Kingston Hospital NHS Foundation Trust

Clinical Quality Report
December 2013 (Month 9)

Trust Board Meeting: 29th January 2014

Executive Summary

The Trust Clinical Quality Report provides the Board with an overview of clinical quality. The metrics should be considered in the context of the overall performance of the Trust and in particular to determine if there are any changes in quality that might be due to the productivity programme.
There are some areas of concern regarding quality of care in the Trust in December 2013. However mortality rates are maintained at a low level. The most recent in-hospital SHMI (November 2013) being 59 and the unadjusted mortality for December 2013, 1.3%. The Quarter 2 SHMI (the most recently published result) is 93.1. This is in the 'as expected range' and includes deaths within 30 days of discharge as well as the in hospital figures.
Performance in safety KPIs, in particular hospital acquired infection, remains an area of specific attention and the action plans in place robustly implemented.

There were no occurrences of C.difficile in December 2013, the number of cases year to date remaining at 21, though the Board will be aware that the winter months do present the greatest challenge in controlling this infection. An independent review of was commissioned by the Trust and took place in December 2013 and the Trust received the final report in January 2014. Key findings of the report are; identified significant progress since review in November 2012; the Trust is strongly focused on the issue; good adherence to national testing and reporting guidance; many examples of best practice already in place e.g. antibiotic practice; high level of awareness and clinical engagement with the issue; increased vulnerability of patients recognised –local demographics; supports reinvestment of fines in the Trust. Areas for identified for further work include; Diarrhoea assessment and stool specimens; Cleaning – stopping routine use of chlorine; Isolation of patients – reduce frequency of bay closures ; Highlight more the good practice of antimicrobial prescribing compliance; Nursing leadership – continue approach to enhance leadership ; Infection control team – reduce audit burden to release more time; Prescribing across whole health economy – Protein Pump Inhibitors (PPI's). An action plan to address the issues arising from the report is being compiled.

A quality improvement project has recently commenced to undertake work to improve and manage the introduction and on-going care of intravenous long lines with the aim of reducing the occurrence of line related infections such as MSSA. Catheterisation training and assessment continues with the band 6 nurses and a new catheterisation policy is being progressed to address issues of catheter associated urinary tract infections which is linked to Ecoli.

The VTE risk assessment scores have still not recovered to the target rates reported earlier in the year. All clinical areas are focussing on improving this. There are data quality issues with this indicator, which are being addressed, but the performance in the areas of high admissions is significantly below previous performance. All ward areas are receiving the information on a weekly basis. Focussed attention will be given to AAU and maternity.

There were 6 pressure ulcers in December 2013, all of which were grade 2. Falls rates are slightly higher than November. Two falls are reported to have resulted in severe harm and are being investigated through the Serious Incident (SI) process; a further three are reported as moderate harm. The falls exception report details the various avenues of work occurring through the falls group to reduce falls further.

The number of complaints to the Trust was significantly lower in December 2013 than other months. This is a pattern seen in most years and is often followed by higher numbers in January. There were no re-opened complaints or referrals to the Ombudsman. The report details the eighth month of the Friends and Family test. The exception reports provide a breakdown of FFT score by ward for December 2013. The scores for inpatients are stable. The wards are now receiving their information with a comparison to other ward areas in preparation for the data to be presented on screens at the ward entrances by April 2014.

The Board is asked to review and discuss the findings of the report.

Clinical Quality Dashboard - December 13							Actual performance (latest 3 months)								Future performance, trends and commentary			
	Strategic objective	KPI description	Exec Owner	Indicator also reported in	Target	P/YR	October	November	December	Q1	Q2	Q3 (to date)	YTD	Qtr Trend	Mnth trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC	<=0.5	16	1	1	0	3	2	2	7	→	↓		Target set as reduction of 10% on 2012/13 target.
	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC	<=0.06	0.12	0.09	0.09	0.00	0.09	0.06	0.06	0.07	→	↓		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC	<=3	39	3	7	6	12	14	16	42	↑	↓		Target set as reduction of 10% on 2012/13 Outturn. See Exception report 1
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC	<=0.3	0.3	0.3	0.6	0.5	0.4	0.4	0.5	0.4	↑	↓		
	1*	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC			0	0	4	1	6	4	11	↓	↑		
	1	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC	<=4.8	5.6	5.5	6.3	6.7	5.5	5.6	6.1	5.8	↑	↑		Target is National Patient Safety Agency (NPSA) benchmark See Exception Report 2
	1	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC	<1	1	0	0	0	0	1	0	1	↓	→		Target set by Department of Health Public Health England data shows for 2012/13, KHT's rate of hospital acquired bacteramias was 0.7 per 100,000 bed days, National rate was 1.2. Benchmark data is published annually.
	1*	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC	<=1	23	3	3	0	8	7	6	21	↓	↓		Target set by Department of Health Public Health England data shows for 2012/13, KHT's rate of hospital acquired infections was 15.8 per 100,000 bed days, National rate was 17.3. Benchmark data is published annually.
	1	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC	<=1	10	0	2	2	4	3	4	11	↓	→		MSSA is new to the CQR. Exception reports will be produced quarterly if required. See Exception Report 3
	1	E.coli Bloodstream Infections (Hospital Acquired)	DB	CQIC	<=1.5	18	1	4	4	4	10	9	23	↓	→		Target based on a reduction on last year's outturn See Exception Report 4
	1	Nutrition - compliance with MUST assessment	DB	CQIC	>=85%	92.1%				91.2%	93.1%		91.7%	↑			Data is collected tri-annually as part of nutrition audit.
	1	Completed Patient Observations	DB	CQIC	>=97%	94.9%											Collection method of this data is changing to NEWS .
	1	Medication Incidents	JW	CQIC		551	48	53	62	158	135	163	456	↑	↑		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	% of Medication Incidents Where Moderate or Severe Harm Occurred	JW	CQIC	<=4%	1.3%	2.1%	0.0%	3.2%	0.6%	0.7%	1.8%	0.9%	↑	↑		
	1	Number of Serious Untoward Incidents	JW	CQIC		45	0	5	4	5	19	9	33				No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	Number of Never Events	JW	CQIC	0	2	0	0	0	1	0	0	1	→	→		
	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC		90.5%	89.7%	93.0%	91.8%	92.7%	92.2%	90.3%	91.7%	↓	↓		Previous year figure is July 12 to March 13

