Patient Safety Webinar Quarter 2 2022/23

17 November 2022
Zoom 88690822612 pass 12345

17 November 2022 Patient Safety Webinar 13.00 – 14.30hrs

Welcome. Thank you for joining us today.

We are just setting up. Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault and you can of course unmute yourself any time).

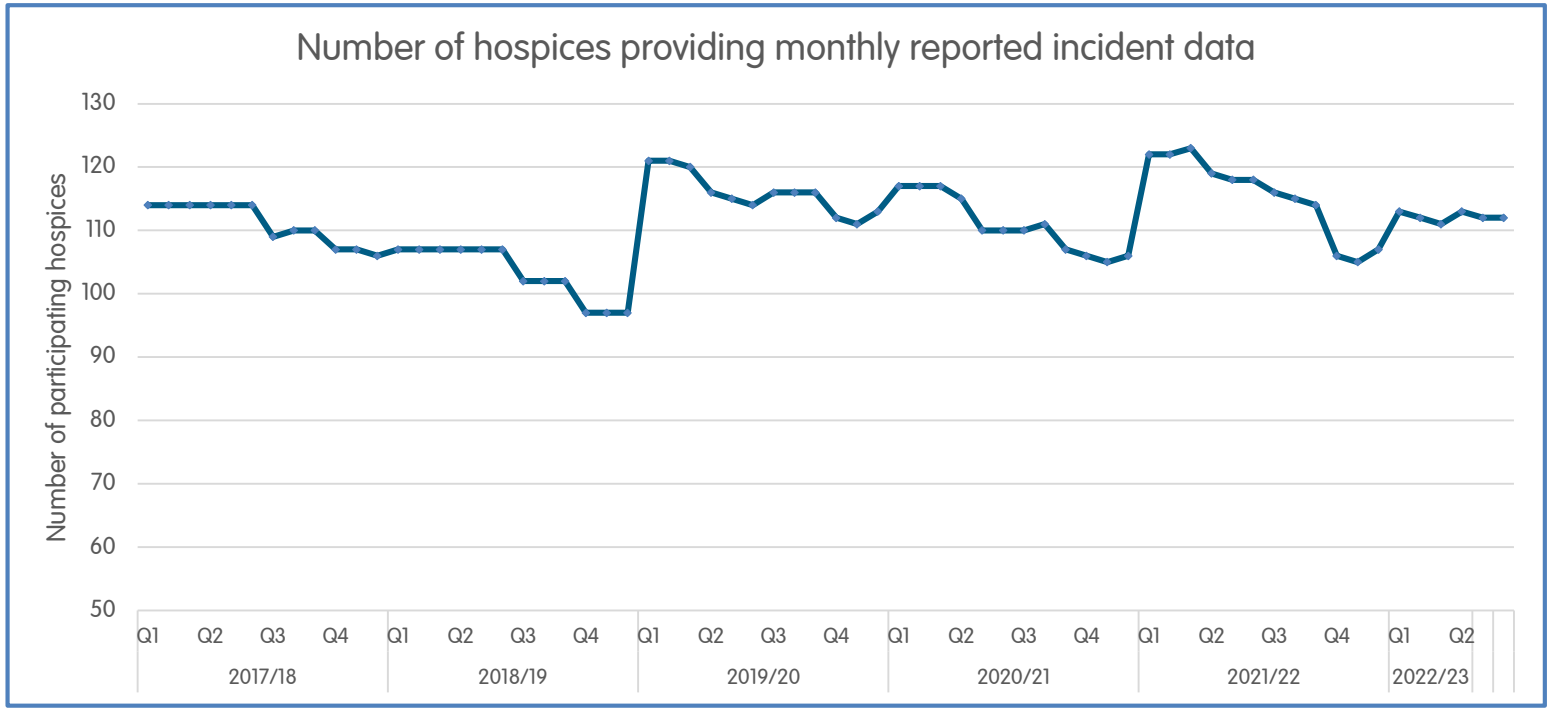
Please introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Any issues please message ‘Stuart Duncan’ in the Chat Box and we will try to assist.

AGENDA

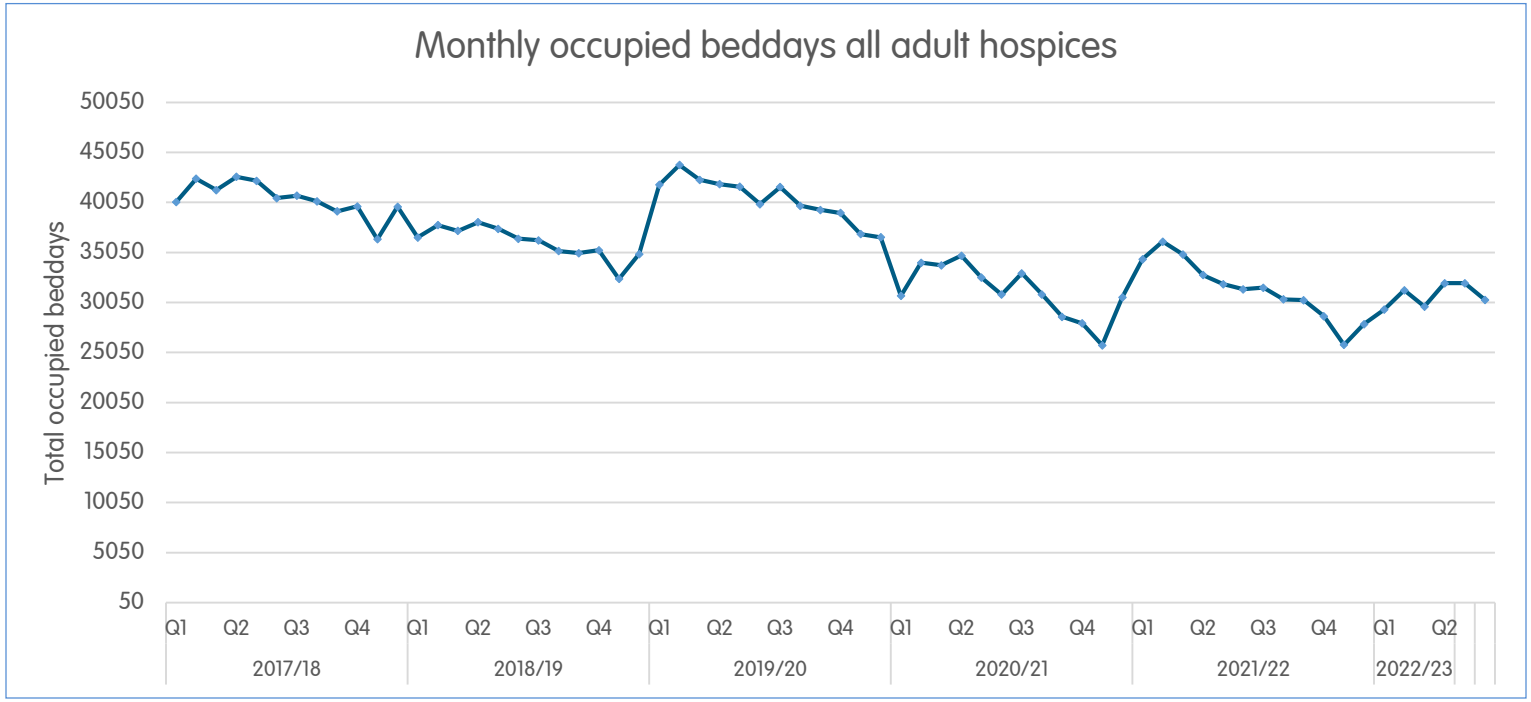
13:00	Welcome and Introductions	Julia Russell, Senior Clinical and Quality Improvement Manager, Hospice UK
13:10	Quarter 2 Incident Data	Julia Russell
13:30	#makingdatacount.	Karen Hayllar Senior manager – Making Data Count, NHS E + I.
14:15	Questions & Discussion	All
14:30	Summary & Close	Julia Russell

Data Submissions: Years and Quarters



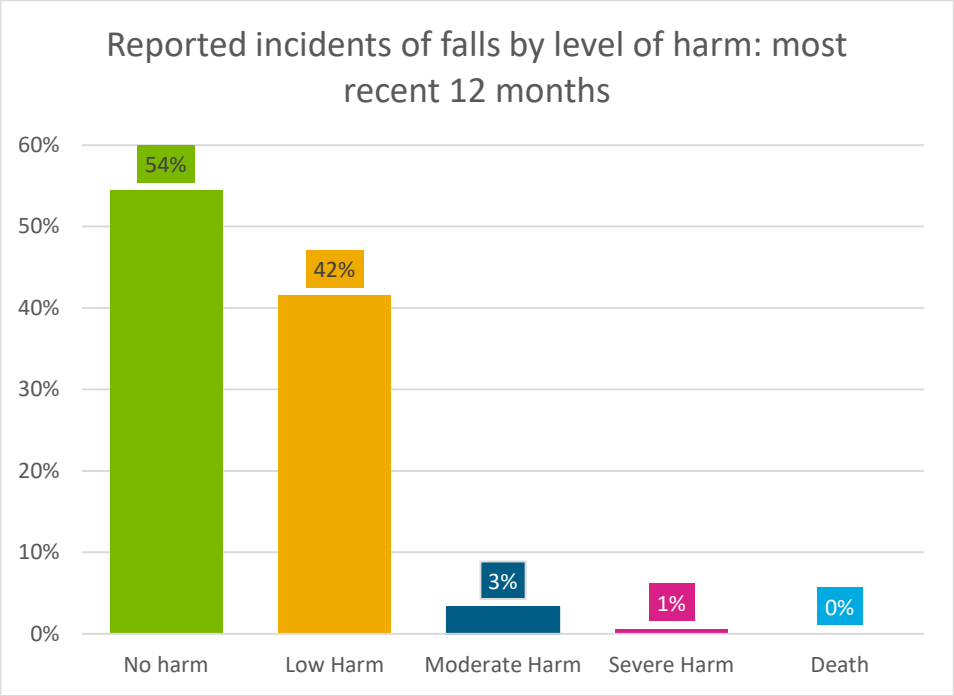
From the beginning!

Monthly occupied bed days – adult hospices




hospiceUK
Falls

Adult reported falls:
Categories & proportions



Five categories of falls

Most recent four quarters 12 months from Oct 2021 to Sept 2022

- 54% no harm
- 42% low harm
- 3 falls at the highest level

Total opportunity in this period

- 358,492 occupied bed-days

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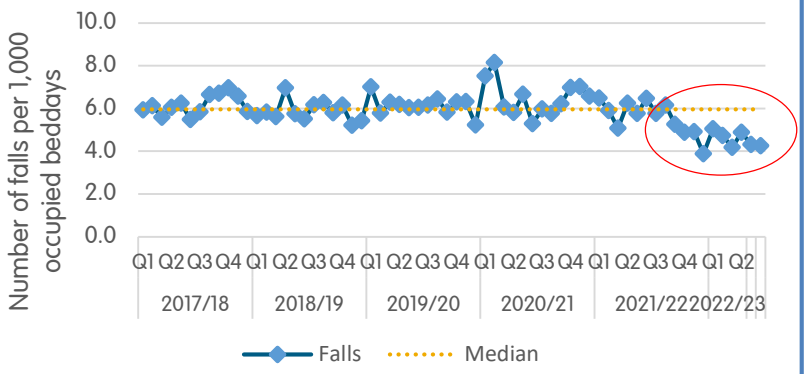
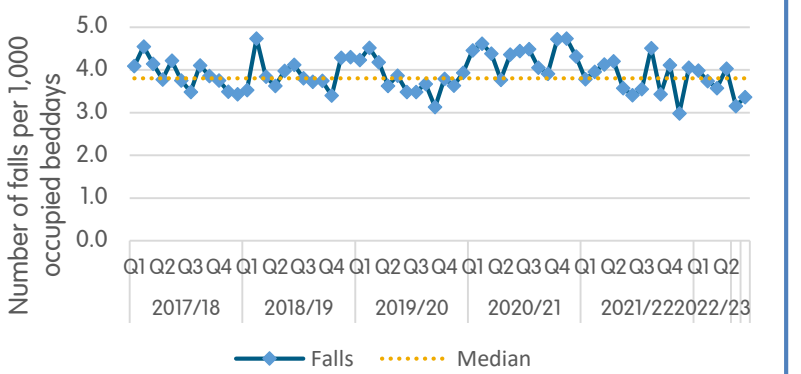
Rate of reported level 1 falls (no harm)

54%



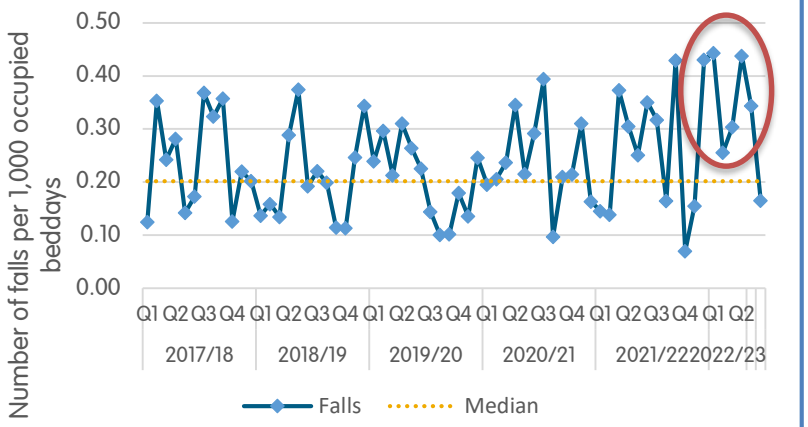
Rate of level 2 falls (low harm)

42%



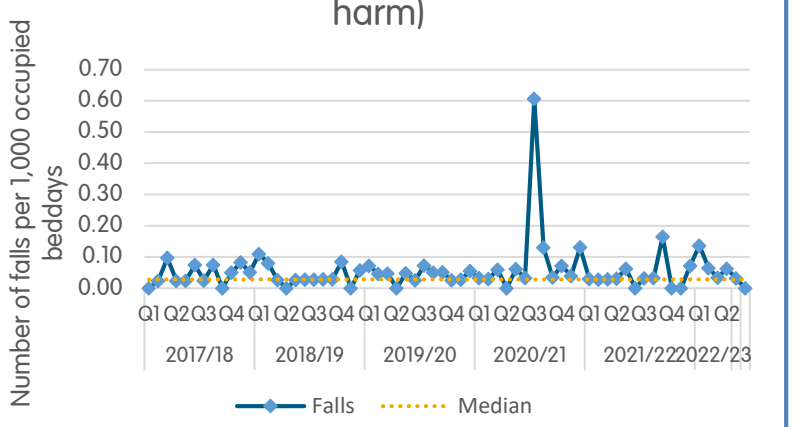
Rate of level 3 falls (moderate harm)

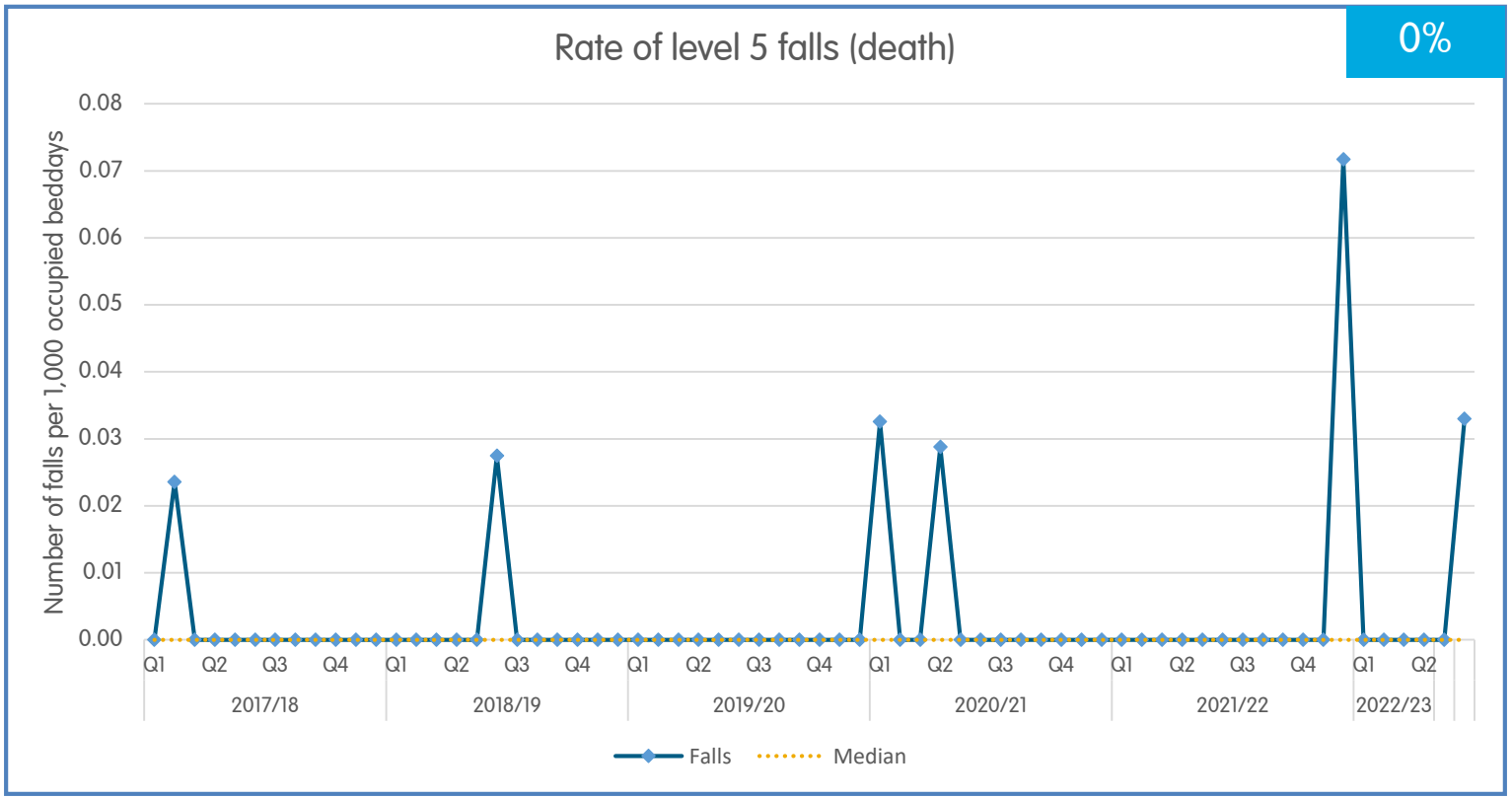
3%



Rate of reported level 4 falls (severe harm)

1%




Rate of level 5 falls (death)
0%
Number of falls per 1,000 occupied beddays
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0.00
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Falls
Median

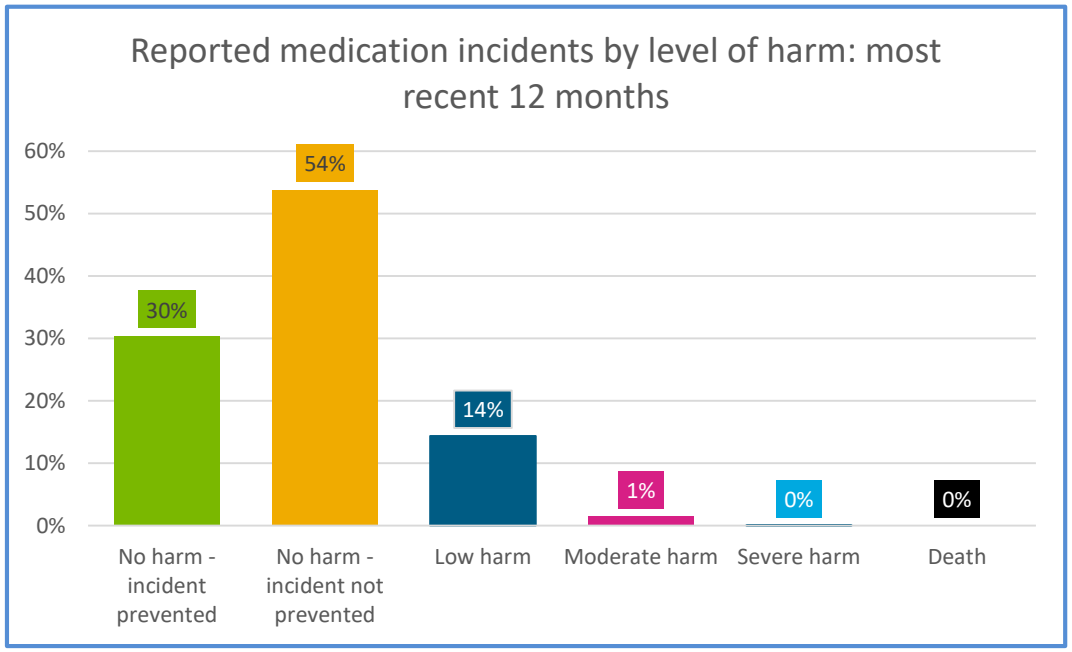
Observations

Please comment in the chat about the Falls incident data – any thoughts?

Level 1 (no harm) and level 3 (moderate harm)


hospiceUK
Medication

Adult's hospices –reported medication incidents

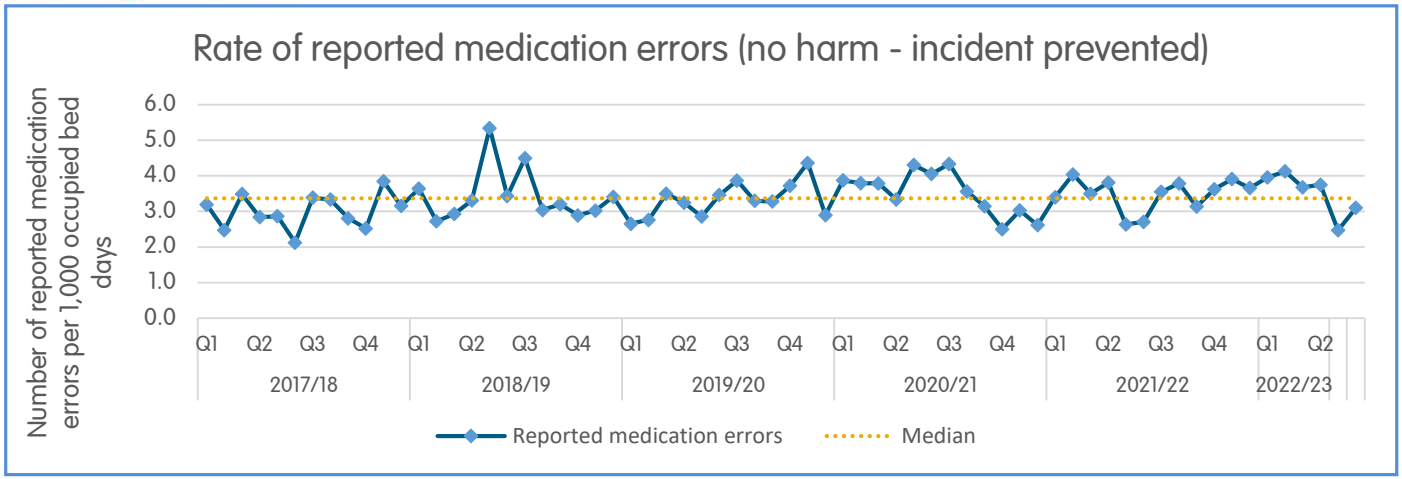


Six categories of reported in-patient medication incidents.

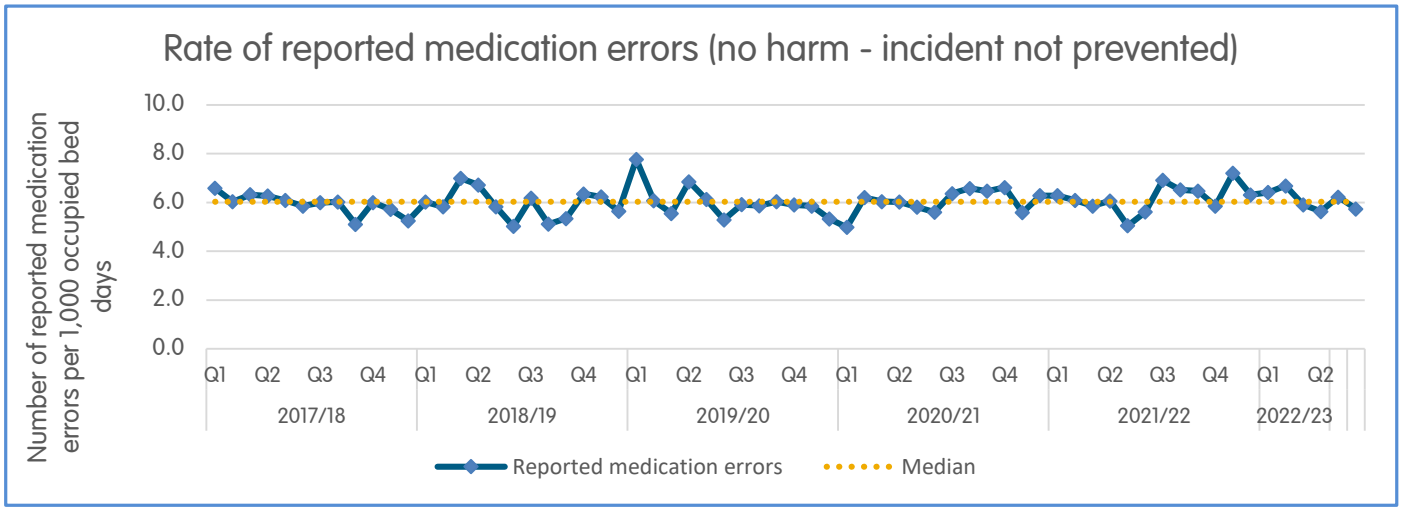
Most recent four quarters

- 84% no harm
- 14% low harm

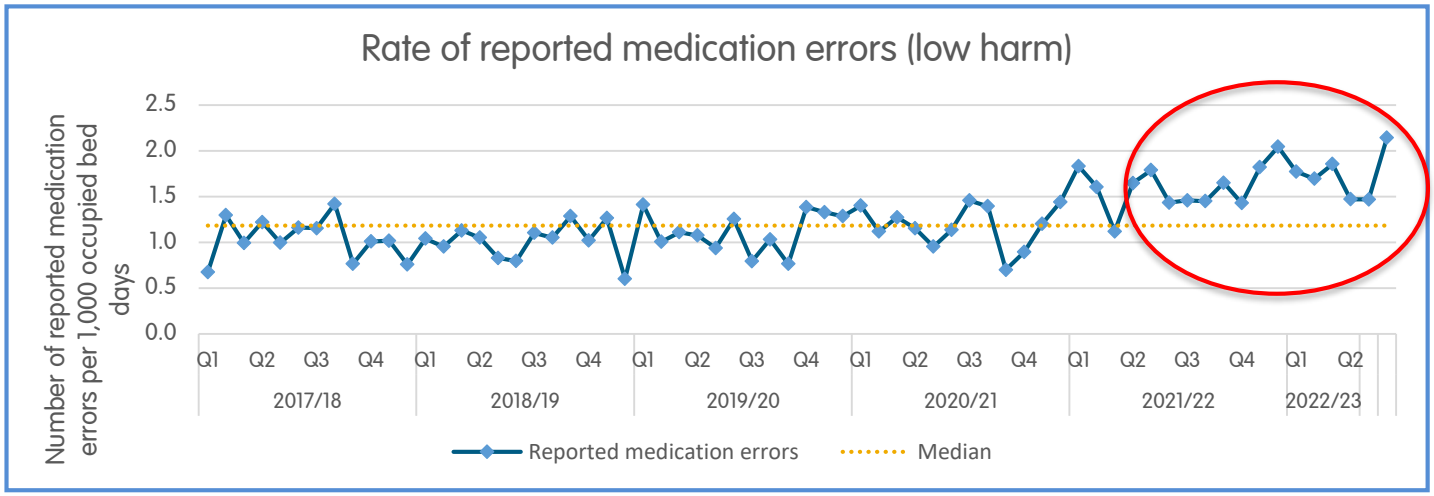
Total opportunity in this period


Rate of reported medication errors (no harm - incident prevented)
Number of reported medication errors per 1,000 occupied bed days
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

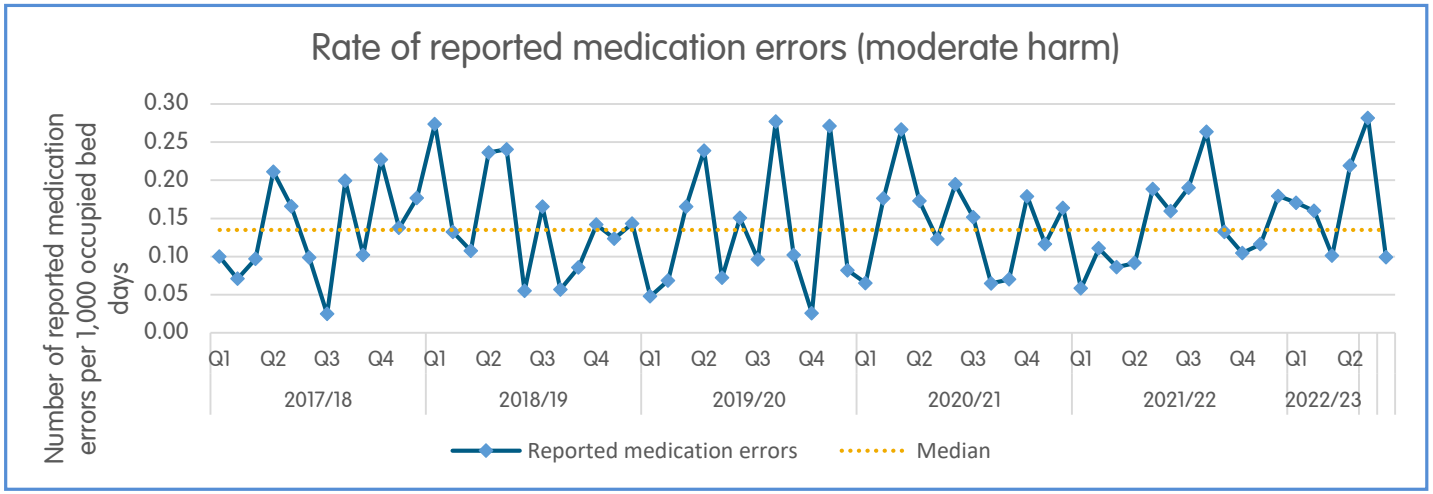
30%


Rate of reported medication errors (no harm - incident not prevented)
Number of reported medication errors per 1,000 occupied bed days
10.0
8.0
6.0
4.0
2.0
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

