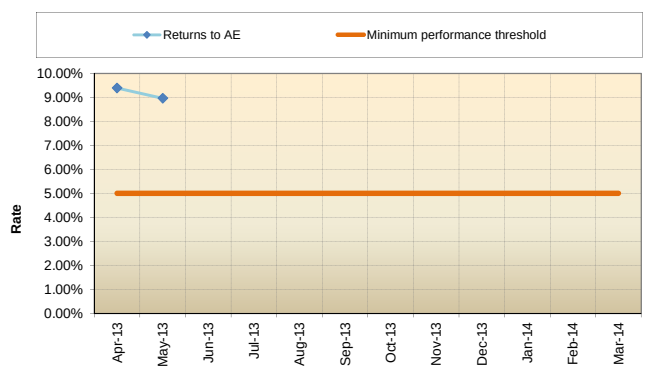
LIVERPOOL WOMEN'S HOSPITAL NHS FOUDATION TRUST 2013/14
Accident & Emergency Department Clinical Quality Indicators

Unplanned re-attendance [HQU09]

Unplanned re-attendance rate



Description of data

Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)

Key messages

· The re-attendance rate can reflect quality of care on the initial attendance but does not demonstrate the cause of any problems. Good practice is for a reattending patient to be seen by a different and more senior clinician.
· Rates above 5% are likely to reflect poor quality care but rates below 1% may reflect excessive risk aversion.
· A rate above 5% may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Narrative

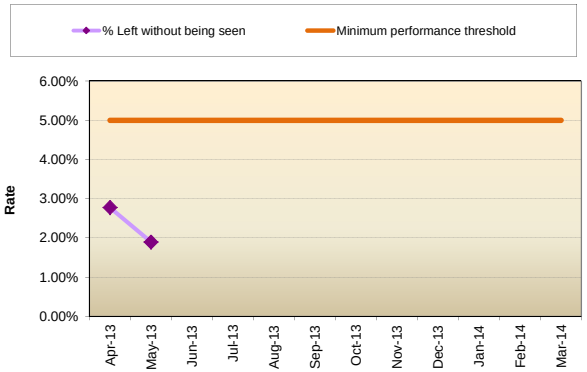
Internal validation work continues and demonstrates the unplanned re attendance rate of 8%. Re attendance of patients with early pregnancy related conditions is considered clinically appropriate. We are progressing the development of emergency room follow up clinics for specific pathways were clinically appropriate.

Description of Performance

0.0%	Rate this month
5%	Target
	Data quality

Left without being seen [HQU11]

Left without being seen rate



Description of data

The percentage of people who leave the A&E without being seen.

Key messages

· LWBS reflects the satisfaction of patients with the initial management and experience they receive in A&E.
· The left without being seen rate should be minimal and best practice would be to have level below 5%.
· A rate at or above 5% may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Narrative

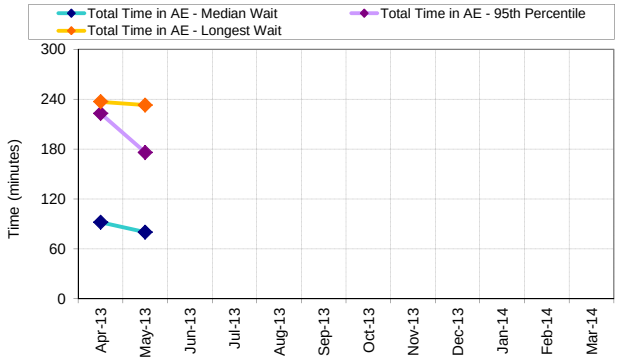
Compliance achieved, continue to monitor and utilise information to inform future developments in the ongoing emergency access service review work.

