Sandwell and West Birmingham Hospitals NHS Trust

Board Level Metrics & IQPR Exceptions

INTEGRATED PERFORMANCE REPORTING – OCTOBER 2021

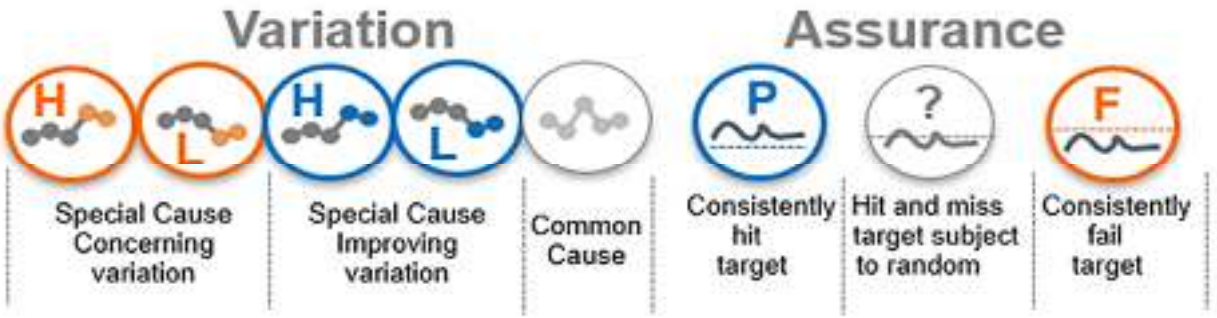
Contents

Item	Slide
Board Level Metrics Development Update	3
Performance Summary Matrix	4
Board level Metrics Exceptions	5
Well Led	6
Patients	7 – 15
Safe	7 – 10
Caring	11
Responsive	12-13
Effective	14
Use of Resources	15
People	16
Appendix	17
How to interpret SPC charts	17

Board Level Metrics Development Update

Domain	Finalised	In Development	To Amend	No Target Set
Safe Medical Director	HSMR , SHMI, C-diff E-coli, Patient safety incidents, NRLS Patient Safety Incidents Moderate Harm & Above, Serious incidents, Safe Staffing (doctors)	**Safe Staffing.** Will need additional graphs to show bank/agency fill rates for doctors, nurses and HCAs. Safe Staffing (Nurses, HCA)	**MRSA Bacteraemia.** This event is too rare (2 in 2 years) to be meaningfully displayed in an SPC chart as a count. This measure should be removed and reported as an exception. ***MRSA screening is suggested as an alternative.*** **NRLS Patient Safety incidents Moderate Harm & Above.** Progress is being made to amend the data for this to incident date rather than date reported to STEIS. The Governance team are working towards completing by December 2021 to report data up to November 2021.	Patient safety incidents, NRLS Patient Safety Incidents Moderate Harm & Above.
Caring Chief Nurse	Friends & Family Test (FFT) Recommended% and Responded%	Perfect Ward. This is still being rolled out across the organisation, and in the process of gaining access to the source data from Perfect Ward. We have requested support from Informatics in loading this data : IR44269		Perfect Ward
Responsive Chief Operating Officer	ED – 4 hour target, ED Attendances. Cancer 62 Day. RTT 92% target, Urgent Community Response.		ED Attendances – we wish to amend the target down.	Urgent Community Response
Effective Chief Operating Officer	Readmissions within 30 Days Rate per 1000 Bed Days, SDEC	PREMS / PROMS being investigated with Clinical Effectiveness. We only have 1 current PREM and will be working on how this can be displayed.	**PREMs.** What is the plan to record this, as others being explored. **Place of death recorded** was suggested as an additional indicator from Clinical Effectiveness - the percentage of patients dying in hospital with a preferred place of death recorded against those dying in hospital.	PREMs
Well-Led Chief People Officer & Director of Governance	Days lost to sickness, Turnover monthly, Risk Mitigation, Pulse Survey		**Pulse Survey.** We are investigating the inclusion of the national survey with the communication team to see if we can provide a time series analysis	Risk Mitigations
Use of Resources Chief Finance Officer	Better Practice Performance Compliance			

Board Level Metrics



The matrix below shows how each metric is performing:

- If there is special or common cause
- Pass, fail or hit and miss its target
- No target set

		Assurance			
		Pass	**Hit & Miss**	**Fail**	**No target**
Variation	**Special Cause: Improvement**		MRSA bacteraemia, Emergency Readmissions,		Urgent Community Response
	Common Cause		C-difficile, E-coli, Serious incidents,	HSMR, SHMI, FFT % Recommend, SDEC, Turnover (monthly)	NRLS Patient Safety Incidents Moderate Harm & Above, Doctor – Safe Staffing
	Special Cause : Concern	ED Attendances	62 Day Cancer, Days lost to sickness absences,	RTT Incomplete Pathways, FFT % Response, ED 4 hour	Patient safety incidents, Risk mitigations

IQPR / Board Level Metric Exceptions

Many indicators have started showing recovery during September but with some notable exceptions.

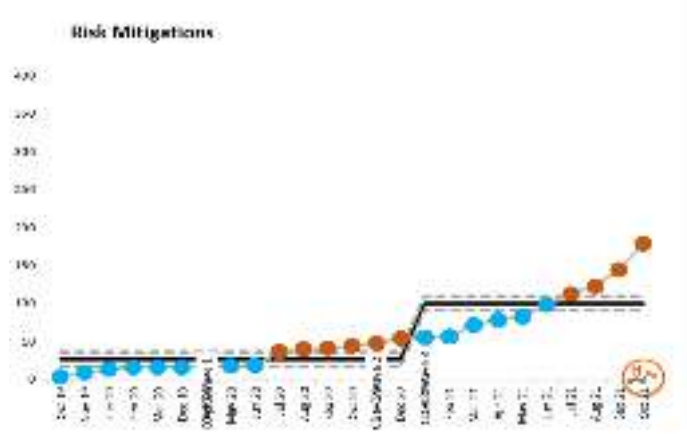
- **Mixed Sex Accommodation** was due to recommence national reporting in June. However, the Trust has not yet reported. Initial plans to report the September data by October 21 did not deliver. The COO is looking into alternative methods of data collection.
- **Friends and Family Indicators** have been systemically poor in % responded and % recommendation.
- **HSMR & SHMI** – Our Clinical Effectiveness team have reported that the national reporting system is late and these indicators will not be available now until 19th November 2021. This is now reporting 4 months behind.
- **Finance –** the Performance Against Better Value Quality Care Plan shows an under delivery of ~£500,000 per month for the last 3 months. With the H2 planning in place the committee may wish to reconsider the initial target, albeit the challenge maybe about achieving run rate by 01/04/2022.
- **Still births (per 1000 babies) –** this was 5 babies in October with a rate 11.1 which is 5 points overs the 12 month average

