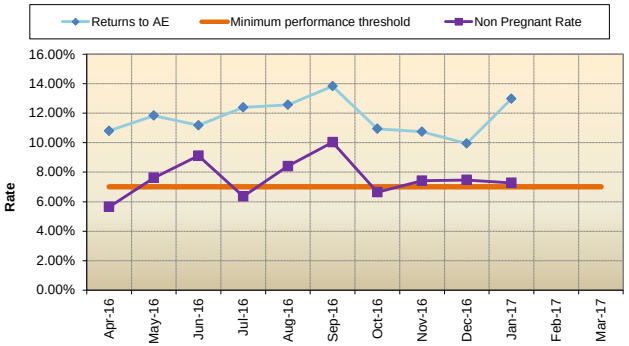
LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST 2016/17
Accident & Emergency Department Clinical Quality Indicators

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)

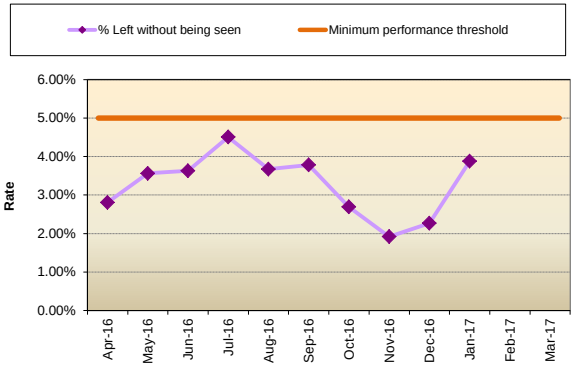
Key messages
· The re-attendance rate can reflect quality of care on the initial attendance but does not demonstrate the cause of any problems. Good practice is for a reattending patient to be seen by a different and more senior clinician.
· Rates above 7% are likely to reflect poor quality care but rates below 1% may reflect excessive risk aversion.

Narrative This Month has seen an improvement in the reattendance figures and for non pregnant conditions we have met the required target. We have for the 3rd month just breached this target - we have identified that it is being arffected by one particular patient and we are discussing with our wider team how we can address the care for this patient

7.28%	Rate this month
7%	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.

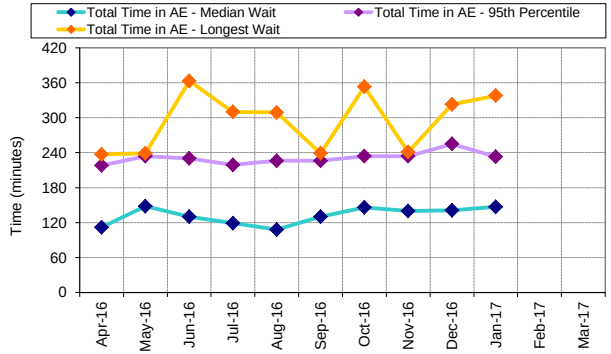
Narrative We aim always to avoid this situation with all our patients. On occasion patients make the decision to leave sometimes this happens without discussion with the nursing team.There appears a slight increase in the figures this month - that is likey due to the activity over the month

Description of Performance

3.88%	Rate this month
5%	Target
	Data quality

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

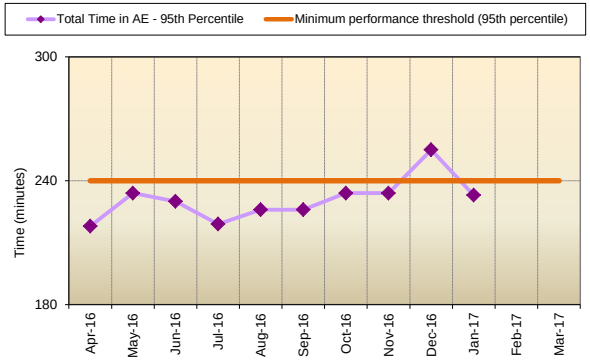
Site-level performance



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 Within the target setting , this month sees a reduction in the total time in GED.