Clinical Quality Dashboard - December 13						Actual performance (latest 3 months)								Future performance, trends and commentary			
	Strategic objective	KPI description	Exec Owner	Indicator also reported in	Target	P/YR	October	November	December	Q1	Q2	Q3 (to date)	YTD	Qtr Trend	Mnth trend	Forecast	Comments
Effectiveness	1	SHMI	JW	Board - CPR, CQIC	<=95	88.7				89.8	93.1			↑			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. Q2 data is for the period Apr 12 to Mar 13 as published by the Information Centre in Oct 2013 Data for prior year is for period Oct 11 to Sep 12.
	1	SHMI (In hospital Mortality)	JW	CQIC	<=73	66	48	59		59	50	53	54	↓	↑		Data from CHKS and reported 2 months in arrears. Previous year and target based on April 2012 to January 2013
	1	Unadjusted Mortality Rate	JW			1.4%	1.0%	1.2%	1.3%	1.3%	1.1%	1.2%	1.2%	↑	↑		CHKS data shows for Apr to Dec 2012, KHT's rate was 1.35% compared to a national rate of 1.30%.
	1	Excess Deaths	JW		<0	-263				-97	-74		-171				Data from CHKS and reported quarterly in arrears. A negative score means that there are less deaths than expected.
		% Emergency Readmissions following elective admission - 30 days	ST	CQIC		1.4%	2.1%	1.5%	1.6%	1.5%	1.9%	1.7%	1.7%	↑	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following emergency admission - 30 days	ST	CQIC		10.4%	10.3%	11.8%	10.7%	10.3%	9.8%	10.9%	10.3%	↑	↓		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	<= 5.8%	5.6%	5.1%			5.5%	5.3%		5.4%		↓		Data reported from CHKS and therefore in arrears. Target based on national peer upper quartile from CHKS.
	1	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQIC	>=95%	91.9%	80.2%	80.0%	76.4%	93.5%	92.2%	78.9%	88.1%	↓	↓		Target is national CQUIN. See exception report 5
	1	Hand Hygiene	DB	CQIC	>=95%	96.5%	91.8%	96.0%	94.7%	94.1%	93.1%	94.3%	94.1%	↑	↓		Target is locally set.
	1	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur	JW	CQIC	>=70.0%	81.8%	77.4%			85.7%	89.7%	77.4%	85.8%	↓	↓		Data from CHKS and will be reported 3 months in arrears. Data benchmarked against national peer performance for 2012/13
	1	Open Incidents - % of Managers Reports Completed within 10 days	ST	CQIC		Not Available	56%	50%	59%						↑		
Patient Experience	1	Number of Complaints received this month	DB	CQIC		391	40	36	28	94	104	104	302	↑	↓		
	1	Number of Complaints reopened this month	ST	CQIC		38	13	2	0	12	14	15	41	↑	↓		
	1	Number of Complaints referred to ombudsman this month	ST	CQIC		5	2	0	0	2	0	2	4	↑	→		
	1	% Complaints responded to within 25 working days	ST	CQIC	>=90%	79.3%	67.5%	77.8%		85.1%	67.3%	72.4%	74.8%	↑	↑		Data reported 1 month in arrears
	1	Friends and Family Score - Trust	DB	CQIC			63	64	64	64	62	64	64	↓	→		The overall Trust Response rate was 8.83% in December. The target is to have a response rate over 15%
	1	Friends and Family Score - Adult Inpatient	DB	CQIC	78		57	62	61	61	61	60	60	↓	↓		The Inpatient response rate was 33.3% in December. Please note that Patients with a 0 LOS are currently being included in the Inpatient data. Once this data can be collected separately they will be included in the A&E data. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts. This has been based on June's published FFT data and will be reviewed quarterly.
	1*	Friends and Family Score - Outpatient	DB	CQIC			66	65	72	75	70	68	71	↓	↑		The outpatient response rate was 3.68% in December
	1	Friends and Family Score - A&E	DB	CQIC	68		61	61	58	42	58	59	55	↑	↓		The A&E response rate was 20.1% in November. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts. This has been based on June's published FFT data and will be reviewed quarterly.
	1	Friends and Family Score - Maternity	DB	CQIC			64	66	64		62	65	64	↑	↓		The overall score has been collated from responses to the 3 maternity touchpoints. This covers the patients experience of antenatal, delivery and postnatal wards/community care.
	1	Friends and Family Score - Paediatric Inpatient	DB	CQIC			90	75	83	82	86	83	84	↓	↑		Includes scores from Sunshine Ward, Dolphin Ward and Neonates
	1	Number of Mixed Sex accommodation breaches	ST	CQIC	0	0	0	0	0	0	0	0	0	→	→		This is based on a national directive.
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	28.3%	28.3%	25.2%	25.2%	27.7%	27.4%	26.8%	↓	↓		
	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	0.5%	0.6%	0.7%	0.5%	0.6%	0.7%	0.6%	0.6%	↓	↓		
	1	Significant Perineal Trauma	JW	CQIC		2.5%	3.2%	1.4%		3.1%	3.0%		2.9%	↓	↓		Data reported 1 month in arrears as requires coding to be completed
	1	Perinatal Mortality Rate per 1000 births	JW	CQIC	<=3.7					2.1	2.7		2.4	↑			Data from CHKS. Target is National Peer rate from CHKS Data will be reported quarterly.
	1	Number of Red Maternity Escalations	JW	CQIC	0		0	0	0	0	0	0	0	→	→		

Key: 1* Quality Account Objective

Qualitative Report for December 2013

Clinical Audit
The Trust has recently undertaken a review of concerns received from community staff following a patient's discharge from hospital. Concerns are reported into the hospital where they are then investigated. The number received compared to the total number of patients discharged is small (0.3%).

The most commonly occurring concerns are those regarding the documentation or communication of information from hospital to community care staff and issues surrounding patients' medication. Whilst the majority of concerns received by the hospital were investigated and an action plan implemented, to improve this further, the 'Concerns' process is being revised and improved. Other actions taken as a result of this audit include amending the hospital's Discharge Policy, improving the clarity of discharge information that is sent out with the patient, reviewing the process for the supply of medication to take home and improving communication between community and hospital staff.

Complaints
The Trust received 28 formal complaints in December 2013 compared to 21 for December 2012. Emergency Services received the highest amount of complaints accounting for 39% of the total followed by Specialist Services with 32% and Clinical Support Services received 25% of the total. The most frequent complaint subject within the total complaints received this month related to Appointments (29%). Communication accounted for 25% and followed by Care and Treatment (21%) of the total.

Reopened complaints
5 complaints were reopened in December 2013, arising from complaints first received between September 2013 and November 2013.

The reasons for these complaints reopening were:
Facts Challenged – 4
Further Questions – 1

Ombudsman Referrals
There were no complaints referred to the Ombudsman in December 2013.

Serious Incidents
In December 2013 the Trust declared 4 Grade 1 serious incidents; two related to fractures sustained following a fall, one was an unexpected admission to NNU and the fourth related to an incident in A&E.

The investigations into these incidents have commenced, and the final reports will be signed off by the Serious Incident (SIG) Group. In December the SIG signed off two SI investigation reports.

Themes identified from recently closed investigation reports include; ongoing issues pertaining to accurate documentation, communication between staff, departments and with patients, and the failure to complete the falls bundle. To address these issues, there is ongoing work to improve documentation and communication, the falls bundle is being reviewed with the aim to simplify it. To address issues raised in previous SIs several Quality Improvement Projects have been commenced. These include projects to reduce patient falls, improve the management of sepsis, introduce the communication tool of Situation, Background, Assessment and Recommendations

Staff Award Winners

November 2013
There were two winners in November:
Dorcas Roman, Senior Staff Nurse, ICU won under the value of CARING
Jane Sharman, Medical Secretary, Wolverton Centre won under the value of RESPONSIBLE

December 2013
There was one winner in December:
Laura Hughes, Senior Staff Nurse, A&E won under the value SAFE.

Clinical Quality Report **Author: Alison Williams**

Exception Report 1: Pressure Ulcer Stage 2

In December 2013, a total of 6 patients were reported as having developed stage 2 pressure ulcers (2 x Derwent Ward, 1 x Keats Ward, 1 x Astor Ward and 2 x AAU). There were no stage 3 or 4 pressure ulcers.

