cardiac Pacemaker procedures
A new checklist specific to cardiac pacemaker procedures is being tested and compliance data will be available from November 2017.

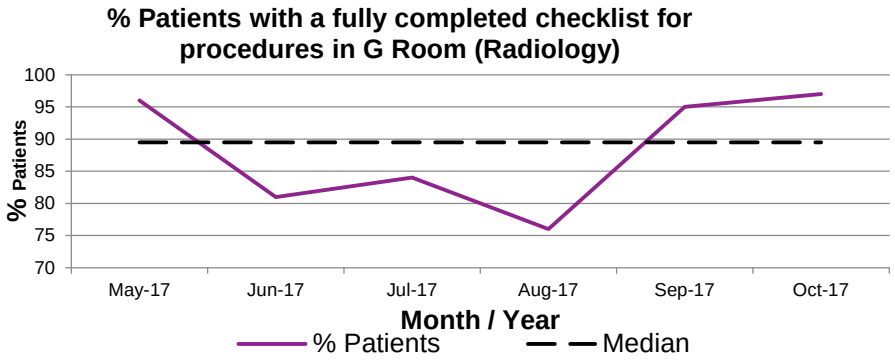
Emergency Department:
ED compliance with standard checklist is shown below. This has improved since June 2017, and with the implementation of First Net in November which will facilitate documentation, this may improve compliance further.



Patient Safety – National Safety Standards Invasive Procedure (NatSSIPs) — Tim Craft

- **Radiology**

Checklist compliance for Interventional Radiology (IR) procedures in G room is 88% on average (see below). Compliance is less reliable for CT and ultrasound procedures and it has been identified that the specific checklist used for interventional radiology is not appropriate for these procedures. Use of the standard outpatient checklist is to be tested

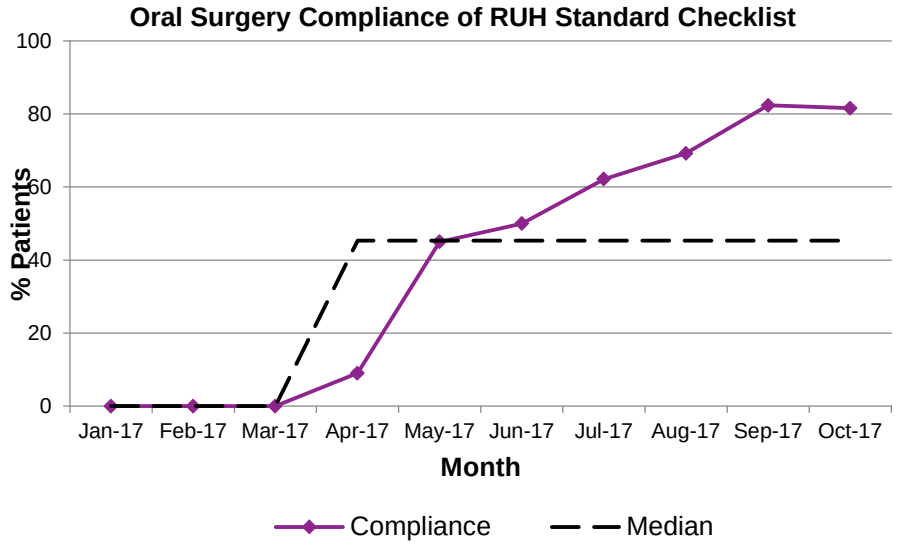


- **Dermatology**

Random note audits have commenced for Dermatology, and an observational visit performed. There are some discrepancies between use of previous checklist and newer version which will be addressed. Compliance with previous checklist in Sept & Oct 2016 showed compliance was 52% and 42% respectively and in October 2017 100% of patients had a checklist present in their notes, but many were not fully were complete. This is on-going work to confirm the checklist in use and ensure fully completed as well as investigate electronic recording of compliance .