Description of Performance

1.90%	Rate this month
5%	Target
	Data quality

Total time in the A&E department (admitted patients) [HQU10]

Site-level performance



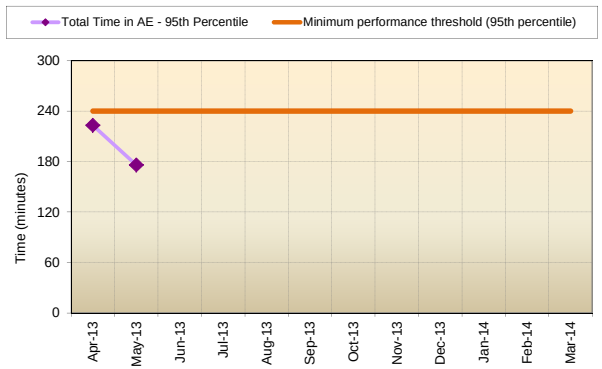
Description of data

The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted patients.

Key messages

· Timeliness of care should not deteriorate from that achieved in the last few years.
· The total time in A&E should not be investigated in isolation, and should be monitored in conjunction with the other A&E clinical quality indicators
· Clinical advice suggests that a 95th percentile wait above 4 hours for admitted patients and with the same threshold for non-admitted patients is not good practice.
· The single longest wait should be no more than 6 hours.
· A 95th percentile wait above four hours may trigger intervention as this is one of the five A&E quality indicators included as a headline measure

Site performance against national benchmarks and performance thresholds)



Description of Performance

Narrative

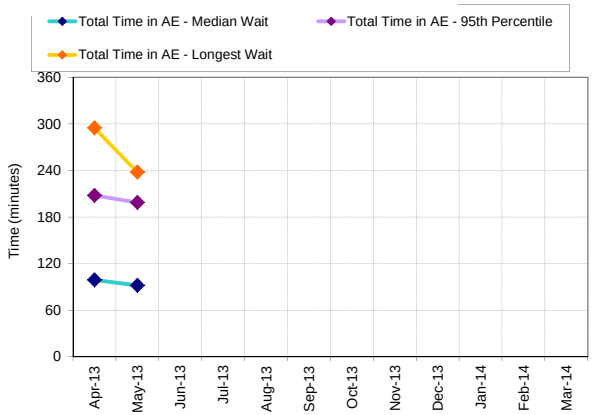
Compliance achieved, continue to monitor and utilise information to inform future developments in the ongoing emergency access service review work.

176	95th percentile this month
240	Target
	Data quality

LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST 2013/14
Accident & Emergency Department Clinical Quality Indicators

Total time in the A&E department (non-admitted patients) [HQU10]

Site-level performance



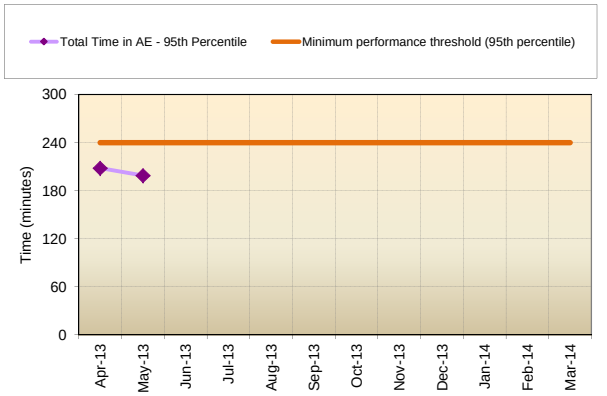
Description of data

The median, 95th percentile and single longest total time spent by patients in the A&E department, for non-admitted patients.

Key messages

· Timeliness of care should not deteriorate from that achieved in the last few years.
· The total time in A&E should not be investigated in isolation, and should be monitored in conjunction with the other A&E clinical quality indicators
· Clinical advice suggests that a 95th percentile wait above 4 hours for admitted patients and with the same threshold for non-admitted patients is not good practice.
· The single longest wait should be no more than 6 hours.
· A 95th percentile wait above four hours may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health under Technical Guidance for the 2011/12 Operating Framework – Draft 22 December 2010 38 national oversight in the NHS Operating Framework for 2011/12.

