Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**30 May 2018**		
Title of Report:	**Quality Report**		
Status:	**For discussion**		
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery** **Bernie Marden, Medical Director**		
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 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**
  - Pressure Ulcers
  - Emergency Department Safety
- Exception reports:
  - Serious Incidents (SI) monthly summary and Overdue SI Report summary
  - Nursing Quality Indicators Exception report
  - Accreditation

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).	

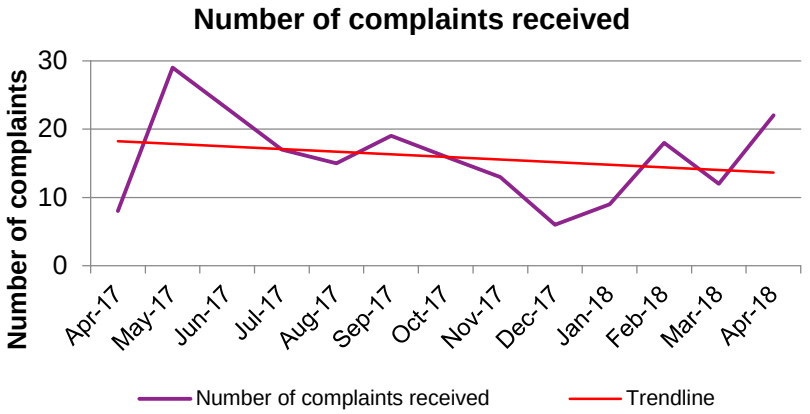
7.	References to previous reports
Monthly Quality Reports to Management Board and Board of Directors	

8.	Freedom of Information
Public.	

QUALITY REPORT

PART A – Patient Experience

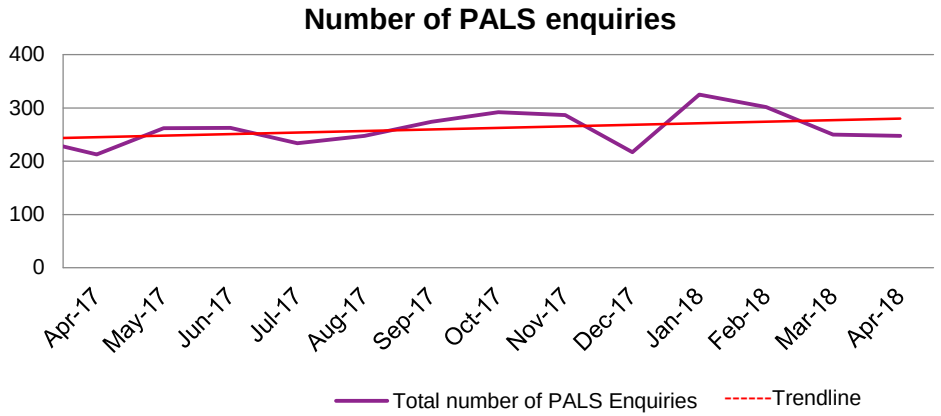
Complaints and Patient Advice and Liaison Report



There were **22** formal complaints received in April. **8** were for the Surgical Division; **12** for the Medical Division, **2** for the Women's & Children's Division. **20** complaints cited Clinical Care and Concerns; **1** was poor communication and **1** was a cancelled procedure.

Complaint response rate by Division	**Division**			**Total**
	Surgery	W&C	Medicine	
Closed within 35 day target	4 (100 %)	0	5 (50%)	9 (60%)
Breached 35 Day target	0 (0%)	1 (100%)	5 (50%)	6 (40%)
Total	4	1	10	15

W & C – response breached as the family were away for 2 weeks in March and requested a meeting with social services present but were not able to make any of the dates offered in April. Meeting arranged for May.
Medicine – 3 needed further reviews which delayed the response; 2 were because of missing medical records.



There were **248 contacts with the PALS** in April 2018:

- 145 required resolution (58%)
- 71 requested information or advice (29%)
- 15 were compliments (6%)
- 17 provided feedback (7%)

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

Clinical Care and Concerns - there were **41** contacts relating to Clinical Care and Concerns, 38 of these were general enquiries, 3 related staff attitude.