Oral Surgery:

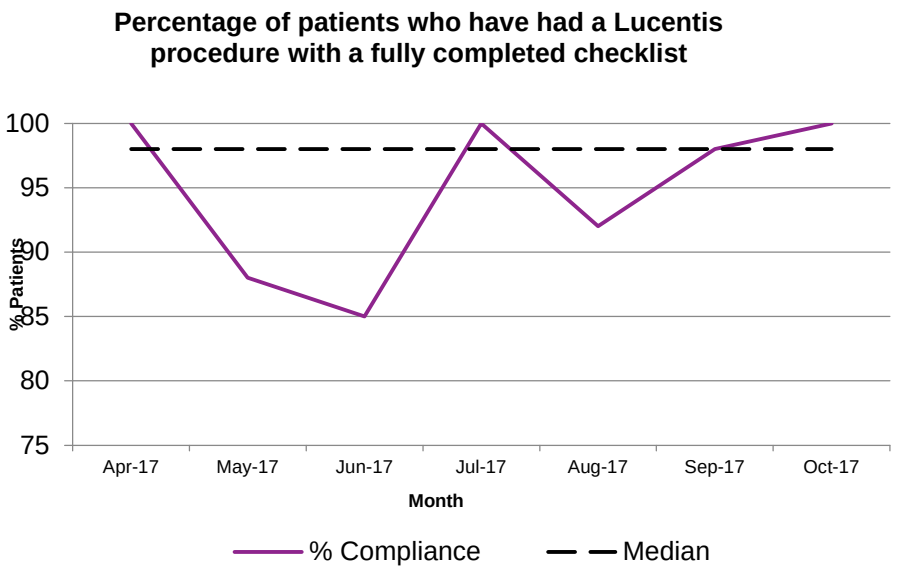
- Compliance has improved significantly, as shown in the run chart, compliance in September and October being over 80%. Data is still being captured from random note audits whilst awaiting IT support for electronic recording of checklist.



Patient Safety – National Safety Standards Invasive Procedure (NatSSIPs) — Tim Craft

Ophthalmology

Compliance of checklist use for outpatient Lucentis injections has been established and is on average 95% , with October 100% patients having fully completed checklist



Checklist in Minor Outpatient Procedures (MOPS) in Ophthalmology was started in September 2017,and has occurred for 89% and 87.5% of patients in September and October 2017.

Outpatient Areas:

- Quality observational audits were performed in Urology and were excellent and data collection for checklist compliance is being investigated.
- Visits are planned for the Breast Clinic, Pain Clinic
- Data collection for orthopaedic outpatients and the above are also being investigated from random note review whilst awaiting IT support to implement electronic, which is expected to be available from January 2018.

Gynaecology

- The standard checklist has been tested in gynaecological outpatient procedures and compliance data has started to be collected for hysteroscopy procedures from random note review. This showed compliance of 37% only and revealed inconsistencies with the recording been as well as variation per consultant. This has been fed back in November. Use of the checklist for colposcopy procedures will also commence on Monday 13th November.

Other Areas

- Visits planned for NICU and Critical Care Services

NEXT STEPS:

- Continue to support embedding of checklist in all areas outside of theatres
- Require IT support for electronic recoding of checklist for robust compliance data. Random note review is a temporary solution but not sustainable long term.

Patient Safety – Improving Insulin Safety

Francesca Thompson

Insulin Safety Workplan		Components and Actions	
Task Ref	Primary Drivers	Secondary Drivers	Progress to date
1.1	Co-ordination of care from admission to discharge	**Medicines reconciliation**	Recording on ePMA.
1.1.1		MMTs to ensure good insulin documentation	This is now electronic as part of the medicines reconciliation
1.2		**Prescribing**	Doctors identified to support development of an education programme for doctors
1.2.1			Only 20% doctors completed e-learning. Timescale for completion to be reviewed . Target 100%
		Dispensing	Insulin requests are priority for dispensing.
1.3		**Insulin administration**	ePMA project implemented and leading to new processes. Will be monitored closely to identify risks.
1.3.1		Reduce insulin administration errors in adult patients with diabetes by 75%	Original 75% error reduction achieved. New ePMA system needs monitoring. Diabetes team and pharmacist part of national QI project going forward.
1.3.2		MMTs audit safety thermo (missed critical med)	Manual data collection will change to ePMA reports once build.
1.4		**Discharge Planning / Documentation**	Discharge summaries now include the insulin. Plan to audit December discharge letters to check for clarity.
2.1	Standardisation of operating procedures	**Identify key risks and errors**	Datix incidents reviewed by insulin taskforce and MAG. ePMA incidents now included.
2.2		**Self-administration**	Self-administration project to be expanded to 5 wards. Insulin storage to be risk assessed and managed appropriately.
2.3		**EPMA design**	Identified gaps in surgical pathway with ePMA and also BM recording.
2.4		**Streamline IT resources**	Current focus on ePMA