Well-Led

Executive Lead: Chief People Officer & Director of Governance

Commentary

The chart demonstrates the count of overdue risk actions growing beyond control limits consistently over time. This makes it difficult to plot on an SPC chart.

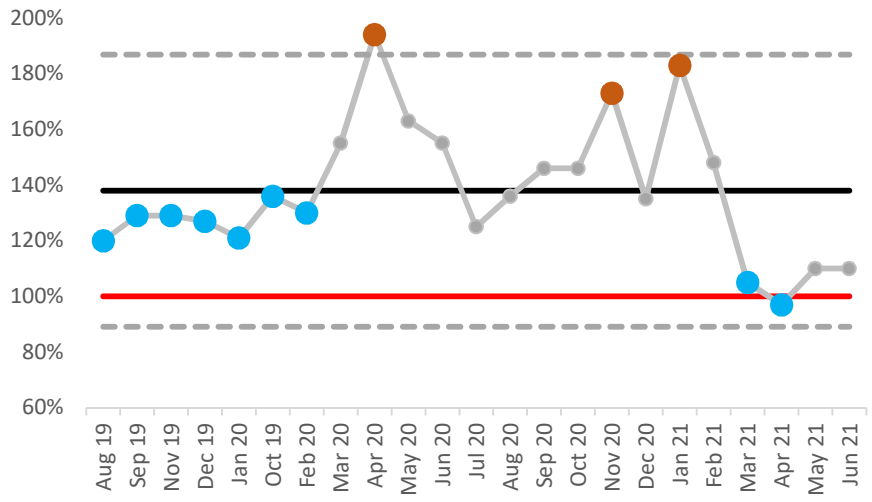


Cause of variation?	What actions have been completed?	What next?	When will it improve?
Risk Mitigations Likely to be changes in personnel, non review of risks and lack of monitoring	**Risk Mitigations** Discussed monthly at Risk Management Committee in addition to regular reports to teams on the overdue risks and actions to target each month. The risk team are supporting areas to address the overdue risk actions and due to the timing of pulling the information does not reflect some of the work that is known to have been done.	**Risk Mitigations** Continue to support staff to review all open actions and look at providing more targeted information to individuals and Groups/Directorates.	**Risk Mitigations** By the end of this Financial year these will have been resolved and better monitoring in place corporately and by teams.

Safe

Executive Lead: Medical Director

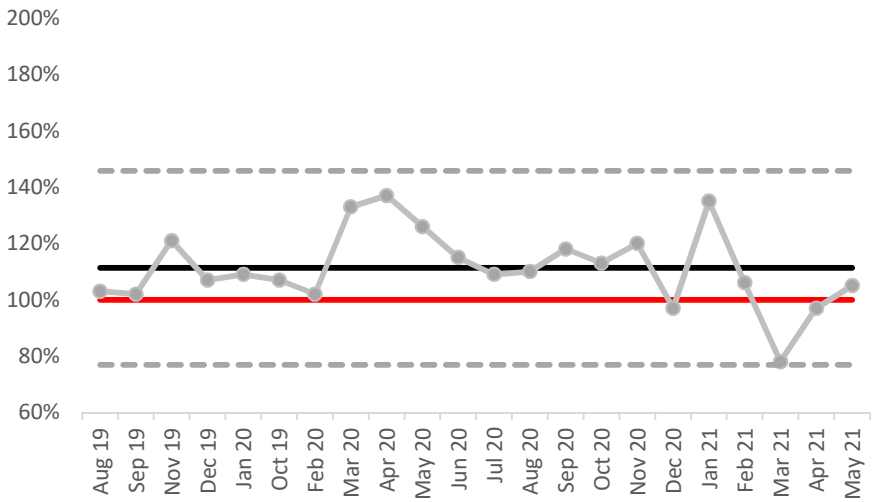
Hospital Standardised Mortality Rate (HSMR) - Overall (monthly)



Commentary

SWB consistently fails HSMR national mean. Prior to COVID, HSMR was elevated above national mean, and has increased demonstrably as shown by special cause variation aligned to COVID peaks. **National systems are late in producing more up to date analysis this has further been delayed until 19/11/2021.**

Summary Hospital-level Mortality Index (SHMI) (monthly)