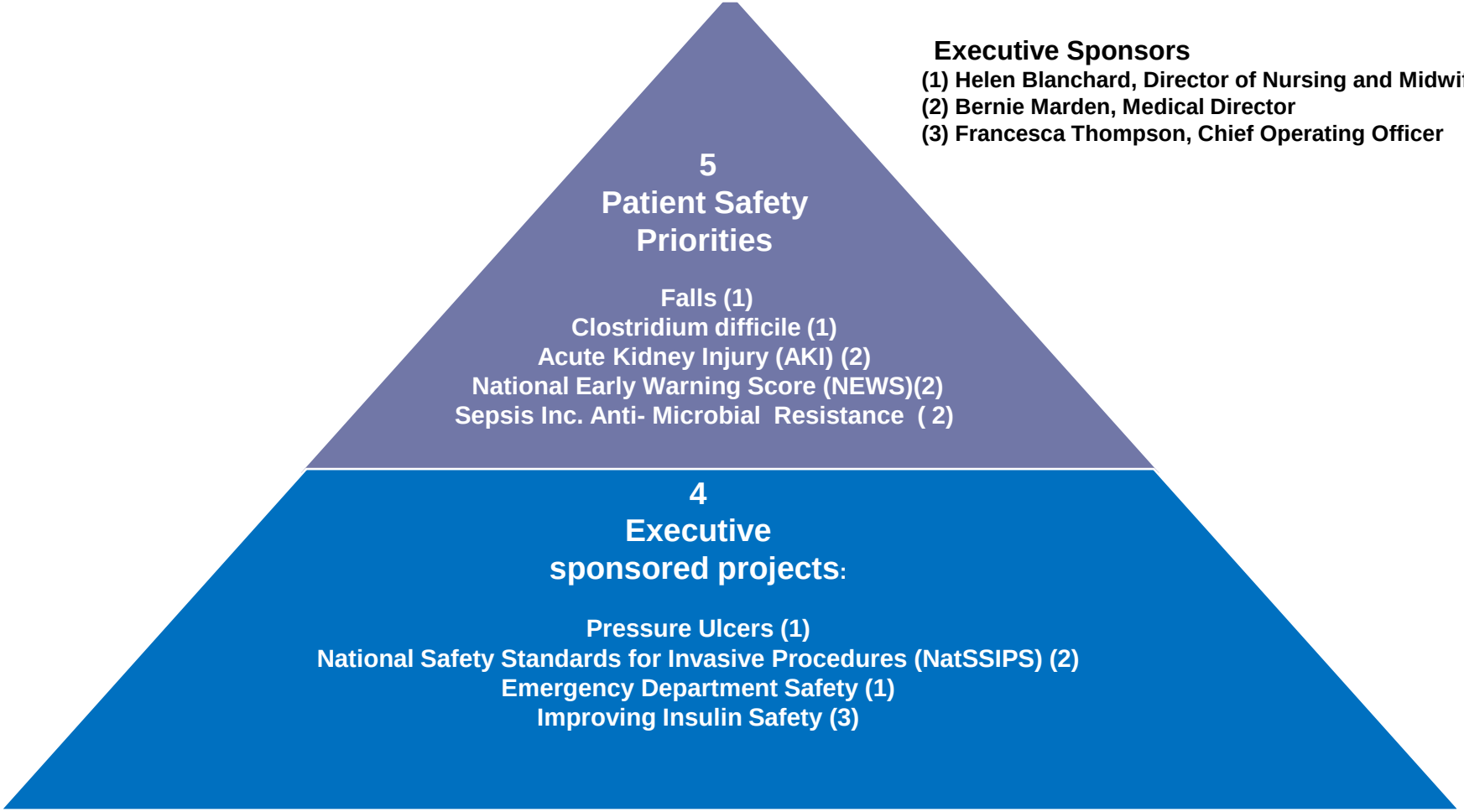
Appointments - there were **37** contacts regarding appointments. 10 of these related to the cancellation of an appointment, 9 requested further information about their appointment date and time. There were no clear trends regarding the remaining queries.

Patient Property - **9** contacts referred to the loss of patient property.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement

Executive Sponsors
(1) Helen Blanchard, Director of Nursing and Midwifery
(2) Bernie Marden, Medical Director
(3) Francesca Thompson, Chief Operating Officer