Site performance against national benchmarks and performance thresholds)



Description of Performance

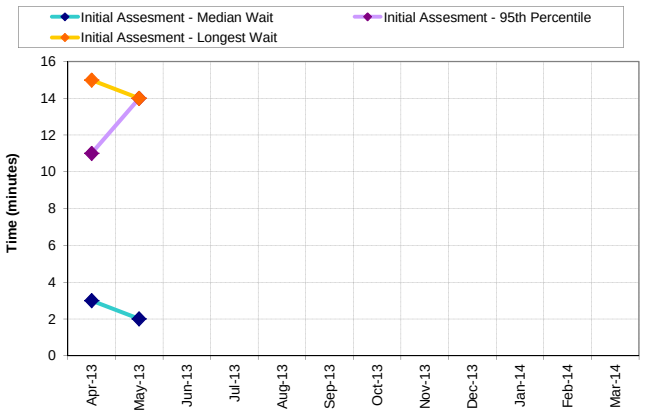
Narrative

Compliance achieved, continue to monitor and utilise information to inform future developments in the ongoing emergency access service review work. Issues relating to ambulance transfers/ discharges are evident and we are working with North west ambulance, escalating these issues and arranging meetings to determine actions to reduce patients waiting longer due to transport problems

199	95th percentile this month
240	Target
	Data quality

Time to initial assessment in A&E [HDQ12]

Site-level performance



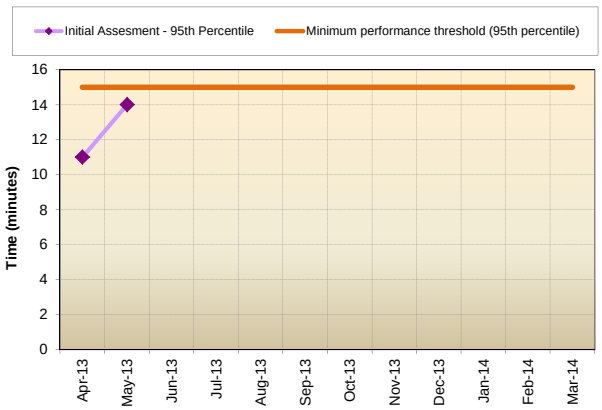
Description of data

Time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs), for all patients arriving by emergency ambulance.

Key messages

· The delay in the A&E department in assessing and then accepting care of the patient should be minimised but that assessment must be meaningful and add value for the patient:
· Patients should be assessed as soon as possible; good practice would be to have all patients assessed within 20 minutes of arrival.
· A 95th percentile time to assessment above 15 minutes may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Site performance against national benchmarks and performance thresholds)



Description of Performance

Narrative

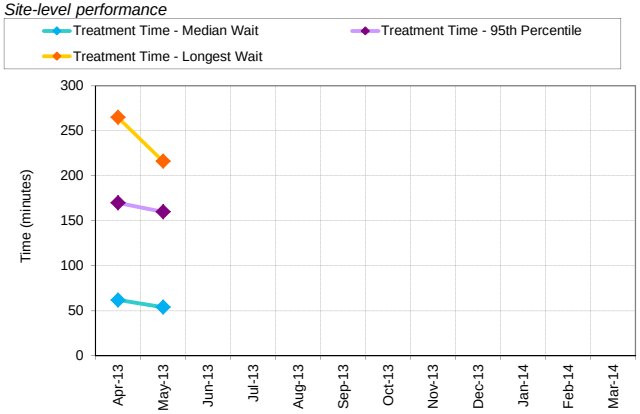
Compliance has been acheived. The Emergency Room has worked with North West Ambulance Service to introduce technology that aids capture of data re ambulance handover times and will aid efficiency and effectiveness of managing ambulance resources.