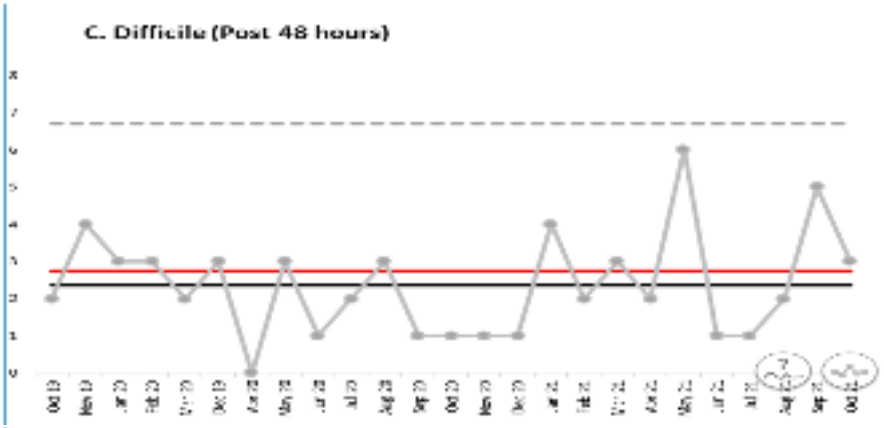
Commentary

SWB over the SHMI national mean most of the time. Common cause variation is seen throughout the period indicating a predictable process. **National systems are late in producing more up to date analysis this has further been delayed until 19/11/2021.** We are ranked 108th out of 123 Trusts as of April '21 using 12 month cumulative performance the monthly performance for May 21 would place us 88th.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Documentation of comorbidities, correct prefix use for diagnosis description, avoidance of R codes and clarification of process for FCE are general factors. Palliative care coding affects HSMR more than SHMI. Number of admitted patient occurrences also influences expected mortality levels, so change in pathways to ambulatory care, covid or diagnosis definitions after 2nd FCE all impact HSMR/SHMI	Information on good documentation, a focus on R codes and prefixes and depth of coding have all been provided to clinical teams. Understanding impact of Same Day Emergency Care (SDEC) and exploration of palliative care codes also needed. QI group has been setup, and a digital fellow has started as a point of reference for clinicians use of Unity, providing support on good documentation standards in Unity.	Review process for recording FCE with current team based approach to patient care, at the elbow support for clinical teams to improve documentation elements, review of deceased care records between M+M leads and coding team. Admin support to identify where FCE can be altered and palliative care recording addressed. SOP approval by executive for M+M meetings with coding team.	Wary of effect that increase in SDEC in MMUH will have on mortality data with reduction in episodes of admitted care, but over next 12 months need to establish process and working practice for the elements outlined earlier. 12 month cumulative indices will improve after covid peaks are greater than 12 months ago . Effect of covid deaths on HSMR/SHMI understood and actions will mitigate any repeat- wave of covid

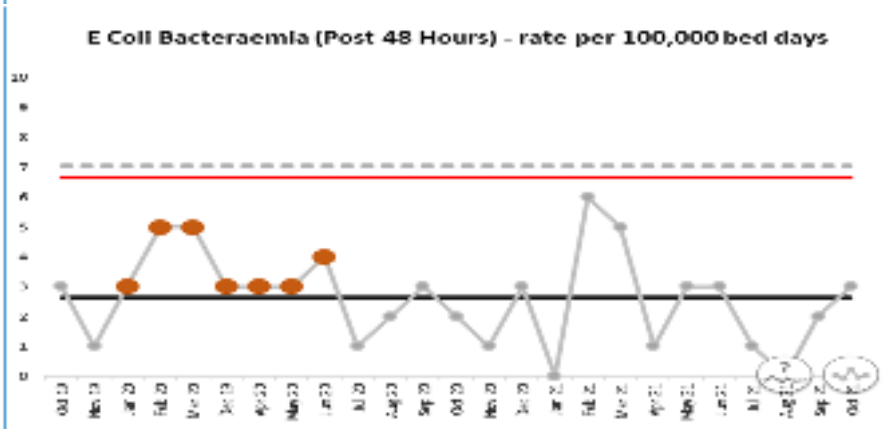
Safe

Executive Lead: Medical Director/Chief Nurse



Commentary

Common cause variation is broadly observed, excluding May 21. This is a largely a predictable process.
SWB was ranked 26rd out of 139 Trusts in August.



Commentary

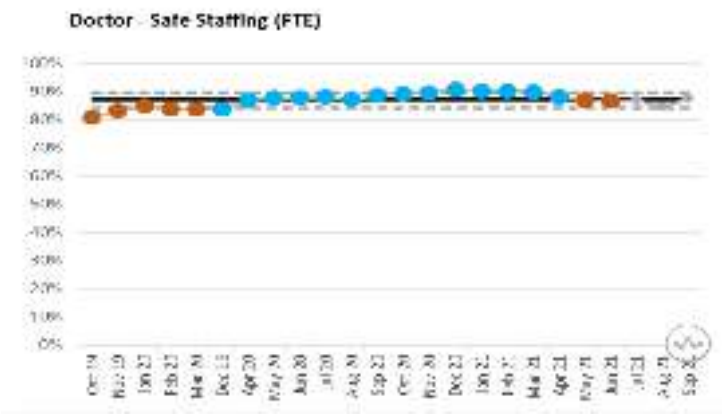
Special cause variation of concern can be seen in the first half of 2020. Performance has been otherwise stable. *SWB is ranked 17th out of 139 Trusts in August.*

MRSA– Bacteraemia

Cause of variation?	What actions have been completed?	What next?	When will it improve?
C-Diff Variation in May was due to antibiotic usage which was identified following Post Infection Review (PIR) process. **E-coli** No variation of concern within past 12 months.	**C-Diff** PIR reviews completed and antimicrobial prescribing was appropriate and in line with formulary **E-coli** Each E-coli case has a Post Infection Review (PIR) completed with no themes or trends identified. No hot spot areas identified.	**C-Diff** Internal target set at 41 cases 2021/22 – below target to date. **E-coli** UTI project under way to review management of UTI this impacts on Blood Stream Infections (BSI), Improvement project around hydration to reduce UTIs and also management of catheters is on-going. Management through the Infection Control Committee.	**C-Diff** Robust processes in place with additional work being undertaken to strengthen antimicrobial prescribing and stop dates **E-coli** Current processes to continue with active surveillance and review of cases and learning disseminated to monitor improvement

Safe

Executive Lead: Medical Director/Chief Nurse



Commentary

This shows common cause variation. We need a Target for this.