Background

Improving Insulin safety is one of the Safer Six Patient Safety priorities. Due to the high risk with insulin therapy, safety work will continue and a work plan is monitored by the Insulin taskforce to identify other key areas for improvement.

Workplan

The work plan has been updated to include the impact and issues with ePMA on insulin safety. Also a team of diabetes specialists nurses and a pharmacist will be part of a Diabetes UK National Quality Improvement project which has just commenced. Kostas Ghastaris , Consultant Endocrinologist will replace Marc Atkin as the clinical lead.

Patient Safety – Improving Insulin Safety

Francesca Thompson

Insulin Safety Workplan		Components and Actions	
Task Ref	Primary Drivers	Secondary Drivers	Progress to date
3.1	Support ward staff to c are for patients who use insulin	**Access to ADT**	Remains 5 wards daily and remainder of access via referral criteria
3.2		**Nurse / pharmacist / Dr Education**	e-learning package to be updated and to include examples of errors specifically linked to ePMA. New group of doctors recruited to support learning and development.
3.3		**Link Nurse Role to be implemented across the Trust**	Working well.
3.4		**Streamline referrals to ADT**	Referral criteria under review
4.2	Audit and Assurance	**Review national Diabetes Audit compliance**	Annual review
4.3		**MMTs med safety thermometer (high risk med)**	Critical meds omitted doses monitored across 10 wards. Going forward the plan is to pull data off the ePMA system.
4.4.1		Medicines advisory group	Review insulin errors reported on Datix and EPMA linked errors. Oversight of Insulin taskforce.
5.1	Documentation	**New insulin chart**	ePMA design different to paper chart system. Will need to monitor impact on safety and workflow.
5.2		**Guidelines to be held in one place on intranet**	A trust wide review of guidelines currently in progress.
5.3		EPMA design for safety	ePMA implemented and gaps identified for development going forward.
5.4		Safety Bulletin to be prodiced re key learning points concering adult treatment	Bulletin circulated widely and currently a new safety bulletin in design stage.
6.1	Links with Primary care	Identify primary care pharmacist	Link with Phamacist in Banes identified. Pharmacist will be invited to attend taskforce for interface issues.

Initial actions include:

- Small scale PDSA test of the use of BM e-recording by nurses on Robin Smith ward to align with insulin prescribing (currently a paper and electronic system in place).
- Regular drop in sessions to doctors training by ePMA pharmacist to ensure consistent safe approach to prescribing on ePMA
- Surgical Insulin pathway identified as a gap in the ePMA. This will be developed over a few months with support from Lesley Jordan and the ePMA pharmacist.

Serious Incident (SI) Summary

Helen Blanchard

Current Performance

During November 2017, ten Serious Incidents were reported.

Date of Incident	ID	Summary
25-Nov-2017	58582	Medication administering error
3-Nov-2017	57948	Neonatal death
23-Nov-2017	58628	Medication prescribing error
4-Nov-2017	57930	Fall resulting in fracture
9-Nov-2017	58071	Fall resulting in fracture
2-Nov-2017	57891	Fall resulting in fractures
23-Nov-2017	58670	Delay in commencing CPR
16-Nov-2017	58278	Fall resulting in a fracture
8-Nov-2017	58077	Deterioration of pressure ulcer
21-Nov-2017	58694	Potential cross infection between patients

Overdue Serious Incident reports summary

Helen Blanchard

The drive to reduce the number of overdue SI reports will continue this year, to a target of zero overdue reports.

As of 23rd November 2017, there are 13 Serious Incidents that remain open. Of these, six incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date; however, of these, three investigation reports are due for submission to the next Operational Governance Committee. The relevant CCGs are aware of the planned dates for submission.