Narrative We have achieved the required target this month , there has been a high level of sickness in the department which is preventing the development of the nurse practitioners who would be able to manage the care of their own patients. There will be a proposal for a reveiw of the staffing numbers which would allow the ENP team to be part of the deceison makimg process andwe would hope this would have an impact on the time waits.

233	95th percentile this month
240	Target
	Data quality

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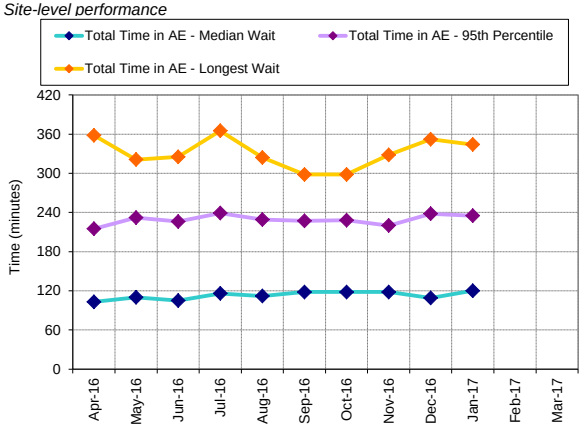
Total time in the A&E department (non-admitted patients) [HQU10]

Site-level performance



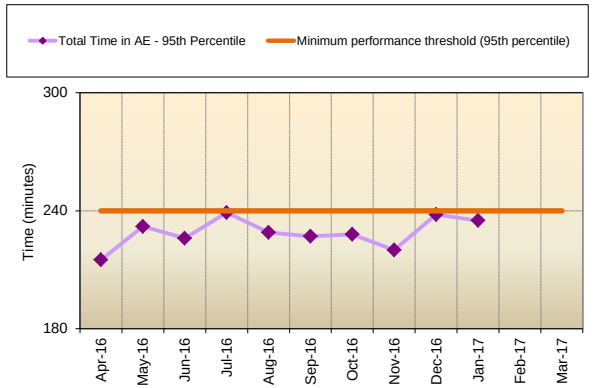
Description of data

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

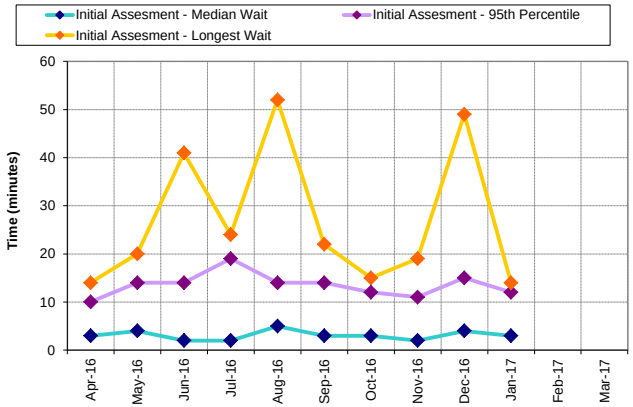
Within target set , we are striving to keep the time in the department to the minimum .

Although we remain in target here we have had 9 episodes of breaches with a total of 30 patients on the 4 hour time wait - this in the main has been due to the activity in the department - staffing shortages and a medical team changeover .

235	95th percentile this month
240	Target
	Data quality

Time to initial assessment in A&E [HDQ12]

Site-level performance



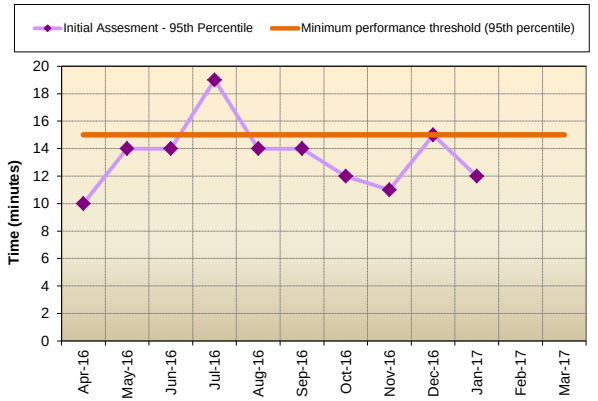
Description of data

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

We have met the target , however we are looking at how the department operates, staffing rotas, to see if this would impact on the busier shift .The aim would be to implement this in the March 2017 and we are changing to an electronic documntation process that is aimed to reduce soem ofd the documenation time.