Patient Safety – Pressure Ulcers

Helen Blanchard

Avoidable Category 2 Pressure Ulcers performance

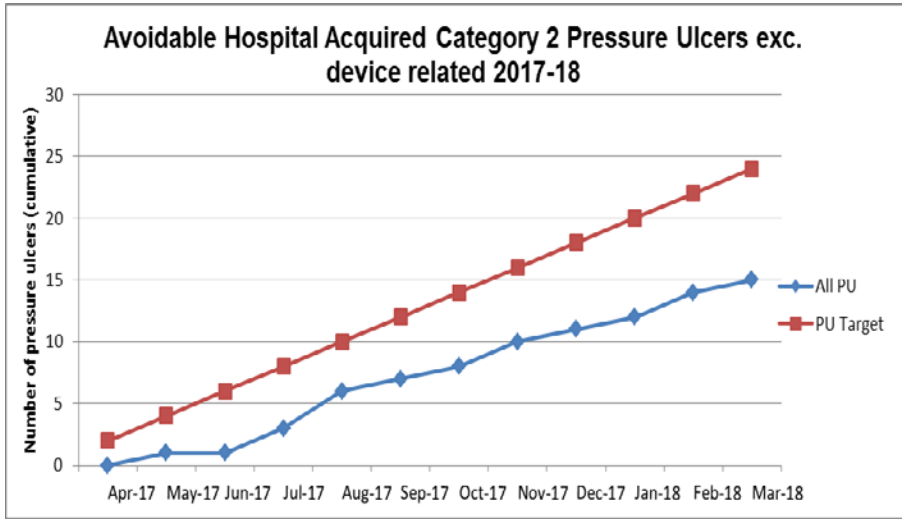
The ambition for 2017/18 was a 25% reduction of category 2 pressure ulcers and the elimination of all category 3 and 4 pressure ulcers, plus a 50% reduction in Medical Device Related pressure ulcers.

The end of year resulted in an actual reduction of **57%** category 2 plus a **47%** reduction in Medical Device Related pressure ulcers..

- Quarter 4 reported four avoidable category 2 and four medical device related pressure ulcer

Avoidable Category 3 & 4 Pressure Ulcers performance

- A category 3 pressure ulcer was reported in January 2018
- It has been 75 days since the RUH reported any avoidable category 3 pressure ulcers.
- It has been 461 days since the RUH reported any avoidable category 4 pressure ulcers.



Key issues identified:

A thematic review of avoidable heel ulcers was undertaken which identified the top 5 issues as inadequate repositioning, lack of offloading of heels in bed bound patients, foot protectors not being used in high risk patients, inadequate skin inspection and all patients were confined to bed.

Next Steps:

- An extraordinary meeting of the Senior Nursing Team was held to agree high level actions and agree upon the ambitions for the year ahead;
- Maintain the ambition to eliminate all avoidable category 3 and 4 pressure ulcers
- 20% further reduction in avoidable category 2 pressure ulcers
- 25% further reduction in avoidable Medical Device related pressure ulcers
- Changes to the comfort record where 2-3 hourly repositioning is expected
- Central stores of Repose foot protectors to be readily available to all high risk patients
- Awareness campaign by podiatry, Diabetic Specialist Nurses, Tissue Viability Nurses and Vascular Nurse to identify high risk patients.
- Support the “end PJ paralysis” campaign for those patients confined to bed as this has a direct impact on pressure ulcer development.
- Increase mandatory training compliance to 95% by July 2018
- Celebrate those wards that have remained pressure ulcer free

1 year	2 years	3 years	4 years	5 years
Respiratory	Pulteney	Children’s Unit	Helena	CCU
Cheselden	Theatres	ED Obs Unit	Charlotte	
Forrester Brown				
Waterhouse				
Cardiac				

Patient Safety – Emergency Department Safety Helen Blanchard

50% Complete - Out of applicable fields only

			Month 11	Month 12	Month 13	Month 14	Month 15
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
	Total Notes Pulled		297	265	179	199	98
	Total Applicable Notes		175	122	103	100	42
	% Compliance		59%	46%	58%	50%	43%
	Red	Green					
Vital Signs measured + News recorded + Pain recorded	49%	80%	99%	100%	98%	100%	100%
Triage completed on Patient First	49%	80%	98%	98%	96%	98%	100%
ECG recorded + Checked (If Appropriate)	49%	80%	85%	82%	66%	87%	97%
Analgesia administered (if appropriate)	49%	80%	83%	63%	32%	55%	87%
Investigations Initiated (as appropriate):							
IV access and / or Blood tests	49%	80%	84%	83%	74%	80%	96%
Hydration Chart / Fluid Chart	49%	80%	85%	59%	46%	61%	47%
Meds on time	49%	80%	84%	25%	23%	14%	22%
Specific Pathway Triggered:							
NoF/Cath Lab/Sepsis/Trauma/Self Harm	49%	80%	87%	44%	40%	44%	67%
Hour Compliance:			**89%**	**76%**	**62%**	**78%**	**89%**
Vital Signs measured + News recorded + Pain recorded	49%	80%	83%	98%	93%	95%	100%
Analgesia administered (if appropriate)	49%	80%	75%	84%	65%	50%	100%
Next of kin aware	49%	80%	89%	95%	85%	93%	98%
Safety magnet (if appropriate)	49%	80%	74%	51%	33%	39%	60%
Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart	49%	80%	78%	83%	79%	83%	100%
Pressure Area Care Assessment undertaken	49%	80%	87%	91%	91%	89%	73%
Hour Compliance:			**81%**	**88%**	**76%**	**84%**	**90%**
Vital Signs measured + News recorded + Pain recorded	49%	80%	65%	95%	77%	92%	100%
Pain score re-assessed	49%	80%	62%	88%	64%	91%	100%
Analgesia administered (if appropriate)	49%	80%	56%	62%	24%	64%	100%
Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart	49%	80%	64%	81%	48%	87%	86%
Hour Compliance:			**62%**	**86%**	**57%**	**86%**	**96%**
Vital Signs measured + News recorded + Pain recorded	49%	80%	73%	100%	48%	85%	100%
Analgesia administered (if appropriate)	49%	80%	67%	80%	26%	29%	100%
Refreshments offered (if not NBM) & Hydration Chart / Fluid Chart	49%	80%	77%	93%	16%	83%	75%
Regular medication administered (if appropriate)	49%	80%	58%	30%	23%	33%	-
Hour Compliance:			**70%**	**87%**	**28%**	**66%**	**90%**