Any delay in providing a final report is escalated to the relevant Divisional Management team, for the identification of what further support can be provided to the investigator to enable them to completing the investigation and draft the report.

The Operational Governance Committee monitors the progress against the action plans developed following the investigation and at the November OGC meeting, the status was reported as:

	Apr-17	May-17	June-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Outstanding Action Plans	8	9	17	21	22	15	19	19
Outstanding Actions	15	13	33	49	44	29	44	31

The Risk Management team continues to provide reminders and support to assist in the completion and closure of actions and the Heads of Nursing and Divisional governance leads are notified of the responsible managers who require support to complete their actions .

The review of outstanding actions is now included in the Divisional Performance review.

Royal United Hospitals Bath
NHS Foundation Trust

Nursing Quality Indicators - Exception Report

Lisa Cheek

Areas of focus
The Nursing Quality Indicators chart is attached as Appendix A.
Four wards has flagged this month as having nursing quality indicators of note (below).

Waterhouse Ward (Older persons)
This is the third consecutive month this ward has flagged.

Quality matrices to note are:
- 5 Falls (3 no harm and 2 minor harm)
- RN sickness 10.1%
- HCA sickness 15.6%
- RN appraisals 62.5%
- RN hours % day and night fill rate <90.0%

RN appraisals are down again this month contributed by staff on long term sickness. The Senior Sister has a plan in place to address this and a new Band 6 Junior Sister in post this month will support these being undertaken. The RN vacancies and hours shortfall are being covered with additional HCAs to maintain safe staffing and the Senior Sister also works clinically as required. Proactive recruitment is in place and rolling adverts are in NHS Jobs as part of a wider Older Persons Unit advert.
Sickness is being managed to Trust Policy and supported by HR and the sickness rates for both RNs and HCAs have improved since last month. Nurses have started to return to work (month lag on data) and therefore sickness rates are expected to improve in the coming months.
It is pleasing to note that the FFT response rate has significantly improved this month to 103% from last month (9%). The Matron will continue to support the Senior Sister to maintain their performance.

As the ward has flagged 3 months in a row the Matron will take the necessary actions as within the Escalation Framework e.g. Taking an Improvement Plan to the Interim Director of Nursing and Midwifery.

Midford Ward (Older persons)
This is the first time this ward has flagged for 5 months, since May 2017

Quality matrices to note are:
- 7 patient falls (5 no harm, 1 minor harm and 1 major harm)
- X 1 category 2 pressure ulcer
- RN sickness 10.8%
- HCA sickness 8.4%
- RN appraisals 69.2%
- RN hours % day and night fill rate <90.0%

Despite several adverts and interviews, the Matron has been unsuccessful in appointing a permanent Senior Sister post, vacant since July 2017. Interim acting arrangements are in place with an existing Junior Sister, plus increased Band 6 posts and a Clinical Development Sister which supports the staff clinically. In addition an interim Band 7 Senior Sister is being deployed from another medical ward from January 2018. This will support staff management on the ward.

A Root Cause Analysis (RCA) investigation has been undertaken regarding the pressure ulcer and the Tissue Viability Nurses are providing increased support to the ward. A Serious Incident RCA is also being undertaken into the patient fall which resulted in a fracture.

Proactive recruitment is in place and a rolling Older Persons Unit advert is out for Registered Nurses and additional HCA hours are covering the shortfall to maintain safe staffing. It is also planned to have the new role of Ward Therapists in post to support the nursing team in January 2018

The Matron is closely supporting the ward with regular staff meetings and working clinically when able. The Matron is taking the necessary actions as identified within the Escalation Framework.

Nursing Quality Indicators - Exception Report

Lisa Cheek

Medical Assessment Unit
This ward last flagged 2 months ago in September 2017.

Quality matrices to note are:
- FFT response rate 14%
- 6 Falls (4 no harm and 2 minor harm)
- HCA sickness 7.9%
- RN appraisals 75.6%
- RN hours % day and night fill rate <90.0%

The Matron will support the Senior Sister to maintain performance with FFT response rates as this had improved since September but performance has slipped again.

Sickness is being proactively managed to Policy and with HR support where required.