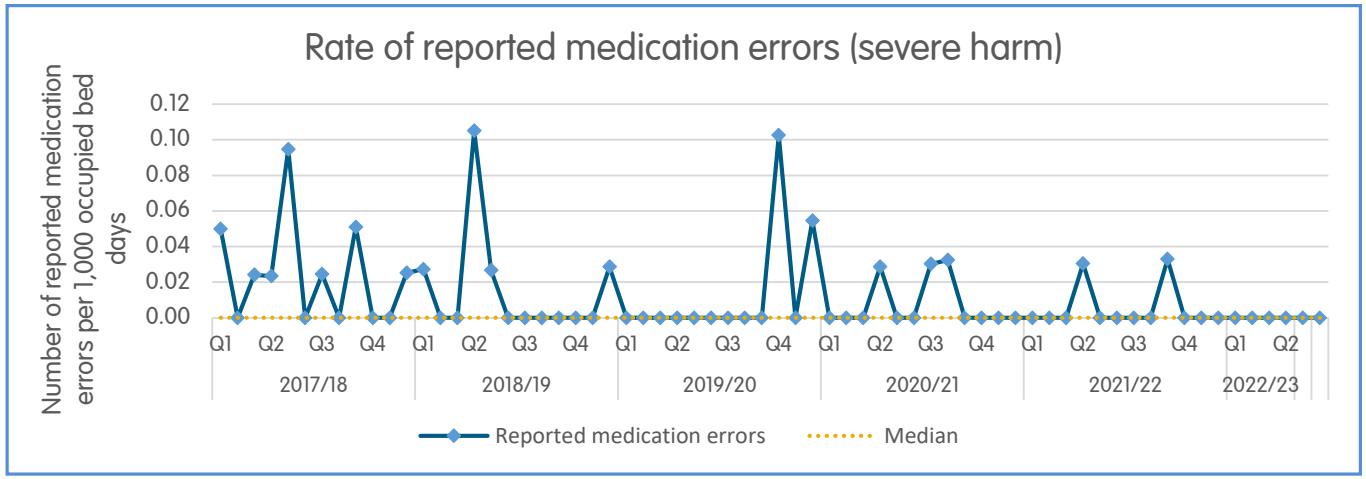
54%


Rate of reported medication errors (low harm)
Number of reported medication errors per 1,000 occupied bed days
2.5
2.0
1.5
1.0
0.5
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

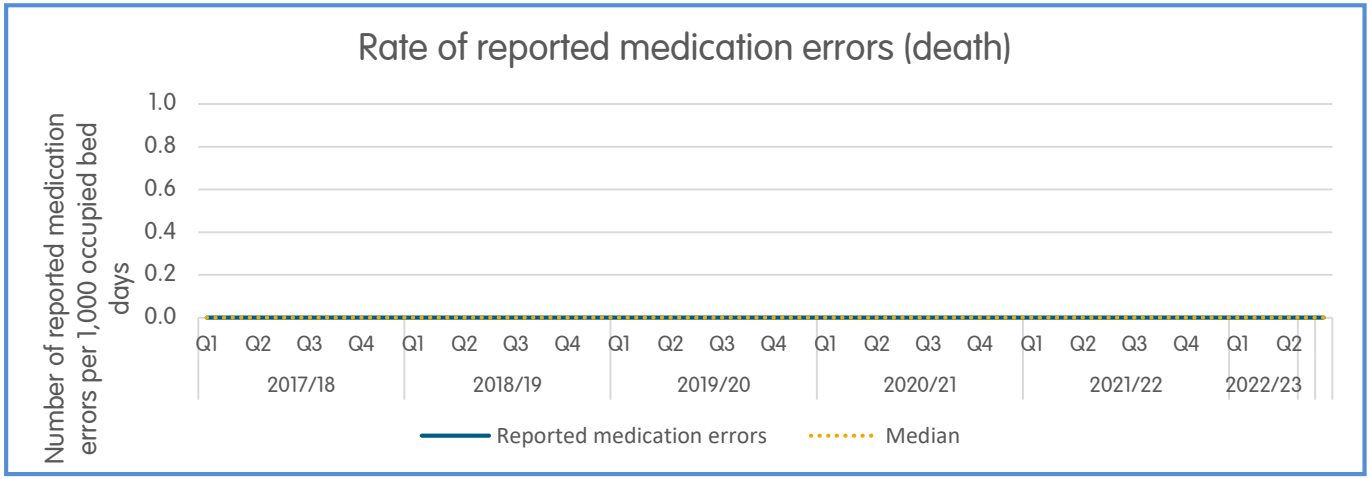
14%


Rate of reported medication errors (moderate harm)
Number of reported medication errors per 1,000 occupied bed days
0.30
0.25
0.20
0.15
0.10
0.05
0.00
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

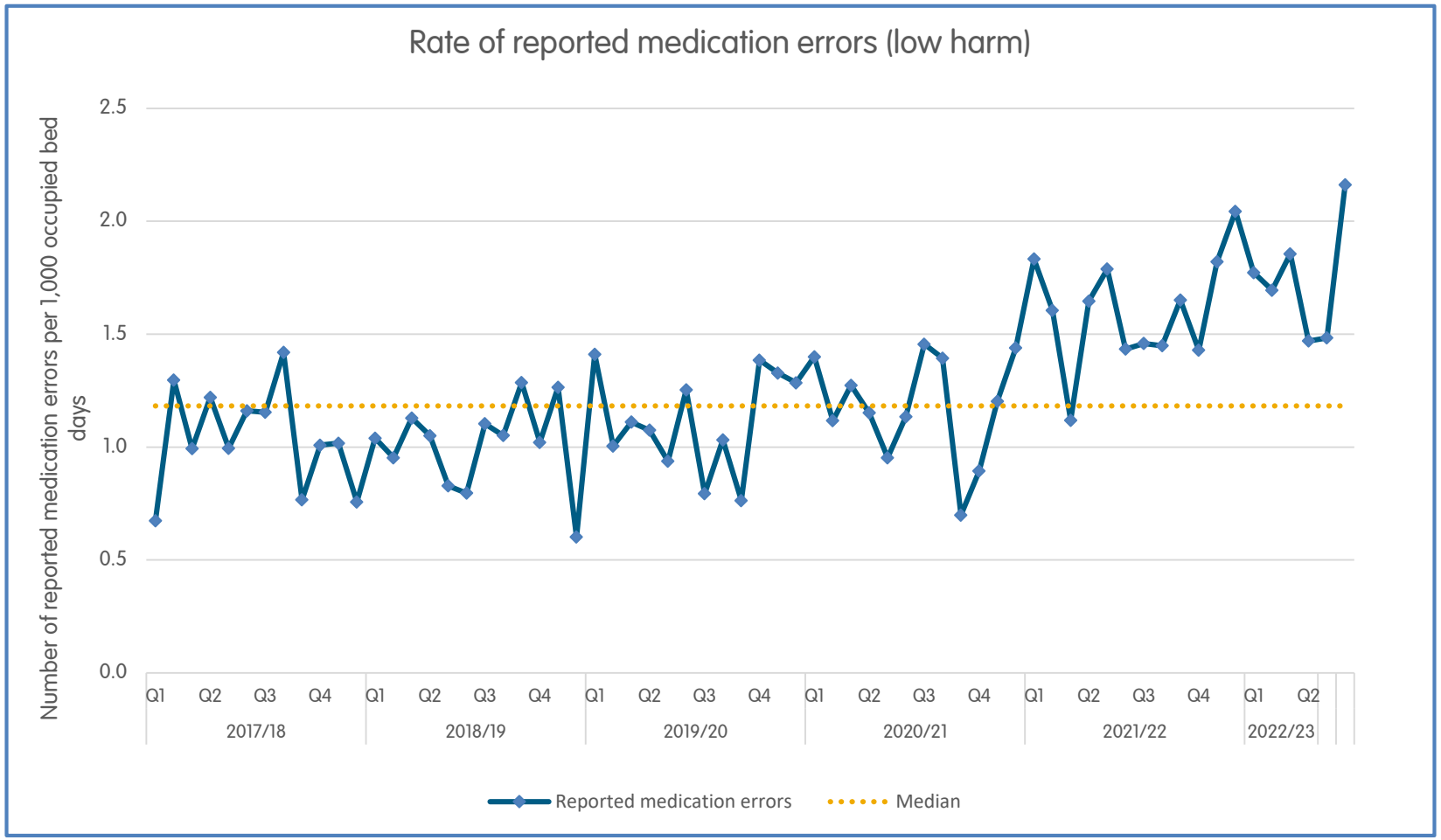
1%

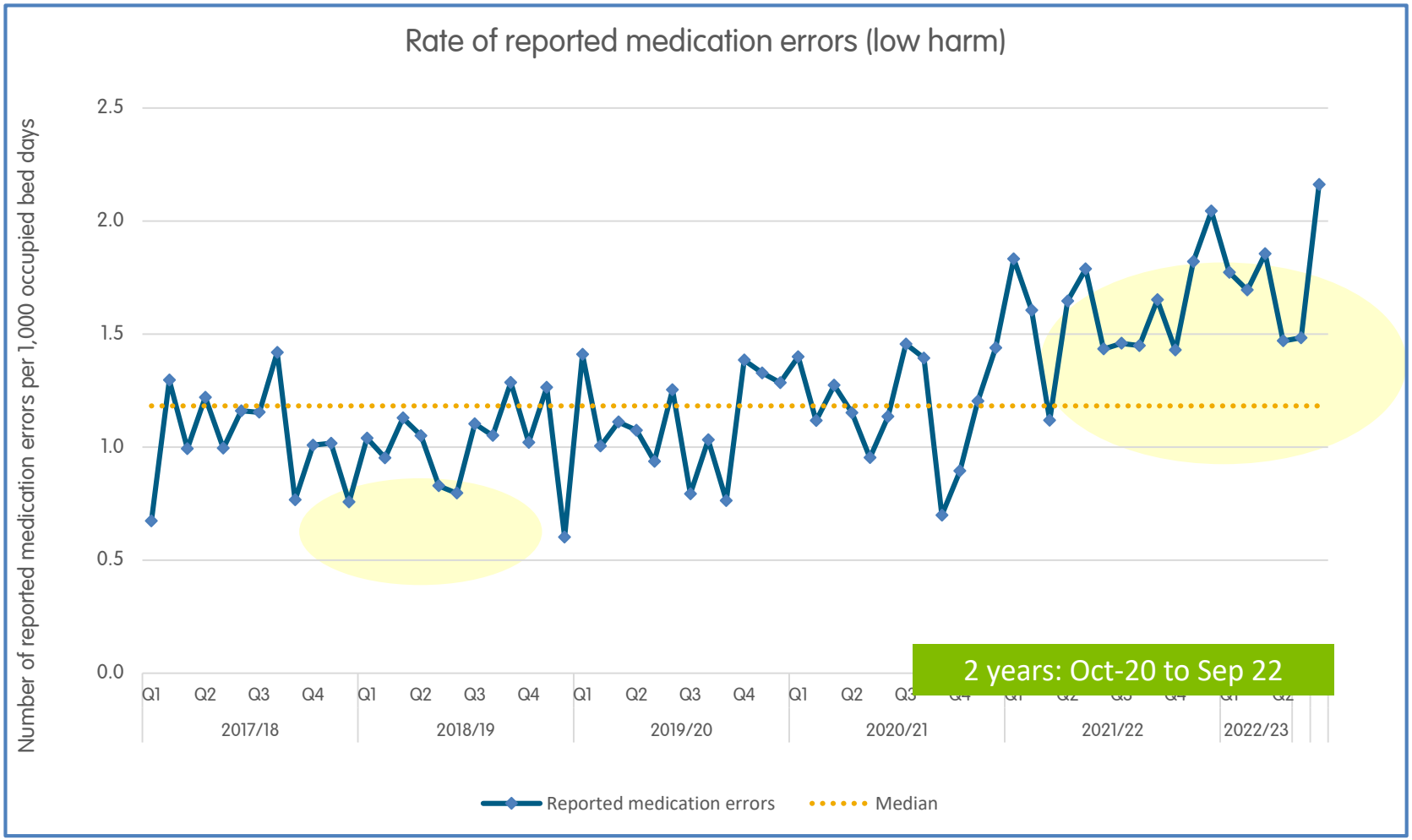

Rate of reported medication errors (severe harm)
Number of reported medication errors per 1,000 occupied bed days
0.12
0.10
0.08
0.06
0.04
0.02
0.00
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

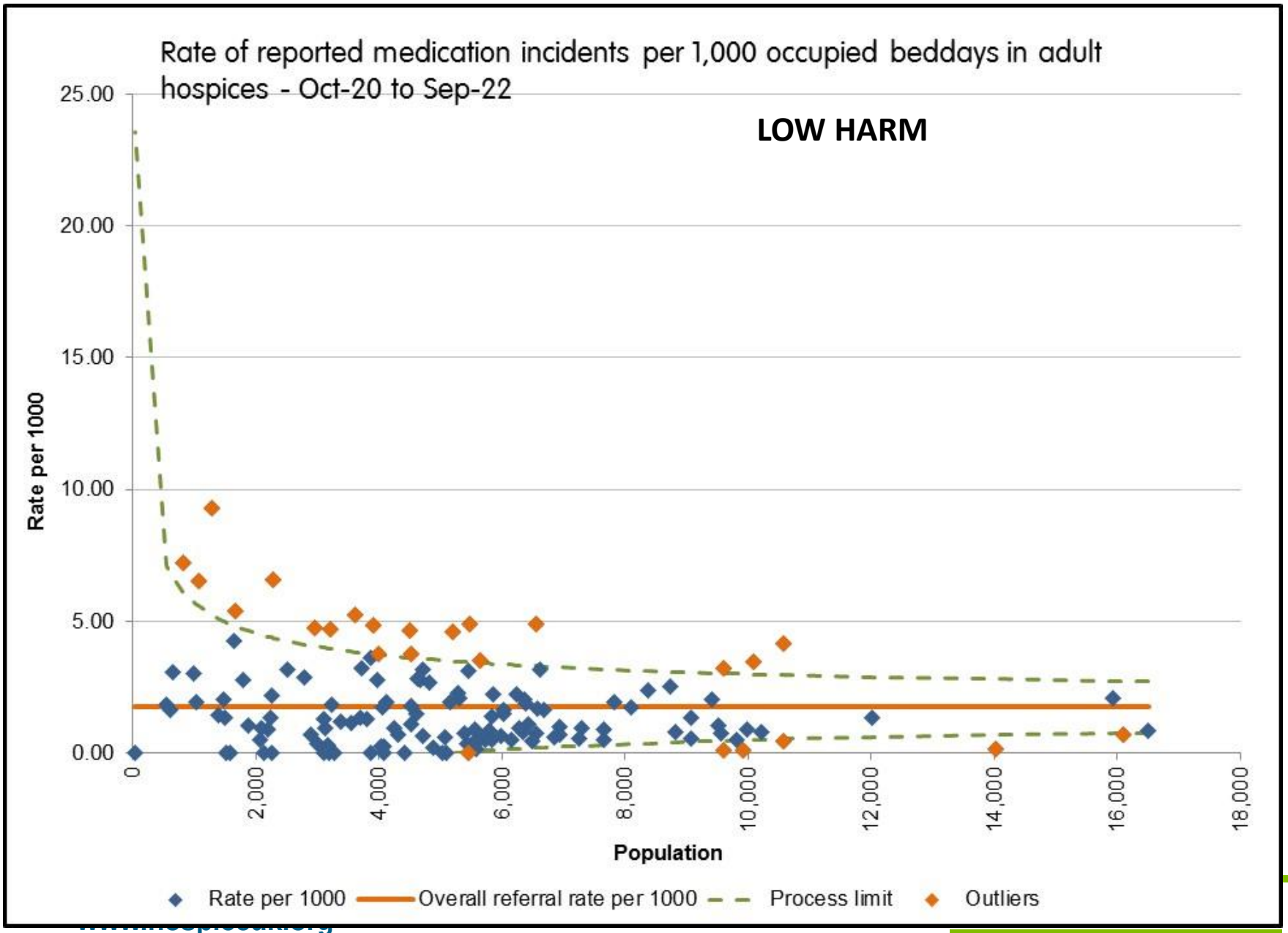
0%


Rate of reported medication errors (death)
Number of reported medication errors per 1,000 occupied bed days
1.0
0.8
0.6
0.4
0.2
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median

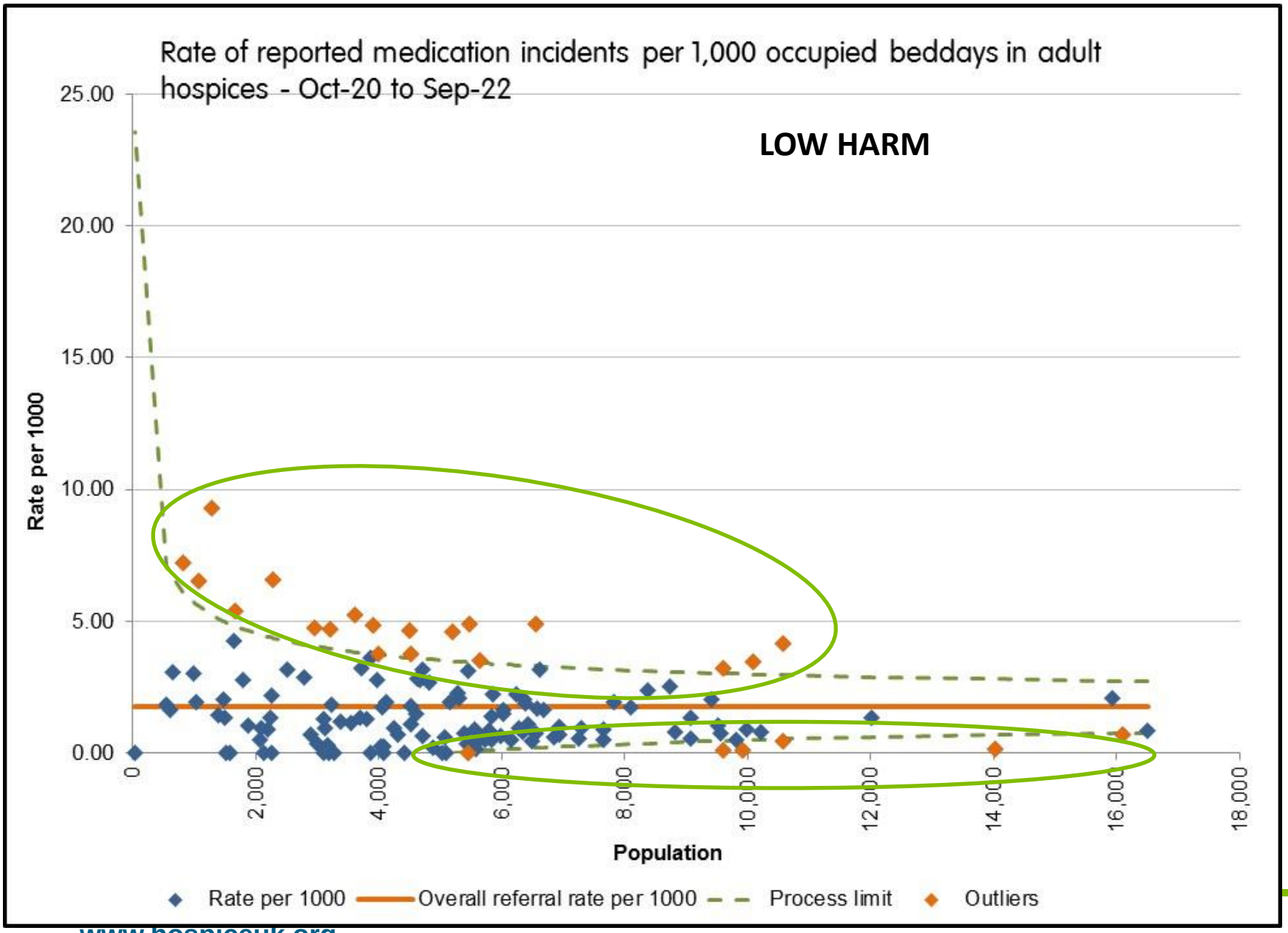
0%


Rate of reported medication errors (low harm)
Number of reported medication errors per 1,000 occupied bed days
2.5
2.0
1.5
1.0
0.5
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Reported medication errors
Median


Rate of reported medication errors (low harm)
Number of reported medication errors per 1,000 occupied bed days
2.5
2.0
1.5
1.0
0.5
0.0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2 years: Oct-20 to Sep 22
Reported medication errors
Median



2 years: Oct-20 to Sep 22

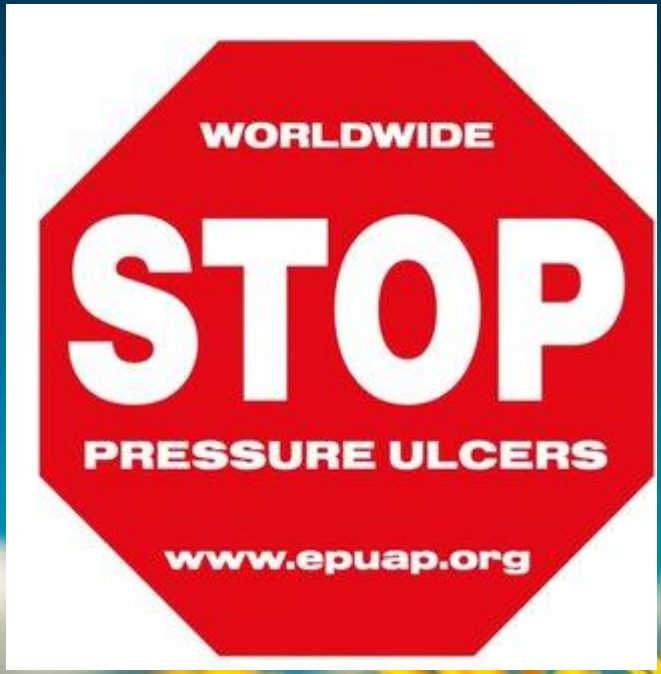


2 years: Oct-20 to Sep 22

Observations

Please comment in the chat about the Medication incident data – any thoughts?

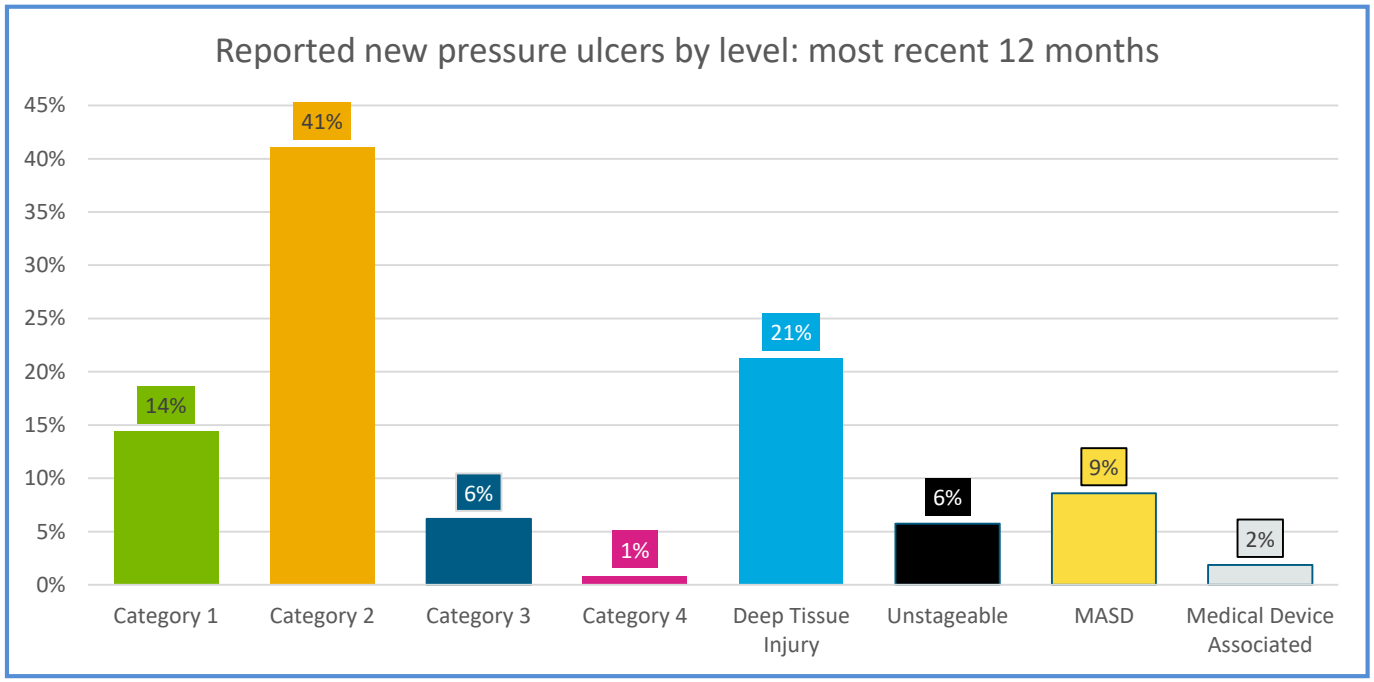
LOW Harm? What is the data telling us?
What do you want to do as a Group?



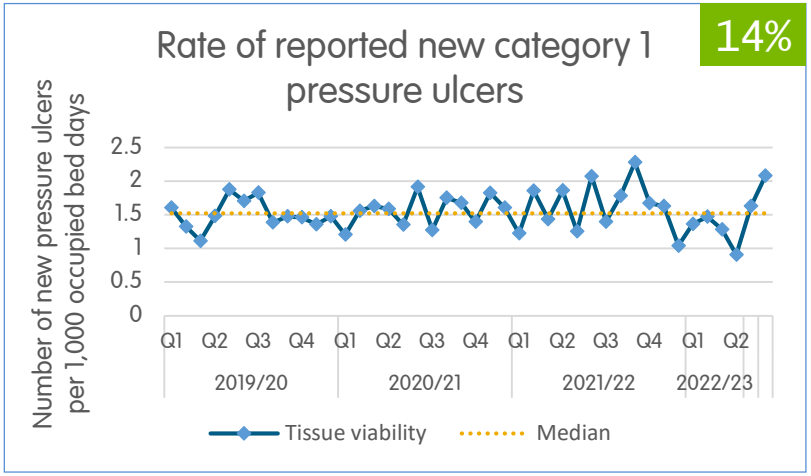
Tissue Viability

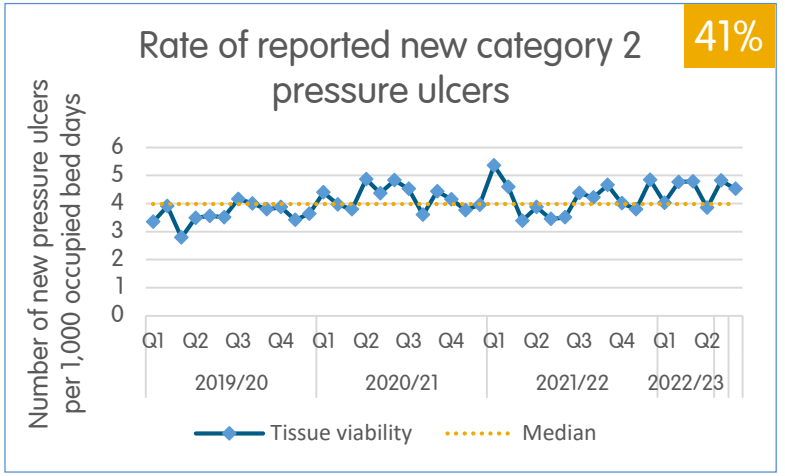
(see Society of Tissue Viability)

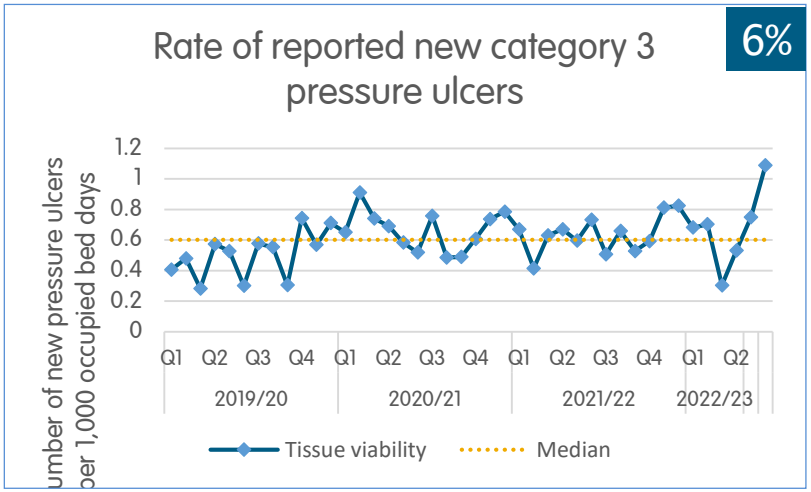
Tissue viability
New pressure ulcers - adults