Patient Safety – Emergency Department Safety Helen Blanchard

Emergency Department NEWS & Pain Audits

Values	Oct	Nov	Dec	Jan	Feb
extreme units recorded as a number compliance	100%	100%	100%	100%	100%
NEWS recorded compliance	92%	93%	90%	75%	92%
NEWS Recorded is accurate compliance	88%	88%	82%	82%	95%
NEWS recorded and accurate compliance	81%	81%	73%	60%	88%
Respiratory Recorded compliance	100%	100%	98%	94%	96%
Sats Score recorded Compliance	100%	100%	100%	97%	100%
Temp recorded Compliance	100%	93%	98%	87%	100%
BP Recorded Compliance	100%	100%	100%	97%	100%
Pulse Recorded Compliance	75%	72%	69%	50%	68%
AVPU Recorded Compliance	100%	100%	100%	88%	100%
Average of Pain Score In use Compliance	75%	72%	69%	50%	68%
Patient name recorded Compliance	100%	100%	100%	100%	90%
DOB recorded Compliance	100%	100%	100%	100%	90%
MRN Recorded compliance	100%	100%	95%	100%	90%
Ward Recorded Compliance	88%	80%	85%	80%	60%
Frequency of Assessment /Target Recorded Compliance	4%	20%	15%	0%	20%
Target Oxygen Sat Range Circled Compliance	64%	90%	85%	60%	70%
Pain Score Recorded Compliance	47%	70%	80%	50%	70%

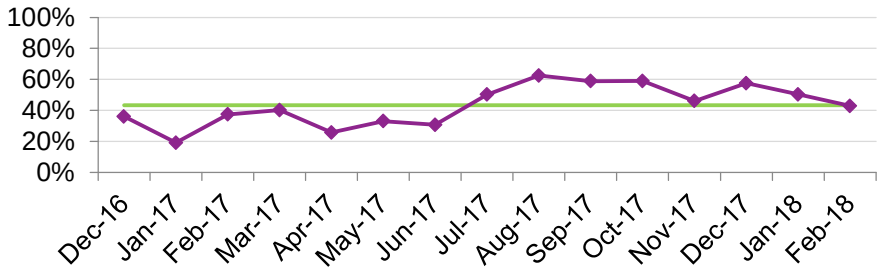
NEWS compliance and accuracy has shown an improvement In February.

Regular audits continue to be undertaken by the Quality Improvement team, feedback through nursing documentation leads. All nursing staff have been reminded to use patient demographic labels.

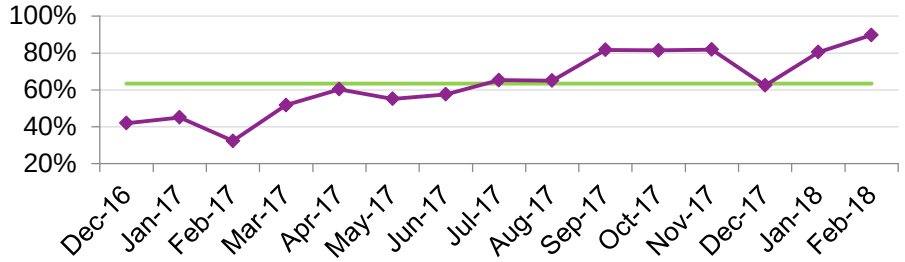
Frequency of assessment whilst showing an improvement will need to be a focus for the remainder of quarter one.

