Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**28 March 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery** **Bernie Marden, Acting Medical Director** **Francesca Thompson, Chief Operating Officer**		
Author:	**Lisa Cheek, Deputy 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 February 2018 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**
  - Falls

    Executive Sponsored Projects:
  - National Safety Standards for Invasive Procedures (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.

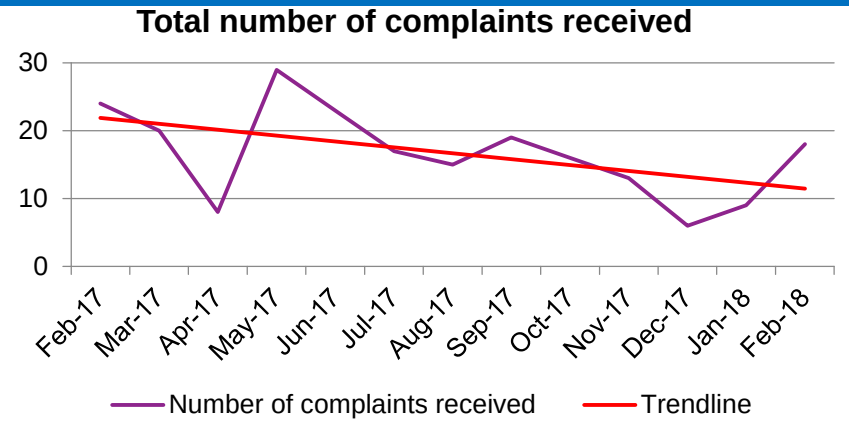
5.	Resources Implications (Financial / staffing)
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.	
6.	**Equality and Diversity**
Ensures compliance with the Equality Delivery System (EDS).	
7.	**References to previous reports**
Monthly Quality Reports to Management Board and Board of Directors	
8.	**Freedom of Information**
Public.	

QUALITY REPORT

PART A – Patient Experience

Royal United Hospitals Bath
NHS Foundation Trust

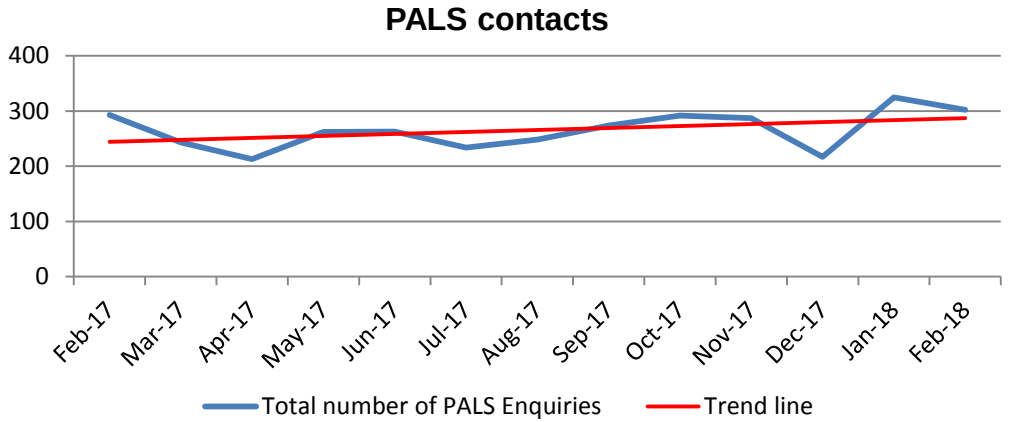
Complaints and Patient Advice and Liaison Report



There were **18** formal complaints received in February. **7** were for Medicine Division; **7** for the Surgical Division, **2** for the Women's & Children's Division, **1** for Estates & Facilities and **1** for Corporate. **11** complaints cited Clinical Care and Concerns as the main issue; **1** Safeguarding; **4** communication and information; **1** appointment waiting times; **1** carparking.

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	0	0	6 (100%)	6 (60%)
Breached 35 Day target	4 (100%)	0	0	4(40%)
Total	4	n/a	6	10

2 breaches were meetings; 1 was a delayed response from the stroke team and 1 related to further questions regarding the Trust response and the Consultant was on annual leave.



There were **302 contacts with the PALS** in February 2017:

- 197 required resolution (65%)
- 80 requested information or advice (27%)
- 15 were compliments (5%)
- 10 provided feedback (3%)

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

Clinical Care and Concerns - there were **49** contacts with queries relating to Clinical Care and Concerns. **32** of these were general enquiries. No trends or themes in relation to these contacts have been identified.