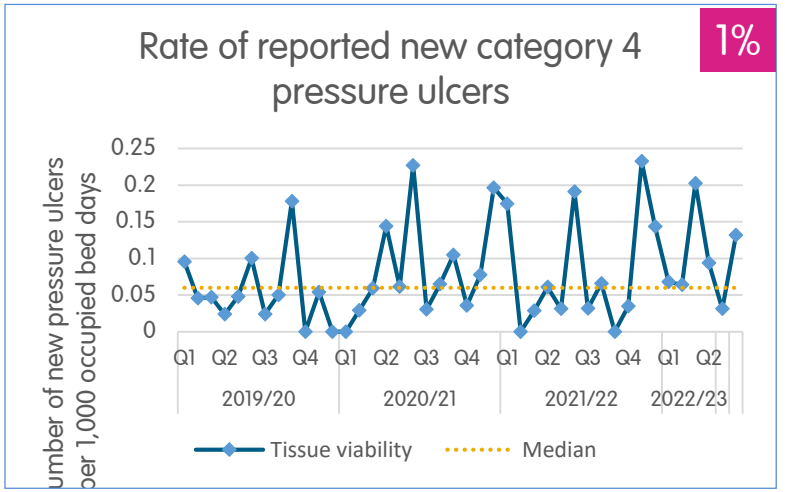


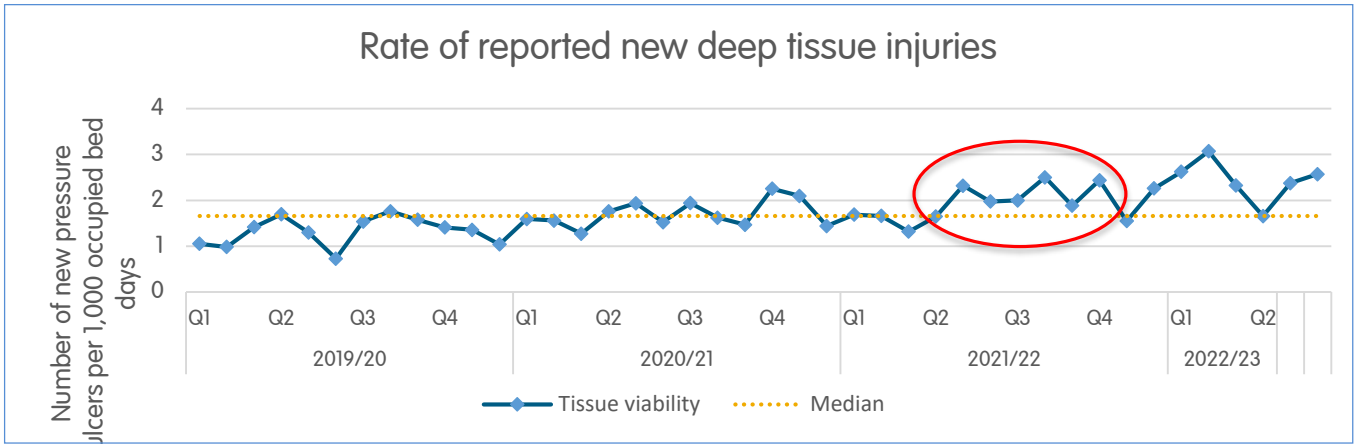
hospiceUK


Rate of reported new category 1 pressure ulcers
14%
Number of new pressure ulcers per 1,000 occupied bed days
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

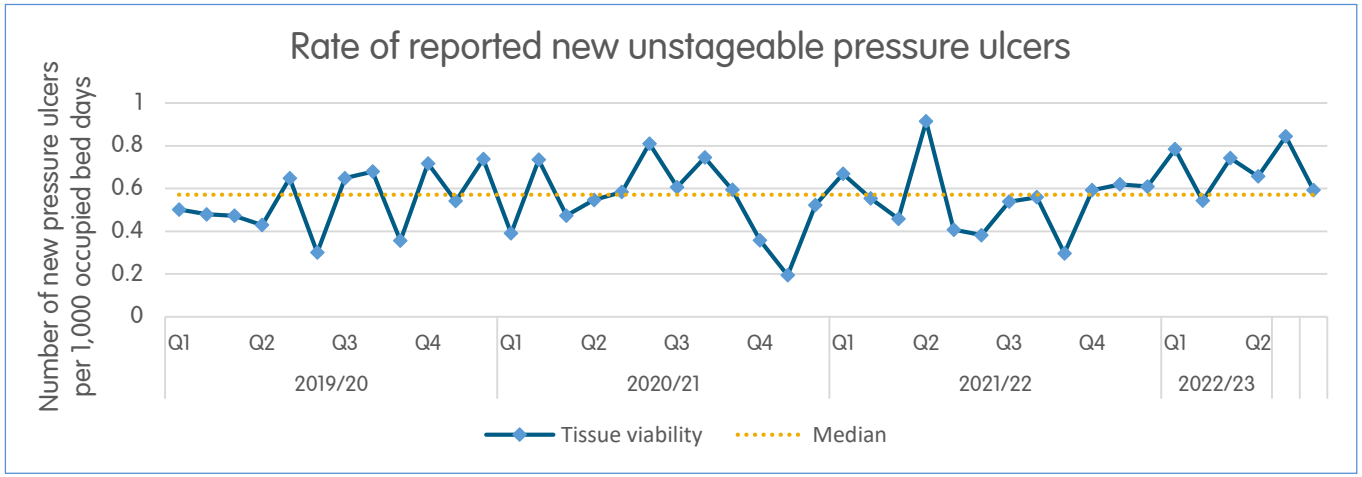

Rate of reported new category 2 pressure ulcers
41%
Number of new pressure ulcers per 1,000 occupied bed days
6
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported new category 3 pressure ulcers
6%
umber of new pressure ulcers per 1,000 occupied bed days
1.2
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

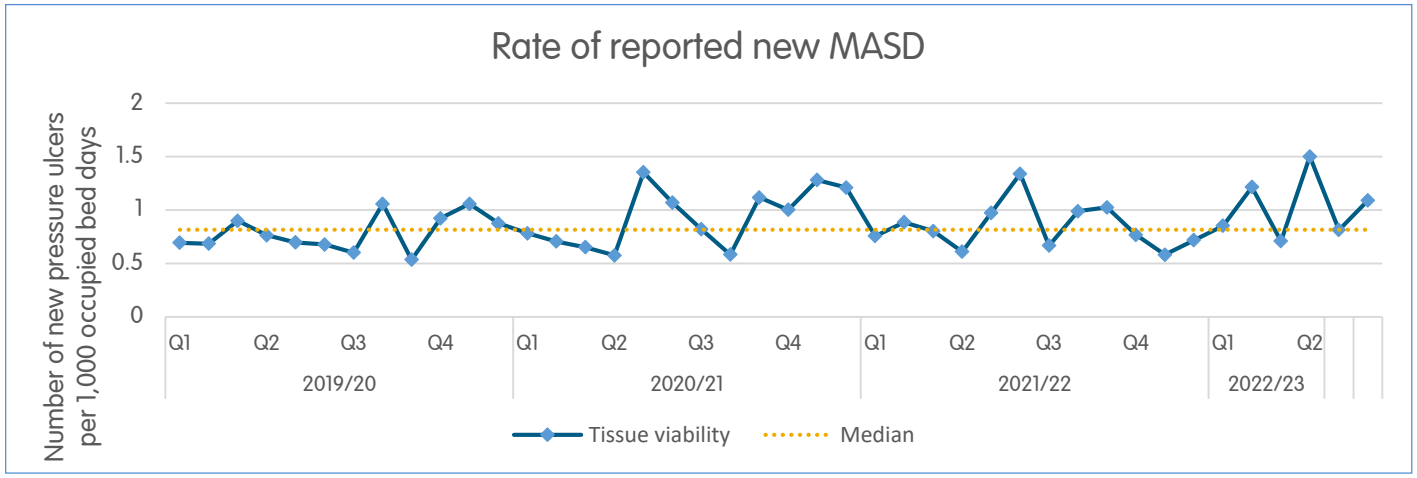

Rate of reported new category 4 pressure ulcers
1%
umber of new pressure ulcers per 1,000 occupied bed days
0.25
0.2
0.15
0.1
0.05
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported new deep tissue injuries
Number of new pressure ulcers per 1,000 occupied bed days
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

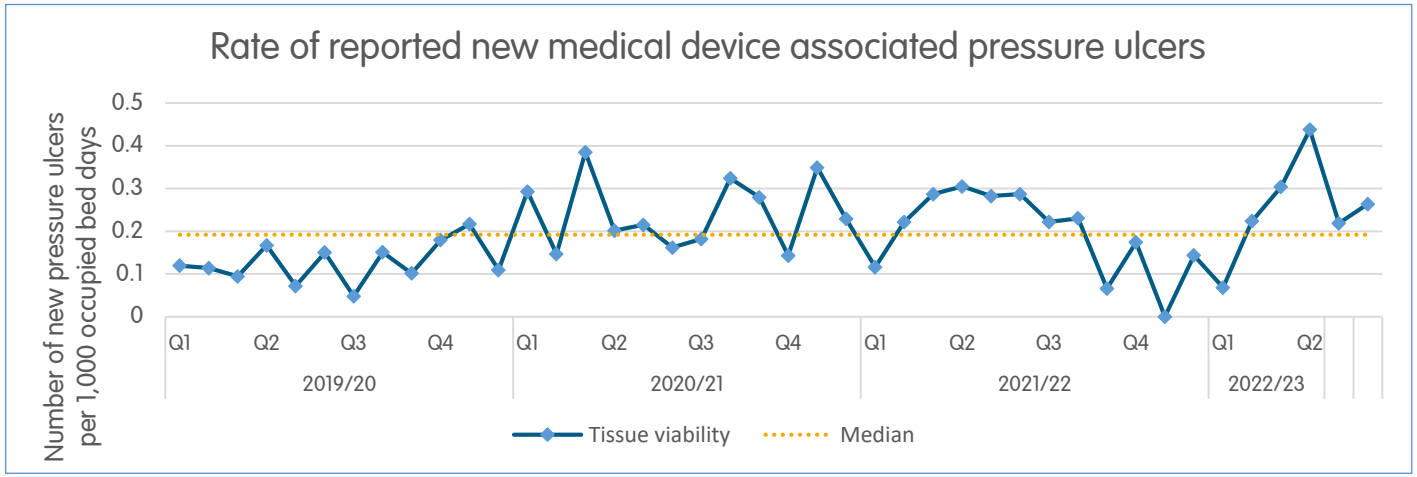
21%


Rate of reported new unstageable pressure ulcers
Number of new pressure ulcers per 1,000 occupied bed days
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

6%

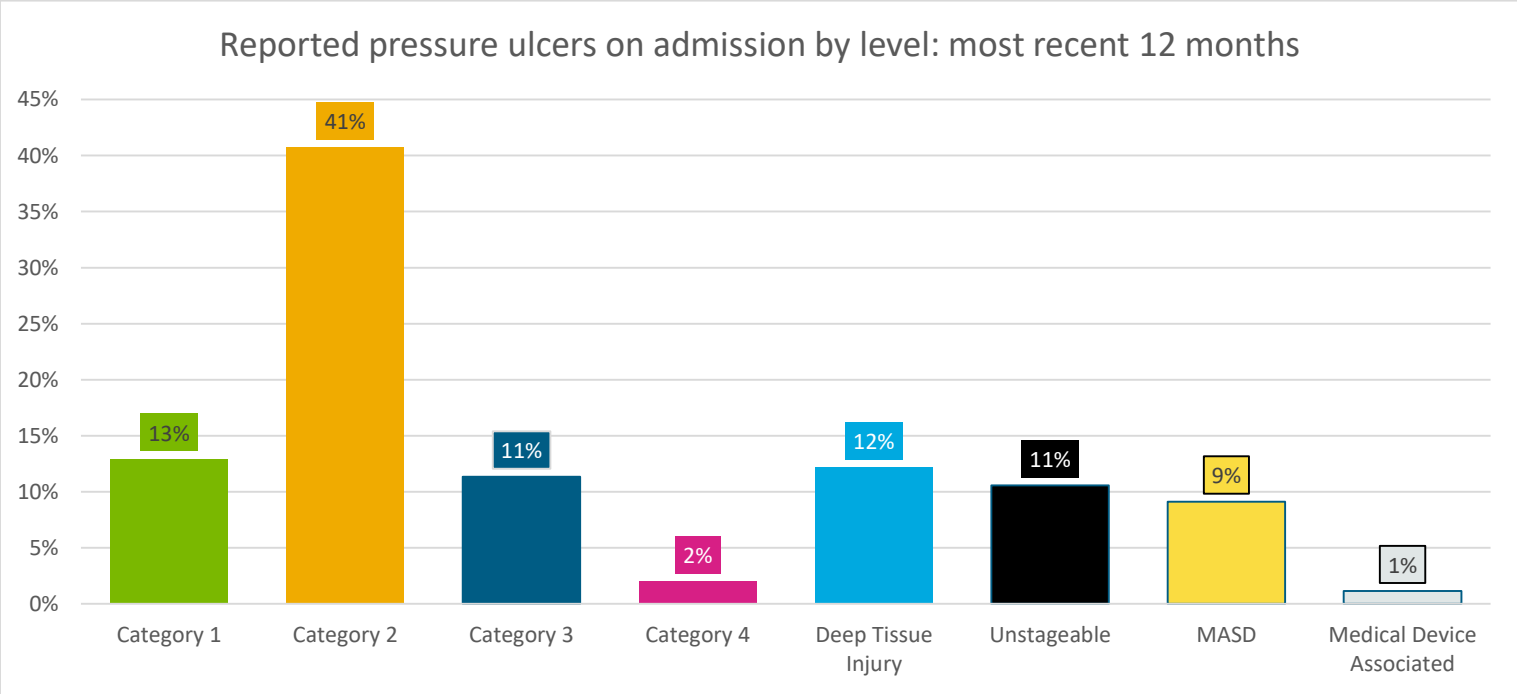

Rate of reported new MASD
Number of new pressure ulcers per 1,000 occupied bed days
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

9%


Rate of reported new medical device associated pressure ulcers
Number of new pressure ulcers per 1,000 occupied bed days
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

2%

Reported tissue viability incidents – on admission



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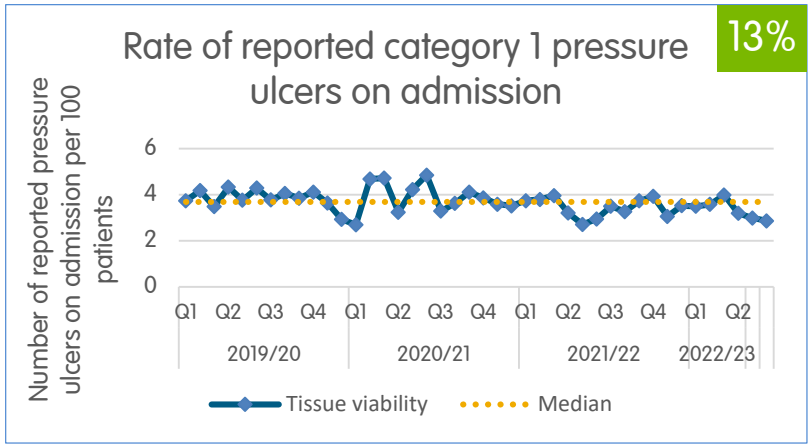
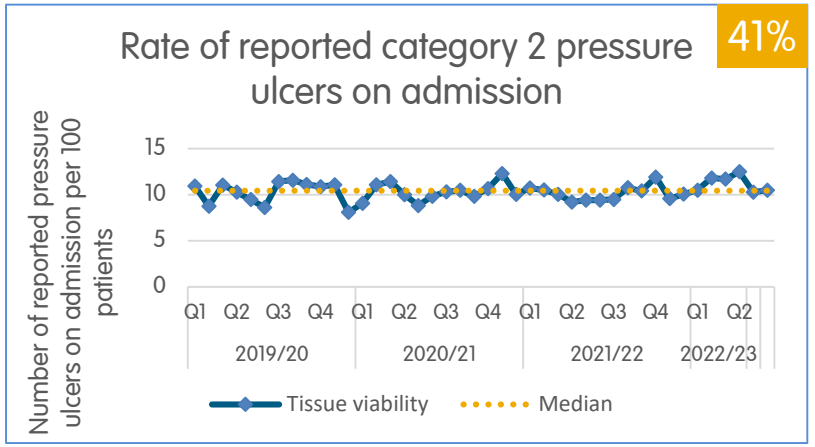
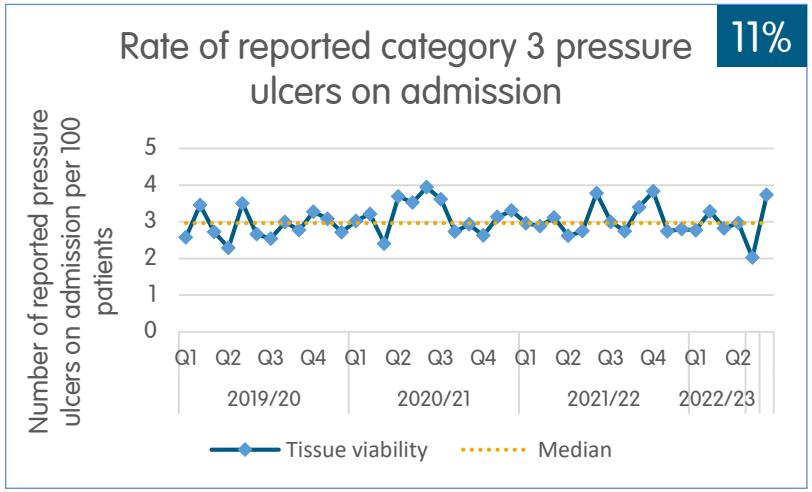
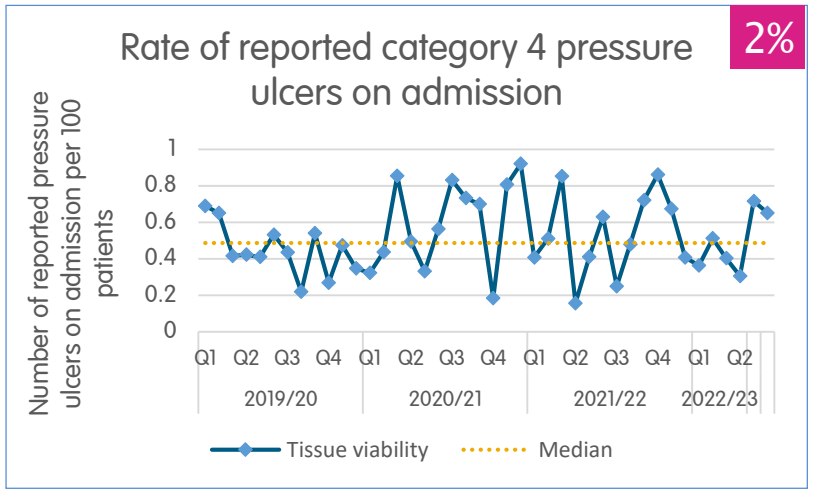
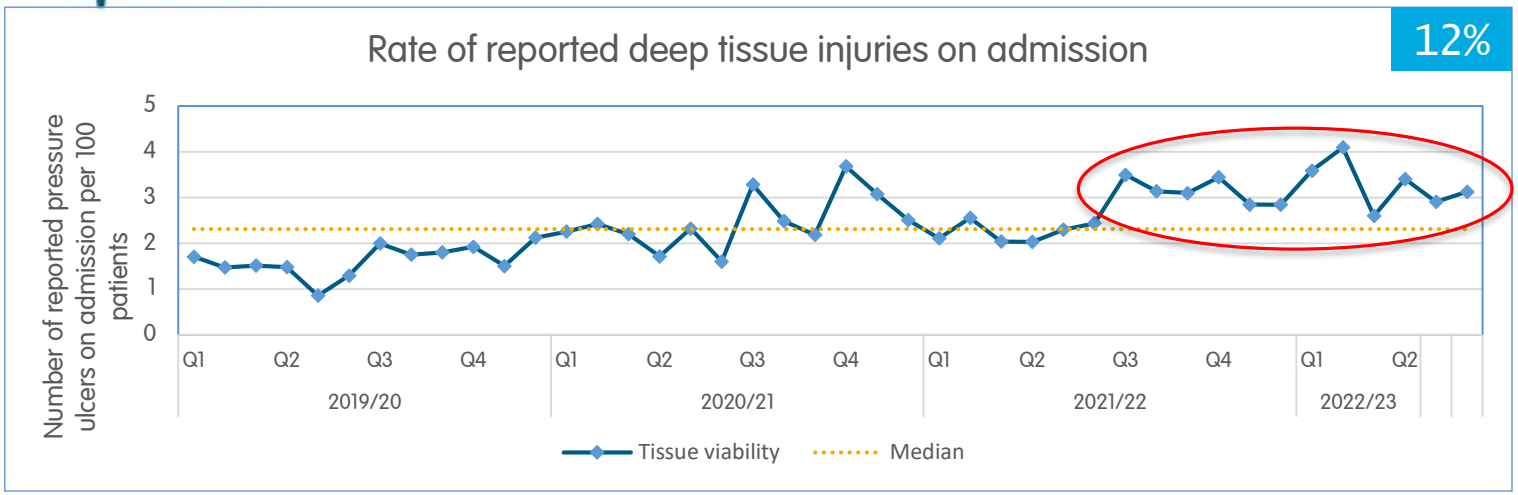
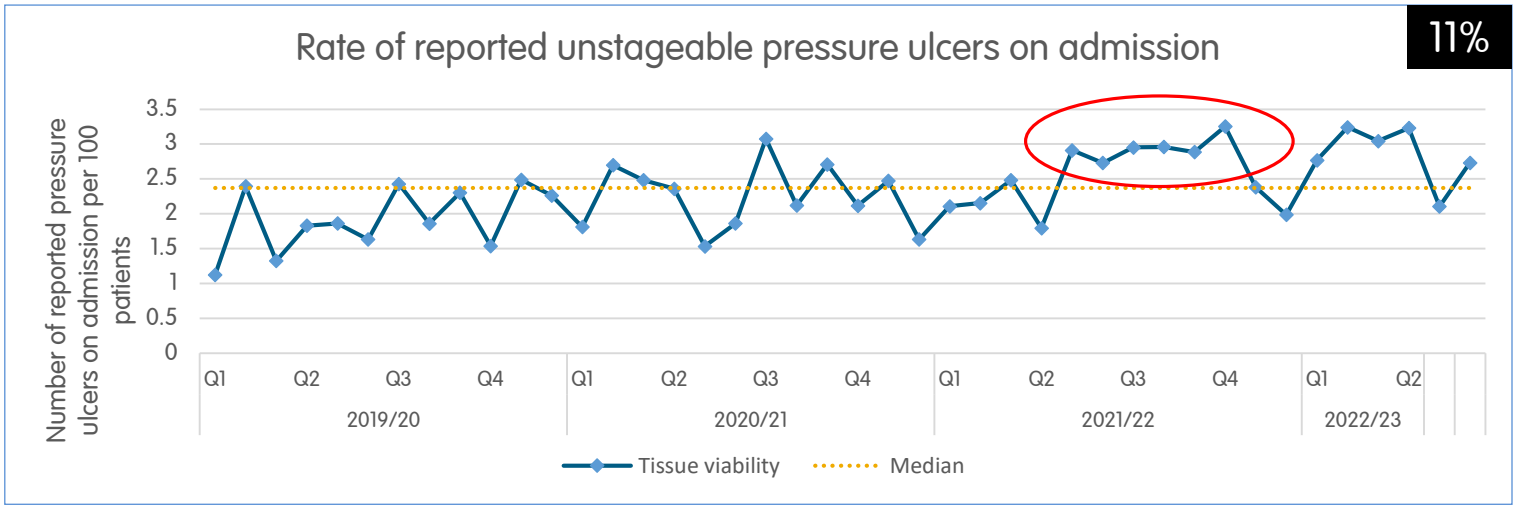

Rate of reported category 1 pressure ulcers on admission
13%
Number of reported pressure ulcers on admission per 100 patients
6
4
2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

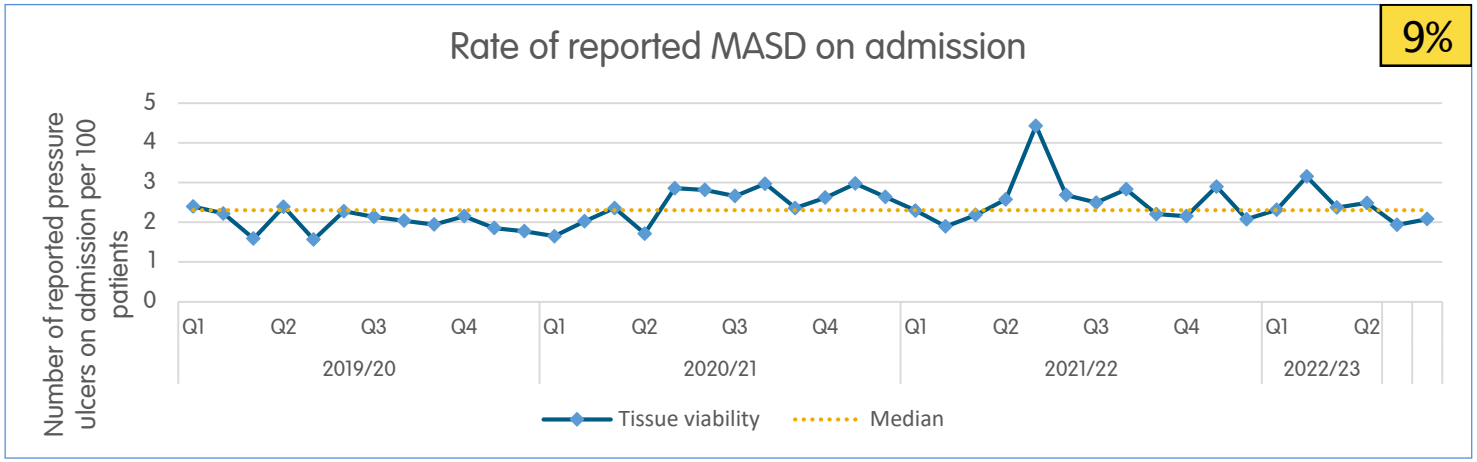

Rate of reported category 2 pressure ulcers on admission
41%
Number of reported pressure ulcers on admission per 100 patients
15
10
5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median

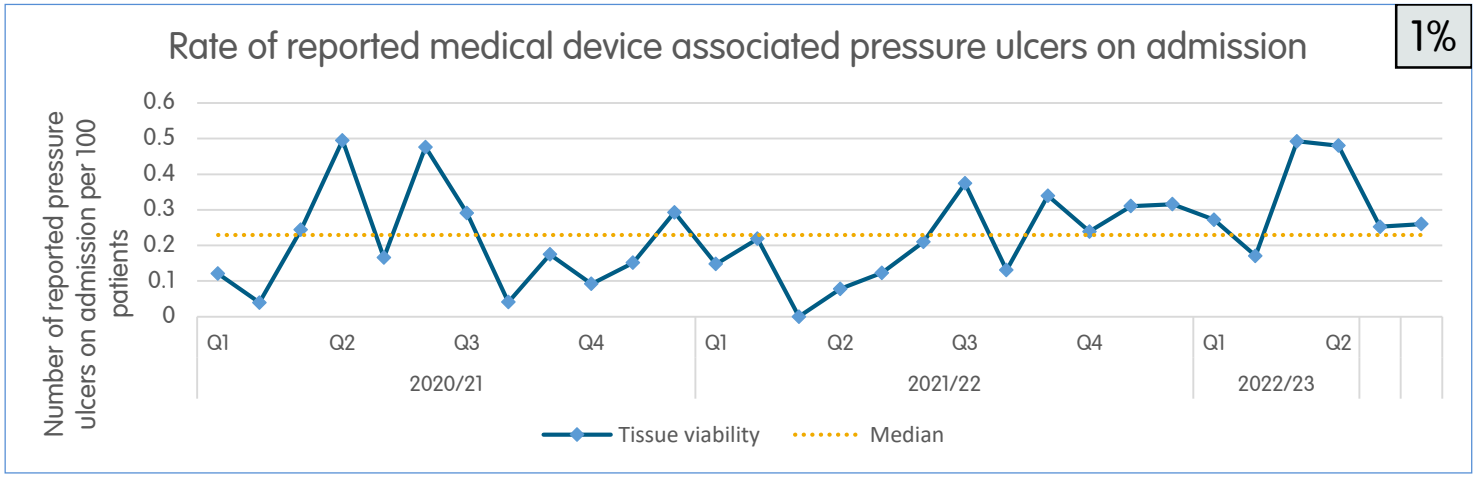

Rate of reported category 3 pressure ulcers on admission
11%
Number of reported pressure ulcers on admission per 100 patients
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported category 4 pressure ulcers on admission
2%
Number of reported pressure ulcers on admission per 100 patients
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported deep tissue injuries on admission
12%
Number of reported pressure ulcers on admission per 100 patients
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported unstageable pressure ulcers on admission
11%
Number of reported pressure ulcers on admission per 100 patients
3.5
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported MASD on admission
9%
Number of reported pressure ulcers on admission per 100 patients
5
4
3
2
1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2019/20
2020/21
2021/22
2022/23
Tissue viability
Median


Rate of reported medical device associated pressure ulcers on admission
1%
Number of reported pressure ulcers on admission per 100 patients
0.6
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2
2020/21
2021/22
2022/23
Tissue viability
Median

Observations

Please comment in the chat about the Tissue Viability data – any thoughts?

New DTI's and DTI's on admission?
Unstageable PU's on admission?

