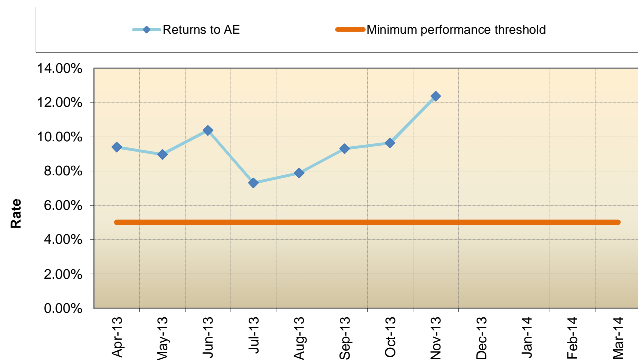
LIVERPOOL WOMEN'S HOSPITAL NHS FOUDATION TRUST 2013/14
Accident & Emergency Department Clinical Quality Indicators

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.

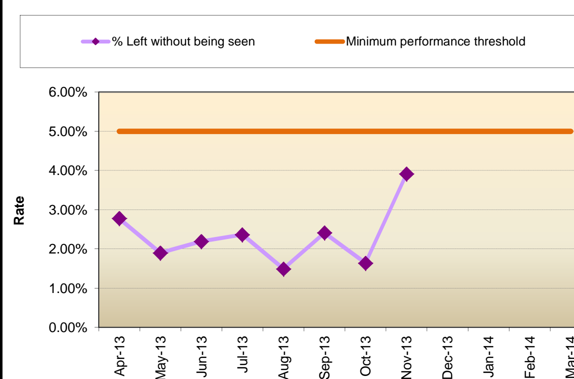
Narrative The unplanned reattandces are now being reviewed on a weekly basis. Unplanned reattendances for pregnancy related conditions are to be excluded, reattending for pregnancy related conditions has been agreed as best practice and acknowledged as an appropriate pathway. The way we collect data has been ammended and weekly validation and qata quality checks are made. None pregnancy related reattendances are in November reported at 4.85%, which is within target. We are preparing an audit proposal in order for us to audit the pathways of patients whom reattend and hope to learn lessons and change practice to improve our clinical management of our patients.

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.

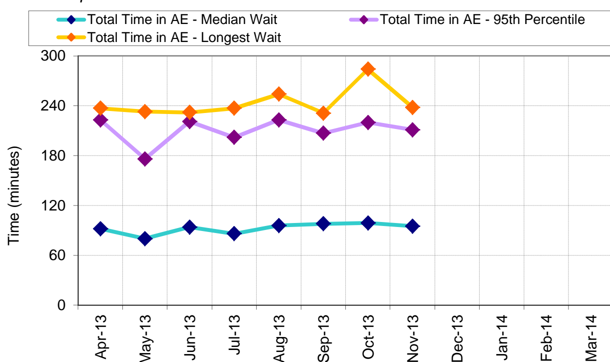
Narrative Performance is within target

Description of Performance

0.00%	Rate this month
5%	Target
	Data quality

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

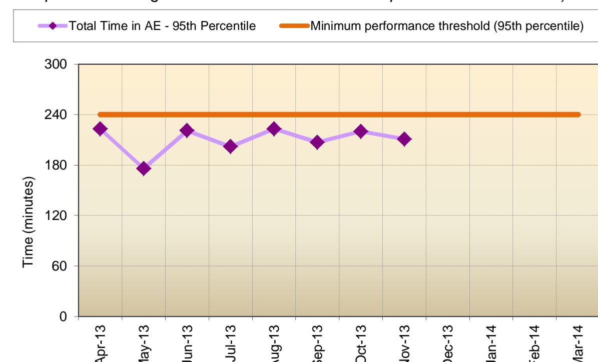
Site-level performance



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

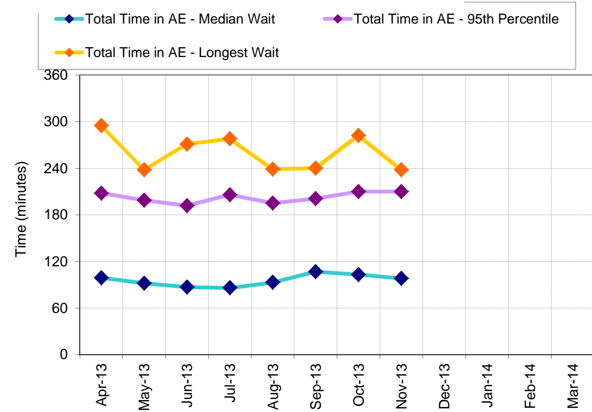
Narrative Performance is within target

211	95th percentile this month
240	Target
	Data quality

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

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

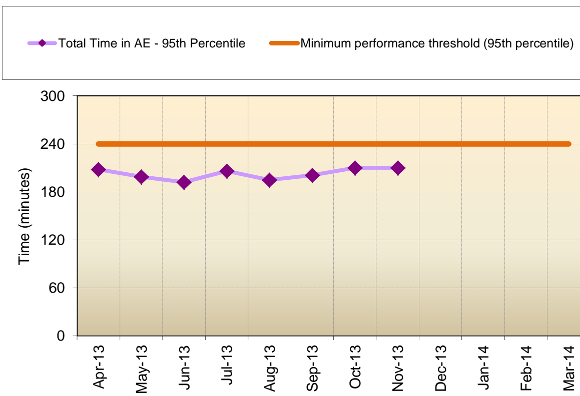
Site-level performance



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)



