Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
27th May 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 There are 5 red areas on the quality dashboard this month. There have been 2 MRSA's identified in April (and a further 1 at time of report that will be reported on in May) Action plans are in place and significant changes have been made to address the issues. There are five wards where ward metrics indicate improvements need to be made and these are being addressed.
BOARD ASSURANCE (Risk) / IMPLICATIONS	There is an increased risk of non compliance with the MRSA target as 3 have already been identified. With a target of 5 for the full year it is disappointing to have 3 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 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:	17th May 2010
Decision:	To Note

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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 C.Difficile 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 3)
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

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	Target	Forecast	Actual	Change			YTD
Standardised mortality (Relative Risk)	82	82	68	▼	▼	▲	81.4
Crude mortality	2.6%	2.6%	2.2%	▲	▲	▼	2.2%
MRSA (Hospital only)	5	5	2	▲	▼	▼	2
C.Diff	90	53	3	▲	▼	▼	3
Patient Satisfaction	100%	97.5%	96.9%	▼	▲	▼	96.9%
Formal complaints	361	397	32	▲	▲	▲	32
SUIs	14	15	2	◄►	▲	▼	2
Falls - resulting in significant injury (grade 3)	29	29	1	▲	▼	▲	1
Hip fractures treated within 36 hrs	85%	85%	61.9%	▲	▲	▲	61.9%
Readmissions within 14 days	2.6%	2.6%	1.8%	▲	▲	◄►	1.8%
VTE Assessment	90.0%	N/A	68.0%	Based on sample audit			
Summated Adverse Report Index (SARI)	TBC	N/A	289	N/A			289

Standardised Mortality
The target for this year has been set at 82 representing the outturn mortality 2009/2010. It is worth noting that a figure of 78 would place the trust in the top 10% of acute trusts nationally. Clearly this months figure of 68 is very encouraging.

The crude mortality will be reported along side SMR to avoid any possibility of missing a trend by relying on SMR. The total CMR for the Trust is 2.2%. It is worth noting that the emergency CMR is 5.5%, the elective crude mortality rate is 0.6% and the day case CMR 0%.

MRSA
There were 2 MRSA cases this month – details are in 2.2 SUI update

Formal Complaints
A 10% reduction target is in place for directorates over the coming year
A ten point action plan has been put in place to promote rapid change in patient experience.
A noise at night initiative has been put in place.

SUI
The 2 SUI's relate to the 2 MRSA cases see below

Hip Fractures treated within 36 hours

The target for this has recently been set by the PCT, informed by best tariff, at 85%. The Trust has made an encouraging start at addressing this Target. The Directorate is clear that this is an absolute priority and they are optimistic that this can be delivered. Changes have included creating extra capacity in theatres on Tuesday and Wednesday, a more robust process of prioritising

trauma and increased ortho-geriatric input. All cases that miss the 36 hr target will be reviewed as a critical incident by the directorate.

VTE assessment

The Trust is urgently discussing the mechanism for automating the collection of this important metric. This is a CQUIN and a national target. The manual audit recently completed shows a further improvement in this metric across the Trust which is now approaching 70%. All directorates are aware of the importance of this priority. It is anticipated that the new pharmacy forms will aid the automation of data collection which will in turn allow the Trust to monitor compliance more readily intervene if required.

SARI

The Trust continues to report the SARI. This should include patients who fail to receive VTE assessment. We have to date not collected this metric. Furthermore VTE will potentially involve larger numbers of people than the other components currently included in the SARI metric, so we are modelling the impact of VTE on the SARI measure and consequently what the target value should be. This will be resolved by the next report.

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

This month has included numbers for blood traceability to provide a more relevant reflection of practice. The methodology has been through numbers of labels returned against number of Blood bags used.

The Matrons have been requested to develop actions to improve those scores that are rated at red or amber and further analysis will need to be undertaken within those Directorates.

Those areas with four or more red indicators for the month of April are:

- Aspen
- Cedar
- Maple
- MAU
- Accident and Emergency

These areas will be further scrutinised to establish any underlying reason for high scoring red indicators by the Chief Nurse.