14	95th percentile this month
15	Target
	Data quality

LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST 2013/14
Accident & Emergency Department Clinical Quality Indicators

Time to Treatment in A&E [HQU13]

Site-level performance



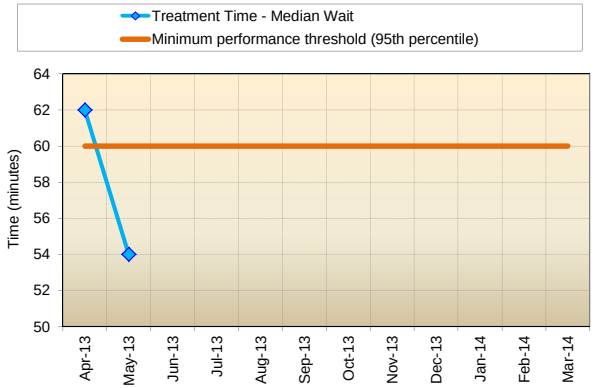
Description of data

Time from arrival to start of definitive treatment from a decision-making clinician (someone who can define the management plan and discharge the patient).

Key messages

· Time to the start of treatment should be minimised but not at the expense of other A&E Clinical Quality Indicators.
· Expert clinical opinion suggests that patients should be seen by a decision-maker within 60 minutes of arrival, but this may be too long for the more serious cases.
· The earlier the correct management plan is made the better for the patient; a wait of over 30 minutes is excessive for certain presentations, e.g., sepsis, stroke, myocardial infarction, respiratory distress.
· A median above 60 minutes from arrival to seeing a decision-making clinician across all patients may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Site performance against national benchmarks and performance thresholds)



Description of Performance

Narrative

A named Consultant has undertaken regulary weekly sessions within the department and has compiled a review and subsequent recommendations to progress the clinical staffing model. Work revising standard operational procedures and clinical guidelines is underway. Plans to proactively manage the changeover/ rotation in junior doctors are being made to reduce potential risk of delays in treatment in December, and junior doctor induction programme has dedicated focus on emergecny pathways, clinical decision making and patient quality indicators

54	Median this month
60	Target
	Data quality

Service experience

What have we done to understand and assess the experience of our patients from January 2013 to March 2013

• Nursing quality indicators have commenced and monthly patient queestionnaires are undertaken and we plan to display results in the department. Display boards have been purchased and are in the process of being displayed in the department. These results will be monitored and reported to the Trust Plans- Action Plans will be generated by the department Manager and the ER team to address any deficits.

Family friendly questions are being asked.

• Formal and informal issues raised through Complaints and PALS have been used to understand and assess the experience of patients attending the Emergency Room, patients are invited to board meeting to share their experiences

•Patient Stories continue to be shared with the Board and departmental staff and we working closely with patients whom are sharing their experiences , recordings of patients experiences are with consent being utilised to widen opportunities to learn from feedback

•NICE guideline on the management of early pregnancy have been released and the organistion is assessing compliance and will develop an plan to address any areas in which defecits may be identified

What has been done to improve services in light of these results?

•Identified funding for additional nurses to be trained in scanning anf working with colleagues in ultrasound to mentor nursing staff in early pregnancy scanning

•NICE guidelines for the management of miscarriage are being assessed to understand compliance levels- if none compliance is identified remedial action plans will be put in place

•Establishe d emergency follow up clinics for patient with pregnancy of unknown location, offering consistent approach with continuity and senior clinical presence

•Introduction of quality indicators that incorporate specific feedback relating to service experience, thus developing an ongoing feedback mechanism for patients , Displayed within department and disseminated to team members

What were results of these assessments?

•Facilities not always availbale when needed

•Electronic patient record not capturing all information required

•Seniority of team members out of hours

•Policy review group established

•Early pregnancy scan availability

•Patient pathways being developed, new treatment options to be piloted- (None surgical management of bartholins) We are also progressing our rapid rehydration proposal to enable us to improve patient experience in the management of hyperemisis 9 morning sickness)

Has this resulted in improved patient experience?

•Local ownership, department managers have increased involvement in problem solving and have ability to influence service provision at the point of care

•Flexible use of additional rooms/ resources.

•Meanigful measurements in place, enabling benchmarking across Trust and Month on Month performance

•Point of care testing aiiding prompt diagnosis and treatment