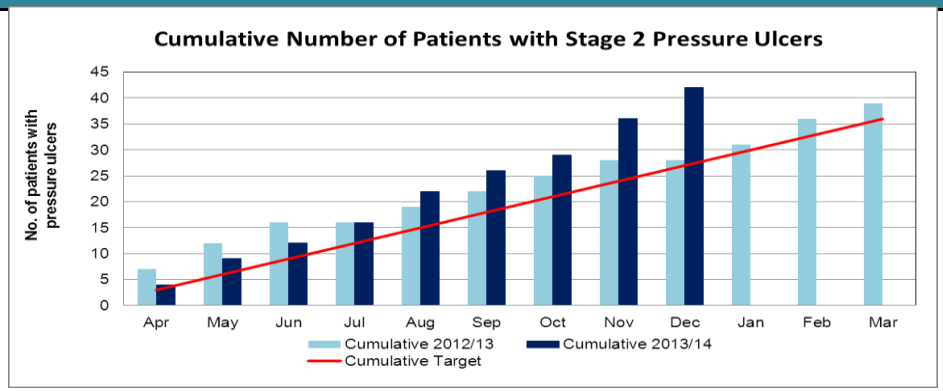
Keats Ward have reported a pressure ulcer this month however this has been the same patient reported on three occasions. This patient has been an inpatient for many months and previous investigations have deemed that the development of these pressure ulcers were unavoidable.

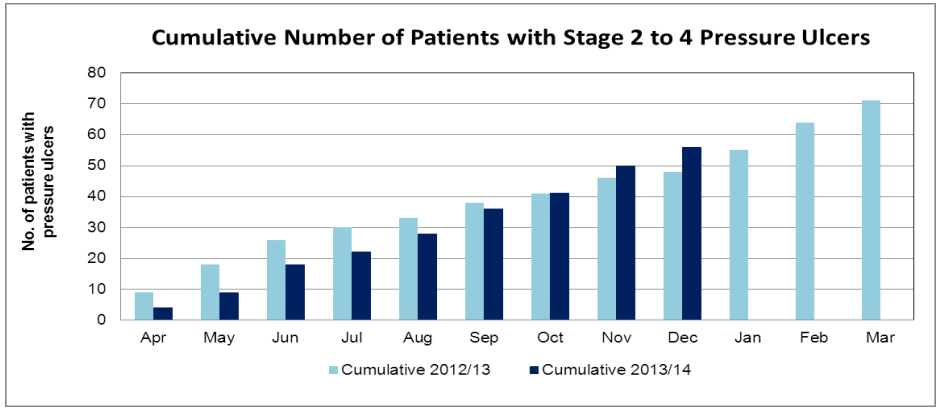
The following stage 2 checklists reports were presented at the Skin HIA meeting held on 20th January 2014.

Representatives from AAU presented two patients who had developed stage 2 pressure ulceration on that unit. Both patients pressure ulcers were deemed avoidable. AAU managers have sent letters to all staff on the unit regarding this as well as tasking the staff involved with writing a piece of reflection to ensure learning.

The Derwent Ward Sister presented one of the patients from Derwent Ward. This patient was receiving palliative care and it was explained that repositioning was difficult as the patient was restless. However the pressure ulcer was deemed avoidable as the documentation was unable to confirm all steps had been taken. Pressure Area Awareness training is in progress for Derwent Ward.

The learning from the case on Astor ward and one other patient from Derwent Ward is to be presented to the meeting in February 2014.





	Person Responsible	Date	Committee monitoring delivery
1. Complete review of Astor Ward and Derwent Ward cases at Skin HIA group.	Ward Sister - Astor/Derwent	1702/2014	Skin HIA
2. Complete pressure Area Awareness training - Derwent Ward	Tissue Viability Nurse Specialist	31/01/2014	Service Line Governance Meeting

Clinical Quality Report **Author: Duncan Burton**

Exception Report 2: Patient Safety Incident Falls

The falls rate in December is 6.7 falls per 1000 bed days. Although this is higher than Novemer it is lower than at this point last year (Dec 12).

The falls per 1000 bed days benchmarking is currently against the 2010 NPSA level. It is becoming increasingly apparent that this benchmark is out of date and not suitable for comparison of the Trusts falls levels. The NHS Quest Falls group will be used to identify benchmarking data & apporach. A review of the thresholds for benchmarking is will take place and be considered in line with the cororpate objectives set for falls in 2014/15 .

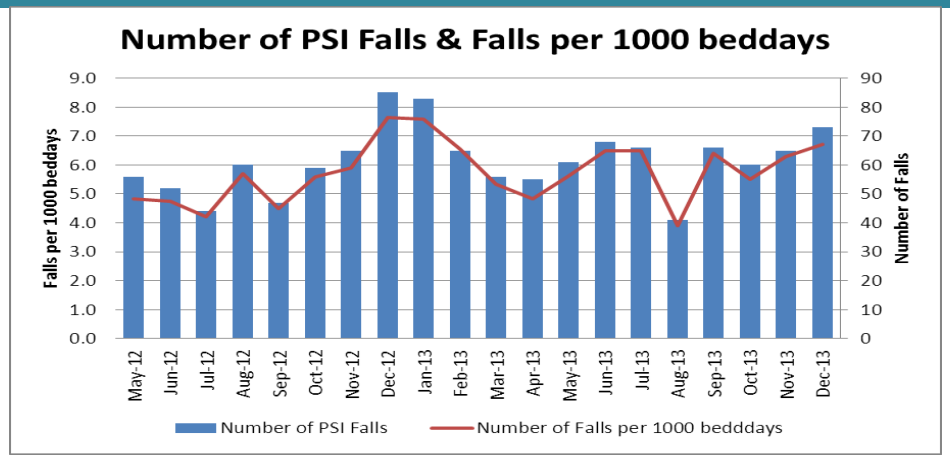
There were 2 falls with serious harm in December 2013, and are subject to Serious Incident (SI) investigations. A further 3 falls resulted in moderate harm.

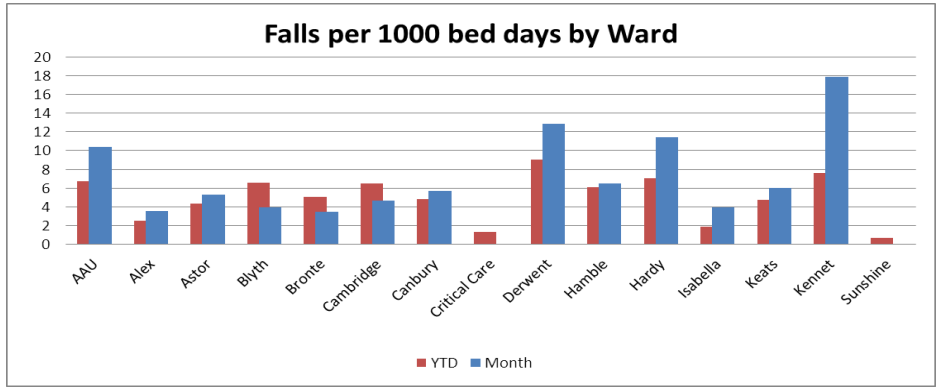
The senior physiotherapist (Olivia Frimpong) continues to be seconded to work specifically on additional falls prevention actions across the Trust. Olivia has been connected to the NHS Quest falls work stream. NHS Quest are treating falls as a 'wicked problem' as the Trust is not alone in being able to substantially reduce falls rates.

Specific ations taken and being progressed by the falls group include:

-A visit to QEH Birmingham has taken place and findings being reported to the January falls group
-Simplification of falls assessment and bundle (reduced to four pages) - for approval at Jan falls meeting
- New patient information on falls prevention - for approval at Jan falls meeting
- Report on the review of falls in toilets and actions to mitigate - falls alarms in bathrooms are being trialled from end January for 2 months on Keats ward
- Kennett ward have been invited to the January falls group to discuss the spike in falls in December, key learning and any actions required

The falls action plan has been refreshed by Olivia Frimpong following her analysis of current falls practice, actions and with and is due to be reviewed and approved at the January 2014 falls group meeting.