2 MORTALITY AND MORBIDITY

2.1 Dr Foster Summary report

There has been no Dr Foster update since Feb 2010.The trust is awaiting the next report.

The Board was asked at the March ‘board to board’ *“ What is your C Diff mortality?*” I have had time to find this precise data, the Trust C Diff mortality in 1996 was 228 with and SMR of 116, In 2009 this had shown a dramatic improvement with a crude mortality rate of 13% and an SMR of 90. We will continue to monitor this with an expectation of further improvement as a consequence of High Impact Interventions.

2.2 Trust Mortality Review Meeting (TMRM)

The Trust held its first Trust Mortality Review Meeting in April.

Although plagued with logistic problems we managed to review a 35% cohort of the deaths in the Trust in March.

We used a modified LIPS proforma, applied to a note review, to determine if the deaths were expected or unexpected. The Audit showed that the Trust had no UNEXPECTED deaths in this cohort, during this period. This is clearly reassuring.

Our aim is to review ALL deaths in the Trust and to provide assurance that the Trust has minimised unexpected deaths and that all cases that may occur are subject to review in the appropriate directorate.

The TMRM will be a monthly meeting with a board update in the quality report

2.2 <u>SUI update</u>

There were 2 SUIs in April 2010, both MRSA cases.

<table>
<tr><th>SUI</th><th>Date of Incident</th><th>Date for RCA completion set by PCT</th><th>Date RCA completed</th></tr>
<tr><td>MRSA</td><td>26/4/10</td><td>14/6/10</td><td>11/5/10</td></tr>
<tr><td colspan="4">Female aged 83 admitted on 22.4.10. Blood cultures were taken following a temperature on 26.04.10. This was MRSA positive. MRSA was also grown from swabs taken from leg and sacral sores by the GP before admission. It is clear this lady was MRSA colonised prior to admission. The reporting the criteria is that positive cultures taken 48 hours after admission has to be classified as hospital acquired, and reported.
The patient died despite treatment</td></tr>
<tr><td>MRSA</td><td>27/4/10</td><td>15/6/10</td><td>12/5/10</td></tr>
<tr><td colspan="4">Male aged 94 admitted on 11.3.10 with aspiration pneumonia. One set of Blood cultures grew MRSA. The patient responded to Tazocin which MRSA should not be sensitive to and a repeat blood culture was negative. It is thought likely that the MRSA was a contaminant. The patient later died from a problem not related to MRSA.</td></tr>
</table>

The first case has been reviewed and the Blood Cultures were taken appropriately. The patients MRSA is almost certainly community acquired despite being classified as hospital acquired if the criteria are strictly applied. This case is now being contested with the PCT and SHA.

The second case illustrates that there was potentially a procedural error in taking the blood sample. The doctor involved (and in fact all junior doctors in the trust) had successfully completed the on line training tracker. No problems were apparent on review of the individual doctors practice.

Actions from this case have included: highlighting the issue to the whole consultant body (18/05). Face to face meetings with all junior medical staff (19/05). Re-circulation of the blood culture policy and procedural guides. (19/05).

With Immediate effect, the introduction of a policy that all blood cultures should be drawn by the registrar, or a junior who has been assessed as operationally competent by the registrar or consultant. All blood culture requests will be signed off by a consultant or registrar and the forms for blood culture requests will only be processed if senior sign off is recorded on this form. All phlebotomy staff will be reassessed re blood culture techniques. Arrangements will be put in place to strengthen formal proficiency testing of all junior doctors at induction.

SUI Framework

A new national framework for Reporting and Learning from Serious Incidents Requiring Investigation has been published by the NPSA. The anticipated update will be available once PCT have responded with information on their requirements.