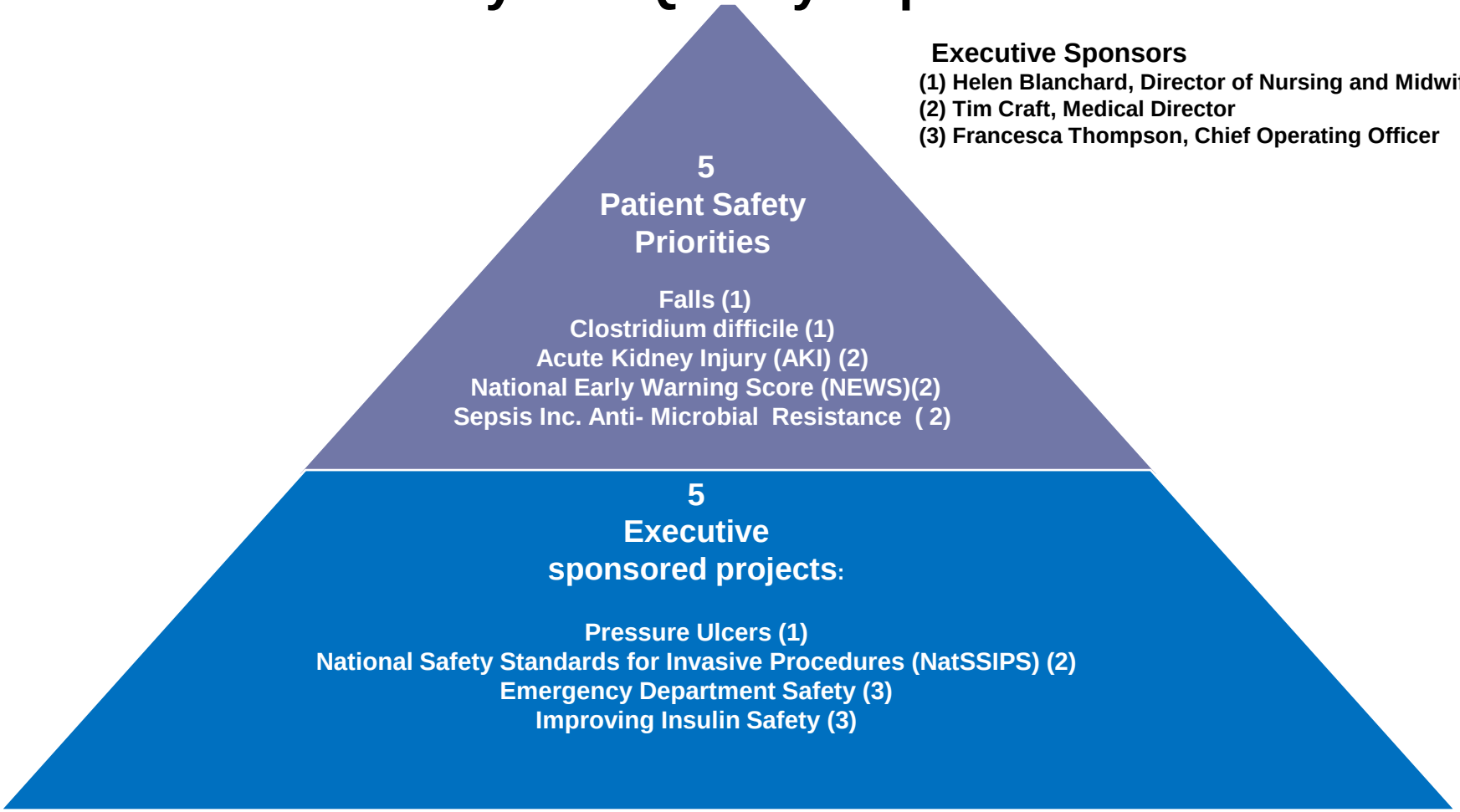
Appointments - there were **36** contacts regarding appointments.**10** of the contacts requested appointment date, time and information**.** There were no trends or themes in relation to the remaining contacts.

Communication and Information - **32** contacts referred to communication and information of which **12** were general enquiries; **7** referred to telephones not being answered; and **2** referred to a missing/incorrect discharge summary.

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



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 numbers are sustained below the median.

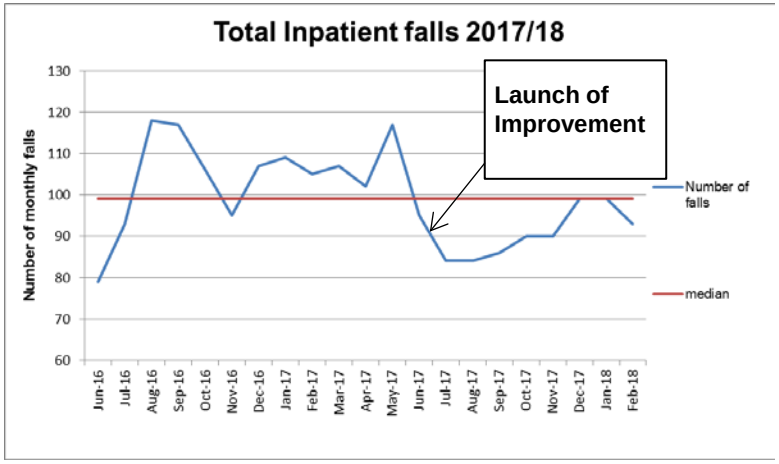


Figure 1

Figures 2 and 3 show comparison with national data.

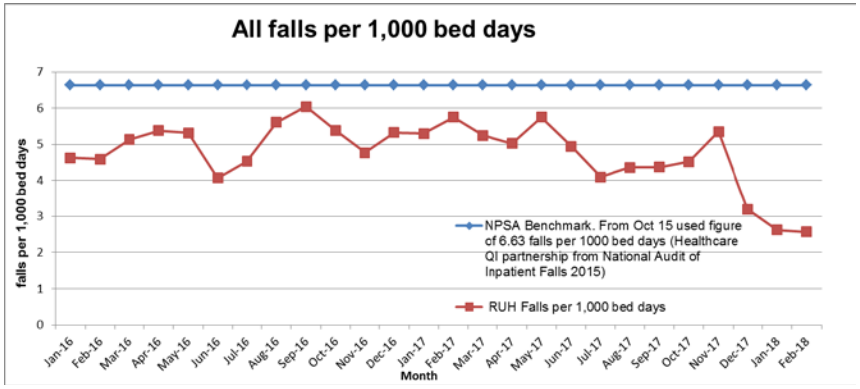


Figure 2

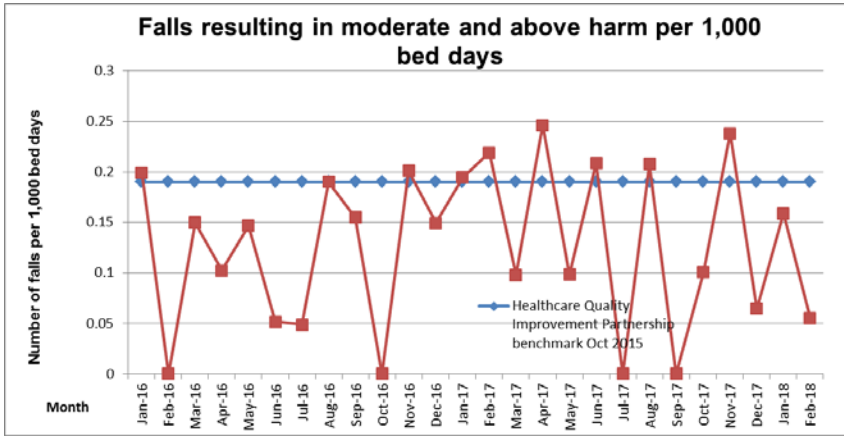


Figure 3

All moderate harm and above harm falls are investigated through the Serious Incident (SI) process and learning incorporated into the Falls Steering group work plan.