Nursing – Safe Staffing

Commentary

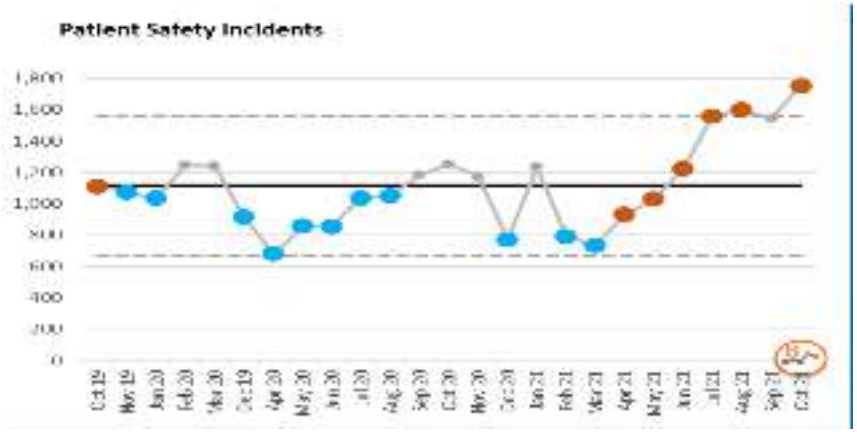
HCA – Safe Staffing

Commentary

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Doctors – Safe Staffing This is caused by our recruitment cycles and hard to fill vacancies.	**Doctors – Safe Staffing** SPC has been built to facilitate our understanding of our current position **Nurses , HCA – Safe Staffing** SPC chart has been generated, Paper to be taken to Quality and Safety Committee and then to Trust Board on a regular basis thereafter.	**Doctors – Safe Staffing** The data reflects substantive and locum posts that are filled for consultant, SAS and trainee posts. Understanding of post fill rates by each category of staff and then by specialty will help identify services under pressure and can be cross referenced with other performance related metrics. It may also help support focus for any work with the iCS and acute care collaboration. **Nurses, HCA – Safe Staffing** An agreed update to Board from January 2022. New staff guidance needs to be reviewed before metric is finalised.	**Doctors – Safe Staffing** To be set after we have identified which category of staff and specialties.

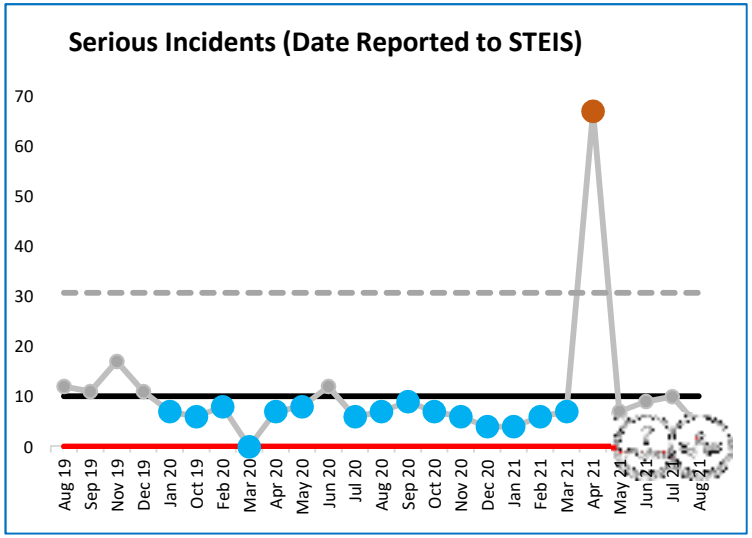
Safe

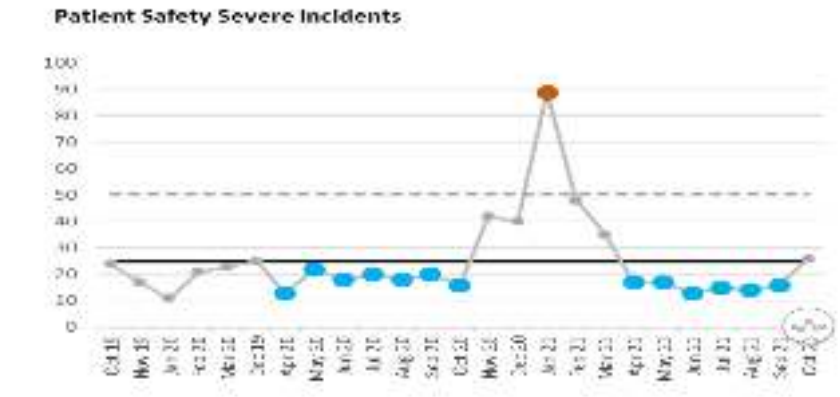
Executive Lead: Medical Director



Commentary

The chart is now showing special cause for concern and needs further investigation.





Commentary

A peak can be observed during Winter 2020-21 with an astronomical data point in Jan '21. This peak lifts the mean and obscures what appears to be common cause variation prior and following this period.