Patient Safety – Emergency Department Safety Helen Blanchard

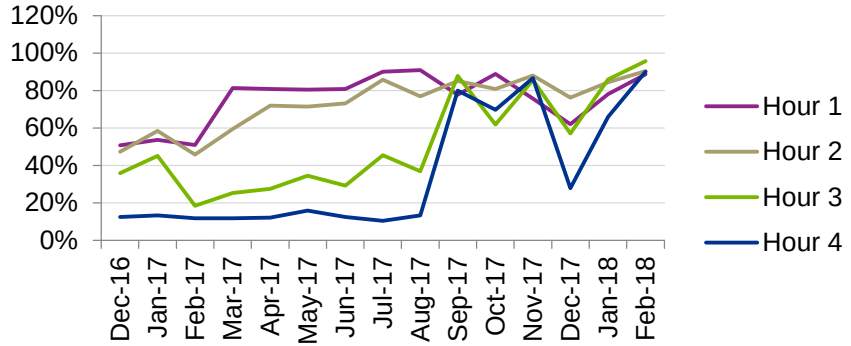
Checklist Compliance
(how often used & >50% complete)



Checklist Completeness
(how much of the checklist is complete)



Checklist Completeness (By hour)



Summary
There continues to be overall improvement across the safety dashboard with hours 2, 3 and 4. Data collection is continuing for February and March. Numbers of notes audited have been reduced due to significant IT changes. It should be noted that there is a reduction in percentage compliance for the month of February due to an incomplete data set.

The Emergency Department continues to be part of the Academic Health Science Network (AHSN) project.

Areas of Improvement
There appears to be more consistent recording between hours 3 and 4.

The number of documentation auditors has been increased In order to ensure that timely patient safety checklist auditing is achieved.

Areas of Concern
The two red areas are completion of Hydration and Fluid chart, and recording of Meds on Time. Spot check auditing has shown that the whiteboard compliance of the Meds on Time magnets is about 80%, this is not being reflected on the patient safety checklist.

Serious Incidents (SI) Summary

Helen Blanchard

Current Performance

During April 2018 five Serious Incidents were identified and reported to the CCG via STEIS.

Date of incident	ID	Summary
24/3/2018	61720	Medication error
31/3/2018	61873	Fall resulting in a head injury
03/04/2018	61948	Medication error
02/04/2018	62085	Hospital acquired infection
16/04/2018	62267	Hospital acquired trauma

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 2nd May 2018, there are 29 Serious Incidents that remain open. Of these, eighteen incident reports are overdue for submission to the Clinical Commissioning Group by the agreed due date. The Head of Risk and Assurance has been in contact with the investigators regarding submission dates.

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 April 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	Mar-18	Apr-18
Outstanding Action Plans	8	9	17	21	22	15	19	19	30	23	28	32	25
Outstanding Actions	15	13	33	49	44	29	44	31	49	43	34	54	42

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

Haygarth ward (Gastroenterology Medicine)
This ward last flagged three months ago in February 2018.

Quality matrices to note are:
- Formal complaint 1 nursing related
- RN sickness 8.2%
- RN appraisals 70.0%
- HCA appraisals 77.8%
- RN hours % day and night fill rate <85%

The senior sister has responded appropriately to the complainant, but following an investigation the senior sister did not find any nursing issues of concern.

Sickness is being closely managed in line with Trust Policy and with support from HR where required.

There has been improvement in appraisal completion since this data (month lag) and at the time of this report there are only 3 staff appraisals outstanding.

There are presently 5.0 wte RN vacancies and 2.0 wte HCA vacancies, however recruitment is being managed proactively and interviews have taken place and posts offered. Bank staff are being booked and where there is a shortfall of RN hours additional HCAs are being booked to ensure appropriate staffing numbers. There were no staffing Datix reports this month.

Pulteney ward (Acute surgery)
This ward last flagged 4 months ago in January 2018.

Quality matrices to note are:
- FFT response rate 34%
- Formal complaint 1 nursing related
- 2 cases hospital acquired C. Difficle
- HCA sickness 5.2%
- RN appraisals 78.3%
- HCA appraisals 61.1%
- RN hours % night fill rate <85%

There are staff who are allocated to ensure FFT cards are completed on the ward, however these staff had periods of absence due to annual leave or sick leave which resulted in a reduced response rate this month. The senior sister has stated that she will work on a contingency plan so that if this scenario should happen again that the FFT cards will be completed.

The formal complaint was investigated by the senior sister who has responded appropriately to the complainant. Following the investigation the senior sister did not find any issues of concern with the nursing care.

There were 2 patients found to have acquired C.Difficle on the ward. Both these cases have had initial root cause analysis investigations undertaken following which no obvious lapses in care have been identified. It has been noted that both patients had been prescribed necessary antibiotics and both cases are being referred to the CCG for appeal.

Staff sickness is being tightly managed with support from Occupational Health where required.