The Senior Sister has been undertaking RN appraisals and there was a very slight increase in the appraisal rate from last month. The planned improvement trajectory was difficult to maintain during November due to the introduction of the IT Big 3, however the Senior Sister has planned to be back on track this month.

RN fill rates remain a concern, however there are new Registered Nurses in post and undergoing induction, therefore fill rates should improve.

To note:
The Acute Stroke Unit flagged last month but their quality indicators have improved this month. This ward will continue to be closely monitored and supported to maintain/improve performance as per the new nursing quality indicators Escalation Framework.

Pulteney Ward (Surgery)
This ward last flagged in July 2017

Quality matrices to note are:
- RN sickness 7.0%
- HCA sickness 10.3%
- RN appraisals 78.3%
- RN appraisals 78.3%
- HCA appraisals 75.0%
- RN hours % day and night fill rate <90.0%

There is long term sickness which is being managed as per policy and with support from HR and Occupational Health.
The Senior Sister has developed a plan to undertake staff appraisals to improve performance.

The Senior Sister is actively recruiting to fill RN vacancies and is introducing the new role of Ward Therapist in January 2018 to support the nursing team.

Other Quality Indicators of note:

Falls: the number of Falls is fairly consistent again this month
Pressure Ulcers: There were 2 Category 2 pressure ulcers this month
C.Difficile: There were 2 cases on Parry ward. Following initial RCA investigations there does not appear to be any issues that link these cases, however samples have been collected for typing.
Nurse staffing: RN vacancies continue to be a challenge and a Business Case to support an International Recruitment Campaign is being presented to Management Board (Dec 2017). A Project group will be set up to manage this initiative.

