Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
29th July 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary for exceptions • Ward Metrics, with associated commentary for exceptions • Quality overview The Quality Dashboard for June shows 3 areas which will require a concerted effort for improvement. 1. Hip Fractures operated on within 36 hours off trajectory 2. VTE assessment (Venous Thromboembolism assessment not on target 3. The ward metrics show concerns in relation to falls & blood traceability compliance in some areas, this will be addressed. (MRSA bacteraemia a good month but needs to be sustained)
BOARD ASSURANCE (Risk) / IMPLICATIONS	There remains a risk from May of non compliance with the MRSA target as 4 have already been identified. With a target of 5 for the full year it is disappointing to have 4 at this early stage.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Good Quality services are essential. The quality metrics are benchmarked by the Strategic Health Authority and nationally. Poor quality services can affect the level of confidence the patients and commissioners place on our services, and affect the organisations reputation.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to the equality on access taking consideration into disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	None identified
The Trust Board is asked to:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter Medical Director & Caroline Becher Chief Nurse
Date:	21st July 2010
Decision:	For Noting

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2008/09 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

3. Forecast - the calculation is as follows:

    - For month 7 (Oct) we divide 2008/09 Total by 2008/09 YTD at month 7 to give us the proportion of activity that historically took place as a guide to how much more activity will take place during the rest of 2009/10. This is then multiplied out by the YTD figure for 2009/10. To further account for recent up or downward trends we have divided the average monthly figure for 2008/09 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 1/(SUM(2008_09 up to m7)/SUM(2008_09 Total)) x 2009_10 YTD x (2008_09 Ave/Last 12 Months Ave)

4. Actual - this is the actual achievement for the month.

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow.

6. Year to Date - The sum of the activity from the beginning of the financial year (April).

Line-by-line explanation of each Measure:

1-01 Standardised mortality (Relative Risk)
This measure is taken from Dr Foster for a limited set of diagnoses standardised across all NHS trusts so that mortality can be compared fairly with other trusts. The data is presented as a relative risk of mortality, a number below 100 means that the trust is better than the average for England, the lower the number the better performing the trust.

1-02 Crude Mortality
Number of deaths per month against number of admissions

1-03 MRSA
Number of hospital acquired MRSA identified, in the month they are identified.

1-04 C. Diff
Number of CDifficile cases identified, in the month they are identified.

1.05 Patient satisfaction
Of the patients who completed a patient comment card in the reporting month, the percentage who expressed they were 'happy or very happy' with their experience.

1.06 Formal Complaints
Total complaints for the month - Data supplied from Datix by Complaints department

1.07 SUI's
Serious Untoward Incidents - Data supplied from Datix by Quality department

1-08 Falls – resulting in significant injury (grade 3and above)
Data supplied from Datix system by Quality department

1-09 Hip Fractures treated within 36 hours
The number of patients admitted for hip fractures that have been treated within 36 hours of admission. We specifically look for the time difference in hours between the admission date and the first procedure date

1-10 Readmissions within 14 days
The percentage of acute patients who have been re-admitted to hospital to the same specialty within 14 days, where the admission method is an emergency admission. We exclude patients who died in hospital, under 16's, maternity, planned and cancer patients

1-11 VTE assessment
Data based on a sample audit of where VTE risk assessment has been completed

1-12 Summated Adverse Report Index (SARI)
This measure is a sum of all the patients who were subject to an adverse event during the month. An adverse event in this case excludes mortality as that is reported 2 months in arrears and excludes VTE.

1.2 Balanced Scorecard and commentary

Balanced Scorecard

Quality Section

Table 1

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

	Patient Safety & Quality	Annual Target	Forecast	Actual	Change			YTD
1-01	Standardised mortality (Relative Risk)*	82	75	55**	▲	▲	▲	55**
1-02	Crude mortality	2.6%	2.0%	1.7%	▼	▼	▲	1.8%
1-03	MRSA (Hospital only)	5		0	▼	◄►	▲	4
1-04	Cdiff	90	50	1	▼	◄►	▲	7
1-05	Patient Satisfaction	100%	98.5%	98.2%	▼	▲	▲	97.6%
1-06	Formal complaints	361	368	37	▲	▲	▼	99
1-07	SUIs	14	16	1	▼	▲	◄►	4
1-08	Falls - resulting in significant injury (grade 3)	29	27	2	▲	◄►	▼	4
1-09	Hip fractures treated within 36 hrs	60%*	83.0%	51.9%	▲	◄►	▼	58.6%
1-10	Readmissions within 14 days	2.6%	2.6%	2.5%	◄►	▼	▼	2.1%
1-11	VTE Assessment	90.0%	N/A	68.0%	Based on sample audit			
1-12	Summated Adverse Report Index (SARI)	tbc				▲	▲	784