Submit

Submission Dates

	Months	Submission Deadline	Final Reports Circulated
Q1	Apr, May, Jun	14 July 2022	30 July 2022
Q2	Jul, Aug, Sep	14 October 2022	27 Oct 2022
Q3	Oct, Nov, Dec	12 Jan 2023	29 Jan 2023
Q4	Jan, Feb, Mar	14 Apr 2023	28 Apr 2023

Submission link request:
https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/quality-assurance/patient-safety

WELCOME

Karen Hallyar

#makingdatacount

Hospice UK
Quarter 2 Patient Safety Webinar

Making data count

Karen Hayllar - Senior Manager, Making data count

17th November 2022

Aims for today

1. Demonstrate the **limitations of popular methods** of measurement e.g. two point data comparisons and RAG

Apr-18	May-18	Jun-18	Trend
96	94	96	

2. Provide an introduction to different types of **variation** and explore how to react to each

3. Introduce **Statistical Process Control** to assist your decision making

Where we are now……

Appendix 1

Safety & Quality Dashboard — Mar 2018

CQC Domain	Indicator	Previous Period	Previous Value	Latest Period	Latest Value	Difference	Trend over previous period	Trend - Apr 2017 onwards	2017/18 Total / 2017/18 Average
SAFE	Patient Falls - Month Total (In-hospital)	January 2018	112	February 2018	120	7	▲		1353
	Patient Fall NO Injury	January 2018	81	February 2018	87	6	▲		1008
	Patient Fall Injury NO Fracture	January 2018	29	February 2018	32	3	▲		120
	Patient Fall FRACTURE	January 2018	3	February 2018	1	-2	▼		25
	Pressure Ulcers - Month Total (In-hospital)	December 2017	28	January 2018	26	-2	▼		216
	Pressure Ulcers - Grade 1	December 2017	2	January 2018	4	2	▲		36
	Pressure Ulcers - Grade 2	December 2017	12	January 2018	19	-3	▼		162
	Pressure Ulcers - Grade 3	December 2017	3	January 2018	2	-1	▼		16
	Pressure Ulcers - Grade 4	December 2017	1	January 2018	1	0	◄		2
	Safety Thermometer - Trust Harm Free Care	January 2018	98.64%	February 2018	97.30%	-1.34%	▼		
	Safety Thermometer - Trust New Harm	January 2018	1.36%	February 2018	2.70%	1.34%	▲		
	Safety Thermometer - In-hospital Harm Free Care	January 2018	97.13%	February 2018	93.75%	-3.38%	▼		
	Safety Thermometer - In-hospital New Harm	January 2018	2.87%	February 2018	6.25%	3.38%	▲		
	Safety Thermometer - Out of hospital Harm Free Care	January 2018	99.59%	February 2018	99.58%	-0.01%	▼		
	Safety Thermometer - Out of hospital New Harm	January 2018	0.41%	February 2018	0.42%	0.01%	▲		
	Never Events	January 2018	0	February 2018	0	0	◄		
	Trust Compliance with National Safety Alerts	January 2018	100%	February 2018	100%	0.00%	◄		
	Clostridium difficile (C diff)	January 2018	3	February 2018	2	-1	▼		
	Methicillin-Resistant Staphylococcus Aureus (MRSA)	January 2018	0	February 2018	1	1	▲		
	Methicillin-Sensitive Staphylococcus Aureus (MSSA)	January 2018	1	February 2018	2	1	▲		
	Escherichia Coli (E.coli)	January 2018	5	February 2018	1	-4	▼		
	Klebsiella species bacteraemia (Klop sp)	January 2018	6	February 2018	1	-5	▼		
	Pseudomonas aeruginosa bacteraemia (Ps a)	January 2018	1	February 2018	0	-1	▼		
	Trust Wide Hand Hygiene Compliance (%)	January 2018	97.00%	February 2018	97.00%	0.00%	◄		
	SPEQIS (Staff, Patient Experience and Quality Standards) - SAFE	January 2018	96.02%	February 2018	93.20%	-2.82%	▼		
CARING	Total - Friends and Family Test - Would Recommend	January 2018	95.30%	February 2018	95.70%	0.40%	▲		
	Total - Friends and Family Test - Wouldn't Recommend	January 2018	1.37%	February 2018	0.85%	-0.22%	▼		
	In-patient - Friends and Family Test - Would Recommend	January 2018	94.30%	February 2018	94.76%	0.46%	▲		
	In-patient - Friends and Family Test - Wouldn't Recommend	January 2018	1.82%	February 2018	1.65%	-1.97%	▼		
	Emergency Care - Friends and Family Test - Would Recommend	January 2018	93.27%	February 2018	95.73%	2.46%	▲		
	Emergency Care - Friends and Family Test - Wouldn't Recommend	January 2018	2.40%	February 2018	0.61%	-1.79%	▼		
	Maternity - Friends and Family Test - Would Recommend	January 2018	96.97%	February 2018	98.01%	1.04%	▲		
	Maternity - Friends and Family Test - Wouldn't Recommend	January 2018	1.43%	February 2018	0.00%	-0.43%	▼		
	Out-patients - Friends and Family Test - Would Recommend	January 2018	94.22%	February 2018	94.46%	0.24%	▲		
	Out-patients - Friends and Family Test - Wouldn't Recommend	January 2018	1.87%	February 2018	2.22%	1.15%	▲		
	Day Case Unit - Friends and Family Test - Would Recommend	January 2018	99.13%	February 2018	97.38%	-1.76%	▼		
	Day Case Unit - Friends and Family Test - Wouldn't Recommend	January 2018	0.14%	February 2018	0.00%	-0.14%	▼		
	Radiology - Friends and Family Test - Would Recommend	January 2018	93.60%	February 2018	94.73%	0.88%	▲		
	Radiology - Friends and Family Test - Wouldn't Recommend	January 2018	1.17%	February 2018	1.15%	-0.02%	▼		
	Community Clinics - Friends and Family Test - Would Recommend	January 2018	100.00%	February 2018	96.65%	-1.35%	▼		
	Community Clinics - Friends and Family Test - Wouldn't Recommend	January 2018	0.00%	February 2018	0.00%	0.00%	◄		
	Community Dental - Friends and Family Test - Would Recommend	January 2018	100.00%	February 2018	97.14%	-2.86%	▼		
	Community Dental - Friends and Family Test - Wouldn't Recommend	January 2018	0.00%	February 2018	0.00%	0.00%	◄		
	SPEQIS (Staff, Patient Experience and Quality Standards) - CARING	January 2018	95.26%	February 2018	97.75%	2.53%	▲		
EFFECTIVE	Hospital Standardised Mortality Ratio (HSMR)	December 2016 - November 2017	100.04	January 2017 - December 2017	101.32	1.29	▲		
	Crude Mortality Ratio - HSMR	December 2016 - November 2017	3.19%	January 2017 - December 2017	3.44%	0.25%	▲		
	Summary Hospital-Level Mortality Indicator (SHMI)	June 2016 - May 2017	109.07	July 2016 - June 2017	108.01	-1.06	▼		
	Crude Mortality Ratio - SHMI	June 2016 - May 2017	3.32%	July 2016 - June 2017	3.48%	-0.03%	▼		
	SPEQIS (Staff, Patient Experience and Quality Standards) - EFFECTIVE	January 2018	92.52%	February 2018	0.00%	-92.52%	▼		
RESPONSIVE	Trust Complaints - Month Total	January 2018	96	February 2018	79	-17	▼		
	Stage 1 Complaints - Informal	January 2018	70	February 2018	50	-20	▼		
	Stage 2 Complaints - Formal Meeting	January 2018	11	February 2018	10	-1	▼		
	Stage 3 Complaints - Formal Chief Executive Letter	January 2018	15	February 2018	19	4	▲		
	25 Day Compliance Rate	December 2017	100%	January 2018	82%	-18.00%	▼		
	SPEQIS (Staff, Patient Experience and Quality Standards) - RESPONSIVE	January 2018	92.52%	February 2018	94.51%	1.98%	▲		
WELL-LED	DAY - Nursing Workforce Average Fill Rate - Registered Nurses/Midwives	January 2018	83.00%	February 2018	82.04%	1.01%	▲		
	NIGHT - Nursing Workforce Average Fill Rate - Registered Nurses/Midwives	January 2018	93.81%	February 2018	92.17%	-1.63%	▼		
	DAY - Nursing Workforce Average Fill Rate - Care Staff	January 2018	131.25%	February 2018	99.91%	-1.32%	▼		
	NIGHT - Nursing Workforce Average Fill Rate- Care Staff	January 2018	133.11%	February 2018	129.22%	6.10%	▲		
	SPEQIS (Staff, Patient Experience and Quality Standards) - WELL-LED	January 2018	95.05%	February 2018	87.50%	-7.55%	▼		

2. TRUST PERFORMANCE OVERVIEW

	Indicator	Objective	Director	Target	Set By	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	17/18	18/19	19/20
Safe	Falls per 1000 occupied bed days resulting in Harm	Patients	LM	<=0.98	QEH	0.08	0.00	0.00	0.00	0.08	0.17	0.08	0.18	0.33	0.09	0.00	0.17	0.24	0.07	0.09	0.12
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	Patients	LM	>= 97.24%	QEH	97.45%	97.28%	97.29%	97.36%	97.57%	97.41%	97.29%	97.36%	97.44%	97.45%	97.31%	97.39%	Data 1M11 in arrears	97.10%	97.41%	97.38%
	Harm-free GEM Care	Patients	LM	>= 95%	QEH	96.40%	97.22%	97.66%	97.49%	98.77%	98.46%	98.62%	99.18%	96.08%	98.29%	99.54%	98.14%	98.32%	96.84%	97.73%	98.70%
	Never Events	Patients	FS	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0
	Serious Incidents (OCCURRED IN MONTH)	Patients	FS	0	Nat	1	5	3	3	4	7	6	4	9	3	3	7	5	29	54	18
	Serious Incidents (DECLARED IN MONTH)	Patients	FS	0	Nat	4	1	1	4	3	8	3	8	7	6	4	9	6			25
	Patient safety alerts not completed by deadline	Patients	LM	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Clostridium difficile (GEM acquired)	Patients	LM	4	Nat	4	6	5	1	3	2	0	1	0	2	3	4	0	49	22	12
	Clostridium difficile per 100k occupied bed days (rolling 12 months)	Patients	LM	<= 17.6	Nat	28.2	30.3	27.7	23.6	23.0	23.8	21.8	19.3	15.3	14.7	16.2	19.0	18.2	32.4	15.3	18.2
	MRSA bacteraemia (GEM acquired)	Patients	LM	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
	MRSA bacteraemia per 100k occupied bed days (rolling 12 months)	Patients	LM	0.0		1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	0.0	0.0	0.0	0.0	0.0	1.4	0.0
	Safe staffing levels (overall fill rate)	Patients	LM	>= 80%	Nat	95.6%	93.5%	95.2%	98.7%	98.1%	98.4%	102.6%	101.2%	111.0%	103.3%	103.8%	97.3%	95.5%		98.9%	99.9%
	No. of wards below 80% fill rate	Patients	LM	0	Nat	0	1	0	0	0	0	0	0	0	0	0	1			1	1
Caring	Cleanliness Scores - very high-risk areas	Places	LM	>= 100%	Nat	94.71%	93.87%	95.45%	95.10%	94.59%	95.71%	94.60%	95.82%	95.48%	95.63%	95.88%	88.38%	96.63%		95.23%	96.63%
	Cleanliness Scores - high-risk areas	Places	LM	>= 100%	Nat	93.78%	93.89%	93.91%	95.29%	96.08%	93.64%	95.25%	96.03%	95.89%	94.41%	95.94%	87.59%	95.59%		94.88%	95.88%
	Cleanliness Scores - significant-risk areas	Places	LM	>= 100%	Nat	90.88%	92.20%	93.06%	92.85%	92.17%	88.11%	92.10%	92.62%	93.59%	94.19%	94.67%	96.22%	94.64%		91.48%	94.93%
	Cleanliness Scores - low-risk areas	Places	LM	>= 100%	Nat	89.38%	84.52%	90.56%	88.40%	94.43%	0.00%	92.03%	90.01%	96.72%	92.33%	95.50%	88.06%	93.57%		83.24%	92.35%
	No. of cleanliness audits complete	Places	LM	37		46	34	29	45	35	31	47	35	34	44	36	35	46		435	161
Effective	SHMI (Trust Level - Rolling 12 Mth position, 6 mths in arrears)	Patients	FS	Not higher than expected	QEH			99.56			99.91		6 months in arrears								
	Crude HSMR Mortality (Trust Level - Rolling 12 Mth position, 3 mths in arrears)	Patients	FS	-		3.53	3.46	3.43	3.36	3.35	3.25	3.14	3.09	3.02	Latest Data not avail	3 months in arrears			3.60		
	HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 Mth position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	106.5	106.7	106.9	105.8	105.8	103.2	101.2	100.5	101.5					104.94		
	WEEKEND HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 Mth position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	115.0	114.4	115.3	116.4	114.7	114.5	112.4	109.0	107.4					111.35		
	Rate per 1000 admissions of inpatient cardiac arrests	Patients	FS	< 2.0	QEH	1.65	1.39	1.44	1.31	1.02	2.05	0.90	1.91	0.40	1.70	1.37	0.53	0.72	1.55	1.34	1.08
	Total C Section Rate	Patients	FS	< 25.00%	QEH	34.39%	27.61%	41.71%	30.77%	30.91%	35.63%	32.18%	34.30%	31.61%	31.93%	29.52%	30.72%		28.87%	33.47%	30.72%
	Stillbirth Rate(per 1000 births/stillbirths-Rolling 12 Mths)	Patients	FS	< 3.73	QEH	3.21	3.24	4.17	3.76	3.31	3.30	3.29	1.88	2.32	1.88	1.88	2.84	1 month in arrears	2.71	2.32	3.91
	Neonatal Deaths Rate(per 1000 livebirths-Rolling 12 Mths)	Patients	FS	< 1.06	QEH	0.46	0.46	0.93	0.94	1.90	2.36	2.36	2.82	2.79	2.82	2.83	3.32		0.90	2.79	1.96
	Extended Perinatal Deaths Rate (per 1000 births/stillbirths - Rolling 12 Mths)	Patients	FS	< 4.79	QEH	3.67	3.70	5.09	4.70	5.20	5.66	5.63	4.69	5.10	4.69	4.70	6.15		3.61	5.10	5.86
	% "Term" admissions to the NNU	Patients	FS	3.0%	QEH	Data not available prior to Apr 2019									6.5%	10.3%	5.7%	4.7%			6.7%
	% "Avoidable Term" admissions to the NNU	Patients	FS	0.0%	QEH										36.4%	16.7%	30.0%	9.1%			22.0%
	Maternal Deaths	Patients	FS	0	QEH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	National Clinical Audits participation rate	Patients	FS	≥100%	QEH													97.5%	95%	95%	97.5%
	No. of patients recruited in NIHR studies	Patients	FS	>600 Annually	QEH	74	111	64	67	123	51	37	153	77	37	29	59	29		594	154
Caring	Same Sex accommodation standard breaches	Patients	LM	0	Nat	16	8	0	8	14	2	7	11	4	6	5	3	7	62	93	21
	No. of Complaints (Clinical & Non Clinical)	Patients	LM	<= 20	QEH	36	41	41	36	32	27	41	37	38	34	47	24	38	362	421	143
	Complaints (rate as proportion of activity)	Patients	LM		QEH	0.10%	0.12%	0.12%	0.09%	0.08%	0.09%	0.11%	0.11%	0.11%	0.09%	0.12%	0.07%	0.10%		0.10%	0.10%
	%Complaints responded to within the national standard of six months from receipt of the complaint	Patients	LM	100%	Nat	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%		99.8%	98.8%
	%Complaints responded to within 30 days from receipt of the complaint	Patients	LM	>=90%	QEH	66.67%	71.88%	36.11%	46.34%	54.17%	33.33%	57.14%	46.43%	36.17%	6.90%	21.28%	8.76%	25.58%		41.36%	16.88%
	Reopened complaints (%of total complaints)	Patients	LM	<=15%	QEH	0.00%	0.00%	2.44%	0.00%	3.13%	11.11%	0.00%	0.00%	0.00%	2.94%	6.38%	20.83%	10.53%		1.66%	9.09%
	%eligible patients who have dementia case find applied	Patients	LM	>=90.00%		41.39%	48.32%	40.48%	38.76%	48.98%	45.80%	45.79%	44.66%	43.54%	48.94%	51.46%	50.00%	Data 1M11 in arrears	60.97%	44.09%	50.17%
	Friends & Family (Inpatients & Daycases)	Patients	LM	>=95%	QEH	95.48%	95.01%	95.50%	95.15%	96.15%	95.17%	95.05%	95.03%	96.21%	97.01%	94.73%	95.80%	96.35%	95.53%	95.53%	95.90%
	Sample Size: Friends & Family (Inpatients & Daycases)	Patients	LM	>=30%	QEH	30.36%	34.62%	34.97%	31.47%	33.05%	29.58%	33.67%	37.26%	37.83%	30.17%	36.67%	31.20%	31.31%	30.33%	33.21%	32.38%
	Friends & Family (Accident & Emergency)	Patients	LM	>=95%	QEH	93.15%	93.21%	90.94%	89.42%	89.80%	89.94%	94.32%	95.32%	90.57%	93.25%	94.92%	92.68%	90.93%	83.12%	91.16%	93.03%
	Sample Size: Friends & Family (Accident & Emergency)	Patients	LM	>=20%	QEH	14.65%	13.96%	8.84%	21.32%	20.81%	14.60%	19.20%	11.59%	11.84%	11.35%	11.70%	7.67%	9.81%	16.98%	13.79%	10.16%
	Friends & Family (Outpatients)	Patients	LM	>=95%	QEH	97.70%	97.72%	96.85%	96.03%	96.75%	97.40%	97.07%	96.88%	97.35%	96.98%	96.17%	97.35%	95.77%	96.78%	97.05%	96.54%
	Sample Size: Friends & Family (Outpatients)	Patients	LM		QEH	6.61%	6.05%	5.88%	6.88%	6.19%	5.73%	7.18%	5.63%	6.82%	6.14%	6.15%	6.13%	7.04%	5.41%	6.42%	6.37%
	Friends & Family (Maternity)	Patients	LM	>=95%	QEH	95.12%	100.00%	100.00%	100.00%	94.74%	94.12%	96.67%	100.00%	93.65%	98.04%	100.00%	100.00%	96.83%	96.90%	96.57%	98.62%
	Sample Size: Friends & Family (Maternity)	Patients	LM	>=15%	QEH	21.24%	14.71%	11.58%	22.94%	23.31%	20.12%	17.05%	21.64%	34.62%	31.68%	35.71%	26.67%	27.63%	15.20%	21.97%	30.19%

The importance of focus

Safety & Quality Dashboard		Mar 2018							
CQC Domain	Indicator	Previous Period	Previous Value	Latest Period	Latest Value	Difference	Trend over previous period	Trend - APR 2017 onwards	2017/18 Total / 2017/18 Average
	Emergency Care - Friends and Family Test - Would Recommend	January 2018	93.27%	February 2018	95.73%	2.46%	▲		94.32%

One month trend…….

Is an increase from 95.36% to 95.76% important or distracting narrative?

Caring

7 Family and Friends Test (FFT) (data up to February 2018)

7.2 The Trusts 'Would Recommend' for Friends and Family returns *increased* to **95.76%** for February 2018 from 95.36% in January 2018. The percentage of patients who stated they 'Wouldn't Recommend' *decreased* to **0.85%** in February 2018 from 1.07% in January 2018.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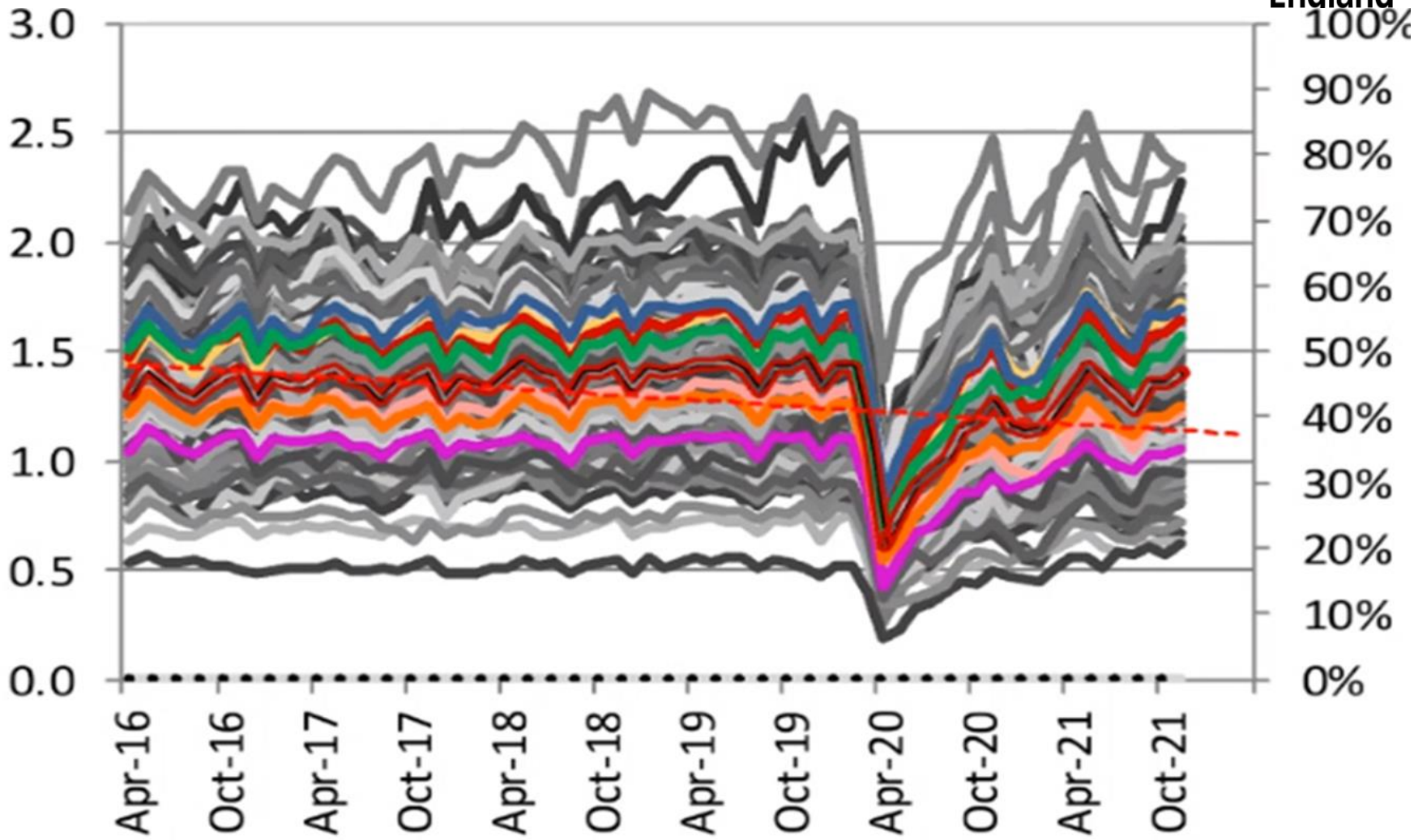
Task


3.0
2.5
2.0
1.5
1.0
0.5
0.0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-16
Oct-16
Apr-17
Oct-17
Apr-18
Oct-18
Apr-19
Oct-19
Apr-20
Oct-20
Apr-21
Oct-21

			18/19 Q1			18/19 Q2			18/19 Q3			18/19 Q4			19/20 Q1			19/20 Q2		
Performance	Trust	Latest	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
A&E	x	Sep-19	75.34%	78.78%	79.79%	78.01%	76.38%	77.76%	75.02%	74.97%	71.04%	71.56%	73.48%	77.67%	76.17%	77.18%	74.40%	76.74%	77.96%	77.64%
12hr breach	x	Aug-19	44	28	3	2	10	19	25	34	99	170	85	16	65	51	134	61	50	
AMB 1 hr	x	Sep-19	266	198	129	217	323	293	425	282	554	821	536	233	508	360	444	395	264	279
DTOC	x	Jul-19	1,919	1,960	2,027	1,839	1,921	1,785	1,653	2,109	1,891	1,841	1,689	1,810	1,500	1,784	1,699	1,746		
	y	Jul-19	830	803	713	617	840	622	523	885	575	607	639	671	515	641	680	560		
	y	Jul-19	1,063	981	1,110	1,012	1,069	1,056	922	1,144	1,199	1,185	1,041	1,090	860	1,056	925	941		
Thrombolysis < 1 hr	x	Aug-19	40.00%	41.70%	33.30%	50.00%	45.50%	14.30%	54.50%	42.90%	33.30%	66.70%	60.00%	0.00%	63.60%	44.40%	62.50%	11.10%	40.00%	
Quality of care and outcomes																				
NE	x	Jul-19	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0		
	x	Jul-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
SI	x	Mar-19	0	6	8	6	7	9	6	11	6	8	6	1						
	x	Mar-19	7	3	3	10	8	5	7	3	3	7	3	6						
MSA	y	Aug-19	52	59	60	46	46	48	41	43	45	52	32	42	47	52	48	48	37	
	x	Jul-19	55	62	62	55	45	55	50	52	54	50	34	45	59	57	52	45		
	x	Jul-19	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0		
MRSA	y	Aug-19	0	1	0	1	1	0	0	1	3	2	0	0	0	0	1	0	1	
	x	Aug-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	
CDIFF	x	Aug-19	8	15	16	14	14	7	13	8	10	13	13	14	7	7	11	9	16	
	y	Aug-19	3	2	3	6	1	3	5	2	4	5	5	4	4	3	5	3	9	
	y																			
Ecoli	x	Aug-19	29	38	31	28	39	48	27	37	36	31	30	38	34	52	38	25	39	
	x	Aug-19	5	5	6	6	7	2	5	6	12	4	9	3	5	6	4	6	4	
	x																			
F&F - IP	y	Jul-19	96.27%	94.45%	94.49%	94.45%	93.65%	92.90%	93.16%	95.47%	95.30%	94.09%	94.60%	94.94%	94.44%	94.38%	96.04%	95.71%		
F&F - A&E	y	Jul-19	81.21%	80.35%	81.46%	73.93%	78.68%	81.35%	81.70%	83.52%	78.27%	82.02%	85.71%	84.14%	86.35%	82.59%	82.06%	75.98%		
F&F - OP	y	Jul-19	92.44%	92.60%	90.79%	92.17%	91.40%	91.01%	92.36%	93.32%	92.48%	92.34%	92.99%	93.18%	91.83%	92.85%	92.09%	93.38%		

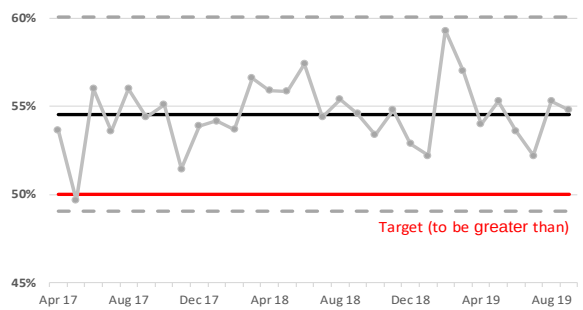
Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

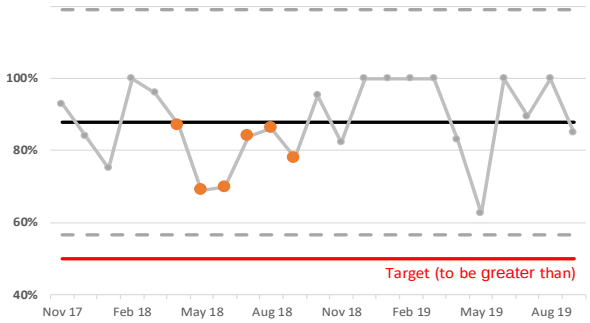
Improving Access to Psychological Therapies – performance against target

Metric	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
IAPT Treatment 18 Weeks	95%	100.0%	99.5%	99.9%	99.8%	99.4%	99.7%	99.6%	99.7%
IAPT Treatment 6 Weeks	75%	86%	84%	83%	81%	75%	80%	81%	81%
IAPT Recovery Rate	50%	59%	57%	54%	55%	54%	52%	55%	55%
EIS First Episode Psychosis	50%	100%	100%	83%	63%	100%	89%	100%	85%

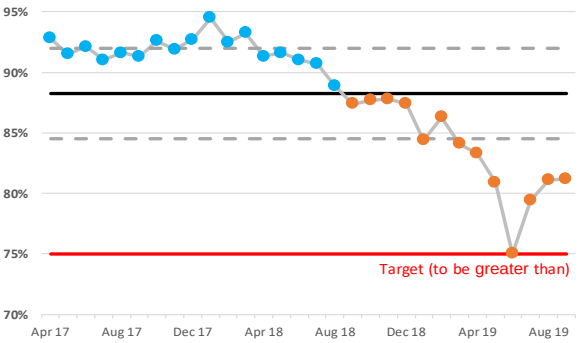
IAPT Recovery Rate



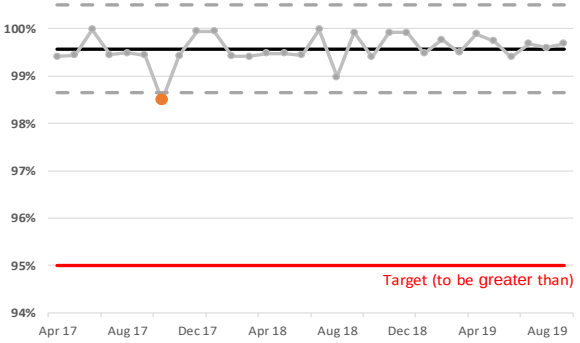
EIS First Episode Psychosis



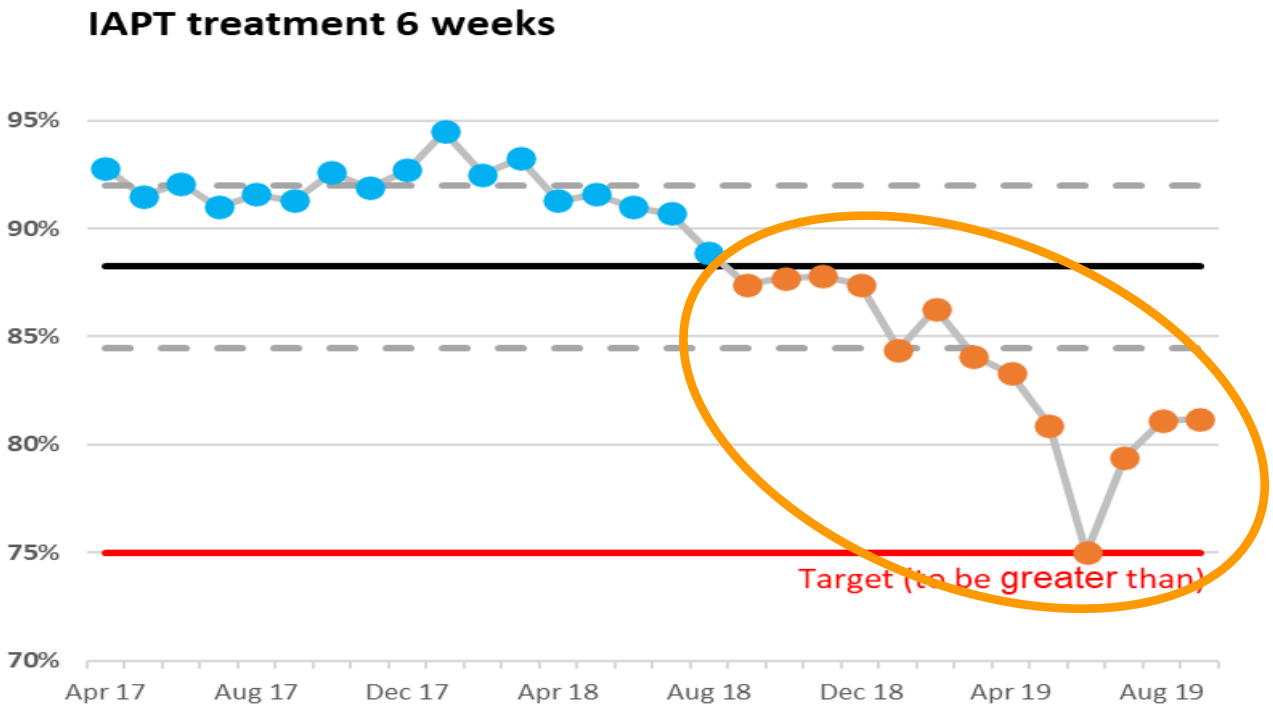
IAPT treatment 6 weeks



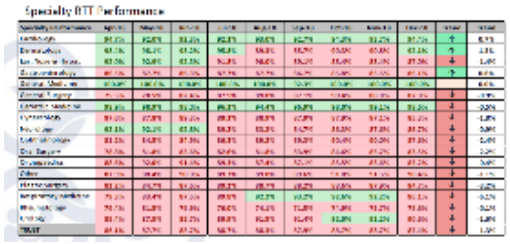
IAPT Treatment 18 Weeks



Did green provide true assurance?