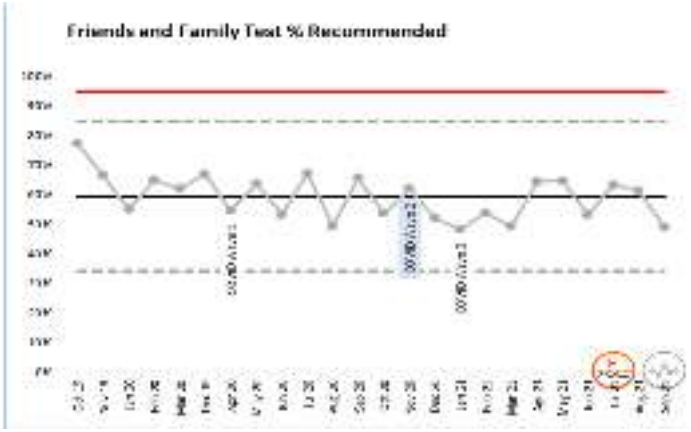
Commentary

The chart shows when serious incidents were reported, rather than the incident date. This explains why there is an astronomical data point in April '21 related to change in STEIS reporting requirements related to COVID (see below), and an appearance of improvement during Oct '20 to March '21. In addition this gives the appearance that the target was met in March '20 which is unlikely. Special cause variation of concern can also be seen in Nov 19. It is recommended that this measure is amended to incident date rather than date reported to STEIS and reviewed for quality of data process. This is with Governance who are reviewing all of the data, before re-publishing hopefully in December.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Patient safety incidents Increase in reporting is an indicator of a good reporting culture. Challenges in ED in admitting patients and seeing them in the outlined timeframes has generated a significant number of incidents. **Moderate and above harm** In November 2020, Trusts were asked to report Hospital Acquired COVID 19 infections and deaths. These are what has caused the rise in moderate harm and above incidents. **Serious incidents** The April rise relates to the Hospital Acquired Covid cases being reported nationally as this is when the information was provided.	**Patient safety incidents** Groups and Directorates are aware of some of the challenges which have seen a rise in incidents and have plans in place. Tissue viability team has been working with specific wards to improve pressure ulcers.. **Moderate and above harm** No specific actions have been carried out. We have moderate harm review process. An action plan for falls has been put in place and we are now below the national average. **Serious incidents** All cases are reported on an ongoing basis moving forward. Action plan identified for Blood transfusion	**Patient safety incidents** Continue to encourage reporting, more importantly encourage robust feedback on incidents raised. **Moderate and above harm** Review of the process for assigning harm level and presentation of the incident. **Serious incidents** Provide training to improve number of people able to investigate Sis to improve timeliness of investigations.	**Patient safety incidents** Increasing numbers of incidents is not necessarily a negative. Groups and Directorates need to be aware of their trends and address where possible. **Moderate and above harm** Aiming for quarter 3, 2021/22 **Serious incidents** Looking to provide a training session in October 2021.

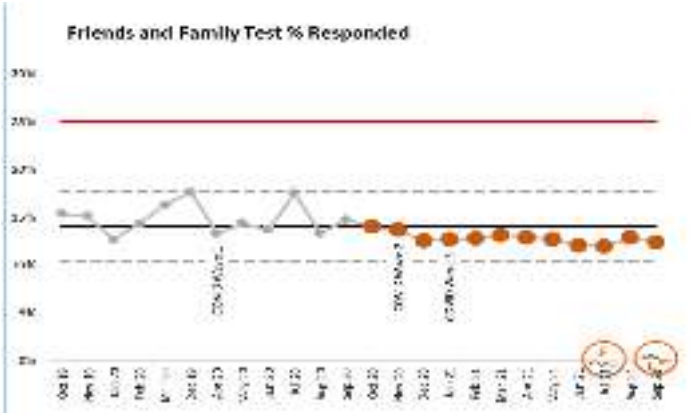
Caring

Executive Lead: Chief Nurse



Commentary

SWB is consistently failing the 95% friends and family test score. Common cause variation can be seen throughout indicating a predictable performance. *SWB ranked 131st out of 137 Trusts for the Inpatient score in Sept 21.*



Commentary

Special cause variation (improvement) can be seen in March and Jul '20. However, since September '20 special cause variation indicating a decline in performance can be seen.

Perfect Ward

Commentary

P&I are trying to gain access to Perfect Ward data. However, there are significant organisational technical barriers from Perfect Ward. It is unlikely we can get this data for several months.

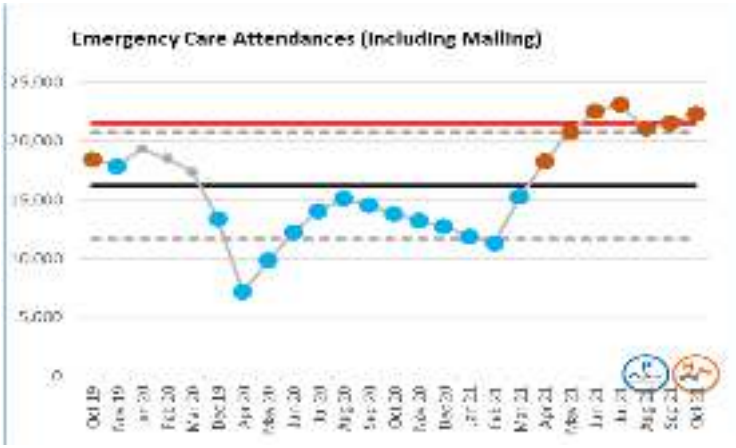
Cause of variation?	What actions have been completed?	What next?	When will it improve?
FFT Recommended & Responded During the pandemic FFT was paused nationally before recommencing January 2021. The Trust lacks a wider patient experience / involvement strategy and framework which FFT would be a part of, hence performance has remained stagnant.	**FFT Recommended & Responded** The Head of Patients involvement and Insights has now been recruited too and commences in post in January 2022 FFT has also been discussed with ward managers and matrons to promote feedback via this route	**FFT Recommended & Responded** Once the lead post holder commences in post the Trust will complete a benchmarking exercise against the NHSE/I improving patient experience standards, and agree the associated action plan to address the identified gaps. A Trust strategy for patient experience and involvement needs to be developed to support taking this important agenda forward. The FFT process needs to be reviewed and reinvigorated as part of this wider work.	**FFT Recommended & Responder** Given the level of the lead post, there will be approximately a 3 month lead in time from interview to commencing in post. It is unlikely that the post holder will commence before January 2022. Considering the work required surrounding this agenda, and the systems and processes that need to be developed, it is envisaged that improvements will be seen over a 12-24month period.