Actions	Person Responsible	Date	Committee monitoring delivery
1. Continue implementation of actions arising through Trust Falls Group	Director of N Director of Nursing & Patient Experience	Ongoing	Trust Falls Group
2.Approve revised falls bundle on 28/01/14 and launch to staff during Feb 14	Olivia Frimpong, Physiotherapist	28/02/2014	Trust Falls Group
3.Approve and launch falls leaflet	Olivia Frimpong, Physiotherapist	28/02/2014	Trust Falls Group
4. Review benchmarking methodology for falls	Olivia Frimpong, Physiotherapist	30/03/2014	Trust Falls Group
5. Review learning from visit to QEH	Olivia Frimpong, Physiotherapist	28/01/2014	Trust Falls Group
6. Review learning from spike in falls in December on Kennet ward	Jemma Tullett, Ward Sister	28/01/2014	Trust Falls Group
7. Undertake falls alarm trial within bathrooms on Keats ward	Julie Drabwell, Ward Sister	28/03/2014	Trust Falls Group

Clinical Quality Report

Author: Shona Ross

Exception Report 3: ***E.coli*** **Trust Acquired Infections**

There were nine Trust-apportioned E.coli bacteraemias in Quarter 3, 2013-14. There are currently no national definitions or benchmarks for hospital acquired E. coli bacteraemias. However the Trust monitors and reports cases to Public Health England (PHE), and has a locally-set trajectory for E. coliis of 1.5 cases per month which is based on last years E.coli figures. This trajectory will be reviewed in Q4 2013/14.

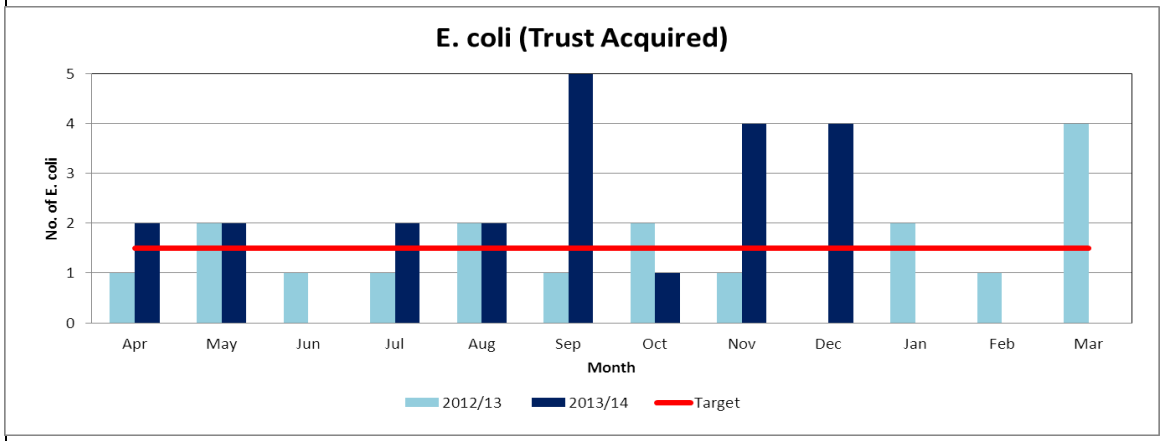
In accordance with locally-set criteria, an E. coli bacteraemia is deemed as Trust-acquired if the patient tests positive on or after day four of their admission. PHE do not apportion E. coli bacteraemias.

The underlying causes of the 9 E.coli bacteraemias are as follows:

- Three due to urosepsis (of which 2 were catheter related)
- Two due to deep seated infection (these were recurrent bacteremias, presumed due to deep seated infection, but no focus found).
- One due to diverticulitis.
- One due to ascending cholangitis.
- One due to febrile neutropenia with no focus found.
- One is possibly a contaminant.

Of these nine cases reported only three have been deemed by the Infection Control Team as true hospital acquired infections, which are :
- one patient had a long-term urinary catheter in situ and a Urinary Tract Infection (UTI)
- one had a hospital-acquired UTI
- one had urosepsis post bladder irrigation.

Urosepsis may be associated with poor technique in catheter insertion and as a consequence the Trust catheterisation policy is being re-written and band 6 nurses are currently undergoing training in catheterisation skills and a new catheterisation policy is being written. The Trust has been unsuccessful despite numerous attempts at recruiting a continence nurse specialist and is therefore focusing on actions within existing roles and processes.



Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
1. Complete new catheterisation policy.	Jane Champion, Senior Nurse	31.01.14	CQIC
2. Complete band 6 nurse catheterisation skills training.	Sarah Connor, Head of Practice Development	30.04.14	NMAC

Clinical Quality Report **Author: Shona Ross**

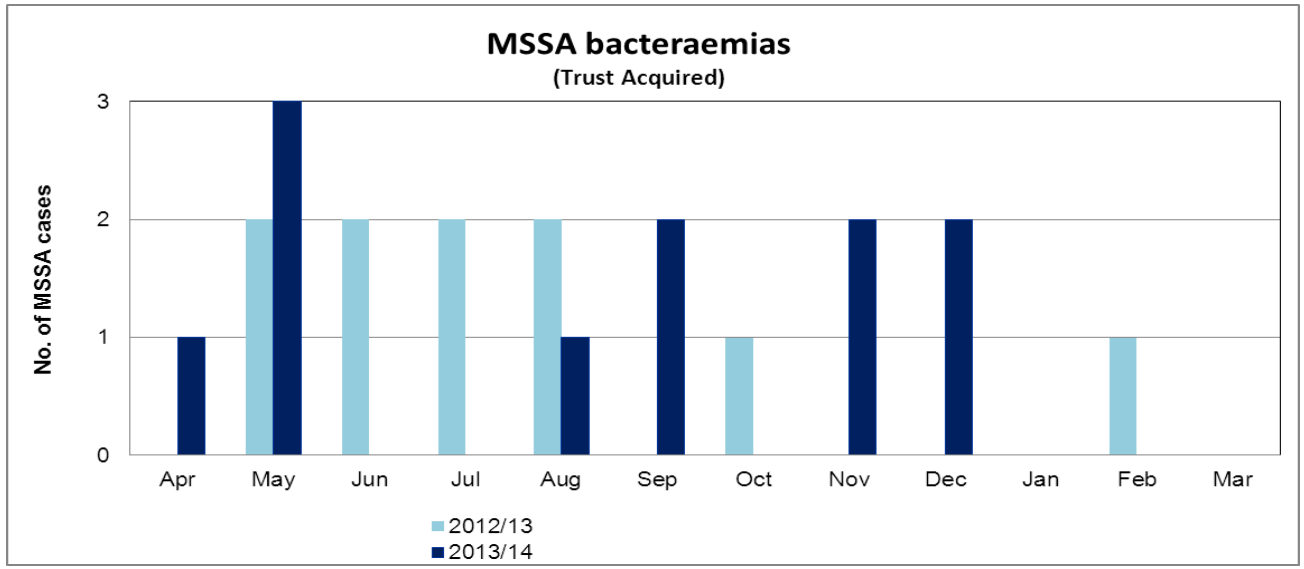
Exception Report 4: MSSA

There were 2 cases of MSSA in December both related to intrvenous catheters.

Case 1: This was likely to be a clinical infection rather than contamination. The patient had difficult IV access due to thrombosed veins, and had previously had a central venous catheter which had been replaced by a more suitable long term line, a Portacath. This was appropraitely inserted by the vascular team. The Portacath had been manipulated in A+E and the correct type of needle required for this (Huber needle) was not available. The use of inappropriate equipment (a standard IV cannula) to access the Portacath may have led to it becoming infected.

Case 2: This was a clinical infection. The focus of infection was an infected pacemaker wire and it is probable that the infection was present prior to her admission. There is a lag of 13 days between admission and positive blood cultures, which is not unusual with deep seated infections.

A Quality Improvement Project is currently being supported with the scope of improving the insertion and management of long term intravenous catheters.