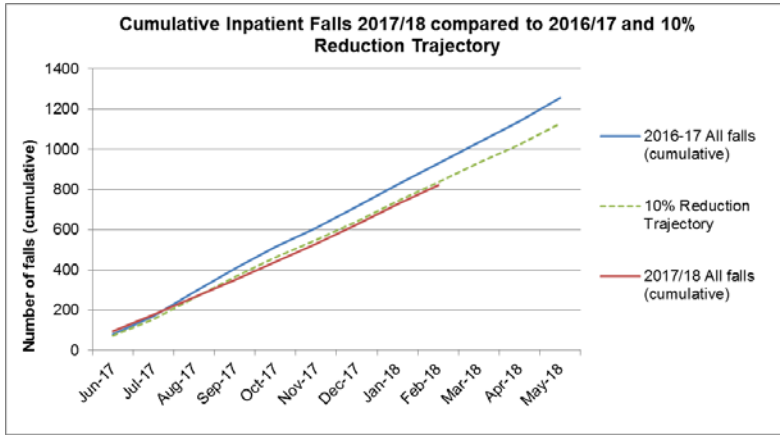


Figure 4

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

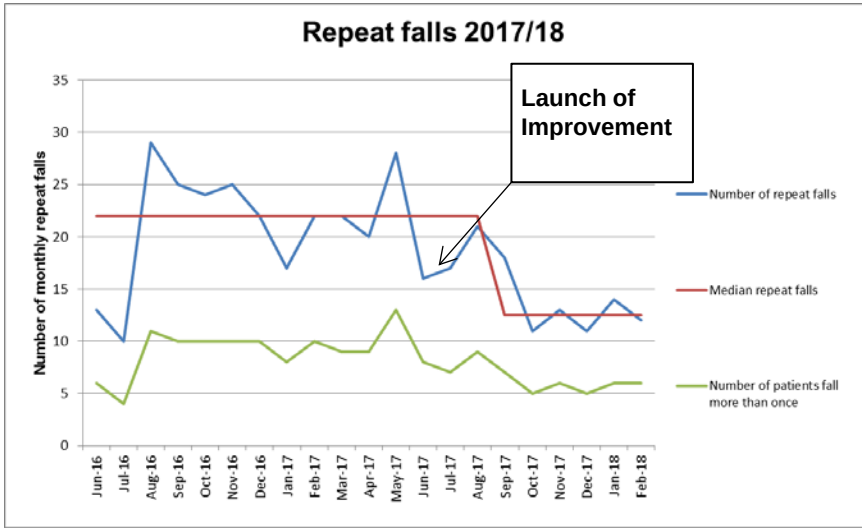


Figure 5

Figure 5 shows the number of repeat falls and the number of patients who have fallen more than once. There has been a notable reduction in the number of repeat falls.

Next steps:

- To review the correlation between the Falls improvement programme and the reduction on the number of repeat falls an improvement project has commenced on Midford to review and further improve the process of Enhanced Observation (a multidisciplinary team approach to the supervision of patients at high risk of falls) and SWARM (an immediate post fall review of every fall at ward level).
- Since 1 January all patients who fall on Respiratory ward are reviewed by an Elderly Care Registrar. This process is to be extended to Cardiac ward from April.
- Following the successful bid to Health Education England South West Simulation Network (HEESWSN) to support Falls simulation training, a part time band 6 and band 4 have been recruited and will take up post in April to lead the Falls Simulation project. Planning has commenced for the project which will focus on the OPU wards.
- Development of a Falls Lead role which will be tested in 4 wards by April 2018 .The aim of the role will be to be the point of dissemination of falls information and to support falls awareness at ward level.
- Exploration of the use of monitoring technology to detect high-falls-risk behaviour. A multidisciplinary team round table discussion will take place on 21 March to explore the issues surrounding falls, and to propose a possible falls prevention approach. The discussion is intended to lead to a joint research project between the RUH and Designability (who will be facilitating the discussion).
- A contemporaneous review of all falls in the trust over a weeks period in March to assess adherence to the falls pathway and review of the patient.
- A review of the SI process for moderate and above harm falls as despite investigating every serious fall thoroughly within the RUH, the number of falls resulting in harm are not decreasing. A more effective approach to falls investigations is needed in order to focus work on prevention rather than investigation. A proposed approach is being developed to promptly undertake a review at the time of the fall to identify if learning is already known or new. New learning would trigger a comprehensive Root cause analysis (RCA).

National Safety Standards for Invasive Procedures (NatSSIPS) Bernie Marden

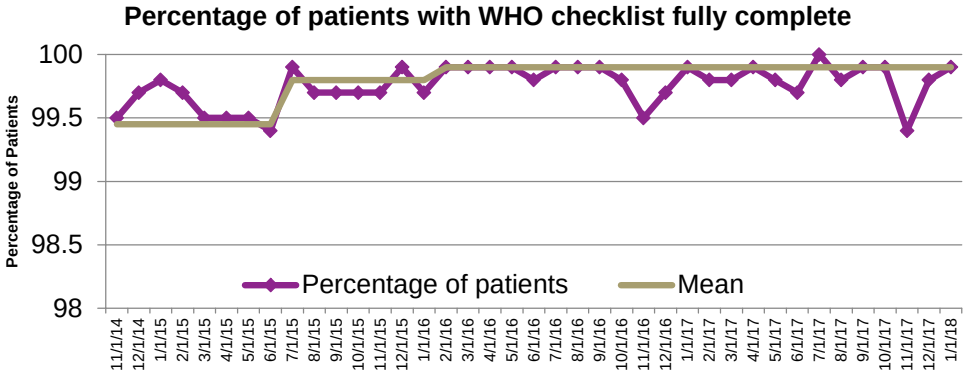
National Safety Standards for Invasive Procedures(NatSSIPs)

- Local policy for all procedures (LocSSIPs) is finalised and checklists are in use for all procedures
- Compliance for procedures outside of the operating theatres continues from random note review whilst awaiting IT support.