Dashboard Commentary

1-01 The Trust's SMR has shown its 3rd consecutive month of improvement.

1-02 The in-month figure of 55 is matched by a 40% reduction in the crude mortality rate to 1.7%. This is a very reassuring figure. The current projection shows that we will deliver the Trust target comfortably. A detailed review of mortality is discussed in section 1.3.

1-03 There have been no further MRSA cases. We have not made a forecast for this objective as it is clear that there is case clustering, which makes predictions very difficult. The important figure in this line is therefore year to date figure of 4 against a target of 5. This is shown as amber rated on the RAG system.

1-04 There has been 1 reported case of C. Diff. The year to date figure is 7 cases. This very impressive performance means that the Trust will easily deliver on its target and should give the Board reassurance about the process and commitment of the Trust to a zero tolerance for HCAI. The C. Diff mortality YTD is 0%.

1-05 Patient satisfaction scores remain high and show a continued trend of improvement. The Trust should be in a position to report the large in-patients survey conducted for all patients in July at the August Board. This will give us insight into our current progress and a preview of the probable (potential) results of the 2010 Picker In-Patient Survey which will be based on a cohort of this group of patients.

1-06 Formal complaints showed a small increase in month (30 to 37). This is the first increase following 2 months' of decline. There is no specific cause/theme although the change in visiting hours may need to be considered. The data for complaints in July will be of interest as the Trust has initiated a programme of increased profile during this month.

1-07 There has been 1 SUI reported. This is classed as a surgical error and is under investigation. The patient has been discharged home.

1-08 There are 2 reported falls resulting in significant injury in this month's report. Both injury's were fractured hips and are being investigated as grade 3 incidents. A significant reduction in falls has been seen on maple ward following a local initiative, and this is being rolled out across other wards to accelerate improvement.

1-09 Data for hip fractures treated within 36 hrs is still below target. The figure reported this month is below the Q1 trajectory of 60%, and in Q2 the Trust needs to be delivering 70%.There had been progress in identifying additional theatre capacity. The impact of this intervention should be seen in the July data

1-10 Readmissions within 14 days are still on target at 2.5% and well below the PCT set target. The Board will be aware that there is considerable interest in the 30 day readmission rate and it was reported verbally at the last meeting that ASPH 30 day rate is 8%, which benchmarks well with the SEC quality data where the Trust is in the top quartile. This represents around 200 patients per month and work is in place to understand this cohort in more detail, and how we might reduce the numbers involved.

1-11 VTE assessment is now proceeding using an automated system. The first results will be available for the next quality report. The data presented represents the last audit performed.

1-12 The SARI requires valid VTE data to inform it and this will therefore be presented in the next Board report. Using the data that is available the SARI saw a small fall month on month from 231 to 226, this represents a consistent fall in adverse reports seen within the Trust which is reassuring.

1.3 WQI (Ward Quality Indicators) commentary

The WQI definitions can be found at Appendix 1

The WQI scorecard can be found at Appendix 2

2 MORTALITY AND MORBIDITY

2.1 Dr Foster Summary report

There are no current alerts or adverse reports following the most recent Dr Foster run. The Trust remains double green rated.

2.2 Trust Mortality Review Meeting (TMRM)

The Review Group meet to review cases reported in the Trust in April 2010.

The demographic data showed there had been 90 deaths in the Trust which was identical to the figure in Feb (91).

The racial demographics were unchanged with white British being the most represented group, which is representative of the catchment population.

There was a small clustering of mortality on one of the medical wards, this is being investigated but almost certainly represents patient case mix.