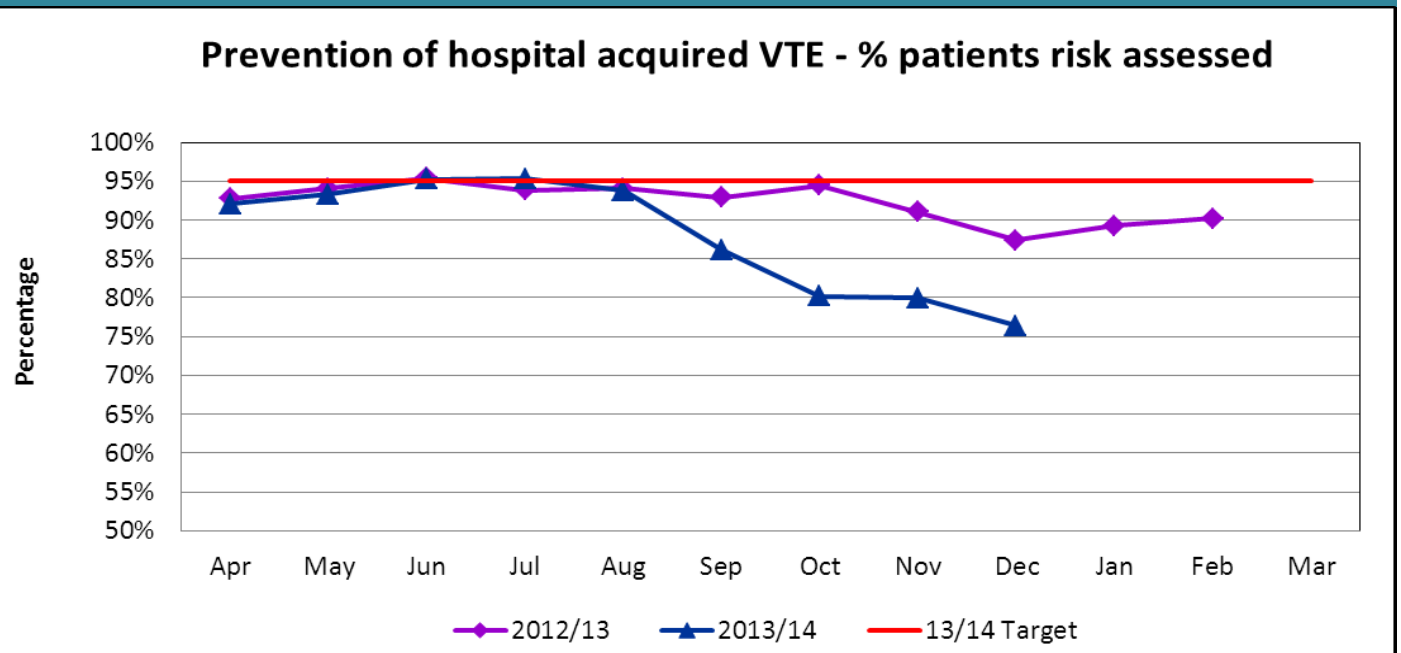
Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
1. Medical staff to be reminded of the importance of documenting the date and time of inserting IV devices.	Jane Wilson/ Sarah Furrows	31/01/2014	IPCG
2. Implement programme to introduce ANTT training and competency assessment for all clinical staff undertaking aseptic procedures.	IPCT/ Debbie Norton	30/06/2014	IPCG
3. Complete intravenous catheter Quality Improvement Project	Alison Curtis	30/10/2014	CQIG
4. Training for A&E staff on the use of tunnelled lines in A+E	Sarah Furrows, Dan Harris	31/03/2014	IPCG

Clinical Quality Report **Author: Jane Wilson**

Exception Report 5: VTE Risk Assessments

Commentary:

Performance with VTE risk assessment recording has been well below target in recent months. Problems with recording the assessments had occurred following the CRS upgrade in October however most of these issues have been resolved and it can be seen in this trend graph that the problem arose prior to the change. The majority of admissions to the Trust are via the AAU and Maternity and improvement in recording in both these areas would significantly improve the Trust overall performance. The timing of the fall in performance would suggest that changes in junior doctors could have had an impact on the assessment in AAU but this would not explain the fall in Maternity.

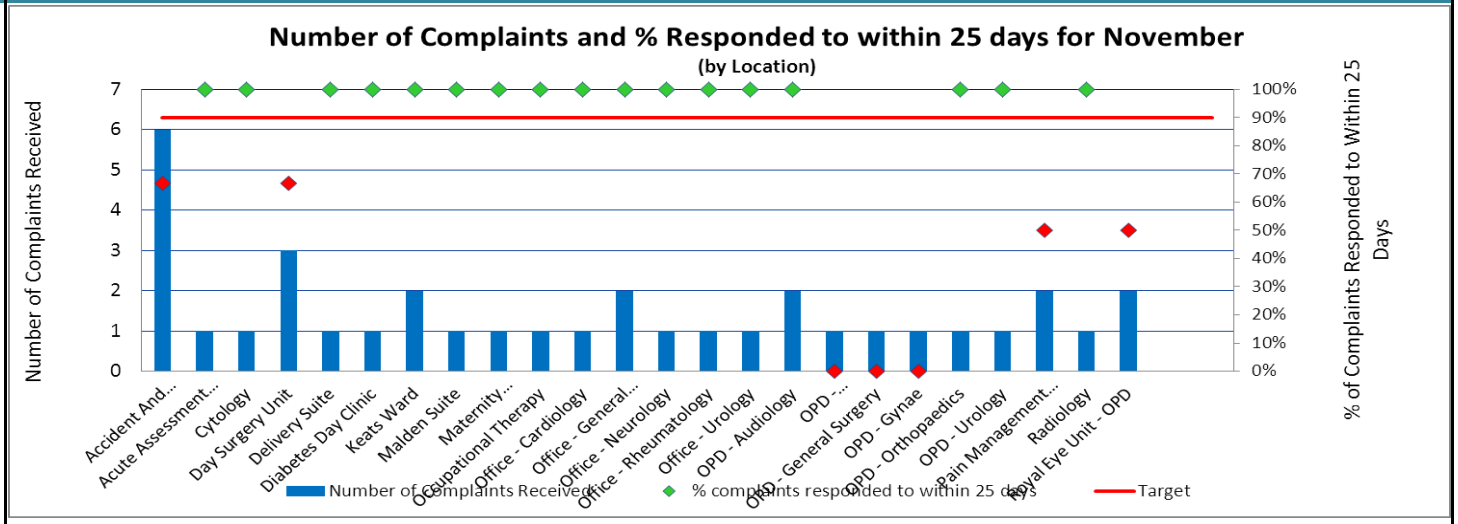


Actions	Person Responsible	Date	Committee monitoring delivery
1. All Clinical Directors made aware of the poor performance and asked to develop local actions for their areas.	Medical Director	01/01/2014	EMC
2. Clinical Directors in AAU and Maternity to develop specific plans to improve assessment recording in their areas.	Medical Director	01/03/2014	EMC

Clinical Quality Report
Exception Report 6: Complaints responded to within 25 working days

Commentary

There have been a number of service lines where complaints have been delayed. This has been as a result of a contribution of personnel issues including: Annual Leave, Vacancies, and staff movement between specialities. The complaints process in A&E, Day Surgery Unit, OPD, Gynae, Pain Management and the Royal Eye Unit has been reviewed and documented to ensure key staff changes do not impact on the timeliness of returns.