Operating Theatres:

Compliance with WHO Surgical Safety checklist in Theatres

Compliance remain high with 100% patients undergoing surgery having a WHO checklist performed, 99.9 % of which are fully complete.(1300-1600 patients). There have been no never events for nearly 6 years



Quality audits continue, including out of hours procedures and demonstrate excellent quality in 98% of audits. Themes are used to further increase quality of the checklist.

Prelist Briefing

Pre-list briefing is well established , compliance being 99.2%.

Debriefing

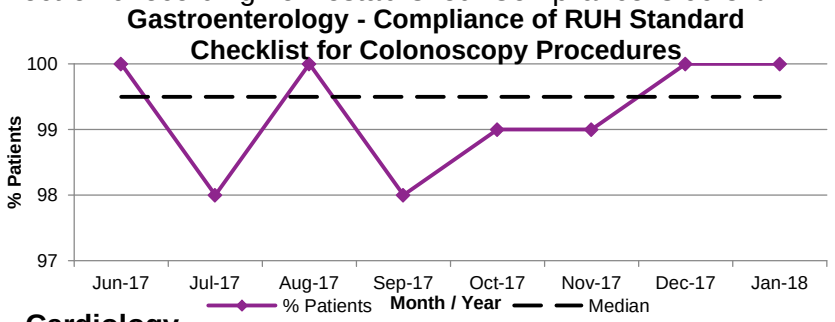
Work has commenced on implementing regular debriefing at the end of each operating list. This is being tested in PAW theatre , with aim to be in all theatres by end 2018. This is part of the NHS Quest theatre safety community which RUH has joined and is actively working with.

Checklist implementation for procedures outside theatres:

Data is now available in the majority of areas from random note review. This is labour intensive and IT support is required to establish electronic recording in the majority of areas.

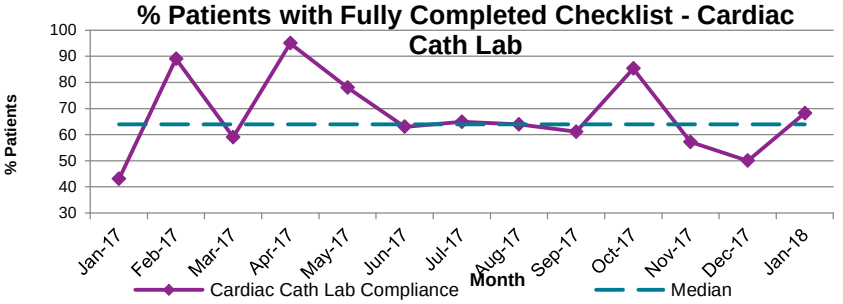
Gastroenterology:

Electronic recording now established. Compliance is 99.5%



Cardiology

Compliance recorded from random note reviews:



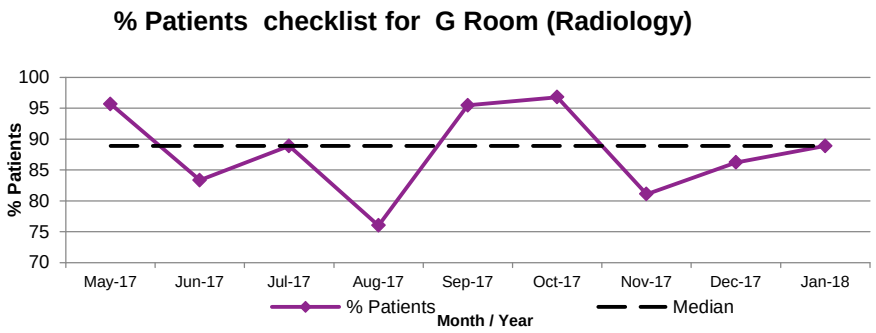
91% of patients had a checklist, 68% were fully completed, the sign out being omitted. The Natsips Lead and Cardiology Lead have planned ideas to be tested for improvement from March 18

Cardiac Pacemaker procedures

The new pacemaker checklist has been implemented and compliance is 63% for January 2018. The sign out is the commonest uncompleted section, which is being addressed.