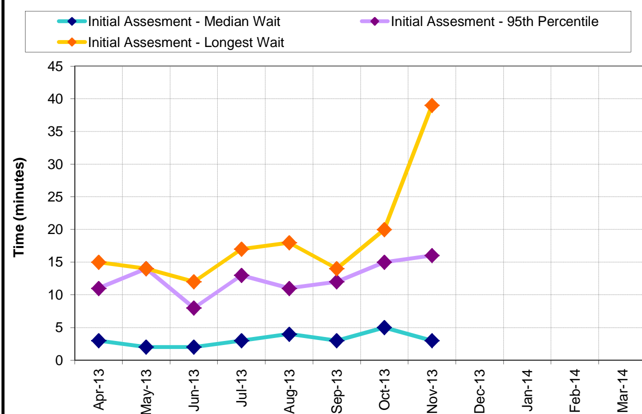
Description of Performance

Narrative Performance is within target

210	95th percentile this month
240	Target
	Data quality

Time to initial assessment in A&E [HDQ12]

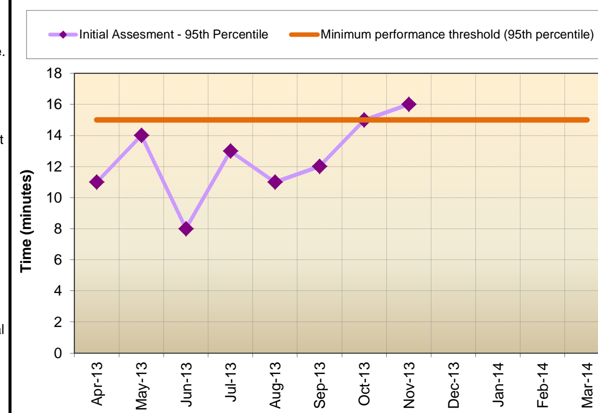
Site-level performance



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 This target has been breeched by one minute. We are reviewing our environment which restricts us at times, with only one triage room and three cubicles. We are investigating opportunities to enhance our enviroment so it can be more flexible and conducive to managing the peak times. We are also discussing with our information technology department the potential of getting electronic soloutons to help us communicate waiting times to the whole team, investigation live informmation that red flags waiting times that are deemed unacceptable/ outside of the quality target.

16	95th percentile this month
15	Target
	Data quality

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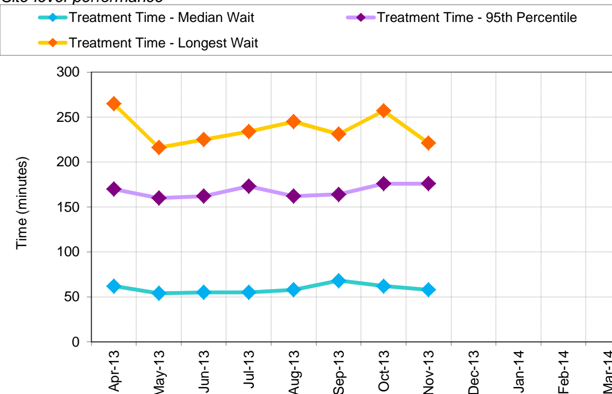
Time to Treatment in A&E [HQU13]

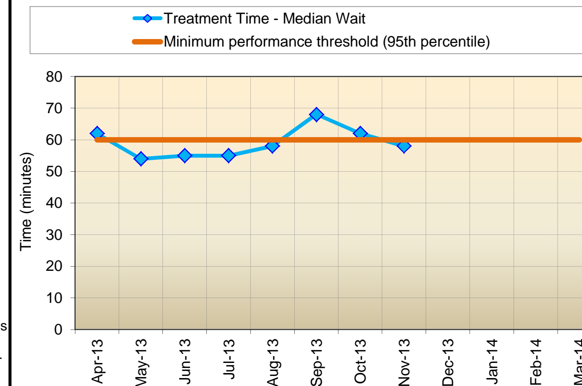
Site-level performance



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 Time to treatment has been within tolerance in November. Feedback from our Friends and Family test does however indicate that some of our patients are not satisfied with their waiting times. As above, we are looking to invest in electronic soloutions to help us better manage patients in the Emergency Room.

58	Median this month
60	Target
	Data quality

Service experience

What have we done to understand and assess the experience of our patients from July 2013 to Sept 2013

• Nursing quality indicators are now embedded and monthly patient queestionnaires are undertaken and we plan to display results in the department. Display boards are now in place in the department to share feedback. 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 and results are now available and published for ER.We are actively promoting feedback and have a kiosk now located outside the ER for feedback to be given. Social media, twitter is also being used to encourage our patients to give feedback about the Er Services

• 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

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

•Identified funding for additional nurses to be trained in scanning and working with colleagues in ultrasound to mentor nursing staff in early pregnancy scanning, One additional memebr of our team has completed competencies and another member has commenced training

•NICE guidelines for the management of miscarriage have been 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

•We are trailing a new way to manage patients suffering from Bartholins cysts, developing a new pathways with a less invasive technique

•Named Clinician to Lead Early Pregnancy pathway development

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

•Feedback kiosk and systems and processes to address feedback timely