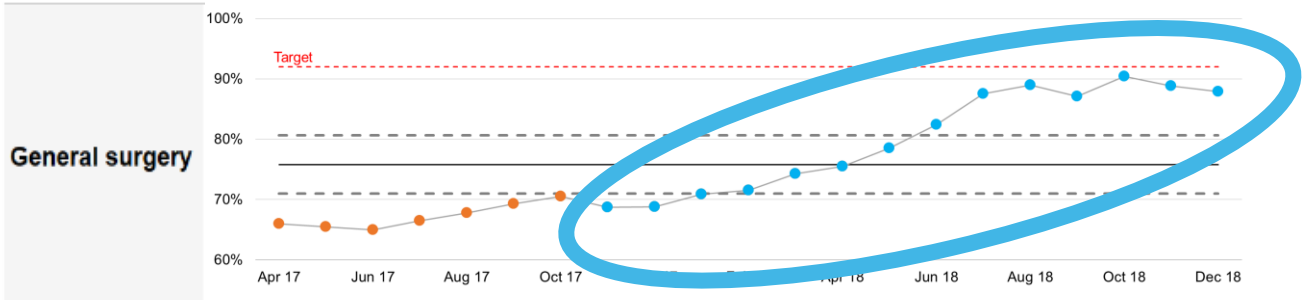


Might red hide improvement?

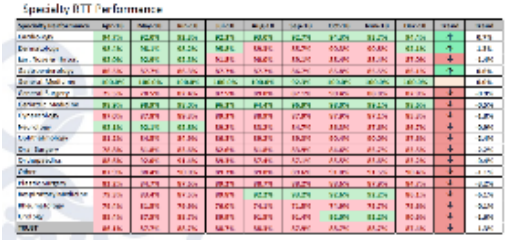


General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	-0.9%

Decline & Failing?



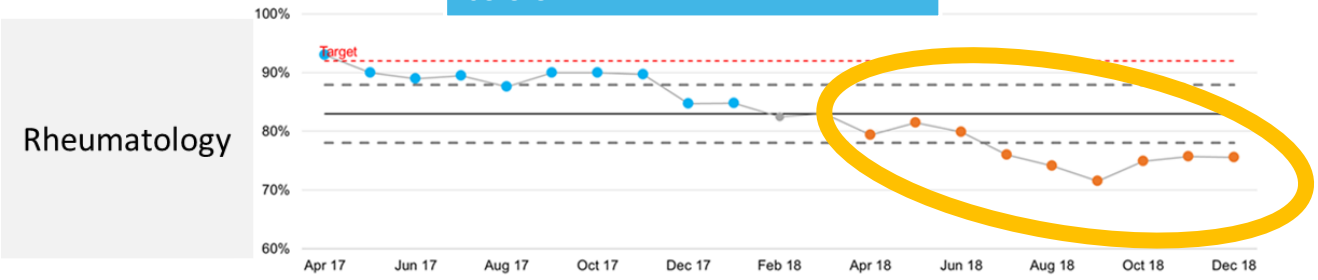
Might red hide improvement?



Rheumatology

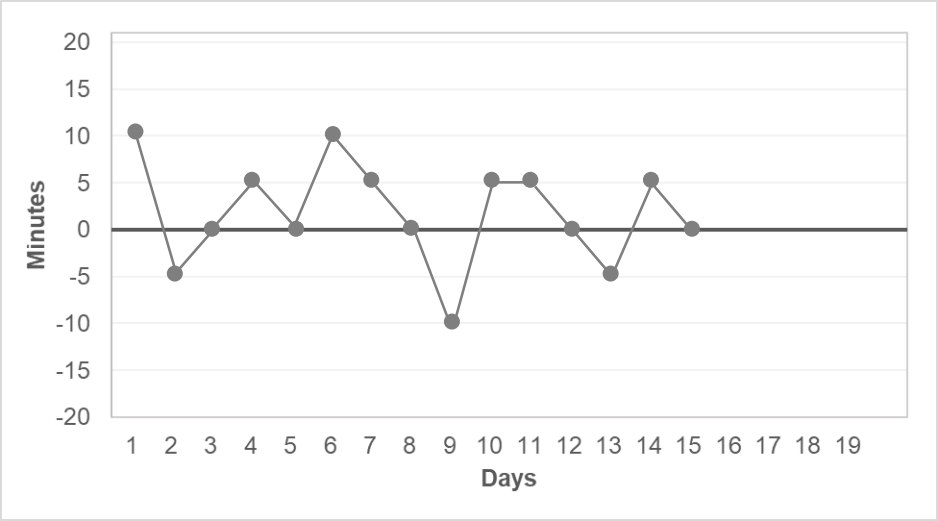
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%

Same misinterpretation as before?



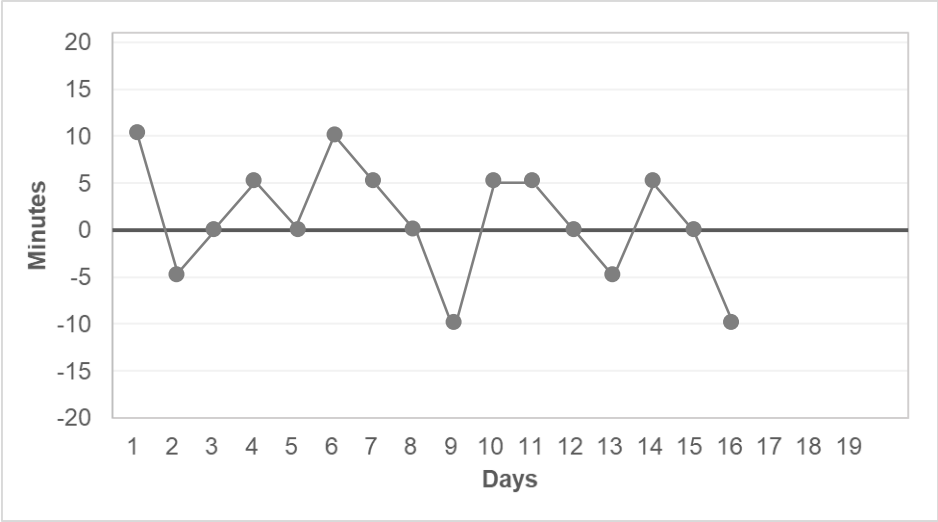
Introducing John and Mary

Sainsbury's



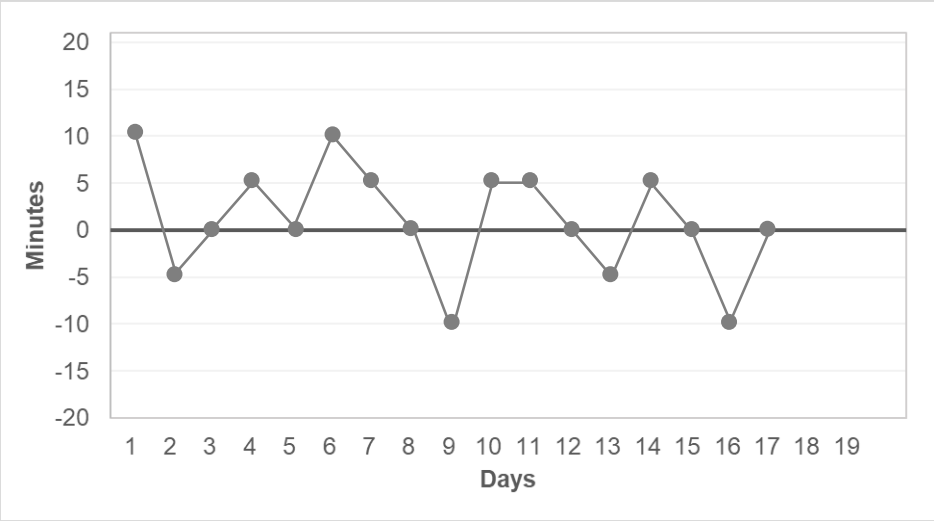
7pm

Now John comes back...



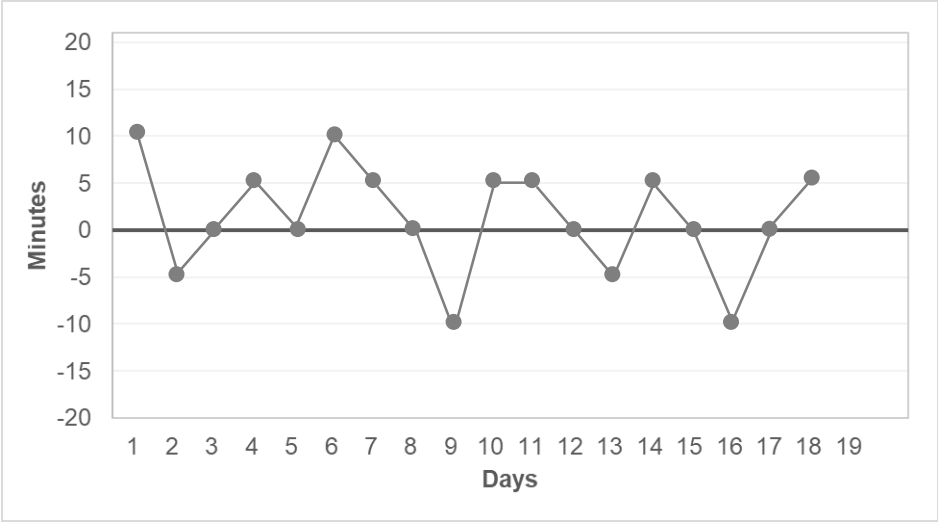
Mary arrives at 18:50

John asks, why have you arrived 10 minutes early?



Mary arrives at 19:00

John asks: yesterday you arrived at 18.50 – why have you arrived at 19:00 today?



Mary arrives at 19:05

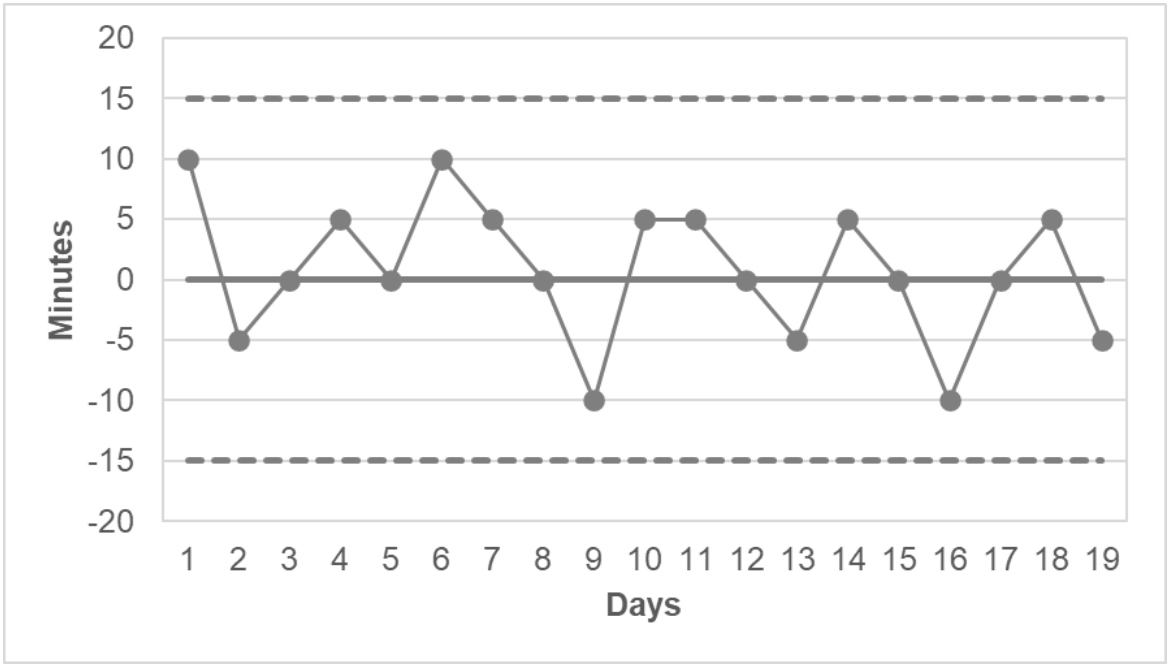
John asks: yesterday you arrived at 7pm – why are you late?

Mary arrives home at 18:55

John: Yesterday you arrived at 19:05, why are you early today?

Thoughts on the John & Mary story?

What would help?

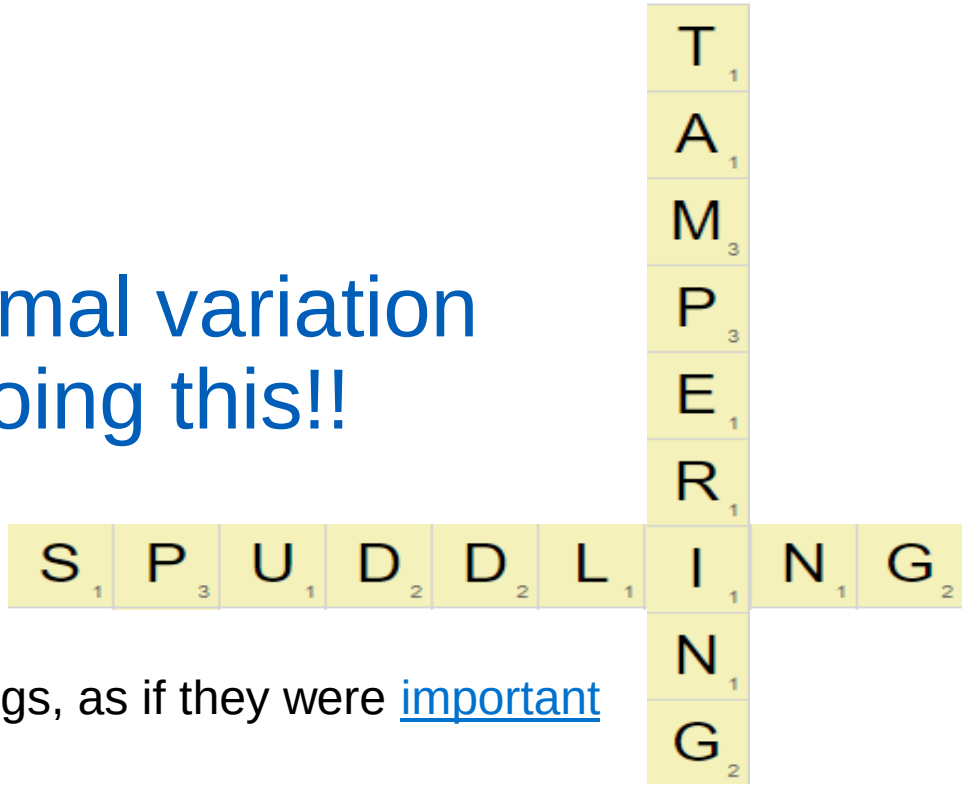


Describe the expected range of variation

Two goals

1. Improve performance
2. Reduce variation

When we react to normal variation we are in danger of doing this!!



To make a lot of fuss about trivial things, as if they were important

Are you spuddling?

Strong evidence base

THE PROBLEM WITH...

The problem with red, amber, green: the need to avoid distraction by random variation in organisational performance measures

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'The Problem with…' series covers controversial topics related to efforts to improve healthcare quality, including widely recommended but deceptively difficult strategies for improvement and pervasive problems that seem to resist solution.

INTRODUCTION

Many healthcare organisations now track a number of performance measures like infection and complication rates, waiting times, staff adherence to guidelines, etc. Our own organisation, The Capital Region of Denmark, provides healthcare for 1.7 million people and runs 6 hospitals and 11 mental health centres. Measures of clinical quality have been widely used in our region locally at hospitals and departments for many years. Recently, our region started to systematically define and track strategical key performance measures also at the top management level. Approximately 25 measures on a wide range of subjects from hospital infections to public transportation are being tracked by the top management and the Regional Council.

The measurement strategy for hospitals involves a bottom-up approach allowing each hospital and department to, if needed, define its own performance measures that feed into one or more of the overall measures. For example, bacteraemia is one of the overall measures, and some acute-care departments, who rarely see hospital-acquired bacteraemia, have started to work on reducing the use of bladder catheters in order to reduce the risk of bacteraemia from catheter-related urinary tract infections diagnosed after their patients have been transferred to other departments. To support their work, they have developed a handful of measures that track the use of catheters and staff compliance with standard procedures related to catheter use.

We welcome this development very much. The choice of relatively few overall measures combined with the bottom–up approach is a helpful strategy that focuses and aligns improvement work and stimulates the use of data at all levels of the organisation while leaving room for meaningful local adaptations of performance measures.

However, we do not at all welcome the widespread use of red, amber, green approaches to data analysis that is everywhere in our organisation.

By 'red, amber, green', we are referring to graphical data displays that use colour coding of individual data values based on whether this value is on the right (green) or wrong (red) side of a target value. Often amber or yellow is used to indicate data values that are somewhere between 'right' and 'wrong'.

The problem with red, amber, green management is that at best is it useless, at worst it is harmful.

THE PROBLEM WITH RED, AMBER, GREEN

Figure 1 was captured from the February 2015 report on regional performance measures. It shows the monthly count of a certain type of unwanted incident in mental healthcare. The horizontal line represents the target value of 10.5. That is, we do not want more than 10 incidents per month. Red bars show months above target. Green bars show months below target.

The data display in figure 1 is formally correct (green is better than red). However, it fails to convey a very

Linked

► http://dx.doi.org/10.1136/bmjqs-2015-004067
► http://dx.doi.org/10.1136/bmjqs-2016-005303

CrossMark

To cite: Anhøj J, Hellesøe A-MB. *BMJ Qual Saf* 2017;**26**:81–84.

EDITORIAL

From stoplight reports to time series: equipping boards and leadership teams to drive better decisions

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One of us was shown a letter received by a hospital infection control leader from the CEO congratulating her on an excellent monthly performance—for the previous month MRSA infections had decreased from 4 to 2 cases. A couple of months later the same CEO sent a letter expressing serious concern, asking for an explanation of why the monthly MRSA cases had doubled from 2 to 4. Implicit in the CEO's letter is an all too common misunderstanding when using point-to-point data comparisons that every data point is a signal of meaningful change. Absent any information about or understanding of the nature and extent of the underlying variation of the process or event type being analysed, in point-to-point comparisons the only thing one can be sure of is that the second data point will likely be either higher or lower than the preceding data point.

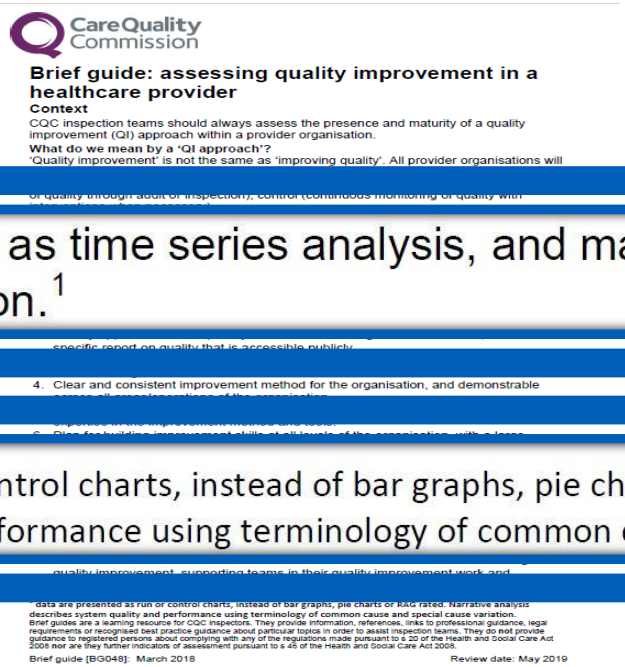
Common to board members, corporate-suite executives, directors and managers is the need to rapidly interpret key data and to decide what if any actions are needed. Two papers in this edition highlight the critical need to ensure that such data presentations do not lead decision-makers astray. In the first paper by Schmidtke *et al*,[1] analysing data presented to Boards of English NHS

isolation. Together these two papers are useful contributions to a literature about what forms of data decision-making groups should see in order to focus attention on the most pressing areas, to understand the causes that underpin what the data show, and determine what action should follow. The central question is: how to get data to decision-makers in a form which drives the most useful decision-making?

Anhøj *et al* make the striking claim that red, amber, green management reporting is at best useless and at worst harmful. These reports rely on the simple colour-coded heuristic of 'green is good… proceed as is', 'yellow or amber is warning…proceed with caution' and 'red is bad…stop and take action'. We think their critique is a bit too stark: there are situations when application of the stoplight type reporting may be appropriate. For example, in situations in which process reliability should be 100%—for example, as with never events—each data point can represent a meaningful signal. Likewise for well understood, tightly controlled processes with little inherent variation, stoplight reports may be of value. The primary advantage of stoplight reports is their simplicity and ease with which a large amount of information can be quickly presented.

Linked

Signs of a mature QI approach



CareQuality Commission

Brief guide: assessing quality improvement in a healthcare provider

Context

CQC inspection teams should always assess the presence and maturity of a quality improvement (QI) approach within a provider organisation.

What do we mean by a 'QI approach'?

'Quality improvement' is not the same as 'improving quality'. All provider organisations will

3. The Board looks at data as time series analysis, and makes decisions based on an understanding of variation.[1]

4. Clear and consistent improvement method for the organisation, and demonstrable

[1] data are presented as run or control charts, instead of bar graphs, pie charts or RAG rated. Narrative analysis describes system quality and performance using terminology of common cause and special cause variation.

Brief guide [BG048]: March 2018 Review date: May 2019

https://www.cqc.org.uk/sites/default/files/9001395_Brief_guide_Assessing_quality_improvement_in_a_healthcare_provider.pdf

Making data count

Kirkup report

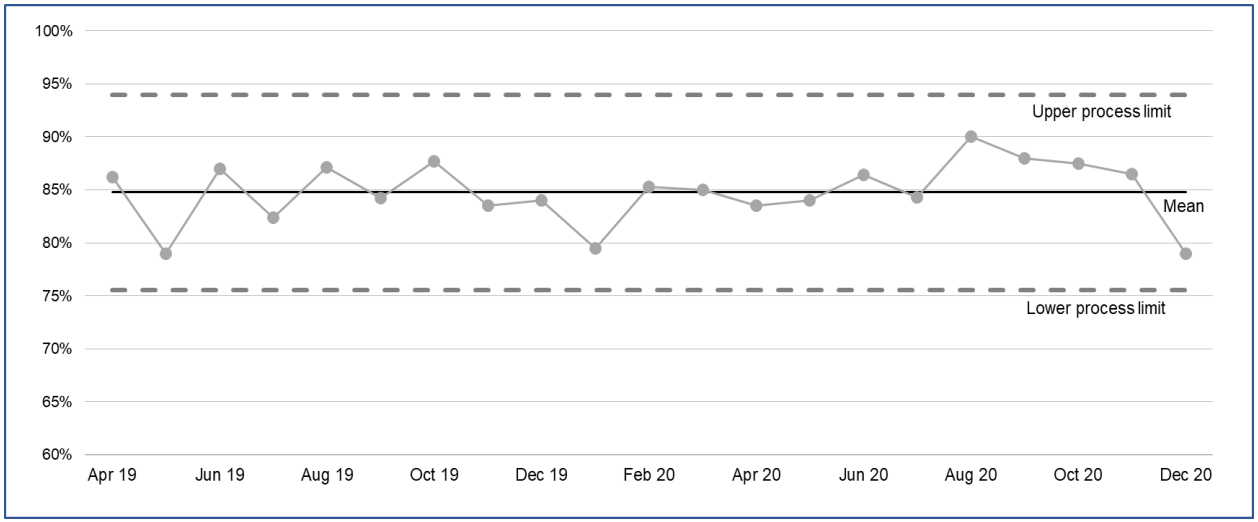
6.10 (Page 166)

The second requirement is that the measures are analysed and presented in a way that shows both the effects of the random variation inherent in all measures, and those occurrences and trends that are not attributable to random variation. ……
There are sound, statistically based approaches to detecting the signal among the noise, and presenting this graphically to show not only the level of variation but also the significant trends and outliers in the form of statistical process control charts and funnel plots. Useful work on these techniques is already being carried out by NHSE, but it is important that this is extended to clinically relevant outcome measures

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

Understanding variation

Time series line chart with 3 reference lines

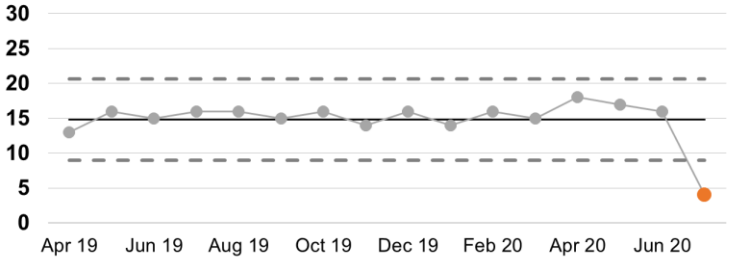


≈ 99% of data

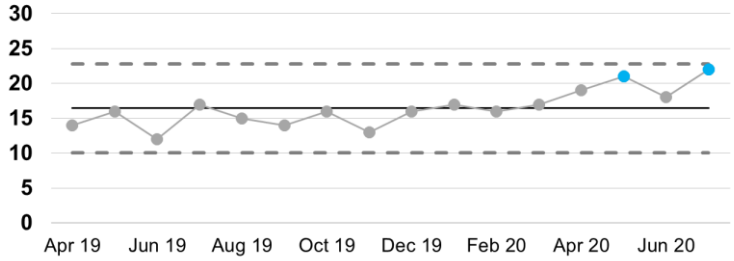
15+ data points for a robust analysis

SPC rules : special cause variation

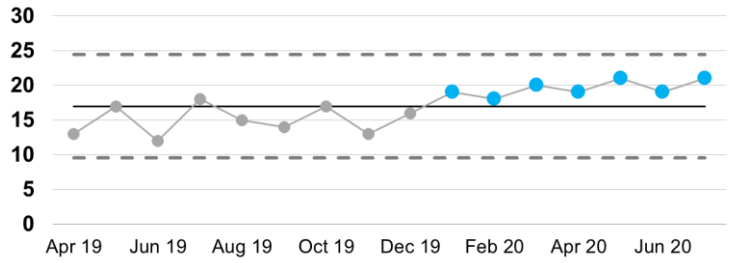
A single point outside the process limits



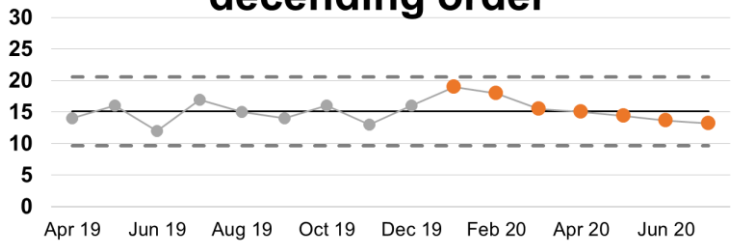
Two out of three points close to a process limit



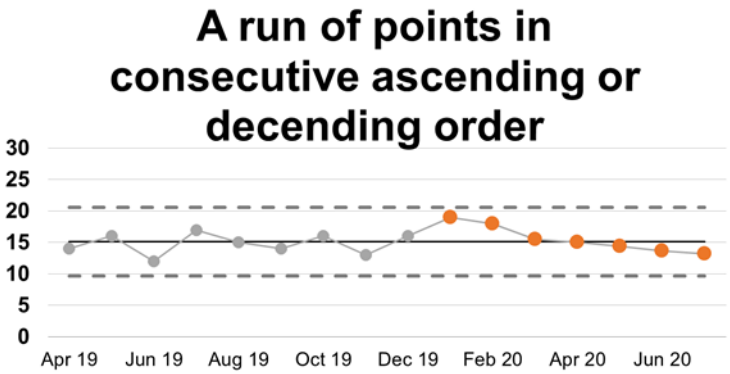
A shift of points above / below the mean



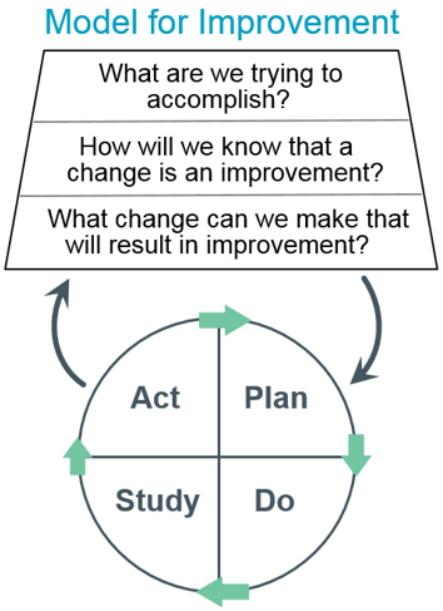
A run of points in consecutive ascending or decending order



If there is ‘special cause’…..