Nursing Quality Indicators Exception Report Helen Blanchard

Pulteney ward cont;
The senior sister states that staff appraisals have been a challenge with their staffing vacancies, however the senior sister has a plan in place and will be reviewing this with the new Matron in post to see how this can be supported to enable staff to be released.

There are presently 3.5 wte RN vacancies however there are also 7.0 wte RNs on maternity leave. The senior sister is proactively managing recruitment and is over recruiting HCAs to support the shortfall of RNs. Daily staffing is supported by the senior sister working clinically during the day shift and at night the ward booked additional HCAs to support the shortfall of RN hours.

Acute Stroke Unit
This ward last flagged 6 months ago in October 2017.

Quality matrices to note are:
- 13 patient falls (9 nil harm, 4 minor harm)
- RN sickness 12.3%
- HCA sickness 7.3%
- HCA appraisals 60.0%
- RN hours % day and night fill rate <85%

Of the falls there were 2 patients who fell on multiple occasions. Providing consistent enhanced observation for patients at a high risk of falls can be challenging.

Acute Stroke Unit cont:
Staff sickness is being well managed with the support of the Matron and HR where required.

The ward has recently reconfigured their nursing team structure and this has impacted on the appraisals being undertaken as new line managers get to know their staff. However, there is a plan to undertake staff appraisals with a trajectory to complete them in place.

There are 12.0 wte RN vacancies on the ward and whilst there is positive recruitment in place in the interim there are Pool nurses assigned to support the ward. This will be one of the first wards to receive Philippine nurses when they arrive.

To note:
Combe ward and William Budd ward 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.

Nursing Quality Indicators Exception Report — Helen Blanchard

Other Quality Indicators of note:

Formal complaints:
There were 13 formal complaints across the wards this month which is high in comparison to previous months (2 last month).
The Board have been provided with a monthly report from Complaints and PALs within this Quality report which is across the whole Divisions not just wards and it is noted that there is a 'spike' of complaints in April which is demonstrated in the complaints monthly line graph.

The Complaints manager has undertaken an analysis into these complaints to see if there are any trends emerging and there does not seem to be an common issues or trends.

Falls: There were a total of 74 falls this month which a reduction on the usual number in month (last month 92). However the Falls lead has noted that there was an increase this month of patients who had multiple falls (9 patients) and has informed the Senior Sisters and Matrons to make them aware and therefore review and manage these high risk patients more closely.

Pressure Ulcers: There was 1 hospital acquired Category 2 pressure ulcer this month and the Board has been provided with a more detailed update report this month within the Quality report.

C.Difficile: There were 5 cases of C.Difficile this month.
The Infection Control Nurse has stated that there were no consistent themes emerging, however the Trust Spring clean Programme is starting week commencing 21st May and will start on Pulteney ward first. The infection control team have also been raising awareness with ward teams regarding robust management e.g. early stool sampling.

Nursing and Midwifery Accreditation Programme — Helen Blanchard

Background

The Ward and Outpatient Accreditation programme has been developed to recognise and incentivise high standards of care and reduce variation in practice at ward and department level. It also provides assurance that regulatory requirements including the Care Quality Commission (CQC) fundamental standards are being met and identify where improvements in practice are required. Wards and departments are scored against each of the performance indicators based on their levels of performance over the last 6 months on a sliding scale. Bronze level is achieved with a score of 75% or more for each of the CQC domains assessed.

Ward Accreditation: Bronze Level Update

Table 1 summarises progress for assessment of wards at Bronze level. The assessment is based on data routinely collected, observations of practice including quality of safety briefings, handover and whiteboard rounds, and interviews with patients and staff.

Progress:

- October 2017 – Bronze level re-assessment in 1 or 2 domains in 8 wards – of these 5 wards ACE, CCU, Helena, MAU, Philip Yeoman achieved
- March 2018 –Bronze level full re-assessment in all domains in 8 wards – of these 5 wards Respiratory, Violet Prince, Critical Care Services, Forrester Brown and Pierce achieved
- March 2018 – Bronze level first assessment in 4 wards BBC, Mary, ED and ED Observation of these BBC and Mary achieved

Summary:

To date 20 of 30 wards have achieved Bronze Level. 10 wards remain at Foundation Level with a supportive programme and timeframe for re-assessment.