Responsive

Executive Lead: Chief Operating Officer

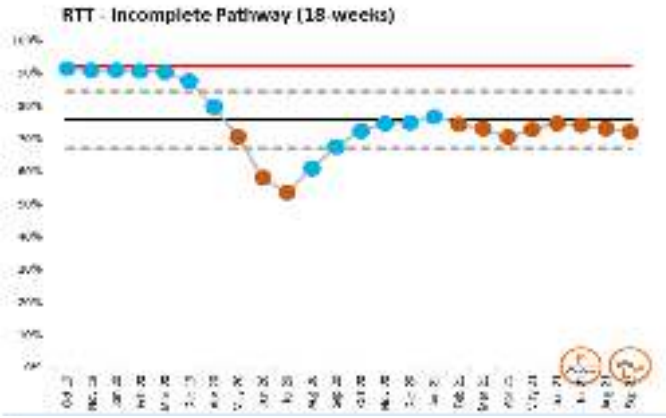
Commentary

The blue special cause variation observed from Dec '19 to May '20 shows a upward trend, followed by a downward trend. This correlates with seasonal variation and attendance figures. *SWB was ranked 68rd out of 133 Trusts in Oct 21.*



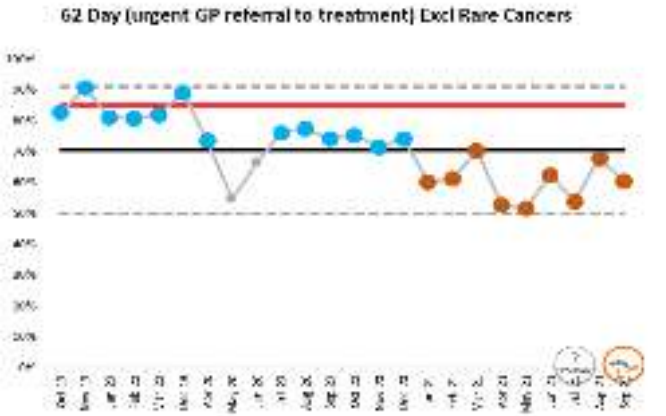
Commentary

SWB took on Sandwell UCC in Apr 21 and so new levels of activity is around 21,000 pcm. Looking at SWB we are 22nd out of 147 trust in terms of volume of A&E attendances in Oct 21.



Commentary

Special cause variation (6 points above mean) can be seen from March to September '20. However, the astronomical data point in Jun '21 pulls down the mean in an otherwise stable process. *SWB was ranked 84th out of 171 Trusts in Sept 21.*



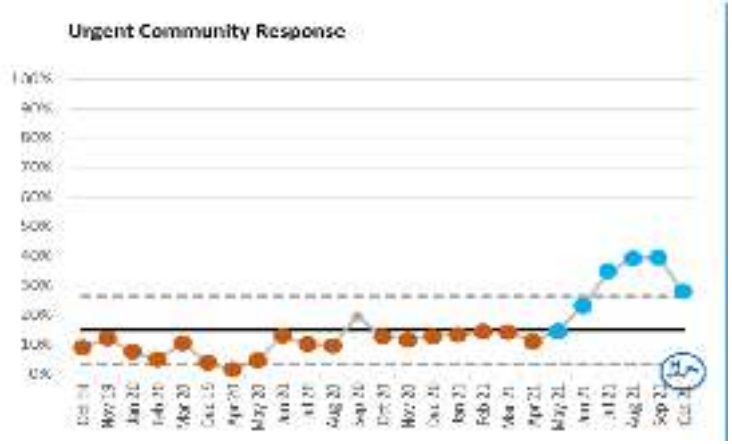
Commentary

Special cause concern and improvement can be seen. The vast change in performance obscures reliable control limits even when re baselined as shown. *SWB was ranked 104th out of 135 in Sept 21.*

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Emergency Care – We have continued to hold our ED performance despite sustained pressure at the front door evidenced by the increased attendances. **62 Day Cancer –** We are still clearing our backlogs following Covid but our 104 and 62 day backlogs are still reducing, which will be linked to improved performance in months to come **RTT –** Recovery from Covid is slow as clinical prioritisation has an impact.	**Emergency Care –** We are now tracking Covid attendances with the aim of re-setting the EDs into 2 from 4, which will have positive impact on staffing and flow. We have located larger footprints for our SDEC areas and increased staffing under the winter plan **62 Day Cancer –** as we are working through backlog this adversely affecting our in month performance. All tumour sites have had individual reviews of any complex problems or issues preventing recovery **RTT –** prioritising P2 breach patients which can negatively impact on performance, we have almost eliminated our 104 week patients.	**Emergency Care-** return to the ED footprint of 2 ED's, operationalise new SDEC areas **62 Day Cancer –** continue clearance, Work with BCPS to clear histology backlog. Implement PACU to support Gynaecology Oncology. **RTT –** deep dives into main contributing specialities with COO have been arranged. Actions will be agreed to mitigate.	**Emergency Care –** recovery trajectory showing incremental improvements with 90% delivery by March 2022 **62 Day Cancer –** aiming to recover the 62 day position by December 2021 **RTT –** aiming to be back compliant by Aug 2022

Responsive

Executive Lead: Chief Operating Officer



Commentary

This is a new national indicator, it is due to nationally start reporting in April 2022.

Commentary

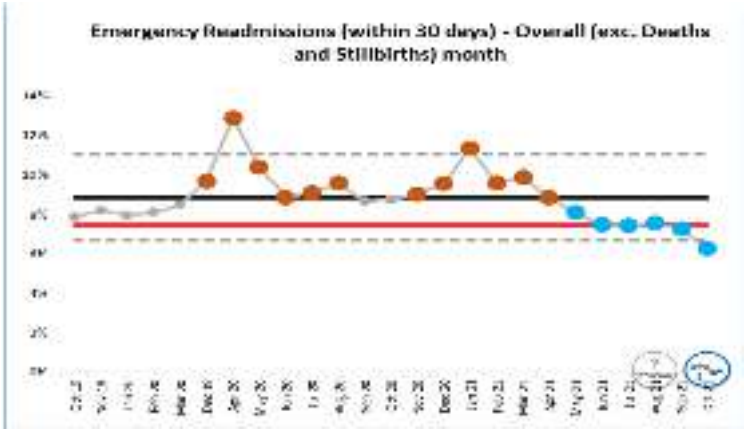
Commentary

Commentary

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Urgent Community Care – This is a new metric which is part of the NHS Long term plan and is due to commence on the 1st April 2022, we have just started to measure this to get a baseline position.	**Urgent Community Care –** Identification of which patients this covers service covers. Services are starting to be rebuilt in SystmOne to better align and hence allow a correct measure of the response time	**Urgent Community Care –** We are investing from the winter plan into the UCR Team. As more of our Community Services are modified to align to this metric we will see a steady increase in the performance	**Urgent Community Care –** When we have completed the data capture and services we will be aiming to have above 80% response rate by April 2022