National Safety Standards for Invasive Procedures (NatSSIPS) Bernie Marden

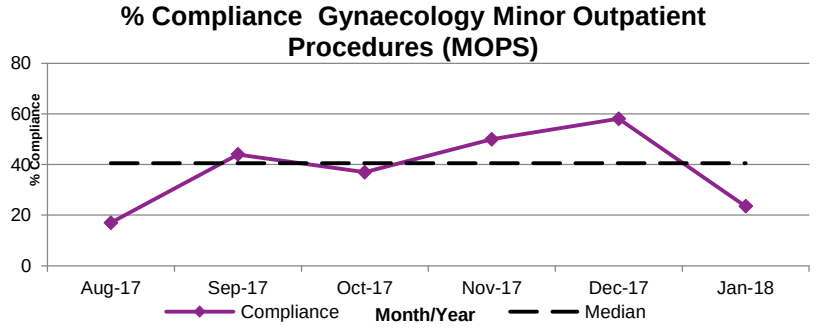
Radiology : compliance 89%



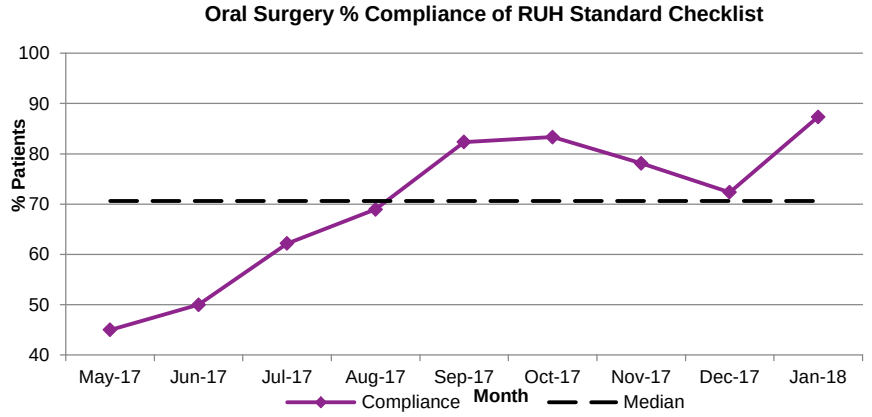
Dermatology, ED, Chest procedures on ward & in Outpatients

Checklists have been implemented. Data is awaiting IT support. Checklist compliance for chest drains performed electively in chest clinic is 100% to November 2017.

Gynaecology : Compliance is inconsistent, depending on clinician which is being addressed.



Oral Surgery: Improved over the last 5 months.



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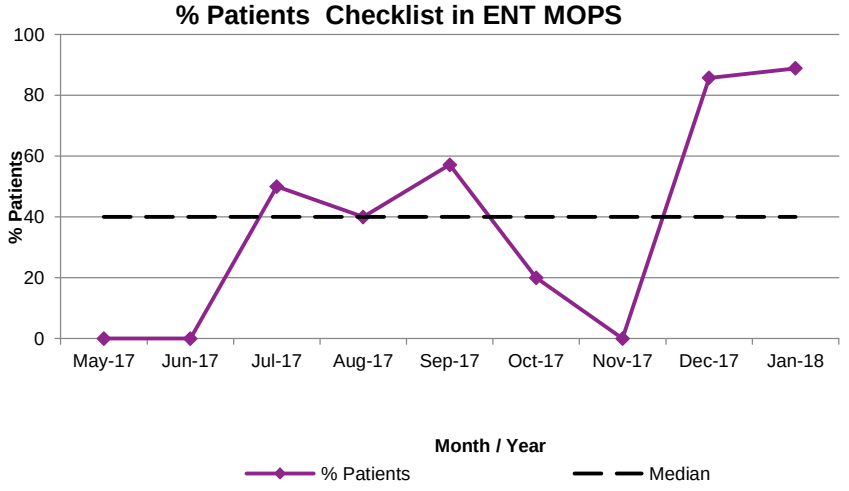
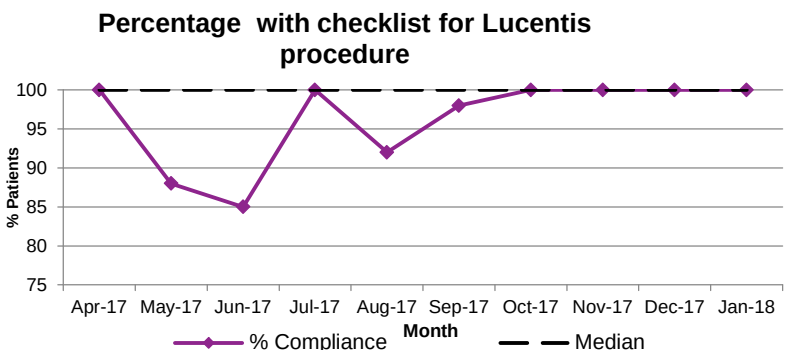


National Safety Standards for Invasive Procedures (NatSSIPS) Bernie Marden

Ophthalmology: Lucentis injections - last 4 months- 100%



Urology

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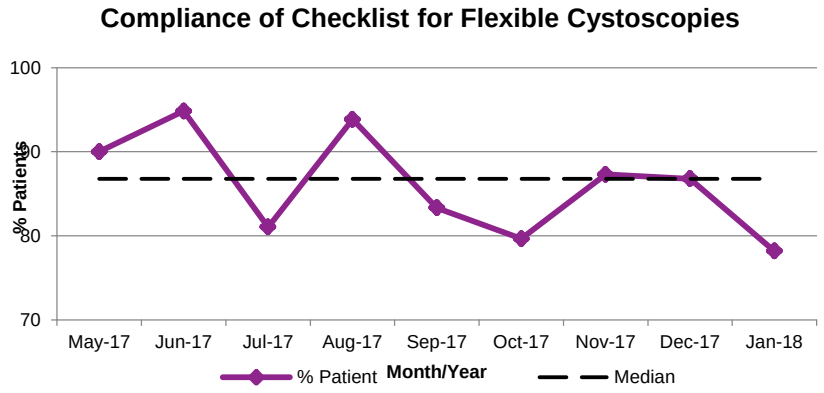
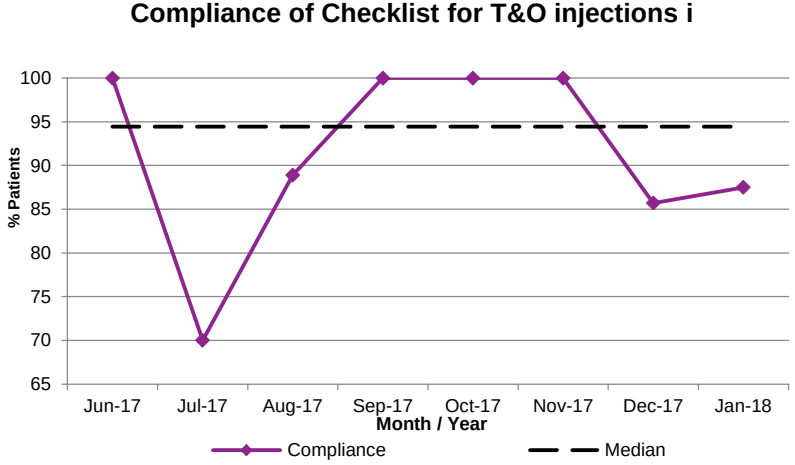
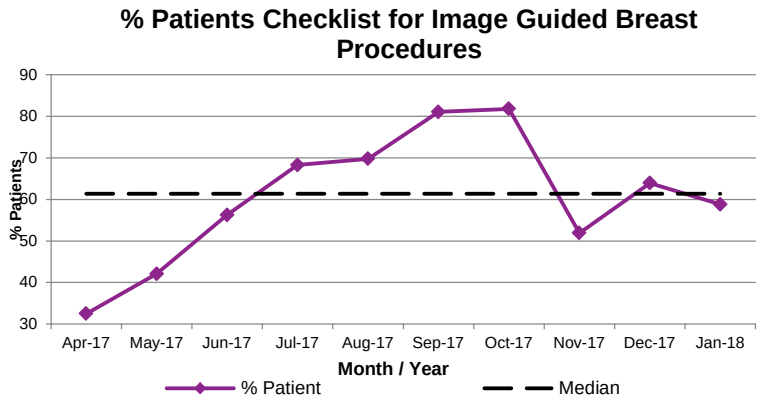