The most common diagnostic HRGs reported in the Trust are pneumonia related. This is identical to local acute trusts. Data has recently been presented to the Board showing that ASPH has the 3rd best mortality for these HRGs in the SHA. There has been no adverse change in these HRGs in 2010.

86% (77) of deaths were in the Medical Directorate reflecting the activity pattern of the Trust and a mirror of all local acute trusts. There are no adverse trends in these figures which represents a crude mortality in April of 4.08 %.

Crude mortality rates where 0.4% in surgery and 0.33% in orthopaedics.

In the Trust Mortality Review Group meeting 33% (30) of the notes were reviewed. 29 (97%) sets of notes showed an expected outcome. In 2 sets of notes there was thought to be unnecessary delays in the patient pathway, which although not affecting outcome would have adversely affected the patients' experience. This was referred to the directorate for review. In 1 case there was a request for further review and this was re-referred to the directorate for review and discussion at the directorate M&M meeting. The outputs from these reviews will be reported to the CGC.

The Mortality Review Group considered its role and function. With the development of the mortality demographics the group felt that we had moved forward significantly.

The demographic data has shown that 80% plus of deaths are in the Medical Directorate and allowed identification of individual consultants who were involved in the patients care.

Using this data the group decided that a steering group composed of MD, CD and Clinical Governance Leads in medicine and A&E would review the demographics information and instigate investigations based on trends.

The group will inform all consultants that a death has occurred under their care and ask for a review of the case the notes and complete the proforma (developed by the Mortality Review Group) to classify the death as expected or unexpected.

All unexpected deaths will be reported and treated as a clinical incident. The steering group would review a 15% sample of the note review to ensure consistency of note assessment.

The data will be filed on the T drive for all directorates to review.

3 Quality update

3.1 Safety alerts

Overdue alerts

There are currently 4 overdue alerts compared with 5 last month. One overdue alert has now been closed. It is anticipated that two of the alerts will be closed in August following ratification of policies and confirmation of adequate process in place at the Drugs and Therapeutics Committee. The software required for adequate assurance on radiological imaging reports has been positively received and we hope to close this alert sooner than the anticipated end of year.

Deadline	Description	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Software is currently being tested and it is expected that this alert will be closed sooner than the anticipated December 2010
31-Mar-08	Actions that make anti-coagulation therapy safer	Policy has been drafted and is due to be ratified at the Drugs and Therapies Committee in August when the alert will be closed.
09 June 09	Reducing risk of overdose with midazolam injection in adults	Policy has been drafted and is due to be ratified at the Drugs and Therapies Committee in August when the alert will be closed.
19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Our planned solution is to use iSOFT (PAS) there is a new release (4.3) due in Oct 2010 that will enable us to validate the correct NHS number with the correct patient. This will enable us to move forward with this alert. Other Trusts are in a similar position in that they have to wait for the IT software to be completed and implemented.

New Alerts

Date of Issue	Description	Deadline	Lead	Status
16 June 2010	Safer administration of Insulin	16 December 2010	Debbie Hindson	On target

Current Alerts
There are currently 10 alerts open (inclusive of this month's new alert) Work is underway to ensure these are completed before the deadline and there is no anticipated risk currently.

3.2 Complaints

On 3 June a confidential draft report was received from the Health Service Ombudsman following their review of complaint ref 07/346. This complaint was made by the daughter of an elderly patient regarding his treatment and assessment for Discharge in December 2008.

In the provisional report the Ombudsman has upheld the complaint and has identified a service failure in discharge planning and has made recommendations for action to the Trust. On receipt of the draft report the Trust convened an action planning group to respond to the recommendations for action, pending receipt of the final report, this work is being led by the Deputy Chief Nurse, supported by the Complaints Manager.

As an addendum, the final report was received on 5 July and action to address the recommendations is underway.

The Trust also received confirmation that a further case previously referred to the Ombudsman will not be reviewed and is closed with no further action for the Trust. There is currently one case under assessment with the Ombudsman.

3.3 Privacy and Dignity

In June, a group of senior nurses and managers visited Dartford and Gravesham NHS Trust and undertook a Peer Review. In July this was reciprocated and initial results demonstrate significant improvement from when last undertaken. The team based at Darrant Valley praised ASPH and areas of excellence they observed were:

- The rest period after lunch & the tranquillity that ensued
- Clean spacious environment of Aspen, MAU & Heron (Elm ward was tight)
- Clean & Nicely smelling patient toilets every where
- Staff speaking to patients with respect and warmth
- Passion palpable
- Pride within teams

The formal report will be issued in July.