	Person Responsible	Date	Committee monitoring delivery
1. Clear back log of complaints - there are currently 10 in progress across the 2 service lines.	Service Manager REU and specialist outpatients	12/02/2014	Executive Management Committee
2. Implement robust administrative system for all areas in conjunction with the service line admin managers.	Service Line Managers REU and specialist outpatients	31/01/2014	Execitutive Management Committe

Clinical Quality Report

Author: Reinette Nell

Exception Report 7: Friends and Family Test Inpatient

The inpatient FFT response rate for December 2013 was 33%. From January 2014 onwards we are required to achieve a minimum of a 20% response rate.

Our overall inpatient FFT score for December was 61. National benchmarking of the November FFT score puts the KHT inpatient wards in the bottom quartile of Trusts nationally. However, 95% of our patients said they would be 'extremely likely' or 'likely' to recommend us. We were 139th out of 156 Trusts in November. Our score was 62. The national average was 74 and to be in the top quartile of Trusts nationally, requires a score of 80 or above.

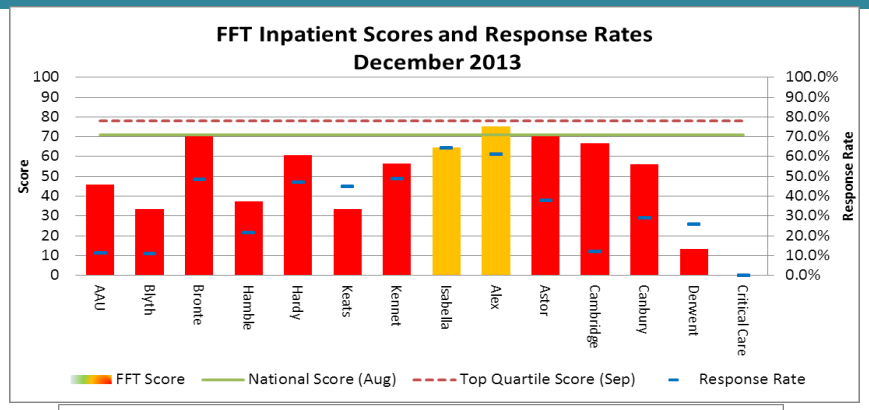
Response rates and scores of different wards remain variable. The main themes for positive feedback over December were around staff being welcoming, staff treating people as individuals, and people receiving good clinical care. The main areas that patients wanted us to improve were to do with waiting times, food, and perceptions about staff numbers. An analysis of information was undertaken over a 3 month period regarding what patients are asking us to improve and this also showed that perceptions of staff numbers, improving food, and waiting for a range of things on wards are consistent themes. A further analysis of themes by wards will be available at the end of January 2014. This will include further analysis of what is driving comments regarding waiting times on wards.

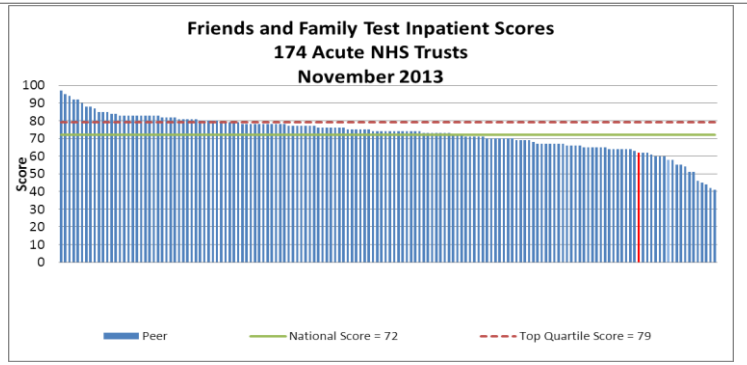
From the end of January 2014 staff will be able to view their Friends and Family Test results in DISCO and this will include information about scores, response rates, reasons for ratings and rankings when compared with other wards. This will improve access and analysis of the information. Ward rankings have been included in the team brief in November and December.

The purchase of ward level information screens has been approved by the EMC and these will be in place before 1st April 2014. This will improve information for patients/visitors/staff on a range of areas which include assurance on staffing levels, the FFT score and FFT ranking position with other wards.

Improvements to food are taking place at ward level and a review of the meals available is taking place. Availability of Ice cream at ward level has been approved by the EMC and roll out of freezers is progressing. A trial of thermal plate and bowl covers has been completed in December 2013 to improve the temperature of food, and these are now being ordered - this is from direct comments of patients, staff and volunteers. The dining companions project continues with additional support with focus to evening meals.

The inpatient experience action plan is due to be reviewed and refreshed in February 2014 by the Patient Experience Committee, and will consider the results of analysis arising from the FFT feedback and latest national inpatient scores which are due.





Actions	Person Responsible	Date	Committee monitoring delivery
1. Weekly review of FFT comments for wards	Matrons and Ward sisters	ongoing	Patient Experience Committee
2. Implement FFT reports in Disco system to enable tracking of scores, response rates, feedback themes and rankings compared to other wards	Business Intelligence Team	31/01/2014	Patient Experience Committee
3. Complete review and refresh of Inpatient Experience Action Plan to include emerging themes	Director of Nursing & Patient Experience	31/01/2014	Patient Experience Committee
4. Implement ward level electronic information screens with key patient & visitor information	Director of Nursing & Patient Experience	30/03/2014	Patient Experience Committee
5. Complete purchase and implement thermal plate covers	Estates Director	31/01/2014	Nutrition Steering Group
6. Complete review of inpatient meals	Director of Nursing & Patient Experience / Estates Director	31/06/2014	Patient Experience Committee
7. Complete ward level theme analysis	Patient Experience Manager	31/01/2014	Patient Experience Committee