Orthopaedics Outpatients



Breast Clinic

There is inconsistent depending on clinician and procedure, Observational audits planned for March.



Executive Sponsored Project – Improving Insulin Safety Francesca Thompson

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.

Work Plan Progress
The **self administration** of insulin has commenced on Cardiac and the Acute Stroke unit. 8 patients have self administered following assessment using a tailored care plan. There is also a roll out plan to extend to 4 more wards. Discussions are currently taking place with BIU to develop a performance report at ward level with the overall aim of driving change.

Link Nurses
Intensive Training of link nurses is continuing with a specifically designed work book. This is seen as a more robust means of embedding continuous support around diabetes care.

Future plan

Training
50% doctors have completed the mandatory e-learning module. This group will be targeted to improve compliance via the appraisal process.
There is a plan to upgrade the e-learning module to include ePMA changes. This will be in place for August 2018.

ePMA
A number of suggested changes are being considered to improve the application of ePMA. A safety bulletin was circulated to all staff with top tips.

Learning from Incidents
A medication safety website has been set up under pharmacy, with 2 insulin safety bulletins already on there.

Surgical Insulin Pathway
This work has not yet started but will be prioritised over the next quarter.

Barriers
The current operational pressure on ward staff appears to be having an impact on ability to engage with some of the projects.

Executive Sponsored Project – Improving Insulin Safety Francesca Thompson

Insulin, National Diabetic Inpatient Audit (NaDIA) results

- National Audit March 2017. Results available 14th March 2018
- Reduction in medication errors from 64.4% to 29.2% vs a national average of 31.3%.
- Reduction in prescription errors from 50.7% to 21.3% vs a national average of 19%.
- Reduction in glucose management errors from 30.1% to 14.6% vs a national average of 18.5% and insulin errors down to 18% from 37% vs a national average of 18.6%.
- Hypoglycaemic attacks: We have reduced the mild attacks from 24% to 17.1% vs a national average of 16.7% but the severe ones remain at 11.2% vs 7.1% nationally. This remains the main focus of our ongoing work and projects.

Serious Incidents (SI) Summary

Helen Blanchard

Current Performance

During February 2018 five Serious Incidents were reported to STEIS.

Date of Incident	ID	Summary
27/01/2018	60263	Fall with Fracture
06/02/2018	60523	Pressure Ulcer Category 3
01/02/2018	60382	Fall with Fracture
15/02/2018	60792	Fall with Fracture
10/02/2018	60643	Unexpected admission to NICU

Overdue Serious Incident Report

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 08th March 2018, there are 29 Serious Incidents that remain open. Of these, thirteen incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. A telephone conference meeting has been arranged with the Head of Risk and Assurance and the CCG's for the 20th March 2018 to discuss the delays and actions going forward.

Delays 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 January OGC meeting, the status was reported as:

	Apr-17	May-17	June-17	July-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Outstanding Action Plans	8	9	17	21	22	15	19	19	30	23	28
Outstanding Actions	15	13	33	49	44	29	44	31	49	43	34

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.

Nursing Quality Indicators Exception Report — Helen Blanchard

Areas of focus
The Nursing Quality Indicators chart is attached as Appendix A.

The Nursing Quality Indicators have been amended this month after discussion with the Matrons to try and reflect a more balanced view.
The changes are:

- Reporting compliments received by PALS and letters to the Chief Executives office
- Reporting Care Hours Per Patient day (CHPPD) as another measure of actual care hours provided
- Staffing level fill rates reduced to 85% or less (from <90%) as the fill rates do not capture other care staff such as ward Therapist roles, or reflect a reduced number of patients and staffing levels appropriately reduced.

Five wards have flagged this month as having nursing quality indicators of note.

To note:
Midford, ACE OPU, Waterhouse and Pierce wards flagged last month but their quality indicators have improved.
These wards will continue to be closely monitored and supported to maintain/improve performance as per the nursing quality indicators Escalation Support Framework.

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Combe ward (Older Persons)
This is the third consecutive month that this ward has flagged.

Quality matrices to note are:

- FFT response rate 11%
- RN sickness 9.2%
- HCA sickness 21.3%
- RN appraisals 80%
- HCA appraisals 75%
- RN hours % day and night fill rate <85%

The FFT response rate was a result of a key member of staff being off sick. They have now returned to work, however the Matron will enforce the message about FFT responses with all staff so that everyone supports compliance.

The ward Sister has an appraisal improvement trajectory in place and has improved the position from last month. It is anticipated that this will improve again next month (month lag on data).