3.4 Falls

There is an improvement in the number of falls on Maple and Holly wards but an increase in the number of falls in Orthopaedics. This general improvement in Medicine reflects the recent review of the Falls Group lead by the Head of Nursing for Medicine and Emergency Services. This group now has a new Chair and members of the group are taking responsibility to improve and reduce the number of falls that patients may incur. The Matron in Orthopaedics will be developing an action plan to address and reduce this increase in patient falls.

3.5 Agency Nursing - Revision of Decision Tree

Agency Nursing Usage- Due to an increase in the use of agency nurses the Chief Nurse has issued a revised decision tree which includes a directive for no agency usage except through Executive Director approval. This decision tree highlights contingency steps to be taken in support of staffing levels across the Trust such as more coordination cross Directorates approach.
The Specials policy is nearly complete to support and guide decision making for those patients requiring 1:1 care.

3.6 Nutrition

Nutrition has been a high priority for the Trust and through an enterprising approach; an opportunity has arisen to incorporate nutrition into the professional development role which is currently being recruited to. This would support a nursing nutrition service for 15 hours per week. Each Acute Trust is recommended by Nice to have a Nutrition Nurse on the Team. The aim of this service would be to work with the Lead Consultant for Nutrition, the lead Pharmacist for Nutrition and the Dietician to reduce the use of parenteral nutrition and encourage more enteral feeding. Linking this position to education will raise the training profile of nutrition for both Doctors and Nurses and therefore improve both the Patient Experience and Patient Outcome. Once this post has been recruited into, there will be a drive to incorporate the MUST (Malnutrition Universal Screening Tool) into the Ward Quality Indicators.

3.7 Specialist Nurses Scoping Exercise

Currently, a scoping exercise is being undertaken of all specialist nurses across the Trust. Essentially this will develop a fully comprehensive portfolio capturing all of our Specialist Nursing Services We can then make sure every ward and department has this information and this can be publicized their skills and specialty which will allow us to make access to them more corporately. This exercise is to be completed by the end of September.

3.8 Blood Traceability

The Ward Quality Indicators continue demonstrate non compliance to return of Blood Tags in many areas. This is of concern and will be taken forward through the development of an action plan in each area to drive through improvements; early indications link this non compliance to patient ward moves.

End -

Submitted by: Caroline Becher, Chief Nurse and Dr Mike Baxter, Medical Director

Date:

Appendix 2 WQI definitions

1 Hand Hygiene Compliance
Audits of members of staff cleaning/decontaminating their hands between procedures

2 Number of MRSA bacteraemia
MRSA isolated in a blood culture therefore present in the patient's blood stream

3 Number of C Diff cases (Hospital post 72 hours)
Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

Saving Lives is the compliance measurements that indicate the use of High Impact Interventions in key clinical procedures which aims to decrease the risk of infection

4 Central Lines
Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections

5 Urinary Catheter
Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections

6 Peripheral Cannula care
Ensures peripheral cannula insertion and after care undertaken in line with good practice to reduce cannula infections

7 Cleanliness
Audit undertaken by facilities on a monthly basis related to cleaning standards

8 Matrons Environmental Audit
Matrons environmental audit undertaken weekly of the ward and department and the mean taken for the month

9 Blood Traceability
Numbers of labels returned against number of blood bags used.

10 Pressure Ulcer Prevention
2 areas are audited: Compliance with the monitoring return, and Actual Grade of Pressure Ulcer

11 Mixed Sex Wards
Number of patients that were in a mixed sex environment for more than 2 hours

12 Total number of falls

13 Number of falls resulting in significant injury,
Falls graded 3, 4 or 5 which indicates harm as reported via incident reporting