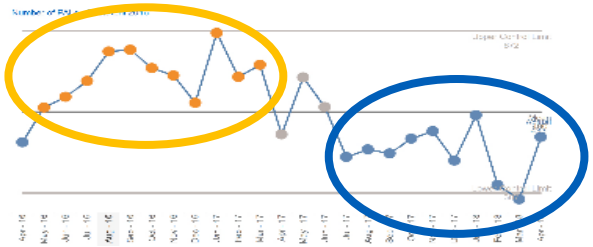
Two key uses for SPC



+

Maximising SPC impact

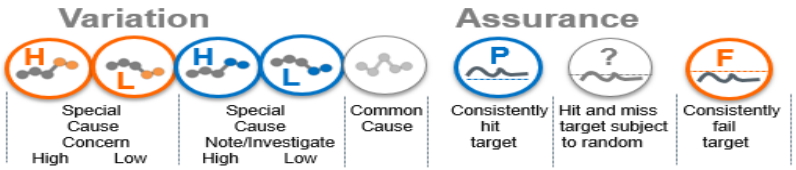
Highlight special cause



Concern

Improvement

Summary icons

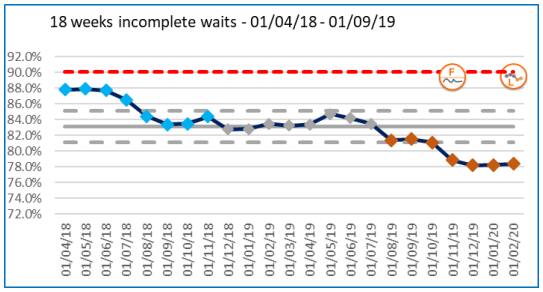


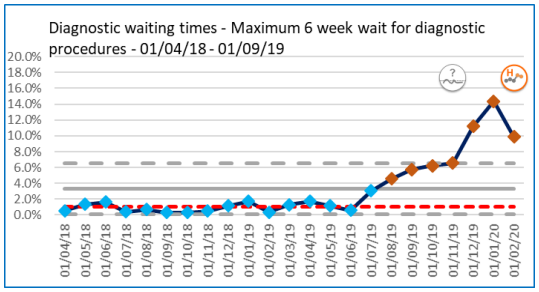
Narrative which supports the data

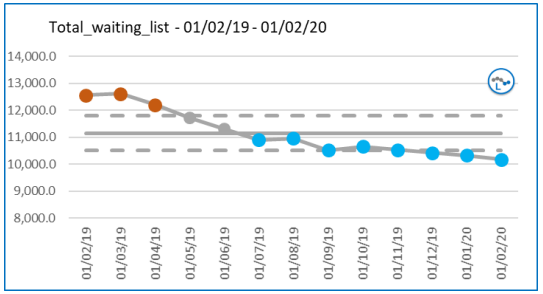
Comment

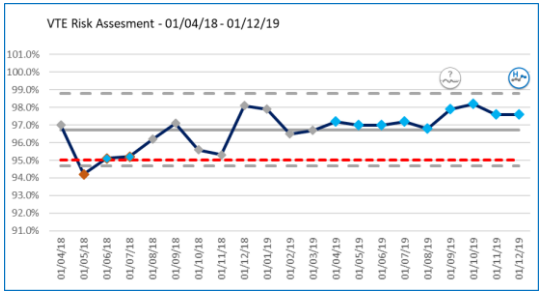
This indicator records 85% in May 2018 and is demonstrating common cause variation.

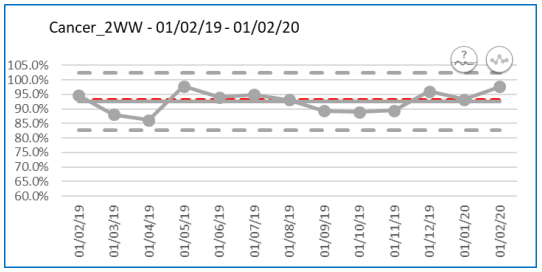
Understanding performance : using icons





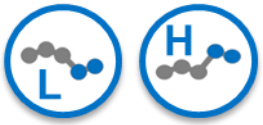






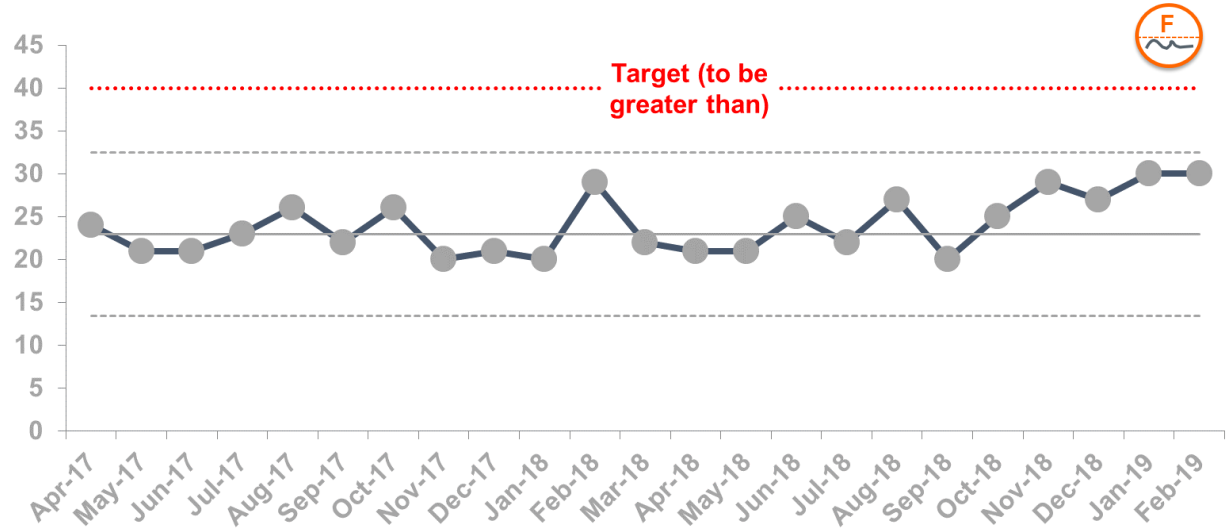
Concerning special cause

Improving special cause



Common cause

SPC for assurance

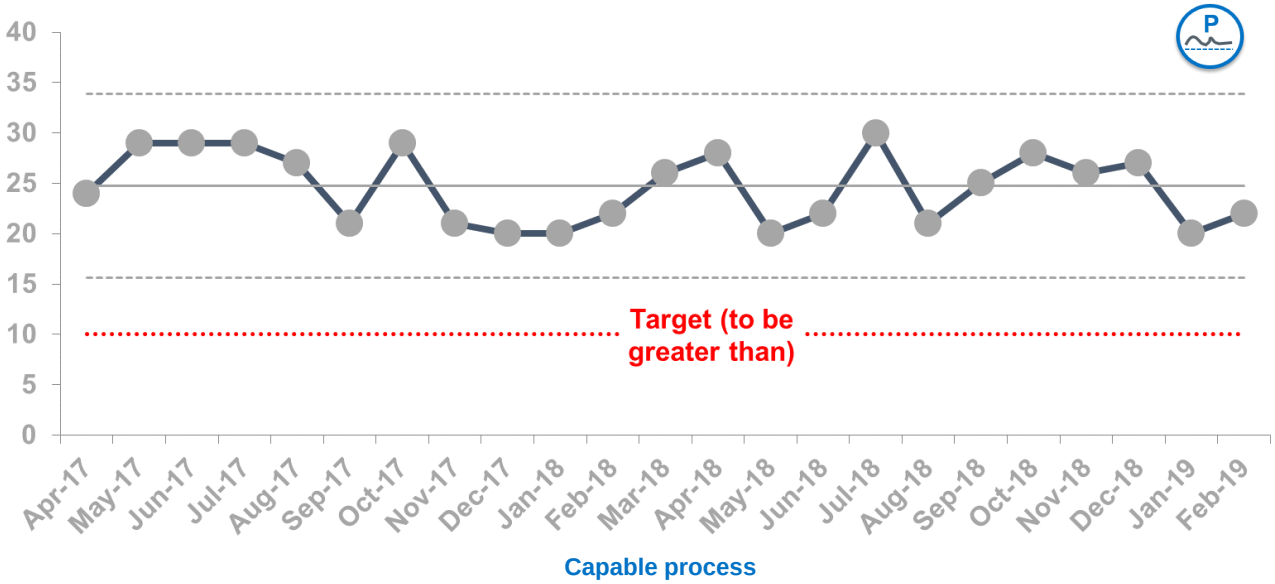


No rules triggered = common cause

Failing process

Redesign the system

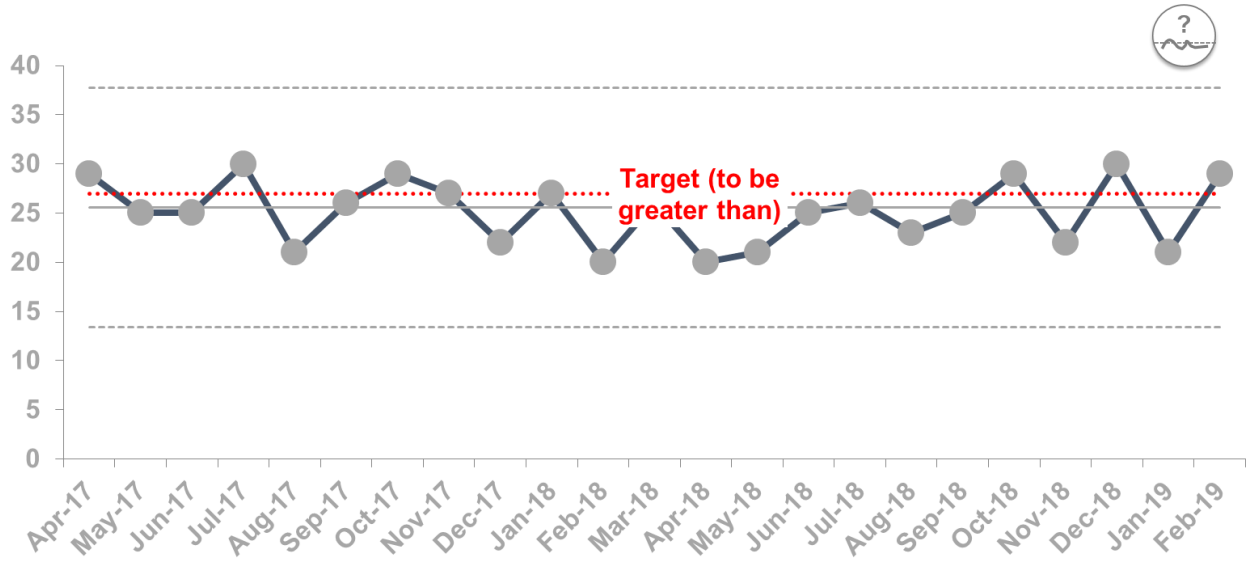
SPC for assurance



Capable process

Celebrate success

SPC for assurance



Unreliable process (flip flop)

Beware of spuddling

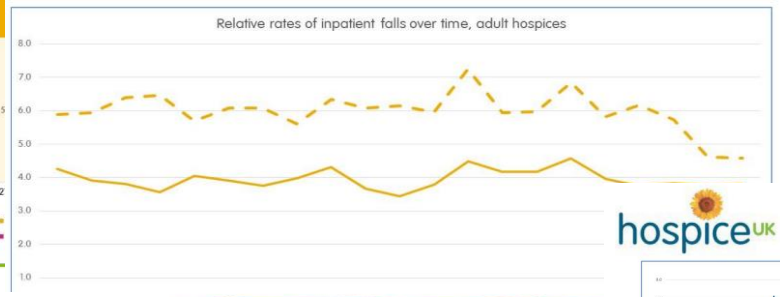
Making your data count

hospiceUK

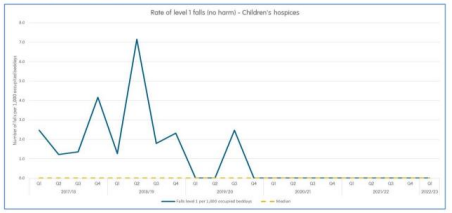
Adult falls:
Categories & proportions

Five categories
Most recent four quarters
- 56% no harm
- 44% harm (4% low harm)
- 2 falls at the highest level

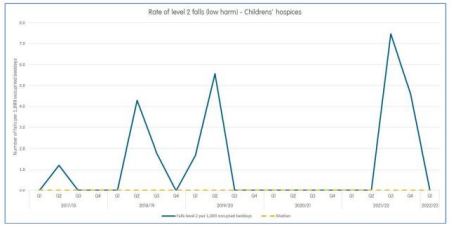
Total opportunity in this period
- 346,551 occupied bed-days



hospiceUK

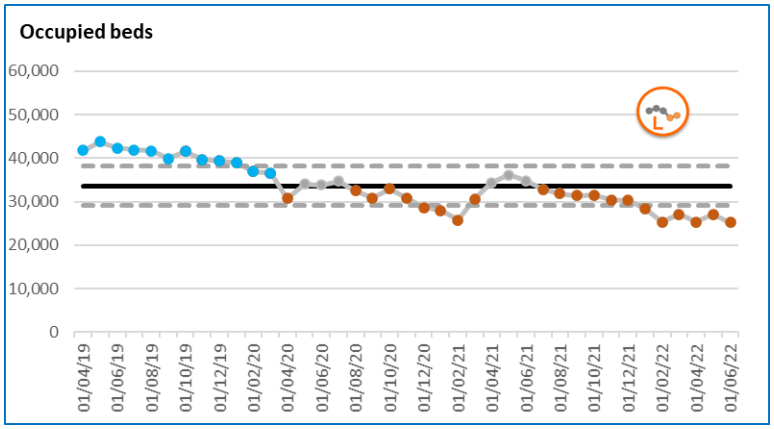


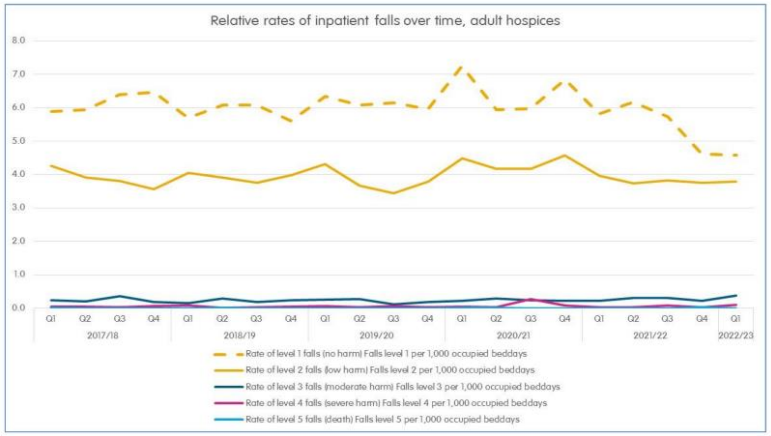
Level 1
57% of falls



Level 2
43% of falls

Using the right data.





The number of falls that occurs must be related to the number of patients in beds.

From this chart we can see the statistically significant decline in the number of occupied bed days since April 2019

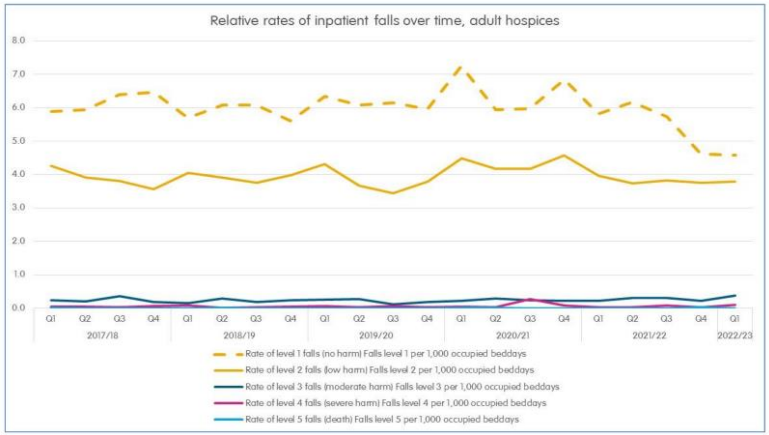
To compare the number of falls from month to month we need to calculate the rate of falls rather than consider the number of falls

This chart shows how the rate of each type of fall has changed over time but spaghetti charts are hard to understand.

Are any of these rates changing significantly?

Is there anything to worry about here?

Summary tables



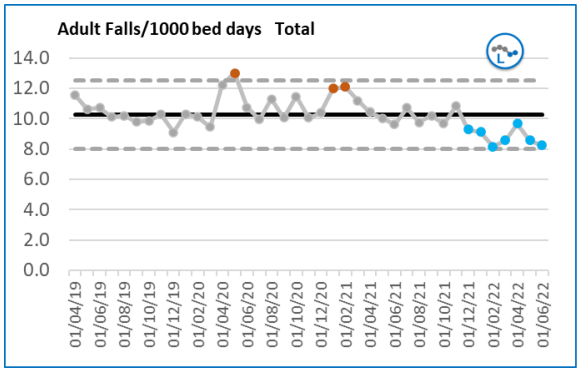
Instead of this chart we could provide a comparative summary table

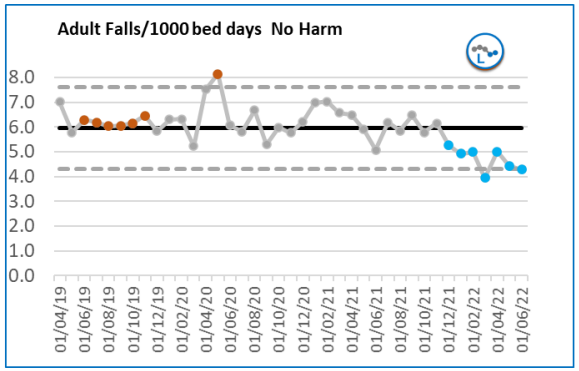
Here we can see that 2 metrics show significant improvement.

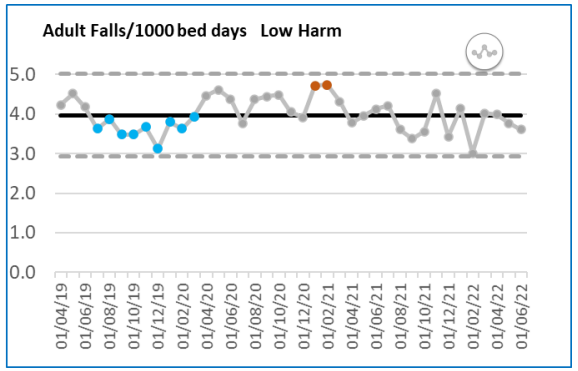
There is a significant reduction in the rate of total number of falls and the rate of falls resulting in no harm.

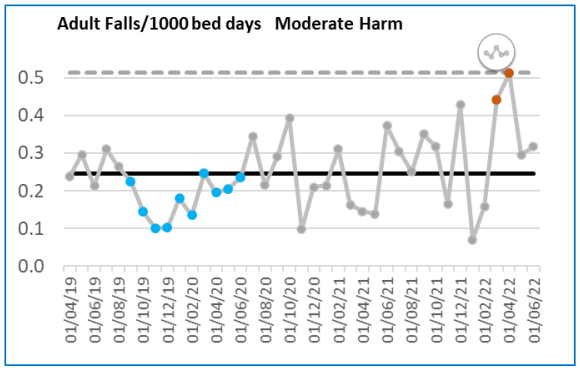
Falls	Latest month	Measure	Variation	Mean	Lower process limit	Upper process limit
Adult Falls/1000 bed days Total	Jun 22	8.3		10.2	8.0	12.5
Adult Falls/1000 bed days No Harm	Jun 22	4.3		6.0	4.3	7.6
Adult Falls/1000 bed days Low Harm	Jun 22	3.6		4.0	2.9	5.0
Adult Falls/1000 bed days Moderate Harm	Jun 22	0.3		0.2	0.0	0.5
Adult Falls/1000 bed days Severe Harm or death	Jun 22	0.0		0.1	-0.1	0.2

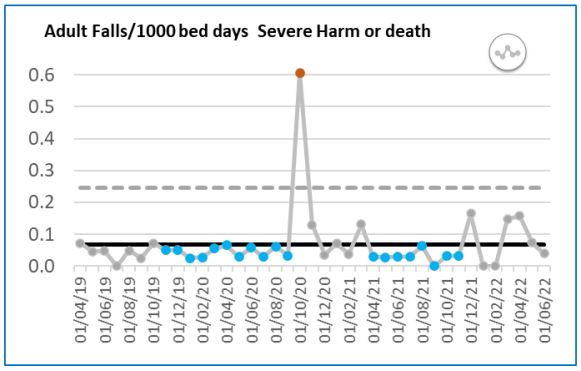
The detail









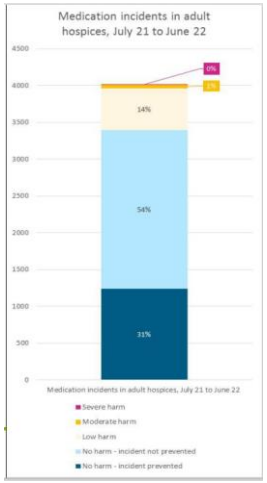


A reduction in the rate of falls resulting in no harm not surprisingly contributes to a reduction in the overall rate of falls.

Before celebrating this success it is important to ensure this is not just a change in the reporting process

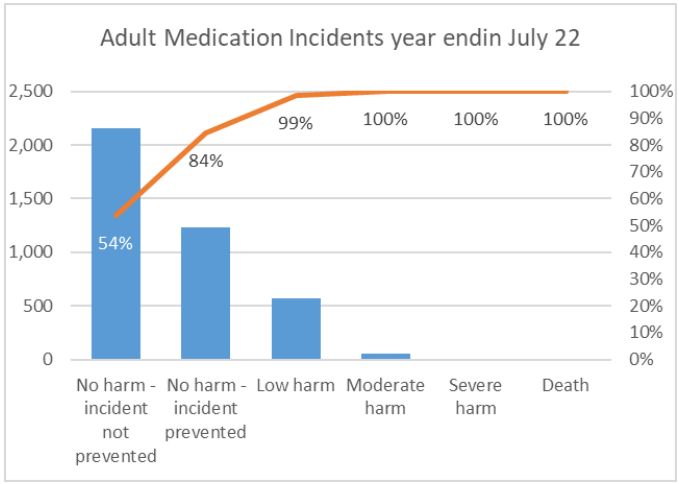
The rates of falls resulting in harm are not changing significantly.
Are these rates acceptable?

Medication errors



We can see that there were a total of 4018 medication incidents.
84% of incidents resulted in no harm

A ranked bar chart or pareto chart is another way to show this data.



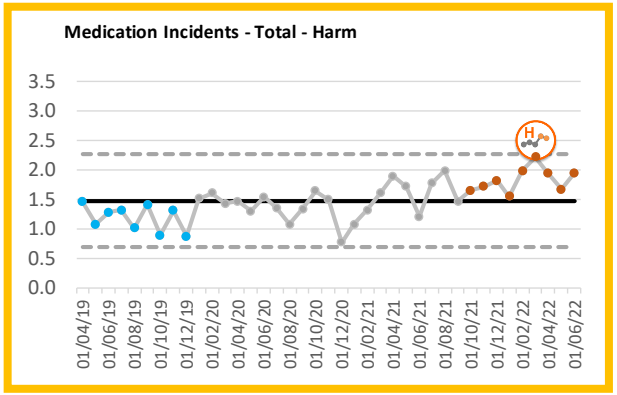
We can summarise this data using an icon table.

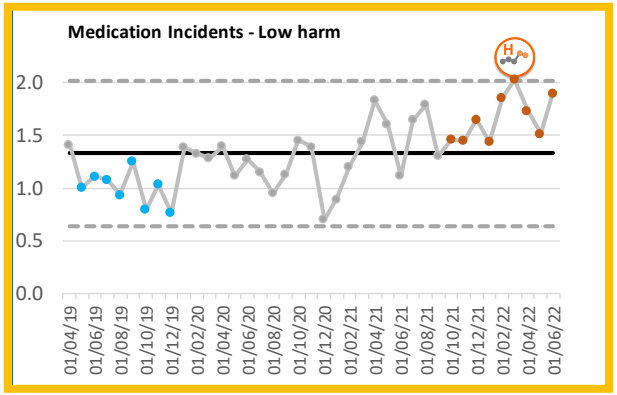
Medication incidents	Latest month	Measure	Variation	Mean	Lower process limit	Upper process limit
Medication Incidents - No harm - incident prevented	Jun 22	4.0		3.5	2.2	4.8
Medication Incidents - No harm - incident not prevented	Jun 22	5.7		6.1	4.7	7.5
Medication Incidents - Low harm	Jun 22	1.9		1.3	0.6	2.0
Medication Incidents - Moderate harm	Jun 22	0.0		0.1	-0.1	0.3
Medication Incidents - Severe harm	Jun 22	0.0		0.0	0.0	0.0
Medication Incidents - Total - Harm	Jul 22	3.5		1.5	0.7	2.4

4 metrics are showing significant variation

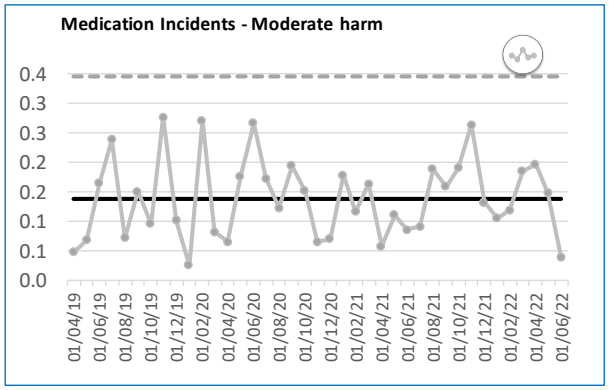
We might choose to investigate the metrics resulting in harm.

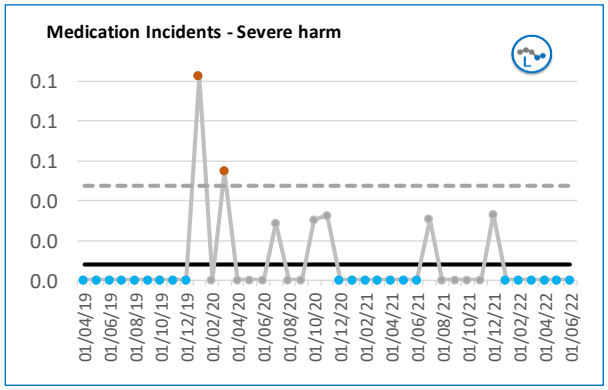
The detail





Here we can see that the cause in the rise in incidents resulting in harm is related to a rise in low harm incidents

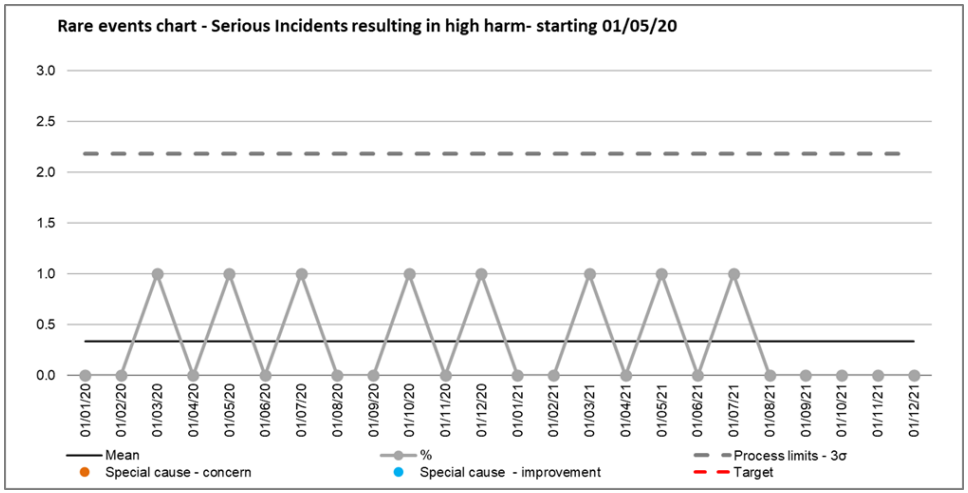




The chart for severe harm is odd and not very helpful.

In fact we need to use a different sort of chart to look at this sort of data.

Dealing with rare events



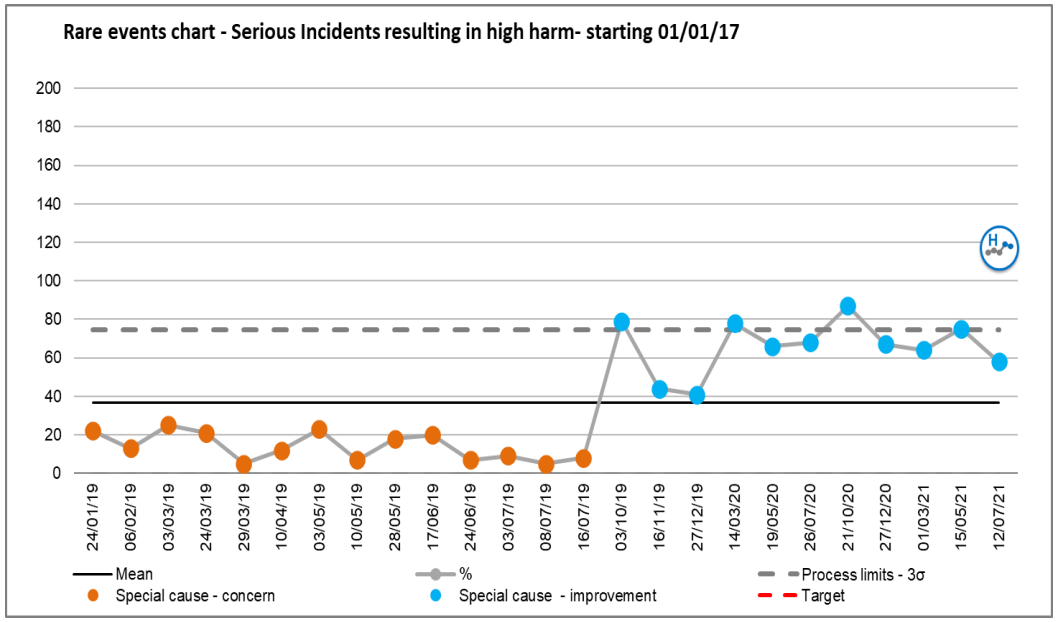
Medication errors

Children Falls

Pressure ulcers in children

Serious incidents

Dealing with rare events

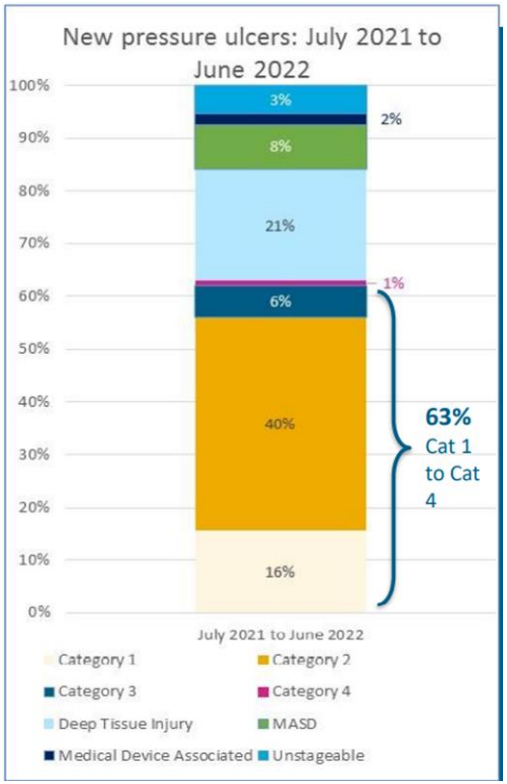


If we plot the days between rare events we can assess if these events are becoming more or less frequent.