3 Quality update

3.1 Safety alerts

There are 5 alerts currently over the deadline for closure

05-Feb-07	Early identification of failure to act on radiological imaging reports	There is an early alert pilot in place currently, prior to implementation of electronic software later in the year. This pilot will be reviewed in July at Clinical Governance Committee, and then closed if review is positive.
31-Mar-08	Actions that make anti-coagulation therapy safer	Heparin policy being ratified at DT C on 20th May, policy for patients needing warfarin on discharge almost completed – this will be ratified by Chairman's actions. Anticipated closure date end of May.
09 June 09	Reducing risk of overdose with midazolam injection in adults	The sedation policy was received by the drugs and therapeutics committee and further amendments are required. These will be made and ratified at the committee on the 25th May when the alert will be closed.
07-Sep-09	Reducing risk of harm from oral bowel cleansing solutions	GP meeting went ahead in April. Proposed process needed to be reviewed, this has happened and amended process put forward which has been accepted by team. Closure of alert is therefore expected at end of May.
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 Sept 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 are having to wait for the IT software to be completed and implemented.

3.2 Coroners Inquest

An inquest took place on Thursday 13th May. The verdict was '*Death as a result of a necessary therapeutic procedure'*. (Note: undertaken in a nursing home – this was not a matter for the Trust)

During the evidence hearing the patient's relative expressed unhappiness regarding the communications with the family following the patient's admission regarding the limited treatment options available. Mr. Chisholm, Clinical Director for Surgery, spoke directly to the family and will take these issues back to his department for consideration and action as necessary.

- End -

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

Date: 18th May 2010

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 - April 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		Central Lines After Care		Urinary Catheter Insertion		Urinary Catheter After Care		Peripheral Cannula	
		>=90%		=0		=0		>=95%		>=95%		>=95%		>=95%		>=95%	
		89% - 80%						94% - 85%		94% - 85%		94% - 85%		94% - 85%		94% - 85%	
		<80%		>=1		>=1		<85%		<85%		<85%		<85%		<85%	
Medicine 1, 2, 3	ASPEN	100 %	⇔	0	⇔	1	⇩	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	CCU	100 %	⇧	0	⇔	0	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	BIRCH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	MHDU	100 %	⇔	0	⇔	0	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	HOLLY	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	CEDAR	100 %	⇧	0	⇔	1	⇩	N/A	⇔	N/A		100 %	⇔	86 %	⇩	70 %	⇩
	MAY	93 %	⇩	N/A	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔	N/A	⇩
	MAPLE	96 %	⇩	1	⇔	1	⇩	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	COLPOSCOPY	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	ANGIO SUITE	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	RHEUMATOLOGY	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Ashford	CHAUCER	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔	N/A	⇔
	WORDSWORTH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	FIELDING	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	DICKENS	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	N/A	⇔	100 %	⇔
Orthopaedics	ELM	97 %	⇩	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	JUNIPER	98 %	⇩	0	⇔	0	⇧	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	ROWLEY BRISTOW	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Surgery	KINGFISHER	93 %	⇩	0	⇔	0	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔

	FALCON	100 %	⇧	0	⇔	0	⇔	N/A	⇔	100 %		100 %	⇔	100 %	⇔	100 %	⇧
	KESTREL	100 %	⇔	1	⇔	0	⇧	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	SDU	99 %	⇧	0	⇔	0	⇔	N/A	⇔	90 %	⇔	100 %	⇔	100 %	⇔	100 %	⇧
	ADMISSIONS LOUNGE	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔
	HERON	99 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A		100 %	⇔	100 %	⇔	100 %	⇔
	MAXFACS CLINICS ASH	94 %	⇩	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Emergency Services	MAU	97 %	⇩	0	⇔	0	⇧	N/A	⇔	N/A	⇔	100 %	⇔	N/A		100 %	⇔
	SAU	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	A&E	96 %	⇧	0	⇔	0	⇧	N/A	⇔	N/A	⇔	N/A	⇔	N/A		90 %	⇩
Paediatrics	OAK	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔
	ASH	94 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇩
	PAED A/E	96 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	NICU	98 %	⇧	0	⇔	0	⇔	N/A	⇔	100 %	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Theatres	THEATRES SPH	100 %	⇔	0	⇔	0	⇔	100 %	⇔	100 %	⇔	100 %	⇔	N/A	⇔	100 %	⇔
	THEATRES ASH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	DSU SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔
	DSU ASH	85 %	⇩	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔
Imaging / Endoscopy	ENDO	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇔
	IMAGING ASH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	IMAGING SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Critical Care	ITU	100 %	⇔	0	⇔	0	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
Maternity	JOAN BOOKER	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	90 %	⇩	N/A	⇔
	LABOUR	78 %	⇩	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	N/A	⇔	40 %	⇩
	LABOUR THEATRES	N/A	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	MATERNITY TRIAGE	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Outpatients	OUTPATIENT ASH	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	OUTPATIENT SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
Ophthalmology	EYE CLINIC ASH	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	EYE CLINIC SPH	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	EYE WARD ASH	100 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔

				Pressure Ulcer Prevention		Patient Falls			Medication Errors	
Peripheral Cannula After Care	**Cleanliness**	**Matron Environment Audit**	**Blood Traceability**	Compliance with monitoring of Pressure Ulcer	**Mixed Sex Wards Compliance**	Number of falls	Resulting in Injury	**Complaints**	Administration	Prescribing
>=95%	*>=85%*	*>=90%*	*=100%*	*=100%*	*=0*	*=0*	*=0*	*=0*	*=0*	*=0*
94% - 85%	*84% - 75%*	*89% - 80%*		*99% - 76%*						
<85%	*<75%*	*<80%*	*<100%*	*<=75%*	*>=1*	*>=1*	*>=1*	*>=1*	*>=1*	*>=1*
100 % ⇧	91 % ⇧	96 % ⇩	11/11 ⇔	75 % ⇩	0 ⇔	6 ⇩	0 ⇔	0 ⇧	3 ⇩	9 ⇩
N/A ⇔	86 % ⇩	98 % ⇩	4/4 ⇔	50 % ⇩	N/A ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇧	1 ⇩
70 % ⇩	81 % ⇩	98 % ⇩	9/9 ⇔	100 % ⇔	0 ⇧	2 ⇧	0 ⇔	1 ⇔	0 ⇔	0 ⇧
100 % ⇔	89 % ⇧	96 % ⇩	18/19 ⇩	100 % ⇧	0	0 ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇔
100 % ⇔	95 % ⇧	95 % ⇩	14/14 ⇔	75 % ⇩	0 ⇔	2 ⇧	0 ⇔	1 ⇔	0 ⇔	0 ⇔
100 % ⇔	92 % ⇧	95 % ⇧	6/6 ⇔	75 % ⇩	0 ⇔	9 ⇩	0 ⇔	1 ⇩	0 ⇧	0 ⇧
100 % ⇔	97 % ⇧	N/A ⇧	3/3 ⇩	N/S ⇩	0 ⇔	2 ⇩	0 ⇔	0 ⇔	2 ⇩	1 ⇧
100 % ⇧	93 % ⇩	95 % ⇔	15/15 ⇔	100 % ⇔	0 ⇔	12 ⇩	0 ⇔	0 ⇧	0 ⇧	3 ⇩
N/A ⇔	96 % ⇧	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇔
N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	1 ⇔	N/A ⇔	N/A ⇔
N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔	1 ⇧	N/A ⇔	N/A ⇔
100 % ⇔	97 % ⇧	91 % ⇩	N/A ⇔	100 % ⇧	0 ⇔	2 ⇔	0 ⇔	0 ⇧	0 ⇔	0 ⇔
100 % ⇔	95 % ⇧	95 % ⇧	3/3 ⇔	100 % ⇧	0 ⇔	0 ⇧	0 ⇔	0 ⇔	0 ⇔	0 ⇔
100 % ⇔	92 % ⇧	93 % ⇧	0/1 ⇩	100 % ⇧	0 ⇔	3 ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇔
N/A ⇔	96 % ⇔	95 % ⇧	9/9 ⇔	100 % ⇔	0 ⇔	0 ⇔	0 ⇔	0 ⇧	0 ⇔	0 ⇔
100 % ⇔	90 % ⇩	93 % ⇩	51/56 ⇩	75 % ⇩	0 ⇔	4 ⇔	0 ⇔	0 ⇧	0 ⇔	0 ⇔
100 % ⇔	93 % ⇩	93 % ⇩	29/29 ⇧	75 % ⇩	0 ⇔	4 ⇩	0 ⇧	0 ⇧	0 ⇧	0 ⇔
N/A ⇔	N/A	93 % ⇧	N/A ⇔	N/A ⇔	N/A ⇔	0 ⇔	0 ⇔	1 ⇔	0 ⇔	0 ⇔
100 % ⇔	89 % ⇩	93 % ⇧	34/35 ⇧	75 % ⇩	0 ⇔	0 ⇔	0 ⇔	2 ⇧	0 ⇔	0 ⇔