14 Complaints
Actual number of complaints registered to the clinical area in reporting month.

15 Medicine administration errors
Number of errors reported via incident reporting

16 Medication prescribing errors.
Number of errors reported via incident reporting

Ashford and St Peter's Ward Quality Scorecard - June 2010

N/S: no submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives: Central Lines Insertion	Saving Lives: Central Lines After Care	Saving Lives: Urinary Catheter Insertion	Saving Lives: Urinary Catheter After Care	Saving Lives: Peripheral Cannula	Saving Lives: Peripheral Cannula After Care	Cleanliness	Matron Environment Audit	Blood Traceability	Pressure Ulcer Prevention: Pressure Ulcer Compliance	Mixed Sex Wards Compliance	Patient Falls: Number of falls	Patient Falls: Resulting in Injury	Complaints	Medication Errors: Administration	Medication Errors: Prescribing
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	=100%	=100%	=0	=0	=0	=0	=0	=0
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%		99% - 76%						
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<100%	<=75%	>=1	>=1	>=1	>=1	>=1	>=1
MEDICINE 1,2,3	ASPEN	100 %	0	0			100 %	N/A	100 %	100 %	98 %	95 %	21/27	100 %	0	1	0	0	5	3
	CCU	100 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	86 %	95 %	8/8	100 %	0	1	0	0	0	0
	BIRCH	97 %	0	0			100%	40 %	70 %	100 %	N/A	93 %	9/11	100 %	0	1	1	0	0	0
	MHDU	100 %	0	0	100 %	100 %	100 %		100 %	100 %	89 %	95 %	16/16	100 %	0	1	0	0	0	0
	HOLLY	99 %	0	0			100 %	N/A	100 %	100 %	86 %	95 %	4/4	100 %	0	1	0	0	5	3
	CEDAR	98 %	0	0			100 %		50 %	100 %	95 %	95 %	12/16	100 %	0	4	0	0	0	0
	MAY	100 %	0	0			100 %		100 %	100 %	98 %	N/A	8/10	100 %	0	0	0	0	0	0
	MAPLE	97 %	0	0			100 %	100 %	80 %	100 %	89 %	91 %	42/42	100 %	0	3	0	0	0	15
	COLPOSCOPY	100 %	0	0											0	0	0	0	0	0
	ANGIO SUITE														0	0	0	0		
	RHEUMATOLOGY						N/A		N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	N/A	N/A
	GENERAL MEDICINE	N/A	N/A	N/A											0			3		
	GERIATRIC MEDICINE					N/A									0	N/A	N/A	2		
	HAEMATOLOGY														0			1		
ASHFORD	CHAUCER	100 %	0	0			100 %	N/A			98 %	94%		100 %	0	4	0	0	0	0
	WORDSWORTH	100 %	0	0			100 %		100 %	100 %	97 %	95%	2/3	80%	0	9	1	0	0	0
	FIELDING	100 %	0	0			100 %		100 %	100 %	96 %	89.5%	N/A	100 %	0	4	0	0	0	0
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0			100 %		100 %	N/A	98 %	95 %	8/12	100 %	0	0	0	0	0	0
	ELM	96 %	0	0			100 %		100 %	100 %	97 %	98 %	17/18	100 %	0	9	0	0	0	1
	JUNIPER	92 %	0	0			100 %		100 %	100 %	89 %	96 %	19/21	100 %	0	10	0	0	1	1
	ROWLEY BRISTOW	N/A	0	0			N/A		N/A	N/A	N/A	91 %	N/A	N/A	0	0	0	0	0	0
	TRAUMA & ORTHOPAEDICS		N/A	N/A								N/A			N/A	N/A	N/A	7	N/A	N/A
SURGERY	KINGFISHER	95 %	0	1			100 %	100 %	80 %	100 %	91 %	93 %	37/41	100 %	0	1	0	0	0	0
	FALCON	100 %	0	0	N/A	100 %	75 %		90 %	90 %	96 %	91 %	38/49	100 %	0	0	0	0	0	0