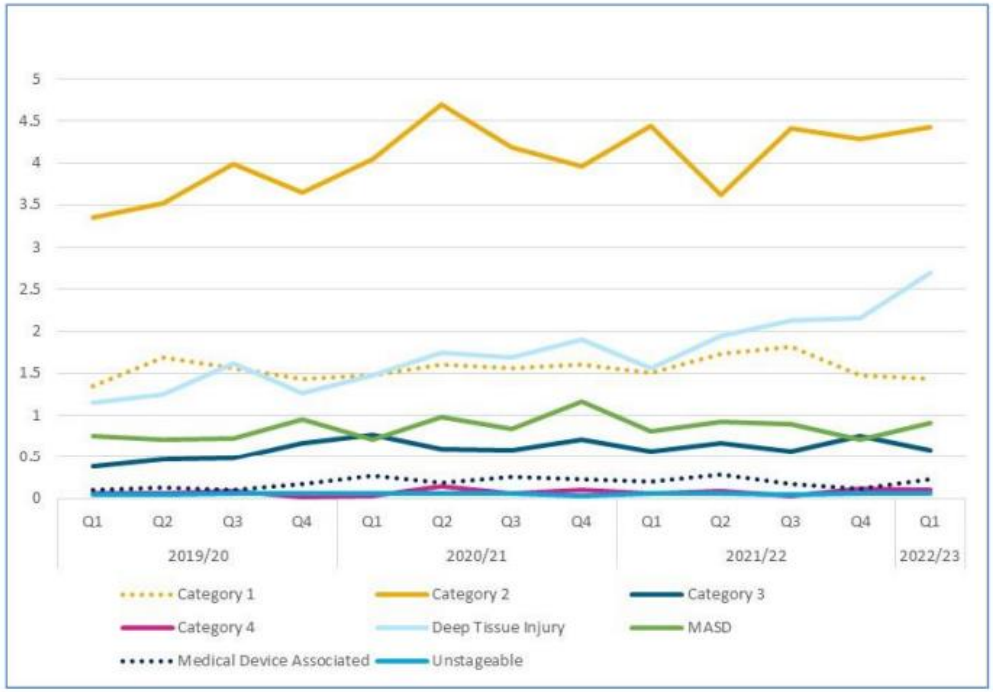
Here the vertical access shows the days between events rather than the number of events.

As the time between events increases we can see blue dots of improvement.

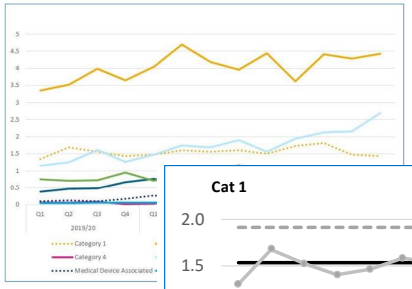
Untangling the spaghetti



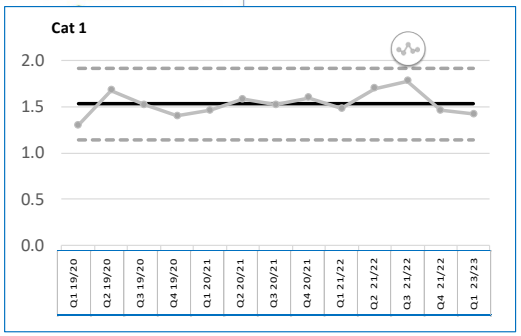
Is any thing changing significantly here?

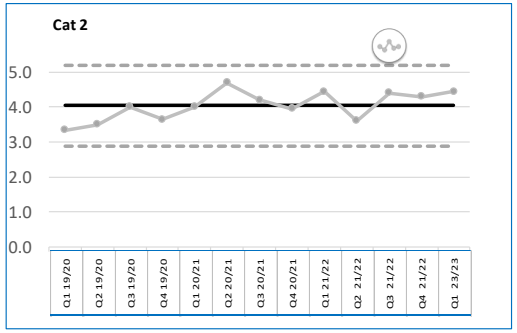


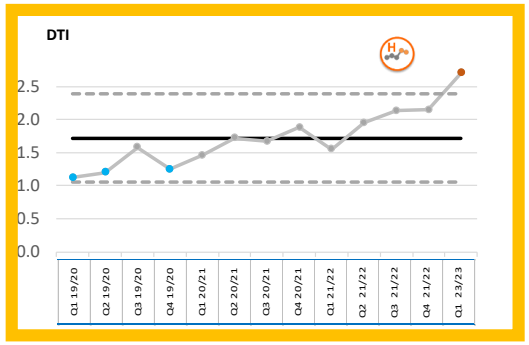
Untangling the spaghetti

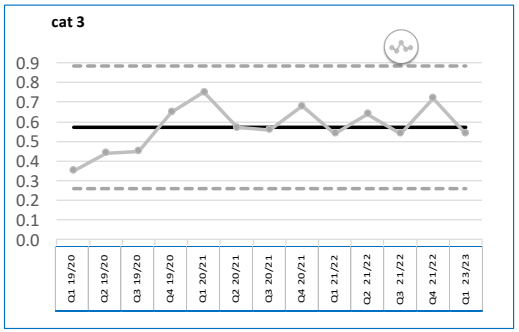


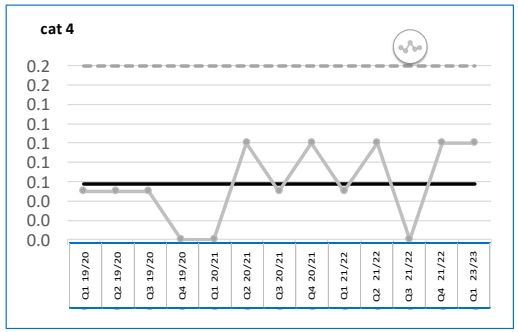
In fact the rate of Deep Tissue Injury has increase significantly over the study period

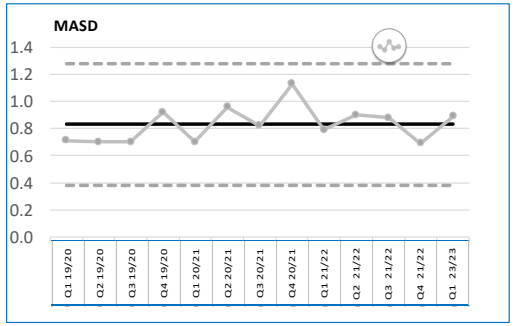












The summary

KPI	Latest month	Measure	Variation	Mean	Lower process limit	Upper process limit
Adult - New pressure ulcers Cat 1	Q1 23/23	1.4		1.5	1.1	1.9
Adult - New pressure ulcersCat 2	Q1 23/23	4.5		4.0	2.9	5.2
Adult - New pressure ulcers Cat 3	Q1 23/23	0.5		0.6	0.3	0.9
Adult - New pressure ulcers Cat 4	Q1 23/23	0.1		0.1	-0.1	0.2
Deep tissue Injury	Q1 23/23	2.7	H	1.7	1.1	2.4
MASD	Q1 23/23	0.9		0.8	0.4	1.3
Medical Device Associated	Q1 23/23	0.2		0.2	0.0	0.3

An example from another hospice

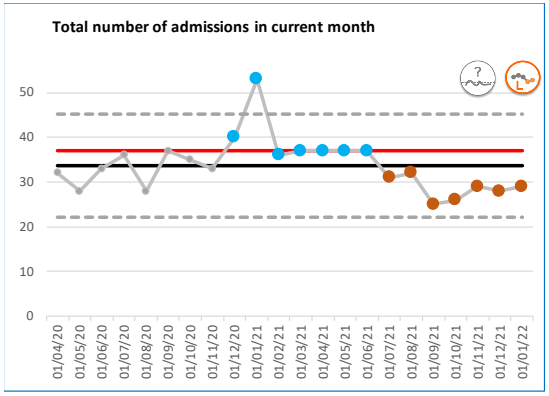
Admissions	2.2.1	Total	Total number of admissions in current month	37	37	37	31	32	25	26	29	28	29				311	355
	2.2.2	Individual patients	Number of individuals admitted once in month (does not include re-admissions)	36	35	35	30	32	25	26	28	26	29				302	n/a
	2.2.3	Home	Admissions from community (home) in current month from total admission	27	28	28	23	24	18	14	21	18	15				216	249
	2.2.4	CRH	Admissions from CRH in current month from total admission	9	7	8	6	7	6	10	7	6	14				80	105
	2.2.5	Other	Admissions from 'Other' in current month from total admission	1	2	1	2	1	1	2	1	2	0				13	n/a
	2.2.6	Weekday Admission	Weekday admission in current month from total admissions	35	34	37	29	27	24	24	27	26	26				289	325
	2.2.7	Weekend Admission	Weekend admission in current month from total admissions	2	3	0	2	5	1	2	2	2	3				22	31
	2.2.8	Current month	Total number of admissions from referrals received in current month	36	35	36	29	31	25	25	29	28	28				302	n/a
	2.2.9	Previous month(s)	Total number of admissions from referrals received before current month	1	2	1	2	1	0	1	0	0	1				9	n/a
	2.2.10	Admitted timeframe	Patients admitted within 2 days of referral in current month (%)	94.6%	75.7%	97.3%	90.3%	90.6%	96.0%	88.5%	72.4%	82.1%	89.7%				87.7%	95.0%
	2.2.11	Throughput / Turnover	Sum of deaths and discharges in current month divided by 21 beds	1.9	1.5	1.5	0.9	1.1	0.8	0.9	1.1	1.5	1.2				12.3	10.5

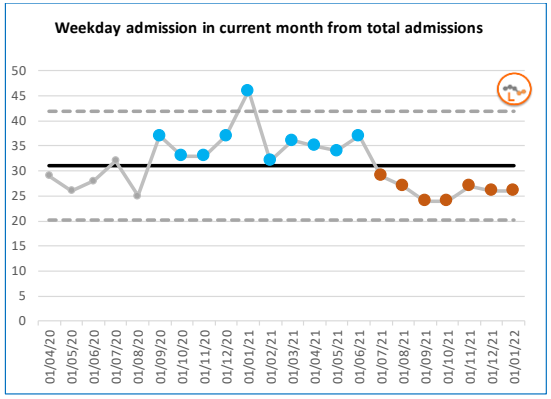
What would this look like on an icon table?

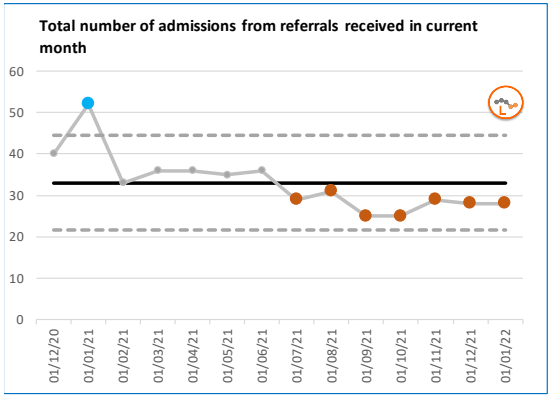
Would we know where to focus?

Inpatient unit Activity	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Total number of admissions in current month	Jan 22	29	37			34	22	45
Number of individuals admitted once in month (does not include re-admissions)	Jan 22	29	0			30	23	37
Admissions from community (home) in current month from total admission	Jan 22	15	0			22	13	30
Admissions from CRH in current month from total admission	Jan 22	14	0			8	1	15
Admissions from 'Other' in current month from total admission	Jan 22	0	0			1	-1	4
Weekday admission in current month from total admissions	Jan 22	26	0			31	20	42
Weekend admission in current month from total admissions	Jan 22	3	0			3	-3	8
Total number of admissions from referrals received in current month	Jan 22	28	0			33	22	45
Total number of admissions from referrals received before current month	Jan 22	1	0			1	-2	4
Patients admitted within 2 days of referral in current month (%)	Jan 22	90%	80%			91%	71%	111%
Sum of deaths and discharges in current month divided by 21 beds	Jan 22	1.2	0.0			1.5	0.6	2.3

We can see what is changing and investigate further







There has been a significant decrease in the number of admissions/month.

Since the majority of admissions are on weekdays not surprisingly there is also a significant decrease in weekday admissions month.

The total number of referral admitted in current month is also a related metric.

Here we can also see how the icons work when there is a target.

The number of admissions per month can not meet the target reliably but will sometimes do so by chance.

Looking at the data in this way prompts further questions.

But it’s not just about the pictures

Narrative writing is vital

Once you have good charts you have an excellent basis for good decision making but adding a good narrative is vital.

But it's a team effort

1. To explain what the chart shows
   General – Example – Exception

Technical analytical input-

In layman's language

2. To highlight performance which requires further attention or focus
   Special cause showing concern or improvement

3. To report on the capability of the process to meet it's target

4. To add insight around issues resulting in conce
   or improvement

Clinical/operational knowledge with defined goals

4. To add dated actions to address the issues which have been identified

5. To identify mitigations to deal with immediate urgent issues

What you need to avoid

Integrated Performance and Compliance Dashboard - March 2020

APPENDIX 1 - SINGLE OVERSIGHT FRAMEWORK

Measure	KPI	Period	Apr-19	May-19	Jun-19	Q1	Jul-19	Aug-19	Sep-19	Q2	Oct-19	Nov-19	Dec-19	Q3	Jan-20	Feb-20	Mar-20	Q4
	Target		85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
	New Cancer GP 62 Day (New Rules)	Mar-20	80.1%	80.2%	90.3%	83.3%	78.1%	82.4%	80.7%	80.1%	79.2%	85.8%	70.2%	78.4%	76.1%	73.9%	85.1%	78.6%

Pressures continued in the first two months…

Recovered the position in March

Pressures have continued….

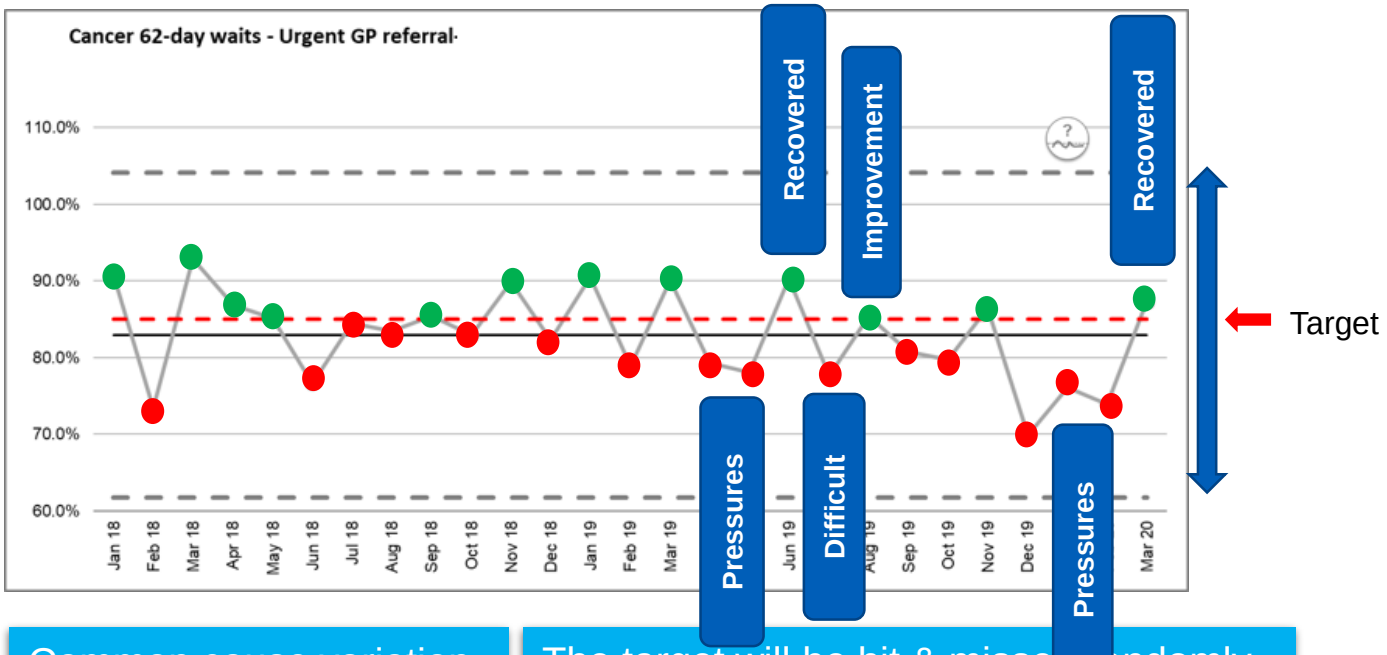
Pressures have continued in Q2 across most of the pathways which has unfortunately impacted upon the cancer 62 day standard. Despite a good recovery in
78.1%) with August showing improvement reporting at 82.4%.

A good recovery in June…

Sustainment was difficult in July…

August showing improvement

And why



Common cause variation

The target will be hit & missed randomly

Process limits are wide - investigate why and aim to reduce

What does good look like?

Maidstone & Tunbridge Wells NHS Trust

Trust-Board-agenda-and-reports-December-2021.pdf (mtw.nhs.uk)

Exec summary : 1 page

Executive Summary

Executive Summary

This report has been developed further to incorporate the Trust Strategy Deployment Review (SDR) process which has been implemented during this highly challenging period of time. This process is in the early stages currently and therefore some of the processes are still being embedded. The full Counter Measure Summaries (CMSs) will therefore develop and improve once these processes are fully embedded across the Trust.

The rate of inpatient falls has moved into special cause variation of a concerning nature after a significant spike in December. This indicator has not achieved the target for more than six months and has therefore been escalated as have both cases of C.Difficiile and Hospital on-set of COVID, which have also not achieved the target for more than six months.

Safe Staffing levels have not achieved the target for more than six months and have been escalated, but significant Recruitment and Retention activity is taking place to address this. In addition, the Trust is managing a programme of work around the NHS Mandatory Vaccination which could have an impact on the future vacancy rate.

The Trust continues to achieve both the National Cancer 62 Day Standard and the 2 Week Wait (2WW) Standard, reporting 85.9% and 94.3% respectively, however, achievement of the these standards continues to remain increasingly challenging with the continued high number of 2WW referrals and increasing 62 Day Backlog .

A&E 4hr performance remains in special cause variation of a concerning nature at 81.1% and has not achieved the target for more than six months. However, the Trust's performance remains one of the highest both Regionally and Nationally.

RTT and Diagnostic Waiting Times performance has remained similar in December as elective activity continues to recover. Activity levels (including activity being undertaken by the Independent Sector) have remained slightly below plan for the last six months with an the estimate for December currently showing 92% of 19/20 levels for Elective Activity and 94% for Total Outpatients. The high level of non-elective emergency admissions as well as the high level of elective activity being undertaken is therefore putting pressure on the bed capacity across with Trust.

Escalations by Strategic Theme:

People:
- Climate Survey Responses
- Vacancy Rate
- Sickness Rate

Patient Safety & Clinical Effectiveness:
- Falls Rate
- Safe Staffing
- Incidents Resulting in Harm
- SIs
- Infection Control

Patient Access:
- RTT Standard & 52 wk Waiters
- Diagnostics <6 weeks
- A&E Performance
- Outpatient Calls answered <1 minute
- Outpatient Clinic Utilisation
- Ambulance Handovers >30 minutes
- Super-Stranded Patients
- % Emergency Admissions to Assessment Areas
- Ensuring Activity Levels Match those Pre-Covid – Inpatients, Outpatients & Colonoscopy

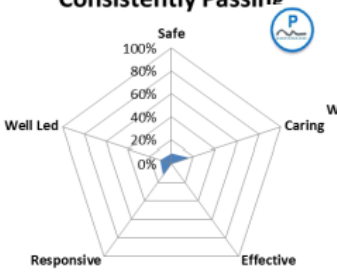
Patient Experience:
- Friends & Family Response Rates
- Friends & Family % Positive Rates
- Complaints

/43 28/21

Assurance view

Executive Summary

Consistently Passing



Consistently Passing:
The following Key Performance Indicators are all consistently achieving the target:

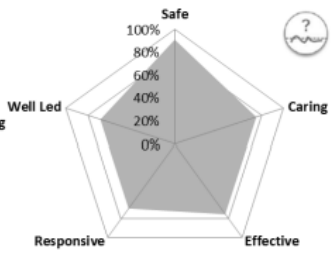
Safe:
- Trust Mortality (HMSR)

Caring:
- Mixed Sex Accommodation Compliance
- % VTE Risk Assessment

Responsive:
- Cancer 62 Day Waiting Times Standard
- Cancer 2 week Waiting Times Standard

Well-Led:
- Mandatory Training Compliance
- Number of Advanced Practitioners

Hit and Miss



Hit and Miss:
The following Key Performance Indicators are experiencing inconsistency (passing or failing target)

Safe:
- Safe Staffing, Infection Control Indicators, Incident Reporting, Harm Free Care Indicators, Never Events

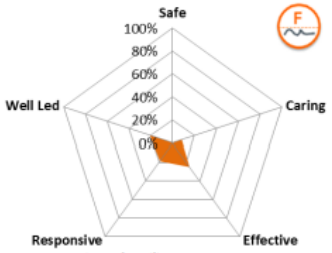
Effective:
- Hospital Cancellations, Readmissions & Stroke Indicators,

Caring:
- Complaints Indicators, Friends & Family Percentage Positive, Friends & Family Response Rates – Inpatients & Maternity

Responsive:
- RTT Number of >52 week Waiters, Cancer 31 Day Standard, A&E 4hr Standard, Ambulance Handovers, Super-Stranded Patients, Bed Occupancy, NE LOS, Cancer PTL – size of Backlog

Well-Led:
- Capital Expenditure, Agency Spend, Sickness Rate, Appraisals and Health and Well-Being

Consistently Failing



Consistently Failing:
The following Key Performance Indicators are all consistently failing the target:

Caring:
- OP Friends & Family Response Rate
- A&E Friends & Family Response Rate

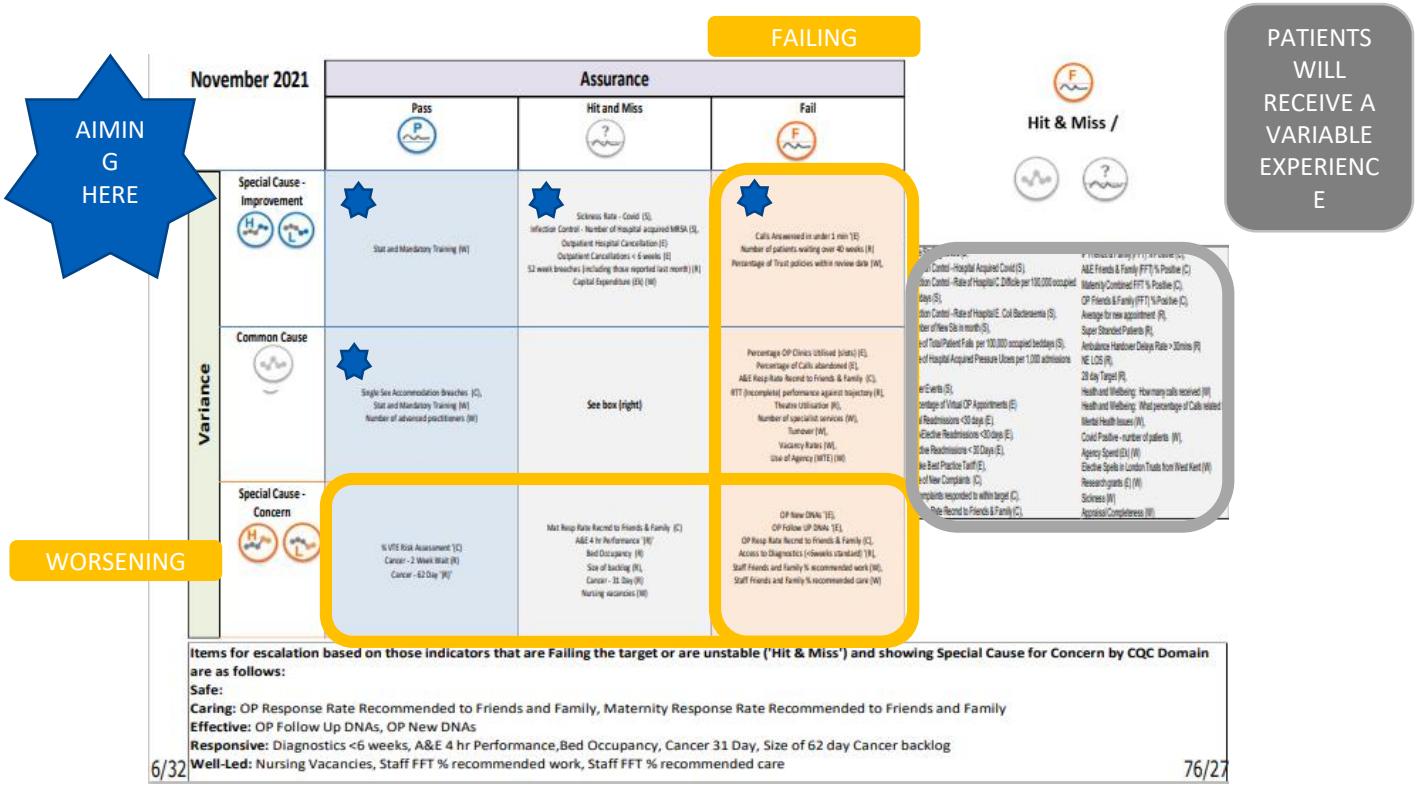
Effective:
- Outpatient Utilisation
- Outpatient –Calls answered within 1 min
- Outpatient – Calls Abandoned
- Outpatients DNA Rates

Responsive:
- RTT performance
- RTT Number of >40 week Waiters
- Diagnostics Waiting Times
- Theatre Utilisation

Well-Led:
- Agency Staff used
- Turnover Rate
- Vacancy Rate
- Number of Specialist Services to London
- Percentage of Trust policies within review date
- Staff FFT Recommended Care or Work

5/32 75/273

Assurance grid



Icon summaries

Caring - CQC Domain Scorecard

Organisational Objectives – Quality & CQC

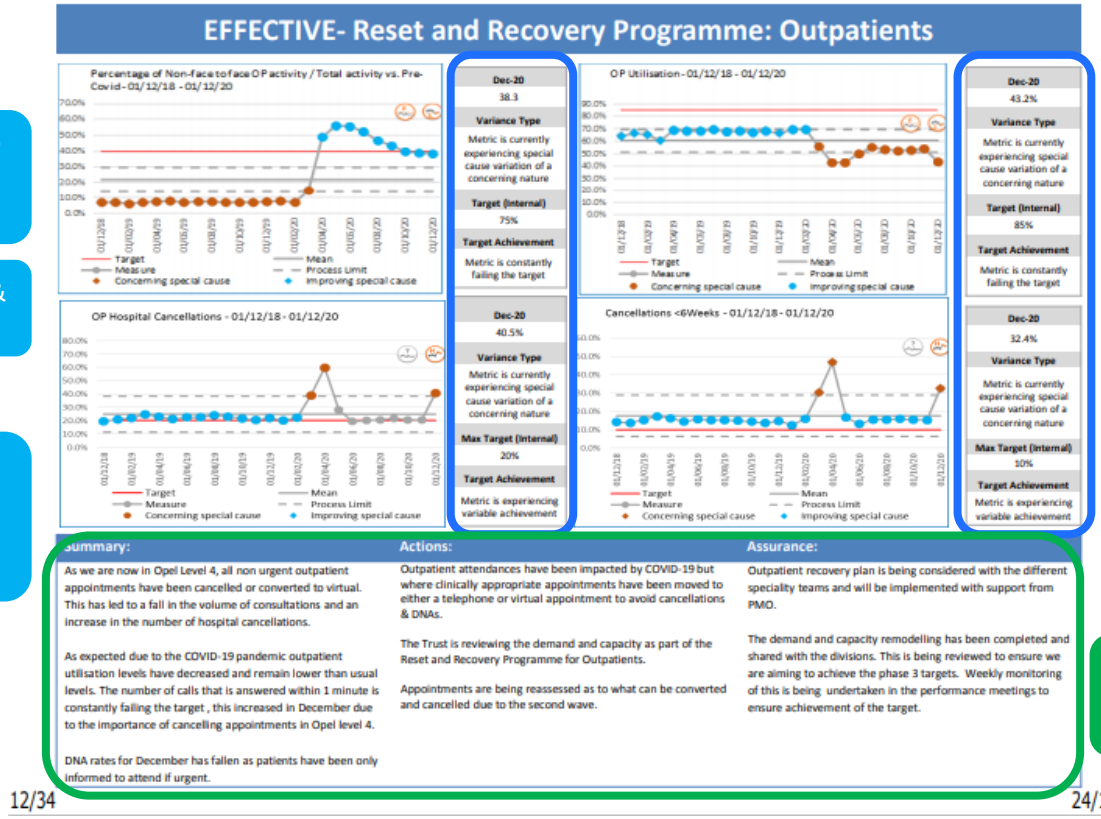
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Single Sex Accommodation Breaches	0	0	Nov-21		0	0	Oct-21	0	0	
Rate of New Complaints	3.9	4.2	Nov-21		3.9	2.1	Oct-21	3.9	2.9	
% complaints responded to within target	75.0%	85.1%	Nov-21		75.0%	60.9%	Oct-21	75.0%	71.3%	
IP Resp Rate Recmd to Friends & Family	25.0%	7.1%	Nov-21		25.0%	9.3%	Oct-21	25.0%	9.8%	
IP Friends & Family (FFT) % Positive	95.0%	97.8%	Nov-21		95.0%	97.4%	Oct-21	95.0%	97.9%	
A&E Resp Rate Recmd to Friends & Family	15.0%	0.5%	Nov-21		15.0%	1.4%	Oct-21	15.0%	2.1%	
A&E Friends & Family (FFT) % Positive	87.0%	100.0%	Nov-21		87.0%	96.0%	Oct-21	87.0%	96.0%	
Mat Resp Rate Recmd to Friends & Family	25.0%	5.6%	Nov-21		25.0%	7.6%	Oct-21	25.0%	8.7%	
Maternity Combined FFT % Positive	95.0%	100.0%	Nov-21		95.0%	95.2%	Oct-21	95.0%	99.0%	
OP Friends & Family (FFT) % Positive	84.0%	82.7%	Nov-21		84.0%	83.0%	Oct-21	84.0%	82.7%	
OP Resp Rate Recmd to Friends & Family	68.0%	13.8%	Nov-21		68.0%	17.2%	Oct-21	68.0%	14.6%	
VTE Risk Assessment	95.0%	94.2%	Nov-21		95.0%	96.3%	Oct-21	95.0%	96.5%	

Inter-related graphs together

Structured narrative

Concise & specific

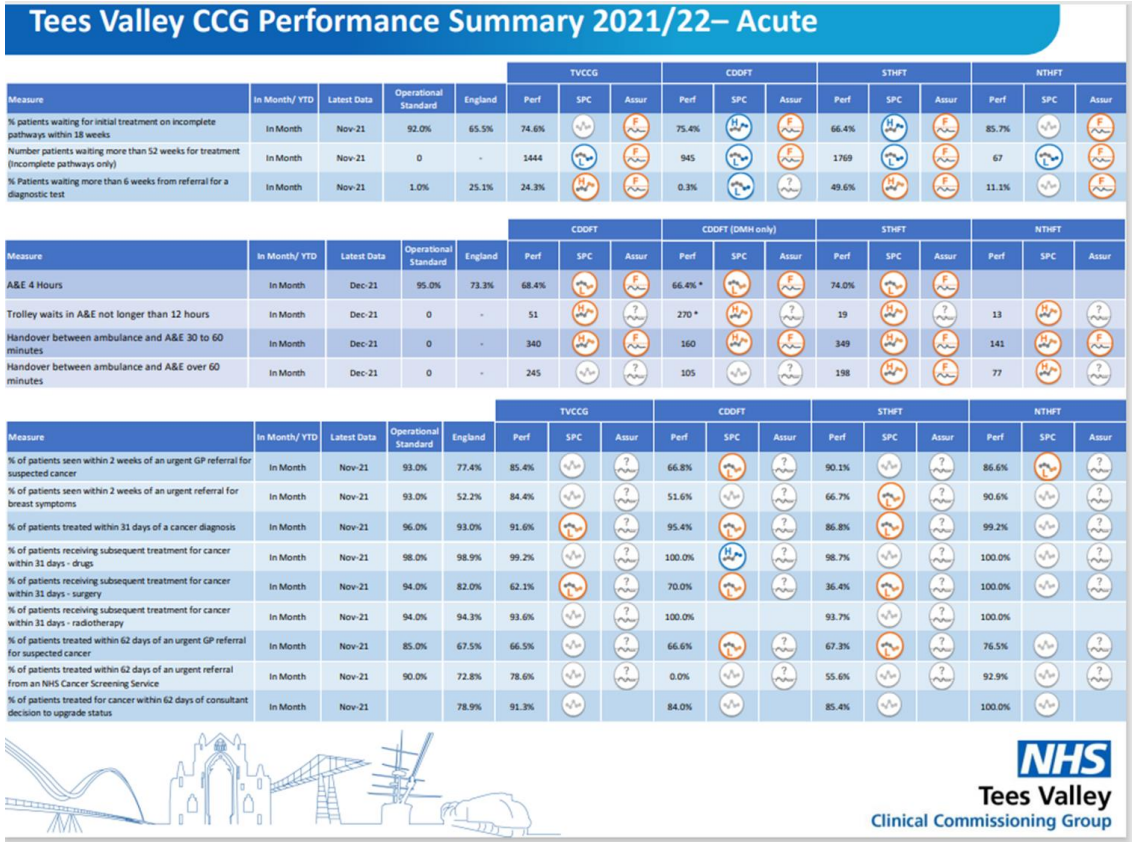
Provided alongside the charts



Data narrative

Clinical / operational narrative

What does good look like?