100 %	⇧	94 %	⇧	91 %	⇩	16/19	⇩	75 %	⇧	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	94 %	⇔	N/A	⇔	33/34	⇩	100 %	⇧	0	⇔	0	⇔	0	⇔	0	⇧	0	⇔	0	⇔
100 %	⇧	88 %	⇩	91 %	⇩	13/14	⇩	75 %	⇧	0	⇔	1	⇩	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
100 %	⇧	95 %	⇧	86 %	⇩	2/2	⇧	75 %	⇩	0	⇔	1	⇩	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	97 %	⇧	N/A	⇔	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
30 %	⇩	90 %	⇩	93 %	⇔	100/105	⇧	100 %	⇧	0	⇔	2	⇩	0	⇔	3	⇩	1	⇔	0	⇔
100 %	⇔	90 %	⇩	95 %	⇔	17/18	⇩	100 %	⇧	0	⇔	0	⇔	0	⇔	0	⇧	0	⇔	0	⇔
N/A	⇔	92 %	⇧	N/A	⇔	17/18	⇧	N/A	⇔	0		4	⇩	1	⇩	5	⇧	0	⇔	0	⇧
N/A	⇔	98 %	⇔	94 %	⇩	10/11	⇩	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	97 %	⇔	93 %	⇔	30/35	⇩	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	84 %	⇩	93 %	⇔	N/A		N/A	⇔	0		N/A	⇔	0	⇔	2	⇩	0	⇔	0	⇔
100 %	⇔	98 %	⇧	N/A	⇧	35/37	⇩	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇧	1	⇔
100 %	⇔	92 %	⇧	N/A	⇔	38/45	⇧	N/A	⇔	0		0	⇔	0	⇔	1	⇩	0	⇔	0	⇔
100 %	⇔	94 %	⇩	N/A	⇧	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	1	⇔	0	⇔	0	⇔
100 %	⇔	98 %	⇩	N/A	⇔	1/1	⇩	N/A	⇔	0	⇧	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	95 %	⇩	N/A	⇩	N/A		N/A	⇔	0	⇔	0	⇔	0	⇔	1	⇔	0	⇔	0	⇔
N/A	⇔	89 %	⇩	95 %	⇧	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	92 %	⇔	98 %	⇧	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	84 %	⇩	98 %	⇧	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
100 %	⇔	85 %	⇩	N/A	⇧	61/61	⇧	75 %	⇩	N/A	⇔	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
100 %	⇔	84 %	⇧	86 %	⇩	10/12	⇩	N/A	⇔	N/A	⇔	0	⇔	0	⇔	1	⇩	0	⇔	0	⇔
N/A	⇧	91 %		84 %	⇩	31/32	⇧	N/A	⇔	N/A	⇔	0	⇔	0	⇔	2	⇩	0	⇔	0	⇔
N/A	⇔	N/A		N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	1	⇔	N/A	⇔	N/A	⇔
N/A	⇔	96 %	⇔	N/A	⇧	N/A	⇩	N/A	⇔	N/A	⇔	0	⇔	0	⇔	0	⇔	0	⇔	0	⇔
N/A	⇔	76 %	⇩	N/A	⇩	N/A		N/A	⇔	N/A	⇔	0	⇔	0	⇔	2	⇩	0	⇔	0	⇔
N/A	⇔	96 %	⇧	N/A	⇔	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	2	⇩	0	⇔	0	⇔
N/A	⇔	N/A	⇩	N/A	⇔	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇧	0	⇔	0	⇔
N/A	⇔	N/A		N/A	⇔	N/A	⇔	N/A	⇔	0		0	⇔	0	⇔	0	⇔	0	⇔	0	⇔