	SDU	99 %	0	0		90 %	100 %	N/A	100 %	90 %	91 %	91 %	16/19	100 %	0	1	0	0	0	0
	ADMISSIONS LOUNGE	100 %	0	0			N/A		100 %	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	1
	HERON	95 %	0	0			100 %	100 %	100 %	100 %	96 %	86 %	30/35	100 %	0	1	0	0	0	0
	MAXFACS CLINICS ASH	95 %	0	0							N/A	N/A	N/A	N/A	0	0	0	0	0	0
	KESTREL		0	0							88 %	93 %	32/33	100 %	0	1	0	0	0	1
	HAEM DAY UNIT												169/172					N/A		
	BREAST SURGERY																	3		
	COLORECTAL																	1		
	GENERAL SURGERY	N/A	N/A	N/A			N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3	N/A	N/A
	NEUROLOGY					N/A												1		
	UPPER GI																	1		
	VASCULAR SURGERY																	1		
EMERGENCY SERVICES	MAU	98 %	0	0					100 %	100 %	90 %	91 %	134/143	100 %	0	6	0	2	0	0
	SAU	100 %	0	0			100 %		100 %	100 %	95 %	92 %	19/21	100 %	0	0	0	0	0	0
	A&E	89 %	0	0					70 %		95 %	95 %	57/63		0	0	0	2	0	0
PAEDIATRICS	OAK	99 %	0	0					100 %	N/A	97 %	96 %	19/19		0	0	0	0	0	0
	ASH	95 %	0	0					100 %		97 %	95 %	18/20		0	0	0	0	0	0
	PAED A/E	97 %	0	0					100 %		92 %	95 %	N/A		0	0	0	0	0	0
	NICU	99 %	0	0		100 %			N/A	100 %	91 %	93 %	10/11		0	0	0	0	0	0
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %			100 %	100 %	98 %	97 %	65/73		0	0	0	0	0	0
	THEATRES ASH	93 %	0	0			N/A		100 %	100 %	100 %	97 %	N/A	N/A	0	0	0	0	0	0
	DSU SPH	N/S	0	0					0 %		98 %	98 %	1/1		0	0	0	0	0	0
	DSU ASH	96 %	0	0					100 %		96 %	95 %	1/1		0	0	0	0	0	0
IMAGING/ENDOSCOPY	ENDO	98 %	0	0	N/A				100 %	N/A	97 %	93 %	8/8		0	0	0	0	0	0
	IMAGING ASH	100 %	0	0							95 %	96 %			0	0	0	0	0	0
	IMAGING SPH	100 %	0	0				N/A	N/A		N/A	92 %	N/A		0	0	0	0	0	0
	GASTROENTEROLOGY	N/A	N/A	N/A								N/A			N/A	N/A	N/A	3	N/A	N/A
CRITICAL CARE	ITU	100 %	0	0	90 %		100 %		100 %	100 %	95 %	95 %	50/53	100 %	0	0	0	0	0	0
MATERNITY	JOAN BOOKER	99 %	0	0			80 %		N/A	90 %	86 %	90 %	11/12	100 %	0	0	0	0	1	0
	LABOUR	89 %	0	0					70 %		91 %	93 %	78/79	100 %	0	0	0	0	0	0
	LABOUR THEATRES		0	0							97 %		N/A		0	0	0	0	0	0
	MIDWIVES	N/A										N/A	34/39		N/A	N/A	N/A	N/A		
	MATERNITY TRIAGE		N/A	N/A							N/A				0	0	0	0	N/A	N/A
	ANTENATAL OBSTETRICS					N/A									N/A	N/A	N/A	1		
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0							90 %	96 %			0	0	0	0	0	0
	OUTPATIENT SPH	100 %	0	0							87 %	98 %			0	0	0	1	0	0
OPHTHALMOLOGY	EYE CLINIC ASH	100 %	0	0							N/A				0	0	0	0	0	0
	EYE CLINIC SPH	N/S	0	0	N/A		N/A		N/A	N/A	95 %				0	0	0	0	0	0
	EYE WARD ASH		0	0											0	0	0	0	0	0
OTHERS	EYE THEATRE												N/A			0	0	0		
	BREAST CLINIC															0	0	0		
	OCCUPATIONAL HEALTH											N/A				0	0	0		
	OFFICE	N/A	N/A	N/A							N/A				N/A	0	0	0	N/A	N/A
	CORPORATE AFFAIRS																	1		
	TRANSPORT DEPARTMENT															N/A	N/A	1		
GYNAECOLOGY	GYNAECOLOGY																	1		
SPECIALIST SURGERY	OPHTHALMOLOGY																	2		