Tees Valley CCG Performance Summary 2021/22– Acute

Measure	In Month/ YTD	Latest Data	Operational Standard	England	TVCCG Perf	TVCCG SPC	TVCCG Assur	CDDFT Perf	CDDFT SPC	CDDFT Assur	STHFT Perf	STHFT SPC	STHFT Assur	NTHFT Perf	NTHFT SPC	NTHFT Assur
% patients waiting for initial treatment on incomplete pathways within 18 weeks	In Month	Nov-21	92.0%	65.5%	74.6%			75.4%			66.4%			85.7%		
Number patients waiting more than 52 weeks for treatment (Incomplete pathways only)	In Month	Nov-21	0	-	1444			945			1769			67		
% Patients waiting more than 6 weeks from referral for a diagnostic test	In Month	Nov-21	1.0%	25.1%	24.3%			0.3%			49.6%			11.1%		

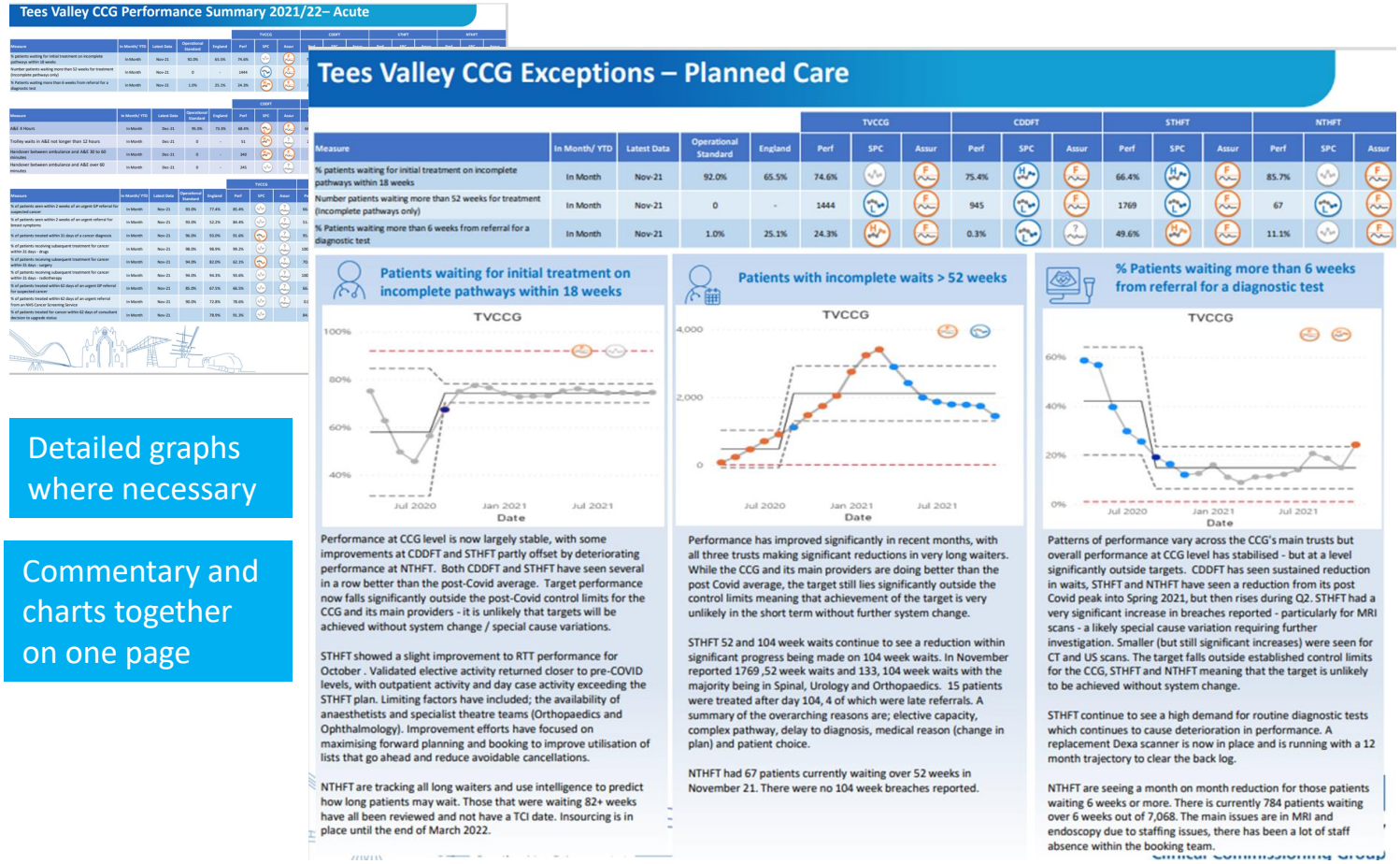
Measure	In Month/ YTD	Latest Data	Operational Standard	England	CDDFT Perf	CDDFT SPC	CDDFT Assur	CDDFT (DMH only) Perf	CDDFT (DMH only) SPC	CDDFT (DMH only) Assur	STHFT Perf	STHFT SPC	STHFT Assur	NTHFT Perf	NTHFT SPC	NTHFT Assur
A&E 4 Hours	In Month	Dec-21	95.0%	73.3%	68.4%			66.4% *			74.0%					
Trolley waits in A&E not longer than 12 hours	In Month	Dec-21	0	-	51			270 *			19			13		
Handover between ambulance and A&E 30 to 60 minutes	In Month	Dec-21	0	-	340			160			349			141		
Handover between ambulance and A&E over 60 minutes	In Month	Dec-21	0	-	245			105			198			77		

Measure	In Month/ YTD	Latest Data	Operational Standard	England	TVCCG Perf	TVCCG SPC	TVCCG Assur	CDDFT Perf	CDDFT SPC	CDDFT Assur	STHFT Perf	STHFT SPC	STHFT Assur	NTHFT Perf	NTHFT SPC	NTHFT Assur
% of patients seen within 2 weeks of an urgent GP referral for suspected cancer	In Month	Nov-21	93.0%	77.4%	85.4%			66.8%			90.1%			86.6%		
% of patients seen within 2 weeks of an urgent referral for breast symptoms	In Month	Nov-21	93.0%	52.2%	84.4%			51.6%			66.7%			90.6%		
% of patients treated within 31 days of a cancer diagnosis	In Month	Nov-21	96.0%	93.0%	91.6%			95.4%			86.8%			99.2%		
% of patients receiving subsequent treatment for cancer within 31 days - drugs	In Month	Nov-21	98.0%	98.9%	99.2%			100.0%			98.7%			100.0%		
% of patients receiving subsequent treatment for cancer within 31 days - surgery	In Month	Nov-21	94.0%	82.0%	62.1%			70.0%			36.4%			100.0%		
% of patients receiving subsequent treatment for cancer within 31 days - radiotherapy	In Month	Nov-21	94.0%	94.3%	93.6%			100.0%			93.7%			100.0%		
% of patients treated within 62 days of an urgent GP referral for suspected cancer	In Month	Nov-21	85.0%	67.5%	66.5%			66.6%			67.3%			76.5%		
% of patients treated within 62 days of an urgent referral from an NHS Cancer Screening Service	In Month	Nov-21	90.0%	72.8%	78.6%			0.0%			55.6%			92.9%		
% of patients treated for cancer within 62 days of consultant decision to upgrade status	In Month	Nov-21		78.9%	91.3%			84.0%			85.4%			100.0%		

NHS Tees Valley Clinical Commissioning Group

Comparative icon summaries

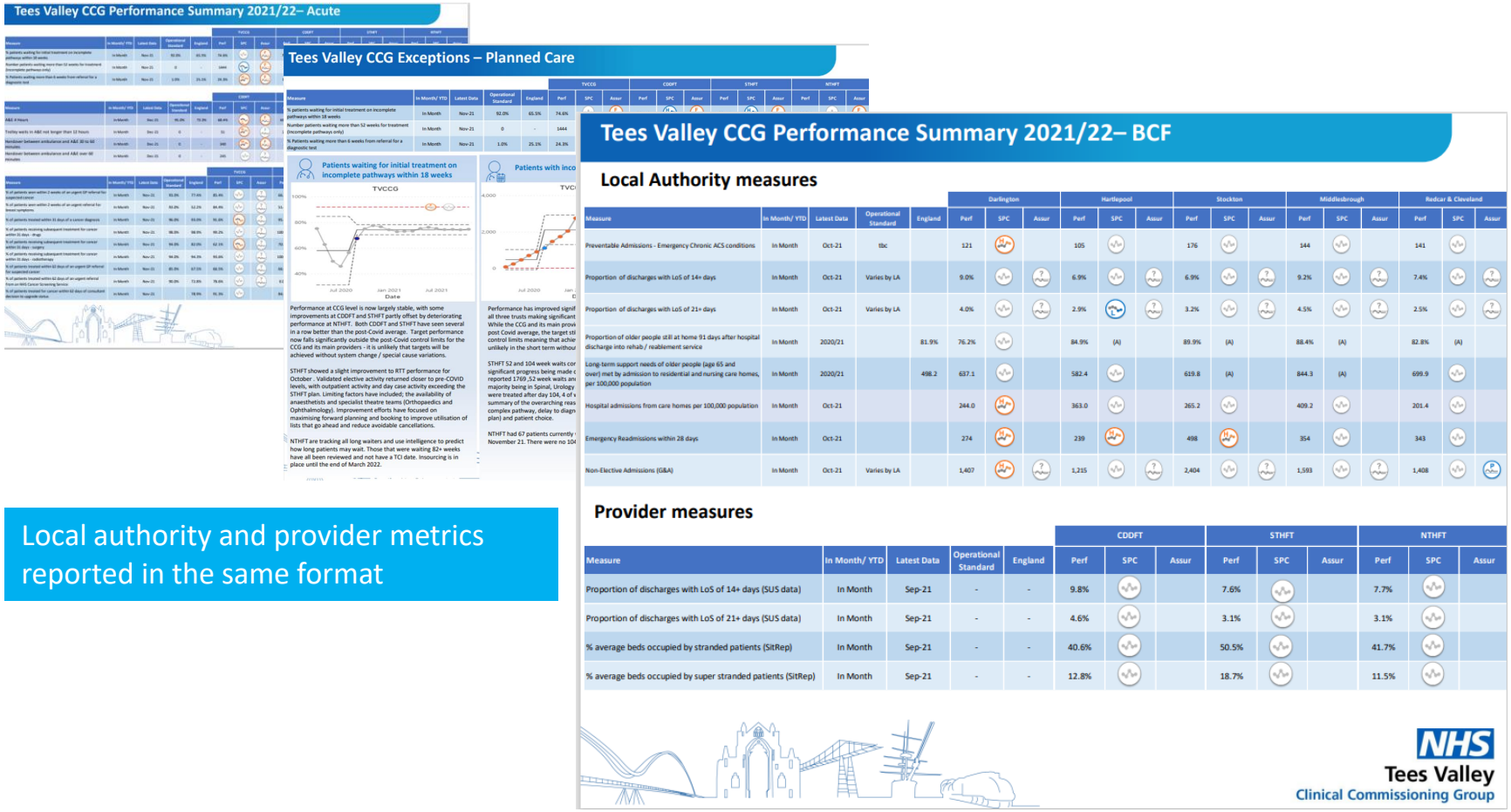
What does good look like?



Detailed graphs where necessary

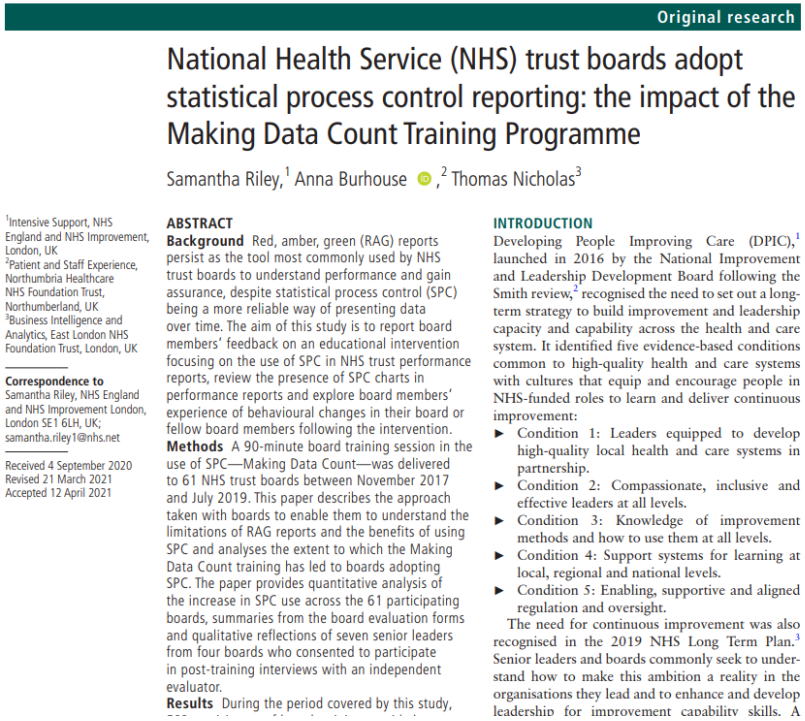
Commentary and charts together on one page

What does good look like?



Local authority and provider metrics reported in the same format

Impact of Making Data Count



Original research

National Health Service (NHS) trust boards adopt statistical process control reporting: the impact of the Making Data Count Training Programme

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ABSTRACT

Background Red, amber, green (RAG) reports persist as the tool most commonly used by NHS trust boards to understand performance and gain assurance, despite statistical process control (SPC) being a more reliable way of presenting data over time. The aim of this study is to report board members' feedback on an educational intervention focusing on the use of SPC in NHS trust performance reports, review the presence of SPC charts in performance reports and explore board members' experience of behavioural changes in their board or fellow board members following the intervention.

Methods A 90-minute board training session in the use of SPC—Making Data Count—was delivered to 61 NHS trust boards between November 2017 and July 2019. This paper describes the approach taken with boards to enable them to understand the limitations of RAG reports and the benefits of using SPC and analyses the extent to which the Making Data Count training has led to boards adopting SPC. The paper provides quantitative analysis of the increase in SPC use across the 61 participating boards, summaries from the board evaluation forms and qualitative reflections of seven senior leaders from four boards who consented to participate in post-training interviews with an independent evaluator.

Results During the period covered by this study,

INTRODUCTION

Developing People Improving Care (DPIC),[1] launched in 2016 by the National Improvement and Leadership Development Board following the Smith review,[2] recognised the need to set out a long-term strategy to build improvement and leadership capacity and capability across the health and care system. It identified five evidence-based conditions common to high-quality health and care systems with cultures that equip and encourage people in NHS-funded roles to learn and deliver continuous improvement:

- Condition 1: Leaders equipped to develop high-quality local health and care systems in partnership.
- Condition 2: Compassionate, inclusive and effective leaders at all levels.
- Condition 3: Knowledge of improvement methods and how to use them at all levels.
- Condition 4: Support systems for learning at local, regional and national levels.
- Condition 5: Enabling, supportive and aligned regulation and oversight.

The need for continuous improvement was also recognised in the 2019 NHS Long Term Plan.[3] Senior leaders and boards commonly seek to understand how to make this ambition a reality in the organisations they lead and to enhance and develop leadership for improvement capability skills. A

[National Health Service (NHS) trust boards adopt statistical process control reporting: the impact of the Making Data Count Training Programme | BMJ Leader]

Benefits

I learnt how SPC can support [Better governance] processes and how it supports the better hygiene of data and increases the level of comfo[Increases assurance]boards. It gives them more assurance than before because the data are more credible. This allows the board more time to devote to strategic leadership, rather than having to challenge or worry about the data. This allows us to spend more time thinking at a system level rather than asking for more clarifying data. In the past, we might see data that was rated 'red', and then, we would request more data, and this process could take 3 months to come back to the board as new work had to be undertaken by managers in the directorate. Things could get 'bogged down' in this process, and often, the additional data requested did not shed any new light on the issue. Now, with SPC, [The board has a better sense of where to focus]us; it helps us to ask strategic rather than operational questions.

The [Board report quality is better and easier to understand]nd; the data are a week closer to real time.

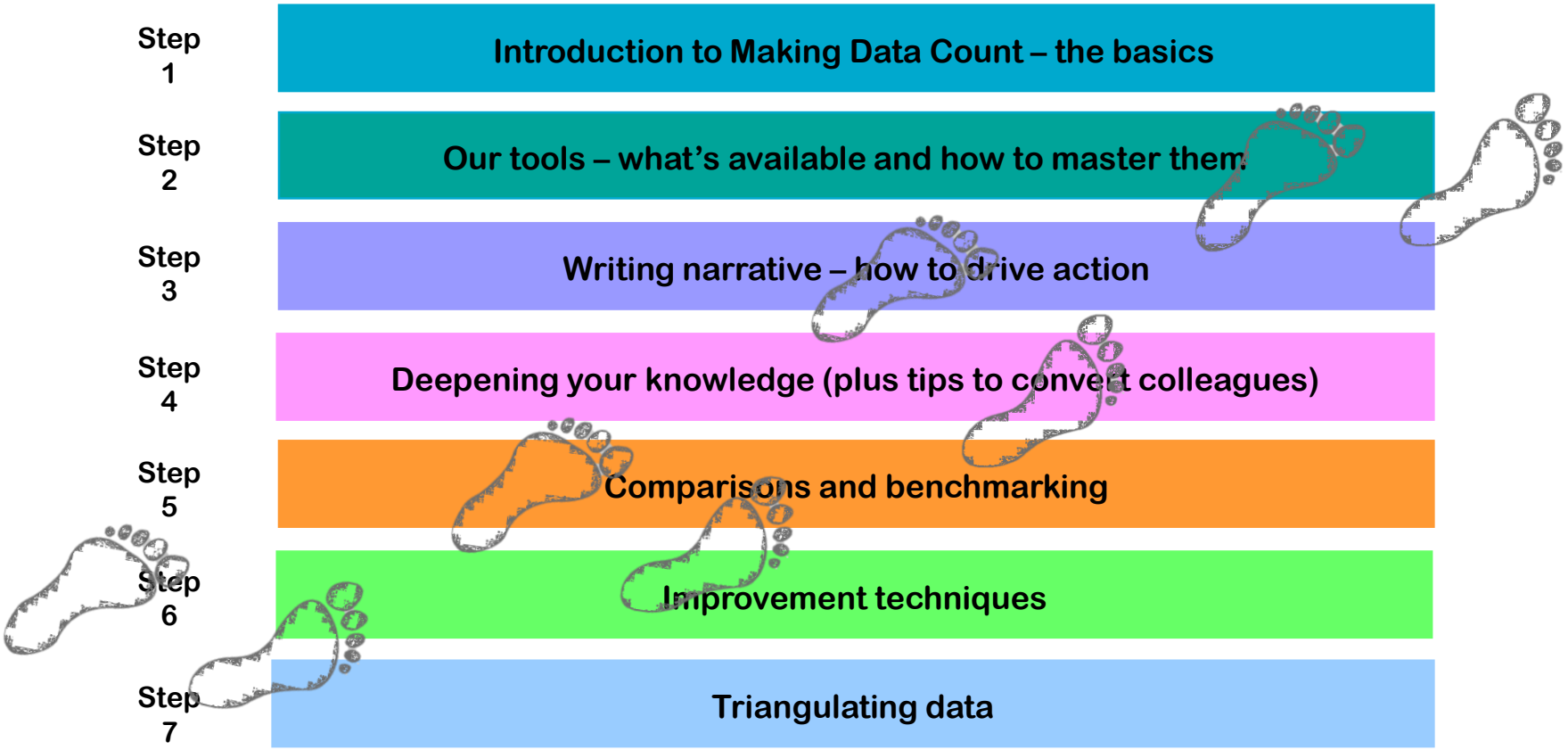
There has almost been a s[Strengthened ability to challenge]' ability to challenge something and then take the correct actions.

https://bmjleader.bmj.com/content/early/2021/10/04/leader-2020-000357

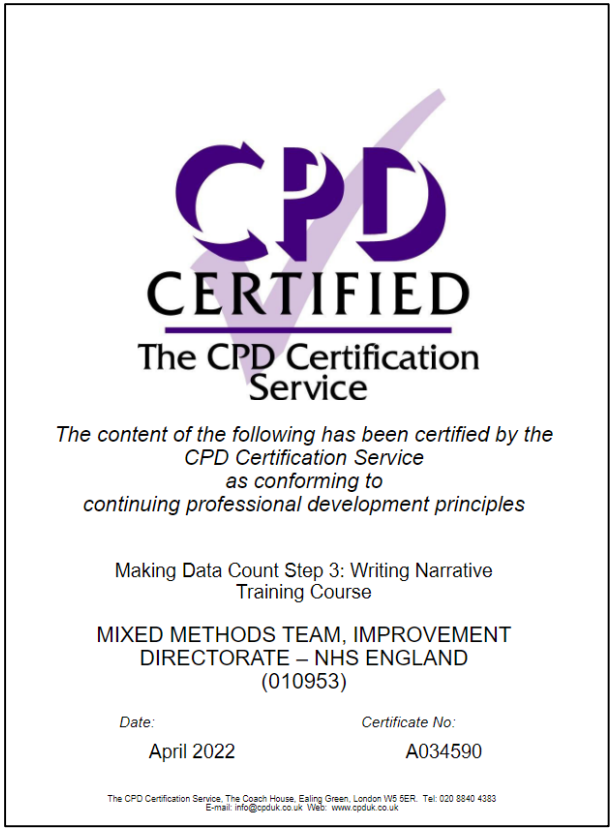
Making Data Count web page

https://www.england.nhs.uk/a-focus-on-staff-health-and-wellbeing/publications-and-resources/making-data-count/

Virtual training



CPD Certified



CPD CERTIFIED

The CPD Certification Service

The content of the following has been certified by the CPD Certification Service as conforming to continuing professional development principles

Making Data Count Step 3: Writing Narrative Training Course

MIXED METHODS TEAM, IMPROVEMENT DIRECTORATE – NHS ENGLAND (010953)

Date: April 2022

Certificate No: A034590

The CPD Certification Service, The Coach House, Ealing Green, London W5 5ER. Tel: 020 8840 4383
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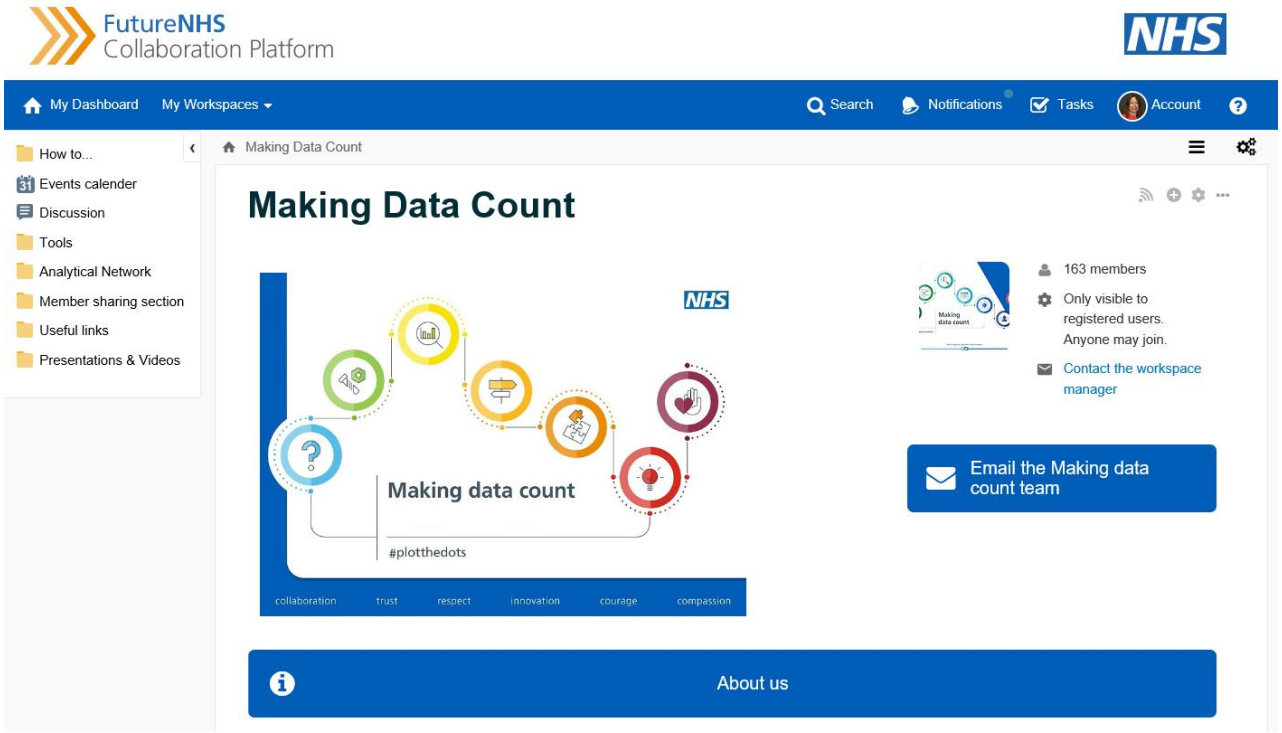
1 CPD point per step completed

Staying connected

https://future.nhs.uk/MDC/grouphome



Webinar Content

Sharing experiences and creating feedback loops

Please share with us:

- Topics for presentations
- Case studies
- Shared experiences
- How you use the data
- Improvements in patient safety

HOSP ONAL CO 022

22 – 24th November, Glasgow.

Register for VIRTUAL attendance:
https://compleathub.co.uk/hospice-uk-2022-conference/hukvirtual-reg/Site/Register

Outcomes Measures in Practice ECHO

Dr Fliss Murtagh is presenting on ‘Using IPOS in the dying Phase of Illness’

30th November 3.30- 5.00pm

Register at:

https://professionals.hospiceuk.org/what-we-offer/clinical-and-care-support/project-echo/echo-hh-participant-registration?knowledgeNetwork=Outcome%20Meaures%20in%20Practice&eventid=EVT00810&groupid=G00273

NEXT MEETING: 16 February

TBC
Any suggestions?

Thank you!

Evaluation -

1. One new thing you have learnt today?
2. What will you change as a result of attending today?

Please write in the chat