Effective

Executive Lead: Chief Operating Officer

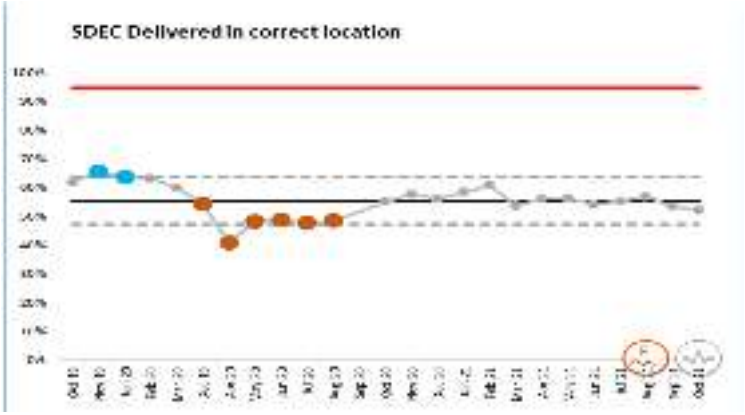


Commentary

Pre COVID performance appears as special cause improvement relative to drop in performance thereafter. Common cause variation is mostly observed excluding astronomical data points correlating with COVID peaks.

PROMS

Commentary



Commentary

This measures the count of patients in medical and surgical ambulatory units (numerator) over the total count of patients eligible for SDEC based on the 55 national pathways within opening hours. Suggested target is 92%. Improvement may not increase prior to MMUH.

Commentary

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Readmissions – We have seen an improvement since the reduction in Covid patients from the organisation. Work will continue with 48 hour post dx contact and community wrap around to support this further. **SDEC –** need greater geographical locations at both sites. As ED attendances increased Need more pathways being implement by screening navigators and increased clinical cover.	**Readmissions –** continue work on data analysis of re-admissions , whilst continuing with enhanced D2A service, demonstrating reduction in re-admissions. **SDEC –** scoped a better geographical location for SDEC and worked through logistics and timeframe for completion Scoped ED front door navigator role for streaming. Agreed target of 95%).	**Readmissions –**Review top 10 specialities or conditions and understand why we are seeing re-admissions in those areas **SDEC –** Empowerment of navigators to implement pathway changes. Increase clinical cover of the SDEC area and move to new location at both sites.	**Readmissions –** it is now better than the national median within model hospital. **SDEC –** February 2022 when pathways are being utilised fully.

Use of Resources

Executive Lead: Chief Finance Officer

Commentary

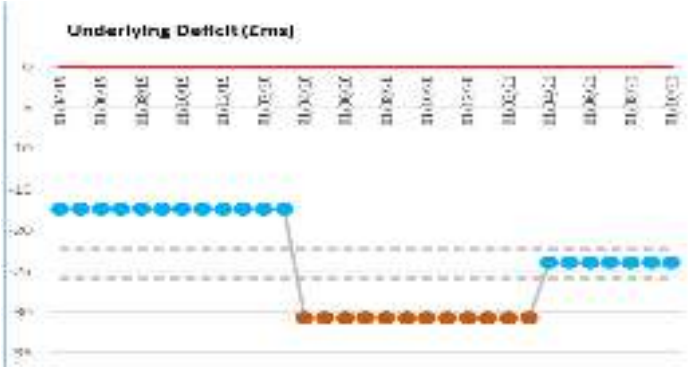
Special cause concern following be special cause improvement can be observed during the period. The organisation has consistently failed this target, however performance is improving and is now just below the target between 90% and 94%.

Commentary

Finance noted that SPC was not an appropriate format to monitor this measure, but have provided an example to illustrate.

Commentary

Finance noted that SPC was not an appropriate format to monitor this measure, but have provided an alternative chart showing in month and cumulative performance



Commentary

Finance noted that SPC was not an appropriate format to monitor this measure as it is reported annually, but have provided an example to illustrate.

BPPC

SPC works well for this measure
The Trust has implemented a number of key actions to deliver the 95% target for both value and volume . The actions include:

- Increasing the number of BACS processing runs each week
- Working with the Pharmacy team on AI invoice processing to improve performance
- Planned Trust wide communications to encourage timely receipting and dispute resolution
- Implementing a Supplier Portal enabling Suppliers to upload invoices directly and allow them to see and assist in progress on invoice approval and payment
- Working with Oracle to identify Invoice hold information in specific circumstances which allows us to exclude the invoice from our performance measure
- Revised method of calculation based on Invoice Receipt Date (replacing Invoice Date) to measure payment performance

BVQC

The SPC chart for BVQC shows the monthly performance against the SWB stretching, £13.2m CIP plan for 2021/22. This target is more than double the nationally driven target reflecting the cost pressures/developments the Trust supported during the planning process
The current key factors are:

- CIP performance YTD of £4.0m, against a Plan of £7.7m
- The forecast CIP performance is £8.3m
- The recurrent CIP delivery as we go into 22/23 is approx. £9m, resulting in an adverse position of £4.2m against the £13.2m target. (noting the position is better than the national requirement)
- As part of the 22/23 planning process there will be a recommendation on the treatment of this shortfall – options include, carrying this forward into 22/23; writing it off from reserves, writing it off by increasing the underlying deficit.
- Quality improvement and enhanced clinical & patient outcomes will be the key driver of next years programme with financial efficiencies an output of this work.
- BVQC will focus om 14 workstreams - details are provided into detailed BVQC paper

Income & Expenditure

· The I&E position isn't really suitable for a SPC chart.
The chart above is recommended chart type

- The blue bars are the monthly plan with the green line being the cumulative plan
- The orange bar is the actual performance with the purple line being the cumulative position

The key points to note are:

- At the end of H1 we reported a small fav variance against plan of £20k
- H2 plan is due for submission on 26 November and will report a breakeven plan.
- There are risks and mitigations to deliver this plan which are described in the more detailed d finance paper
- M7 (to 31 Oct) was a breakeven position in month, maintaining the cumulative position of a £20k favourable variance

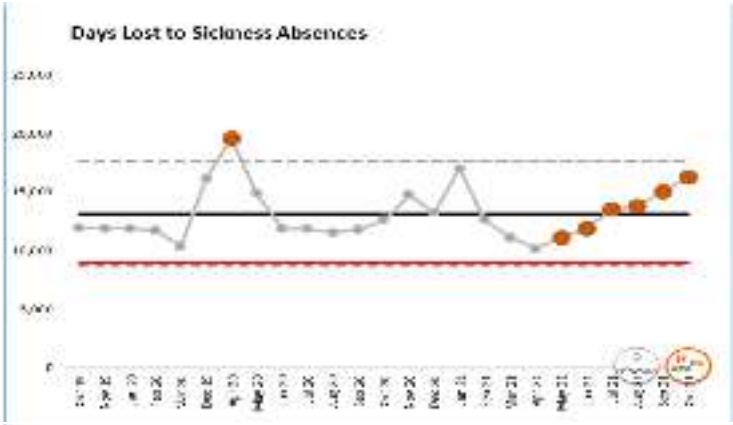
Underlying Deficit

Subjective, strategic measurement not updated any more frequently due to complex work required and impact of strategic external factors, therefore not suitable for SPC. That said,

- The Trust has reported a £24m underlying deficit to CLE, FIC, Trust Board and the ICS, which is an improvement from the £30m deficit previously reported
- Work ongoing at system level to determine underlying system deficit position, of which SWBH would have a share (basis to be determined) – expected to be completed by end 2021
- The Trust is also currently going through the 22/23 planning process with a draft position required by the end of December 2021.
- It is recommended as part of the 22/23 process the underlying position is reviewed and formally reported during the February reporting cycle.

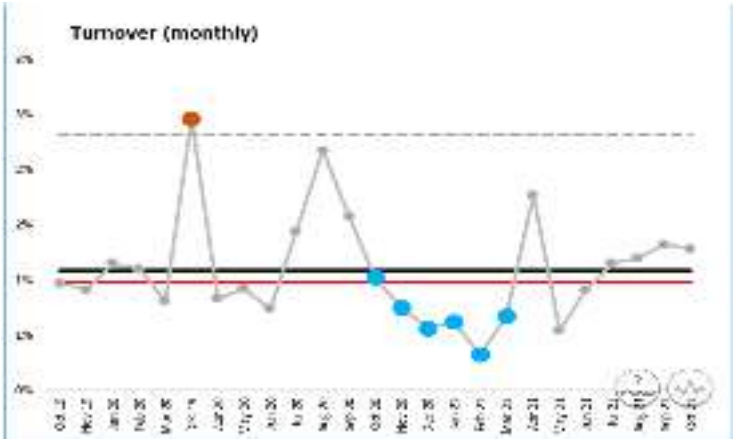
People

Executive Lead: Chief People Officer & Director of Governance



Commentary

Post COVID common cause variation is mostly observed apart from two astronomical data points associated with COVID peaks. On average days lost has increased by 1250 days per month since COVID.
The sickness absence rate was 159th out of 215 Trusts in Jun 21..



Commentary

Special cause signalling improvement can be seen from October '20 to March '21. Since April 21 we have common cause variation.

Q2 21/22 People Pulse Staff Engagement Score

Sub-scale	Score out of 10
Motivation	6.52
Ability to Contribute to Improvements	6.31
Recommendation of the Organisation	6.51
Overall	**6.45**

	Highest	Lowest
Directorate	People & OD 7.43	Maternity & Perinatal 5.26
Staff Group	Healthcare Scientists 7.27	Estates & Ancillary 5.84

Commentary

Overall Staff Engagement is measured as an average across three subscales, consisting of 3 questions each.

1,549 responses were received.

Cause of variation?

Sickness
We have experienced increases in sickness absence due to Covid sickness and also stress and anxiety

Turnover
Increase in rates related to TUPE transfers, end of fixed term training contracts of doctors on training and students who were recruited as additional capacity during Covid19.

What actions have been completed?

Sickness
Corporate focus on health and wellbeing; Well-being hubs; Group focus on Restoration and Recovery;
Turnover
Revised PDR process for this year; Stay conversations guidance issued; Launched new exit survey process and exit interview guidance; POD Heat map and Retention Investigation Tool developed to identify hot spot areas.
Staff Engagement
New Pulse quarterly survey shows a decline in all questions from the 2020 staff survey. This has been shared with all group and corporate leads.

What next?

Sickness
Maintain focus on Heath and well Being; Groups to ensure trigger meetings take place; Staff engagement work in relation to priority areas identified from staff survey results. Training for managers to be reviewed and implemented to support staff suffering from stress and anxiety. When overseas recruitment benefits are felt within establishments, this should have impact on absence rates also
Turnover
Revised Recruitment & On-boarding process ; Nurse retention focus groups ; Support for retaining colleagues in later career ; Revised strategy for Flexible working ; High Impact action plan for Equality , Diversity and Inclusion to be developed in conjunction with ICS
Staff Engagement
HR business partners are looking for any variation in professional groups and directorates.. Quarterly listening events in November.

When will it improve?

Sickness
Revised sickness trajectory forecast sickness rate set at 4.51%

Turnover
When excluding Tupe transfers, doctors in training , end of fixed term contracts the turnover rate is 9.57%

Staff Engagement

Board Level Metrics: How to Interpret SPC Charts

An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation **(common cause)** in performance and unusual patterns **(special cause)** in data which are unlikely to have occurred due to chance and require investigation. They can also **provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target** without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

- Trend: 6 or more consecutive points trending upwards or downwards
- Shift: 7 or more consecutive points above or below the mean
- Outside control limits: One or more data points are beyond the upper or lower control limits

Orange indicates a decline in performance; Blue indicates an improvement in performance.

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.