Nursing Quality Indicators - Monthly Template

APPENDIX A

Ward Group	Ward Name	Report for July 2017 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																										
		FFT % Recomd	FFT Response Rate %	Number of complaints received	Number of PALS contacts		Number of patients with Cdiff	Number of patients who fell				Number of Pressure Ulcers			Human Resources				Nurse Staffing Datix Report	Safer Staffing % Fill rate				Number of times parameters outside of KPI metrics						
															Sickness %		Appraisal %			Day		Night								
					Positive	Negative		No Harm	Minor Harm	Mod Harm	Major Harm	Cat: 2	Cat: 3	Cat: 4	RN/RM	HCA	RN/RM	HCA		Reg Nurses/ Midwives	Care Staff	Reg Nurses/ Midwives	Care Staff	Nov 17 No:	Oct 17 No:	Sep 17 No:	Aug 17 No:	Jul 17 No:	Jun 17 No:	Total
Emergency Dept	A&E	93%	4%	2	3	10		2	0	0	0				4.8	5.6	81.0	71.4		N/A	N/A	N/A	N/A	3	3	4	1	2	2	15
	SAU	100%	18%					0	2	0	0				6.2	4.1	68.0	73.3	1	95.7%	127.5%	80.1%	138.3%	4	5	7	5	4	6	31
	MAU	100%	14%			3		4	2	0	0				3.7	7.9	75.6	82.6		89.9%	106.4%	89.3%	145.2%	6	2	7	6	4	3	28
Inpatient Wards	Charlotte	98%	44%					1	1	0	0				0.2	3.0	100.0	100.0		103.3%	90.9%	98.9%	105.3%	0	0	1	3	3	3	10
	Helena	100%	90%			1		0	0	0	0				1.4	4.1	88.2	100.0		105.4%	131.5%	99.2%	204.0%	0	1	2	3	5	2	13
	Forrester Brown	97%	66%		1			3	1	0	0				3.0	3.1	94.1	100.0	2	111.9%	106.3%	86.5%	117.7%	1	3	3	3	3	3	16
	Surgical Short Stay Unit	97%	40%					0	1	0	0				8.7	1.1	92.0	92.3		120.1%	160.5%	105.0%	201.2%	1	3	4	1	2	3	14
	Violet Prince (RNHRD)	93%	45%					0	0	1	0				1.3	16.9	92.9	85.7		93.8%	85.4%	100.0%	100.0%	2	3	2	2	2	1	12
	William Budd	100%	37%			1		1	1	0	0				7.0	2.2	100.0	100.0	1	85.9%	140.6%	94.5%	147.6%	2	3	5	5	7	7	29
	ACE OPU	100%	39%					1	2	0	0				1.8	1.2	80.0	82.4		71.7%	115.0%	93.1%	140.9%	2	4	4	5	3	3	21
	Children's Ward	98%	19%			1		0	0	0	0				2.2	0.7	82.1	90.0		91.4%	68.0%	93.9%	126.7%	2	4	5	4	4	4	23
	Cheselden	100%	31%					3	1	0	0				4.5	6.4	100.0	100.0		111.4%	84.8%	102.5%	127.8%	3	2	1	1	1	1	9
	Phillip Yeoman	99%	80%					4	0	0	0				0.6	9.8	85.7	92.3		92.2%	77.8%	84.7%	92.3%	3	4	3	6	7	5	28
	Haygarth	97%	44%		1	3		2	0	0	0				1.3	8.8	91.7	88.2	2	70.7%	102.4%	77.8%	130.4%	3	5	3	3	4	4	22
	NICU	100%	8%					0	0	0	0				10.6	3.6	86.7	84.6		100.0%	97.3%	84.2%	91.7%	3	5	7	4	4	4	27
	Cardiac	100%	39%		1	2		5	3	1	0				4.3	6.3	87.5	92.3		86.4%	103.0%	75.2%	157.0%	4	3	2	3	4	4	20
	Pierce	100%	59%					1	1	0	0				1.8	5.5	73.3	73.3	2	91.8%	129.7%	83.9%	186.7%	4	4	2	7	3	6	26
	CCU	100%	73%					0	0	0	0				9.4	0.0	87.5	66.7		72.9%	73.5%	100.1%	99.9%	4	4	5	5	4	5	27
	Mary Ward	93%	26%		1	1		0	0	0	0				3.8	8.5	79.5	80.0		102.3%	90.7%	104.6%	95.6%	4	4	5	5	5	5	28
	Medical Short Stay Unit	100%	9%			1		3	0	0	0				2.3	15.0	100.0	70.0		84.5%	122.6%	103.0%	185.8%	4	5	4	4	2	4	23
	Parry	91%	49%			2	2	2	1	1	0				0.2	3.3	100.0	77.8		81.5%	114.7%	73.2%	191.5%	4	5	4	4	5	7	29
	Respiratory	96%	79%					6	1	0	0				6.2	3.9	84.2	93.3		75.3%	147.6%	76.3%	129.6%	4	5	5	3	4	4	25
	Combe	100%	141%	1	1	2		3	1	0	0				3.3	1.4	68.8	68.8	3	77.0%	125.5%	76.4%	212.0%	4	5	6	5	4	5	29
	Acute Stroke Unit	96%	41%					10	1	0	0				3.2	2.7	83.3	70.6	3	78.8%	92.5%	87.5%	112.1%	4	6	4	4	4	5	27
	Critical Care Services	N/A	N/A					0	0	0	0	1			4.1	0.0	93.0	100.0		84.1%	83.5%	83.0%	36.7%	5	3	2	4	5	3	22
	Robin Smith	93%	57%	1		4		1	1	0	0				6.5	6.1	63.2	80.0		93.9%	103.2%	92.8%	118.1%	5	5	6	2	3	0	21
	Pulteney	100%	61%		1			0	2	0	0				7.0	10.3	78.3	75.0		84.0%	90.8%	87.4%	126.3%	6	3	5	3	7	7	31
	Waterhouse	97%	103%			2		3	2	0	0				10.1	15.6	62.5	93.3	2	70.2%	127.2%	69.4%	141.6%	6	7	7	4	2	4	30
	Midford	100%	53%			1		5	1	0	1	1			10.8	8.4	69.2	88.9	6	67.6%	112.5%	77.4%	149.4%	7	5	5	4	5	4	30
* FFT data taken from Maternity FFT touchpoint 2- Post natal Ward		80% or less	< 35% (< 15% ED, MAU & SAU)	Nursing / Midwifery related	Neg N/M related only		C. Diff (per patient)	5 Falls or more or a major harm				Harms any PUs			5% or more		80% or less			< 90%				More than 5						