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	Oct-13	C diff	1. All nursing & HCA's to have completed the above mentioned staff training and assessment package by 24.11.13.	DB	24/11/2013	
2	Oct-13	C diff	2. Develop a business case for an antibiotic APP.	DB	30/2/2014	
3	Nov-13	C diff	3. Develop an action plan in response to the peer review visit once the report is available.	DB	15/01/2014	
4	Nov-13	C diff	4. Implement Actimel for patients commencing antibiotics and audit the process.	DB	28/01/2014	
5	May-13	Ecoli	1. Reduce the use of indwelling urinary catheters & achieve CQUIN requirements	DB	15/12/2013	
6	Sep-13	Ecoli	A continence nurse is currently being recruited.	DB	15/11/2013	
7	Dec-13	Ecoli	1. Catheterisation policy is currently being re-written.	DB	31/01/2014	
8	Dec-13	Ecoli	2. Band 6 Nurse catheterisation skills training.	DB	30/04/2014	
9	Oct-13	Complaints	1. Introduction of a new administrative system within the division. This includes the following: 1. All draft responses returned to divisional PA by 15th day. 2. If response not received PA to chase 3. If response not received by 17th day Associate Director to chase and agree timescales for completion. 4. To escalate to Divisional Director any consultants statements still not received by 17th day.	ST	30/12/2013	
10	Oct-13	Complaints	2. Arrange complaints workshop, suppported by Claire Parker for investigating officers focusing on style and the addressing of each issue raised in the letter.	ST	30/12/2013	
11	Oct-13	Falls	1. Continue implementation of actions arising through Trust Falls Group	DB	Ongoing	
12	Oct-13	Falls	2. Complete review and ammendments to falls bundle documentation and requirements	DB	15/01/2014	
13	Oct-13	Falls	3. Complete deep dive review of Keats Ward	DB	31/12/2013	
14	Dec-13	Falls	2.Approve revised falls bundle on 28/01/14 and launch to staff during Feb 14	DB	28/02/2014	
15	Dec-13	Falls	3.Approve and launch falls leaflet	DB	28/02/2014	
16	Dec-13	Falls	4. Review benchmarking methodology for falls	DB	30/03/2014	
17	Dec-13	Falls	5. Review learning from visit to QEH	DB	28/01/2014	
18	Dec-13	Falls	6. Undertake falls alarm trial within bathrooms on Keats ward	DB	28/03/2014	
19	Nov-12	C Section	1. Weekly CS meeting & CTG meeting for reflection of practice and learning.	JW	Ongoing	
20	Nov-13	Inpatient FFT	2. Implement FFT reports in Disco system to enable tracking of scores, response rates, feedback themes and rankings compared to other wards.	DB	31/01/2014	
21	Nov-13	Inpatient FFT	3. Complete review and refresh of Inpatient Experience Action Plan to include emerging themes	DB	31/01/2014	
22	Nov-13	Inpatient FFT	4. Implement ward level electronic information screens with key patient & visitor information	DB	30/03/2014	
23	Nov-13	Inpatient FFT	5. Complete purchase and implement thermal plate covers	DB	31/01/2014	
24	Nov-13	Inpatient FFT	6. Complete ward level theme analysis	DB	31/01/2014	
25	Dec-13	Inpatient FFT	1. Weekly review of FFT comments for wards	DB	ongoing	
26	Dec-13	Inpatient FFT	6. Complete review of inpatient meals	DB	30/06/2014	
27	Oct-13	Maternity FFT	Increase response rate for TP1: Use of volunteers in the ante natal clinc to ensourage usage of the device. Set up a meeting with Laura Shalev-Green to identify volunteers to assist.	DB	31/12/2013	
28	Oct-13	Maternity FFT	Ensure all areas display response rate and feedback	DB	31/12/2013	
29	Oct-13	Maternity FFT	Agree an action plan based on feedback from women from each TP with achievable measurable objectives with support from Patient Experience Manager.	DB	31/12/2013	
30	Oct-13	Pressure Ulcers	1. Complete pressure area awareness training - Blyth Ward	DB	31/12/2013	
31	Oct-13	Pressure Ulcers	2. Complete serious Incident Investigation - Derwent Ward	DB	31/01/2014	
32	Oct-13	Pressure Ulcers	3. Complete Pressure Area Awareness Training - Keats Ward	DB	31/12/2013	
33	Oct-13	Pressure Ulcers	4. Complete Pressure Area Awareness Training - Derwent Ward	DB	31/01/2014	
34	Dec-13	Pressure Ulcers	1. Complete review of Astor Ward and Derwent Ward cases at Skin HIA group.	DB	17/02/2014	
35	Nov-13	MSSA	1. Medical staff to be reminded of the importance of documenting the date and time of cannula insertion in the medical notes.	DB	31/12/2013	
36	Nov-13	MSSA	2. Implement programme to introduce ANTT training and competency assessment for all clinical staff undertaking aseptic procedures.	DB	30/06/2014	
37	Nov-13	MSSA	3. Improve adherence to Trust policy on isolation, hand hygiene, peripheral line care and urinary catheter care on AAU.	DB	31/01/2014	
38	Nov-13	MSSA	4. Improve adherence to Trust policy on hand hygiene on Derwent Ward .	DB	31/01/2014	
39	Dec-13	MSSA	1. Medical staff to be reminded of the importance of documenting the date and time of inserting IV devices.	DB	31/01/2014	
40	Dec-13	MSSA	3. Complete intravenous catheter Quality Improvement Project	DB	30/10/2014	
41	Dec-13	MSSA	4. Training for A&E staff on the use of tunnelled lines in A+E	DB	31/03/2014	
42	Dec-13	VTE	1. All Clinical Directors made aware of the poor performance and asked to develop local actions for their areas.	JW	01/01/2014	
43	Dec-13	VTE	2. Clinical Directors in AAU and Maternity to develop specific plans to improve assessment recording in their areas.	JW	01/03/2014	
44	Dec-13	Complaints	1. Clear back log of complaints - there are currently 10 in progress across the 2 service lines.	ST	12/02/2014	
45	Dec-13	Complaints	2. Implement robust administrative system for all areas in conjunction with the service line admin managers.	ST	31/01/2014	

Clinical Quality Report - Change Log

Change Number	Date	KPI	Change	Request Owner	Action by
1	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 3 and 4)	10% reduction to 2012/13 target. Annual target for 2013/14 is now 6	DB	CO
2	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 2)	10% reduction to 2012/13 outturn. Monthly target for 2013/14 is now <=3	DB	CO
3	Apr-13	E.coli Bloodstream Infections (Hospital Acquired)	Amend target to be reduction on 2012/13 outturn (18) Monthly target <=1.5	DB	CO
4	Apr-13	% of Medication Incidents Where Moderate or Severe Harm Occurred	Amend target to be % of all medication incidents rather than number and set target <4% following Deep Dive into medication Incidents.	JW	CO
5	Apr-13	Patient Safety Thermometer - % Harm Free Care	Indicator added. Need to calculate target based on CQUIN	DB	CO
6	Apr-13	% Emergency Readmissions following elective admission - 30 days	Add indicator and base on local data	ST	CO
7	Apr-13	% Emergency Readmissions following all admissions - 30 days	Amended target to be top 25th percentile for Apr to Feb 2013/12 from CHKS and use CHKS data to compare	ST	CO
8	Apr-13	SHMI (In hospital Mortality)	Amended target to be based on Apr to Feb 13	JW	CO
9	Apr-13	Prevention of hospital acquired VTE - % patients risk assessed	Amend target for 2013/14 CQUIN green>95% amber between 95% and 90%	JW	CO
10	Apr-13	Hand Hygiene	Amended Score required for amber to 90%	DB	CO
11	Apr-13	Net Promoter Score	All indicators removed as replaced by FFT in February	DB	CO
12	Apr-13	Caesarean section rate	Target amended based on CHKS - SHA London Peer 75th Percentile	JW	CO
13	Apr-13	Caesarean section rate - primip	Indicator removed	JW	CO
14	Apr-13	% women with a primary postpartum haemorrhage of 2500ml or more	target based on HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	JW	CO
15	Apr-13	Significant Perineal Trauma	Previously % of 3rd and 4th degree tears. Target to be agreed.	JW	CO
16	Apr-13	Perinatal Mortality Rate per 1000 births	New Indicator to be reported quarterly. (previously reported still birth rate)	JW	CO
17	Apr-13	Number of Red Maternity Escalations	New Indicator	JW	CO
18	Apr-13	Spontaneous Vaginal Delivery Rate	Indicator removed	JW	CO
19	Apr-13	Breast Feeding Initiation Rate	Indicator removed	JW	CO
20	Apr-13	Number of post operative PE or DVT	Indicator removed	JW	CO
21	Apr-13	A&E - % of A&E Attendances for Cellulitis + DVT that end in Admission	Indicator removed	JW	CO
22	Apr-13	Number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer	Indicator removed	JW	CO
23	Jun-13	% women with a primary postpartum haemorrhage of 2500ml or more	Amended to 2000ml in line with sector scorecard	JW	CO
24	Jul-13	Friends and Family Score - Inpatient	Amended to include only Adults as submitted to DH	DB	CO
25	Jul-13	Friends and Family Score - Paediatric Inpatient	Include a new indicator to show Paediatric data previously included in inpatient score	DB	CO
26	Aug-13	Friends and Family Score - Inpatient & A&E	Rag rating included following publication of national data	DB	CO
27	Sep-13	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Amended 2012/13 Pressure Ulcer Figure from 14 to 16 following additional data from Alison Williams	DB	CO