Table 1: Bronze Accreditation Ward	Dates of assessments and outcome				Current Level Achieved
	Sep-16	Jun-17	Oct-17	Mar-18	
Medicine Division					
ACE	X		✓		Bronze
Acute Stroke Unit	X		X		Foundation
Cardiac	X				Foundation
Cheselden	✓				Bronze
Combe	X				Foundation
Coronary Care Unit	X		✓		Bronze
Emergency Department (ED)				X	Foundation
Emergency Department Obs				X	Foundation
Haygarth	X			X	Foundation
Helena	X		✓		Bronze
Medical Assessment Unit	X		✓		Bronze
Medical Short Stay	X		X		Foundation
Midford	✓				Bronze
Parry	X		X		Foundation
Respiratory	X			✓	Bronze
Violet Prince				✓	Bronze
Waterhouse	✓				Bronze
William Budd	✓				Bronze
Surgery Division					
Critical Care Services	X			✓	Bronze
Forrester Brown	X			✓	Bronze
Philip Yeoman	X		✓		Bronze
Pierce				✓	Bronze
Pulteney	✓				Bronze
Robin Smith	X			X	Foundation
Surgical Admissions Unit	✓				Bronze
Surgical Short Stay	X			X	Foundation
Women and Children Division					
Bath Birthing Centre (BBC)				✓	Bronze
Charlotte	✓				Bronze
Children's		✓			Bronze
Mary				✓	Bronze

Nursing and Midwifery Accreditation Programme Helen Blanchard

Ward and Outpatient Accreditation - Next Steps:
The timetable below identifies next steps for Ward and Outpatient Accreditation.

Ward Accreditation Timetable (20 of 30 areas have achieved Bronze level)	**Date due**
Foundation assessment • Indicators developed for NICU. Assessment planned • Develop indicators for Community Birthing centres	 June 2018 June 2018
Bronze reassessment • Third assessment in either one or two domains for Acute Stroke Unit, Haygarth, Medical Short Stay, Parry and Surgical Short Stay • Second reassessment for ED and ED Observation • Second full reassessment for Cardiac and Combe • Third full reassessment for Robin Smith	 June 2018 - Sept 2018 September 2018 November 2018
Silver assessment • Draft indicators for Silver developed : broadened to include Multidisciplinary team • Test in one ward	 May – June 2018 July 2018

Outpatient Accreditation Timetable (18 of 20 areas have achieved Foundation Level)	**Date due**
Foundation assessment • Reassess Cardiology and Dermatology • Assess Rheumatology Outpatient areas (first assessment)	 June 2018 June 2018
Bronze reassessment • Bronze indicators developed • Assessment of all areas	 May - June 2018 Commencing July 2018