Sickness has increased slightly this month but is being closely managed as per Policy with monthly review meetings with HR. A few nurses have returned to work from long term sickness and are on a phased return.

Recruitment is being proactively managed and to address the shortfall of RN hours, additional HCA hours are provided to ensure there are sufficient staffing levels.

The Matron is closely supporting the ward with regular staff meetings and taking the actions as identified within the nursing quality indicators Escalation Support Framework

Nursing Quality Indicators Exception Report Helen Blanchard

Cardiac ward
This is the third consecutive month time that this ward has flagged.

Quality matrices to note are:
- FFT response rate 32%
- HCA sickness 10.8%
- RN appraisals 78.3%
- HCA appraisals 69.2%
- RN hours % day and night fill rate <85%

The Charge Nurse is reviewing the process of FFT response collection and discussing with the team how they will improve performance. The Ward Receptionist and Discharge Co-ordinator have been involved in these discussions as they are involved in preparing the patient's discharge and therefore able to support FFT returns. The Charge Nurse will monitor compliance over the next few months.

Staff sickness is being well managed and whilst there has been high long term sickness, these staff are now starting to returning to work. HCA sickness has remained a concern however the Charge Nurse is reviewing all individual staff sickness with HR and Matron support.

To support the RN shortfall of hours additional HCA hours were provided, particularly at night (196% fill rate) for those patients who need enhanced observation.

As per the nursing quality indicator Escalation Support Framework, a Nursing Intensive Support Team (NIST) review has been commissioned by the Director of Nursing for this ward starting March 2018.

Haygarth ward (Gastroenterology medical)
The previous occasion that this ward flagged was in January 2018.

Quality matrices to note are:
- Five falls (4 no harm, 1 minor harm)
- HCA sickness 6.8%
- RN appraisals 70%
- HCA appraisals 64.7%
- RN hours % day and night fill rate <90.0%

Sickness is being closely managed as per Policy. There were 2 HCAs that were on long term sickness but are now on a phased return to work. This should improve sickness levels over the next couple of months (month lag on data).

With regard to staff appraisals the Senior Sister has a plan in place to undertake staff appraisals and to date the appraisal rate has improved (month lag on data). The Senior Sister has also 'cleansed' the individual staff registered to her ward as some staff have now left the ward that were being reported as out of date.

Recruitment is being proactively managed and staff have been appointed, a few will start in the coming months and newly qualified nurses have been appointed to start in September 2018. This will leave 5.0 wte vacancies however the ward will receive Philippine nurses recruited from the International recruitment campaign.

To support the shortfall of RN hours the ward booked additional HCA hours day and night to ensure safe staffing levels. If required the supervisory Sister worked clinically to support the staffing levels and care delivery.

Nursing Quality Indicators Exception Report Helen Blanchard

Medical Short Stay Unit
This is the first time this ward has flagged since the nursing quality indicators chart was implemented.

Quality matrices to note are:
- FFT response rate 16%
- RN sickness 17.8%
- HCA sickness 14.3%
- RN appraisals 78.6%
- HCA appraisals 54.5%
- RN hours % day fill rate < 85%

Staff sickness is being proactively managed as per Policy. There are three staff on long term sickness presently although one will be leaving the Trust by mutual agreement. Short term sickness is being closely managed by the senior nursing team with support from HR.

Appraisal completion is being addressed by the Junior Sisters and Matron and a plan for improvement and trajectory has been agreed.

All staff have been reminded about FFT responses. The Emergency Directorate administration manager is now supporting the ward receptionists to increase their compliance with FFT responses and will frequently monitor progress.

Philip Yeoman ward (Elective Orthopaedics)
The previous occasion that this ward flagged was in August 2017.

Quality matrices to note are:
- RN sickness 8.1%
- RN appraisals 80%
- RN hours % day and night fill rate < 85%
- HCA hours % day and night fill rate < 85%

It is unfortunate that this ward has flagged this month as it primarily due to reduced staffing levels fill rates which are unusual for this ward.

The ward is usually a ring-fenced elective ward, however during winter pressures the ward was used in escalation for non-elective patients. During February the ward was supported to revert back to elective activity and therefore there were less patients. Staff were deployed to other wards and therefore the staffing levels were appropriate for the number of patients.
The Care Hours Per Patient Day figure of 8.7 hrs per patient, demonstrates the staffing levels being appropriate during this time, especially when benchmarked against other comparable wards.

Sickness is being proactively managed and in line with Policy and support from HR.

The Matron will ensure that the Senior Sister has a plan and trajectory in place to improve appraisal compliance and will check if this corresponds to staff who are currently off sick.

Nursing Quality Indicators Exception Report — Helen Blanchard

Other Quality Indicators of note:

Falls: There were 16 minor falls, 2 moderate falls and no major falls this month.

The Falls group have completed a thematic review of falls but there were no significant new themes identified from this. The falls group continue to implement their work plan and in particular are supporting enhanced observation bays on wards.

Pressure Ulcers: there were 2 hospital acquired pressure ulcers this month which is the same as last month.

Following a thematic review the Tissue Viability Nurses have been particularly focussing ward nurses attention to pressure ulcers that develop on heels. In support of this they have led a ‘healthy heels’ campaign.

C.Difficle: There were 2 cases of hospital acquired C.Difficle this month.

Root cause analysis investigations have been undertaken and one key area of learning and action from one case was to educate the clinical team following emergency admission around antimicrobial prescribing.