Clinical Quality Report - Glossary

Strategic Objectives	
1	To Deliver Quality Patient Centred Healthcare Services with an Excellent Reputation
2	To Deliver Care by Competent and Caring Staff Working in Effective and Supportive Teams who Feel Valued by the Trust
3	To Work with Partners to Consolidate and Strengthen the Healthcare we Deliver Together to our Local Community
4	To Work with GPs and Other Providers to Support the Delivery of More Care in Primary and Community Settings
5	To Deliver Well Managed, Quality Services Which are Value for Money for the Tax Payer

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG Score
1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4)	Target set as further 10% reduction on 2012/13 Target. Target is to have =<6 cases in 2013/14	Year to date performance is red	Data Source: Ulysses	Green Red	Full year < = 6 Full year > 6
2	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Integrated Business Plan	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.06 >0.06
3	Number of patients with hospital acquired pressure ulcers (Grade 2)	Number of patients with hospital acquired pressure ulcers (Grade 2)	Target set as further reduction of 10% on 2012/13 Outturn	Year to date performance is red	Data Source: Ulysses	Green Red	Full year <= 36 Full year > 36
4	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 2) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Integrated Business Plan	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.5 > 0.5
5	Number of Patient Safety Incident Falls where moderate or severe harm occurred	Includes falls resulting in moderate harm to severe harm/death	Target is a reduction of 15% on last year's outturn	Exception reports to be produced when severe fall has been reported.	Data Source: Ulysses	Green Red	
6	Number of Patient Safety Incident Falls per 1000 G&A beddays		National Patient Safety Agency - national average in 2010 was 4.8 falls per 1000 bed days.		Data Source: Ulysses	Green Red	<=4.8 >4.8
7	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MRSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
8	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	Number of hospital acquired C diff bacteraemia (admission to positive test >72 hours)	Target set by Department of Health, Full year target is <= 15 cases. This has been profiled evenly over the year.	Year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	Full year < =15 Full year > 15
9	E.coli Bloodstream Infections (Hospital Acquired)	E.coli Bloodstream Infections (Hospital Acquired). Note HPA have not defined 'Hospital Acquired' so using post 72 hrs as with C diff	Target based on last year's outturn and set at <18 for full year, profiled evenly across the year.	Quarterly when year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	<=1.5 >1.5
10	Nutrition - compliance with MUST assessment	Compliance with the Malnutrition Universal Screening Tool (MUST); a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese		Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	>=85% >=70% and <85% <70%
11	Completed Patient Observations		Target is Locally set	Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	> =97% < 97% and > 94% < 94%
12	Medication Incidents	The number of incidents which actually caused harm or had the potential to cause harm involving an error in administrating, prescribing, preparing, dispensing or monitoring medication.	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
13	% Medication Incidents Where Moderate or Severe Harm Occurred	Numerator: Medication Incidents Where Moderate or Severe Harm Occurred Denominator: Total Number of Medication Incidents	Set following Deep Dive into medication Incidents:	Exception report required whenever red in month	Data Source: Ulysses		
14	Number of Serious Untoward Incidents	Total number of serious untoward incidents reported to the Risk Management Team	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
15	Number of Never Events	"Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.		Exception reports will not be produced for never events but instead the comment should reference the SI report.		Green Red	FALSE
16	% Harm Free Care	% of patients audited on Patient Safety Thermometer where no harm recorded.	tbc based on CQUIN	Year to date performance is red	Data Source: Patient Safety Thermometer		
17	SHMI	SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England). The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patients who died in hospital plus those who died within 30 days of discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model using patient age, gender, admission method, Charlson Comorbidity Index and diagnosis grouping.	Figure calculated is based on benchmark across hospitals	Exception report if above target	Data shown are from NHS Information Centre	Green Amber Red	< =95 >95 and < 105 >105
18	In-Hospital Summary Hospital-level Mortality Indicator 2013	SHMI calculated where observed deaths only include deaths in hospital.	National Peer Apr 12 to Jan 13	Exception Report if above target for month	Data Source: CHKS		
19	Unadjusted Mortality Rate	Number of Deaths / Number of discharges (excludes Well Babies)			SSRS Discharge Report		
20	Excess Deaths	The difference between expected Deaths and actual deaths at the Trust	Based on indictor itself		Data Source: CHKS		

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
21	% Emergency Readmissions following elective admission - 30 days						
22	% Emergency Readmissions following emergency admission - 30 days	The percentage of emergency admissions that were subsequently re-admitted to the Trust (via A&E) within 30 days of discharge					
23	% Emergency Readmissions following all admissions - 30 days		Thresholds are based on national upper quartile performance, CHKS analysis for Apr 2012 - Feb 2013.	An exception report will be generated on red performance at YTD.		Green Red	<= 5.8 > 5.8
24	Prevention of hospital acquired VTE - % patients risk assessed	Percentage of admitted patients receiving a VTE risk assessment.	Threshold from NHS Performance Framework 2013/14			Green Amber Red	>= 95% < 95% and > 90% < 90%
25	Hand Hygiene	Number of times hands were washed / number of observed opportunities hand should have been washed. Shown as a percentage.	Target is locally set.	Year to date performance is red	Data Source: Infection Control team - Monthly Audit	Green Amber Red	>= 95% >= 90% and < 95% < 90%
26	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur				Data Source: CHKS		
27	Open Incidents - % of Managers Reports Completed within 10 days				Data Source: KHT Datix/Ulysses		
28	Number of Complaints received this month	The number of complaints received during the reporting month	No target set		Data Source: Ulysses		
29	Number of Complaints reopened this month	The number of complaints that were re-opened during the reporting month	No Target set		Data Source: Ulysses		
30	Number of Complaints referred to ombudsman this month	Total number of complaints received that were referred to the Ombudsman	No Target set		Data Source: Ulysses		
31	% Complaints responded to within 25 working days	Percentage of the received complaints which were responded to within the 25 day deadline. Data are reported 1 month in arrears to allow 25 day deadline.	Target Locally Set	An exception report will be generated when monthly performance red.	Data Source: Ulysses	Green Amber Red	>=90% <90% and >80% <80%
32	Friends and Family Score - Trust	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.			Data Source: FFT - run by external company	tbc	tbc
33	Friends and Family Score - Inpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	Based on National Top Quartile score for Jun 13 data. Amber Is between average and Top Quartile Score		Data Source: FFT - run by external company	Green Amber Red	>=78 <78 and >72 <72
34	Friends and Family Score - Outpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.			Data Source: FFT - run by external company	tbc	tbc
35	Friends and Family Score - A&E	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	Based on National Top Quartile score for Jun 13 data. Amber Is between average and Top Quartile Score		Data Source: FFT - run by external company	Green Amber Red	>=68 <68 and >54 <54
36	Number of Mixed Sex Accommodation breaches	Number of breaches of mixed sex accommodation	NHS 2011/12 Operating Framework	An exception report will be generated for any mixed sex breach		Green Red	FALSE
37	Caesarean section rate	The percentage of deliveries performed as a C section Numerator: Number of C-section deliveries Denominator: Total number of deliveries	CHKS - SHA London Peer 75th Percentile	Exception report if latest 3 months are red	CRS	Green Amber Red	<= 26% 26% - 29% >= 29%
38	% women with a primary postpartum haemorrhage of 2500ml or more	Numerator: The number of women with a primary post partum haemorrhage of 2500ml or more Denominator: The total number of deliveries	HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	Exception report if latest 3 months are red	CRS	Green Red	< =1% > 1.5%
39	Significant Perineal Trauma	The percentage of women with 3rd or 4th degree tears				tbc	
40	Perinatal Mortality Rate per 1000 births	The rate per 1000 births Numerator: The number of stillbirths + neonatal deaths Denominator: Total number of births	Last Year's Performance = 3.7 2011 National Data = 7.5	When Quarterly performance is red	CRS		
41	Number of Red Maternity Escalations						