Appendix A - Nursing Quality Indicators - Monthly Template May 2018

APPENDIX A

Ward Group	Ward Name	Report for May 2018 by ward/area triangulating FFT Percent Recommending; PALS; Complaints; Cdiff; Falls; Pressure Ulcers; HR, Staffing																						Care Hours Per Patient Day (CHPPD) overall	Number of times parameters outside of KPI metrics					
		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									
																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			Apr 18 No:	Mar 18 No:	Feb 18 No:	Jan 18 No:	Dec 17 No:	Nov 17 No:
Emergency Dept	A&E	99	6%	1	6	5	10		0	1	0	0				3.2	2.8	81.9	86.4							2	2	2	1	2	3
	MAU	94	16%	1	1		5		2	0	0	0	1			2.1	11.3	81.4	75.0		85.8%	146.2%	85.9%	144.5%	9.4	3	2	2	2	6	6
	SAU	100	11%	2	1				3	0	0	0				1.1	6.3	84.2	93.8		91.9%	112.7%	83.6%	130.8%	10.4	3	3	1	5	5	4
Inpatient Wards	Cheselden	100	71%						1	0	0	0				1.7	0.0	100.0	100.0		93.6%	95.4%	100.0%	98.3%	5.7	0	0	0	2	2	3
	Charlotte	98	34%		1				0	0	0	0				0.0	1.3	93.3	83.3	4	99.5%	95.6%	99.9%	97.7%	6.6	1	1	2	1	1	0
	Pierce	97	33%	1					3	1	0	0				4.9	2.7	100.0	100.0	2	76.9%	133.5%	86.7%	175.0%	7.4	2	1	2	6	5	4
	Surgical Short Stay Unit	94	22%						1	0	0	0				2.8	0.0	96.2	92.3	1	112.3%	151.9%	63.6%	196.7%	7.4	2	1	3	1	2	1
	Robin Smith	98	41%		1		3		1	0	0	0				8.4	9.6	89.5	82.4		92.4%	110.1%	82.5%	108.0%	6.9	3	2	4	5	5	5
	ACE OPU	98	80%		1				2	0	0	0				1.3	7.3	90.0	94.1		68.9%	101.9%	68.9%	123.7%	7.5	3	4	2	7	5	2
	Mary Ward			1					0	0	0	0				1.8	1.2	79.5	80.0		86.0%	90.5%	84.3%	94.4%	11.1	3	4	3	3	5	4
	Violet Prince (RNHRD)	95	41%						1	0	0	0				2.5	0.0	69.2	100.0		82.3%	74.0%	97.6%	100.0%	5.1	3	4	4	4	3	2
	Phillip Yeoman	97	48%				1		1	0	0	0				4.4	12.1	84.6	84.6	1	91.4%	75.2%	69.7%	86.9%	6.2	3	4	6	3	4	3
	Waterhouse	100	57%	1			1		7	2	0	0				12.6	2.1	92.3	82.4		74.1%	85.1%	107.3%	99.7%	6.0	3	5	5	6	5	6
	Midford	95	54%				2		0	1	0	0				0.8	12.2	92.3	94.1	8	63.1%	136.7%	73.1%	202.0%	6.3	3	5	5	9	8	7
	Forrester Brown	95	47%		1	1	2		1	0	0	1				17.4	12.1	84.2	93.8	5	89.4%	108.0%	72.4%	130.0%	6.9	4	3	3	3	2	1
	Respiratory	96	46%						4	1	0	0				0.3	19.2	94.4	100.0		76.3%	129.6%	78.8%	97.8%	6.1	4	4	4	4	3	4
	CCU	89	75%						0	0	0	0				5.3	5.4	83.3	75.0		79.3%	110.3%	98.3%	98.3%	10.1	4	4	4	5	3	4
	Parry	97	27%		1		4	1	6	0	0	0				2.1	6.8	90.0	88.9		77.7%	102.5%	103.1%	101.1%	5.8	5	2	2	5	3	4
	Helena	96	80%		1				3	1	0	0				0.9	8.3	80.0	78.6		82.5%	137.0%	66.8%	151.8%	8.7	5	4	2	3	2	0
	Critical Care Services							1	0	0	0	0				3.3	13.8	87.0	50.0		92.0%	83.2%	89.4%	43.3%	27.2	5	4	3	2	2	5
	Children's Ward	98	9%		2	2	2		1	0	0	0				6.0	1.7	78.9	100.0		82.5%	81.0%	85.5%	143.5%	7.6	5	4	4	4	5	2
	Cardiac	100	44%	1		1	3		3	0	0	0				2.0	12.6	73.9	69.2	1	73.1%	124.5%	75.5%	194.4%	5.5	5	4	6	6	6	4
	NICU	100	16%						0	0	0	0				4.7	2.6	79.5	92.9		89.3%	84.9%	63.5%	50.0%	7.8	5	5	5	6	5	3
	Medical Short Stay Unit	93	21%				3	1	1	1	0	0				12.1	0.2	78.6	88.9		79.8%	109.3%	101.4%	136.7%	6.0	5	5	6	5	4	4
	William Budd	100	43%						1	0	0	0				6.8	4.3	80.0	66.7		67.9%	85.8%	74.8%	127.1%	7.3	5	7	5	5	6	2
	Combe	91	43%	1			3		3	1	0	0				3.4	15.8	73.3	60.0	13	75.5%	120.3%	71.8%	200.5%	7.2	5	7	7	6	8	4
	Acute Stroke Unit	100	66%				2		9	4	0	0				12.3	7.3	81.3	60.0	6	75.6%	97.2%	84.1%	132.2%	8.2	6	5	4	4	4	4
	Haygarth	97	41%	2			3		3	1	0	0				8.2	4.9	70.0	77.8		59.8%	106.7%	66.5%	186.4%	6.2	6	5	6	5	7	3
	Pulteney	97	34%	2	2	1	1	2	1	0	0	0				0.4	5.2	78.3	61.1	4	88.0%	90.5%	79.1%	109.1%	6.3	7	4	5	7	4	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)

A&E	ED Nursing
SAU	SAU
MAU	MAU

Acute Stroke Unit	Acute Stroke Unit
NICU	Newborn Intensive C U
Pulteney	Pulteney Ward
Medical Short Stay Unit	Med Short Stay
Cheselden	Cheselden Ward
Robin Smith	Robin Smith Ward
CCU	Coronary Care Unit
Helena	Helena Ward
Phillip Yeoman	P.Yeoman/Recovery
Surgical Short Stay Unit	Short Stay Surgical Ward
Children	Paediatric Inpats & Outpats (Pay Only)
ACE OPU	ACE OPU
Cardiac	Cardiology Ward
Parry	Parry Ward
Forrester Brown A	Forrester Brown
Haygarth	Haygarth Ward
Charlotte	Charlotte Ward
Waterhouse	Waterhouse Ward
Combe	Combe Ward (3)
Midford	Midford Ward (9)
Respiratory	Respiratory Unit
William Budd	W Budd Cancer Unit
ITU	Critical Care Unit
Mary Ward *	PAW Mary Ward
Violet Prince (RNHRD)	Rheumatology Inpats