Nursing Quality Indicators - Monthly Template February 2018

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 compliments received	Number of PALS contacts		Number of patients with Cdiff	Number of patients who fell				Number of Pressure Ulcers			Human Resources (1 month lag)				Nurse Staffing Datix Report	Safer Staffing % Fill rate				Care Hours Per Patient Day (CHPPD) overall	Number of times parameters outside of KPI					
																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		Feb 18 No:	Jan 18 No:	Dec 17 No:	Nov 17 No:	Oct 17 No:	Sep 17 No:
Emergency Dept	SAU	98%	24%						0	0	0	0				3.7	3.5	81.0	85.7		80.6%	119.3%	85.7%	132.1%	9.5	1	5	5	4	5	7
	A&E	97%	7%	3	6	6	31		2	0	1	0				2.5	5.0	85.7	87.0		N/A	N/A	N/A	N/A	N/A	2	1	2	3	3	4
	MAU	93%	34%			1	5		4	1	0	0				3.3	5.6	86.4	81.8		82.5%	127.4%	86.0%	166.8%	9.1	2	2	6	6	2	7
Inpatient Wards	Cheselden	98%	132%						1	1	0	0				2.5	0.5	100.0	100.0	1	90.9%	108.3%	100.0%	96.4%	5.8	0	2	2	3	2	1
	Charlotte	95%	40%	1			2	1	1	0	0	0				3.2	3.4	87.5	81.8	4	106.9%	101.2%	100.0%	116.7%	6.8	2	1	1	0	0	1
	Helena	96%	68%						2	0	0	0				2.2	20.9	87.5	100.0	2	95.5%	120.8%	78.9%	164.5%	8.6	2	3	2	0	1	2
	Parry	100%	25%				2		3	1	0	0				2.0	2.2	80.0	100.0		87.4%	96.9%	117.0%	106.5%	6.1	2	5	3	4	5	4
	Pierce	100%	17%						3	0	0	0				4.1	7.8	88.2	93.8	1	85.4%	132.9%	91.5%	187.1%	7.5	2	6	5	4	4	2
	ACE OPU	98%	58%						9	0	0	0				1.0	4.8	90.0	94.1	1	71.90%	86.10%	75.00%	115.30%	7.6	2	7	5	2	4	4
	Surgical Short Stay Unit	96%	67%				7		1	1	0	0	1			2.4	5.0	87.5	91.7		111.5%	173.0%	101.6%	171.4%	6	3	1	2	1	3	4
	Critical Care Services	N/A	N/A		1				1	0	0	0				3.8	0.0	86.0	100.0		87.7%	74.1%	83.5%	53.6%	26.5	3	2	2	5	3	2
	Forrester Brown	95%	75%				3		5	0	0	0				9.0	8.9	89.5	92.9	2	92.5%	105.1%	87.6%	120.5%	6.9	3	3	2	1	3	3
	Mary Ward	96%	23.4%				2		0	0	0	0				3.5	13.3	86.0	89.5	1	92.3%	64.2%	95.0%	90.5%	10.7	3	3	5	4	4	5
	Violet Prince (RNHRD)	94%	29%						0	0	0	0				0.0	15.2	86.7	57.1		92.1%	84.6%	100.0%	110.7%	5.5	4	4	3	2	3	2
	Respiratory	95%	48%						3	0	0	0				4.0	14.4	75.0	93.8		64.9%	133.8%	75.7%	110.7%	5.9	4	4	3	4	5	5
	Acute Stroke Unit	90%	48%						2	1	0	0				6.4	12.9	88.2	72.2	2	77.1%	86.5%	88.2%	110.0%	7.1	4	4	4	4	6	4
	Children's Ward	100%	14%				4		0	0	0	0				6.1	1.6	83.8	80.0		79.3%	87.0%	86.3%	132.1%	7	4	4	5	2	4	5
	CCU	91%	58%						2	2	0	0				8.8	3.5	52.9	75.0		73.9%	137.2%	99.9%	100.0%	9.9	4	5	3	4	4	5
	Robin Smith	96%	50%				1		4	1	0	0	1			1.1	10.0	89.5	82.4		92.9%	113.2%	83.2%	122.9%	6.6	4	5	5	5	5	6
	William Budd	97%	38%				2	1	3	0	0	0				6.7	11.8	87.5	100.0	2	73.7%	129.9%	63.7%	146.9%	6.6	5	5	6	2	3	5
	NICU	83%	27%						0	0	0	0				5.6	0.9	88.0	92.0		97.4%	68.9%	79.5%	66.0%	9.3	5	6	5	3	5	7
	Waterhouse	100%	61%				2		7	1	0	0				15.5	6.2	100.0	93.8		82.4%	83.4%	105.4%	118.6%	6.7	5	6	5	6	7	7
	Pulteney	99%	57%		1	1	4		6	2	0	0				0.0	0.0	56.0	57.9	4	83.2%	87.9%	84.6%	119.8%	6.4	5	7	4	6	3	5
	Midford	93%	52%				1		3	0	1	0				1.7	8.3	75.0	76.5	3	60.1%	117.3%	78.9%	193.3%	5.9	5	9	8	7	5	5
	Phillip Yeoman	100%	65%				1		0	0	0	0				8.1	2.5	80.0	100.0		73.4%	44.8%	69.6%	60.4%	8.7	6	3	4	3	4	3
	Medical Short Stay Unit	100%	16%						2	2	0	0				17.8	14.3	78.6	54.5		71.5%	105.9%	98.2%	135.6%	5.9	6	5	4	4	5	4
	Haygarth	98%	69%	1			5		4	1	0	0				1.4	6.8	70.0	64.7		57.6%	112.8%	65.1%	160.7%	6.4	6	5	7	3	5	3
	Cardiac	96%	32%		1		6		3	1	0	0				3.2	10.8	78.3	69.2	2	78.3%	118.3%	75.9%	196.0%	5.9	6	6	6	4	3	2
	Combe	100%	11%				2		3	1	0	0				9.2	21.3	80.0	75.0	8	74.1%	126.0%	75.6%	222.1%	9.3	7	6	8	4	5	6
* 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				Avoidable harms any PUs			5% or more		80% or less			85% or less					More than 5 Amended metrics for Feb 2018					

Please note: Chart includes amended metrics for Staffing level fill rates and CHPPD (Feb 2018)