12	95th percentile this month
15	Target
	Data quality

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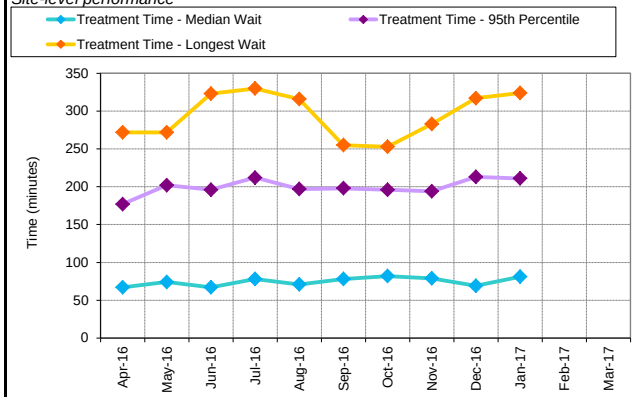
Time to Treatment in A&E [HQU13]

Site-level performance



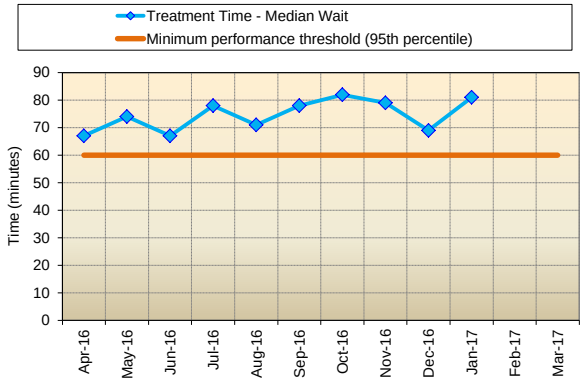
Description of data

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: The 60 minute target waiting to be seen by a decision making clinician has been the one performance target we regularly struggle to achieve. This is for a variety of factors, it could be just demand , patients acuity or the confidence and experience poof the doctors on any given shift. Some may require more support than others and this can impact the flow of the whole review of the patients process. Thius time has increased this month .

81	Median this month
60	Target
	Data quality

Service experience

What have we done to understand and assess the experience of our patients from April 2016 - January 2017

• Nursing quality indicators are now embedded and monthly patient questionnaires are undertaken. These results will be monitored and reported to the Trust Plans-

•Action Plans will be generated by the department Manager and the GED team to address any deficits.

.Friends and Family questions are being asked and results are now available and published for GED
.We are actively promoting feedback

. Social media, twitter is also being used to encourage our patients to give feedback about the our Services. A text reminder is also being introduced

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

•Patient Stories continue to be shared with the Board and departmental staff and we are working closely with patients who are sharing their

•Identified funding for additional nurses to be trained in scanning and working with colleagues in ultrasound to mentor nursing staff in early pregnancy scanning, Two additional members of our team have completed competencies -additional service extension is being considered.
•NICE guidelines for the management of miscarriage have been assessed to understand compliance levels- Action plan to address non compliance
•Emergency Nurse practitioner roles, clinical decision maker time frames should see an improvement over the coming months.
•Established 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 on-going feedback mechanism for patients , Displayed within department and disseminated to team members

•Relocation to a newly developed Emergency department .Designs and furnishings have been installed taking feedback from patients into consideration.
•Local quality meeting is ensuring robust cascading of information, promoting opportunities to learn lessons.

•Work force review staffing increase in place.

What were results of these assessments?

•Waiting times too long
•Communication
•Staff attitude/ Customer care
•Waiting times for scans / inability to offer one stop scan

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.

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

• systems and processes in place to address feedback.

•Department relocation, investment in facilities, new reception area with privacy area, increased rooms , improved waiting area and accessibility to refreshments/ facilities

Liverpool Women's NHS Foundation Trust
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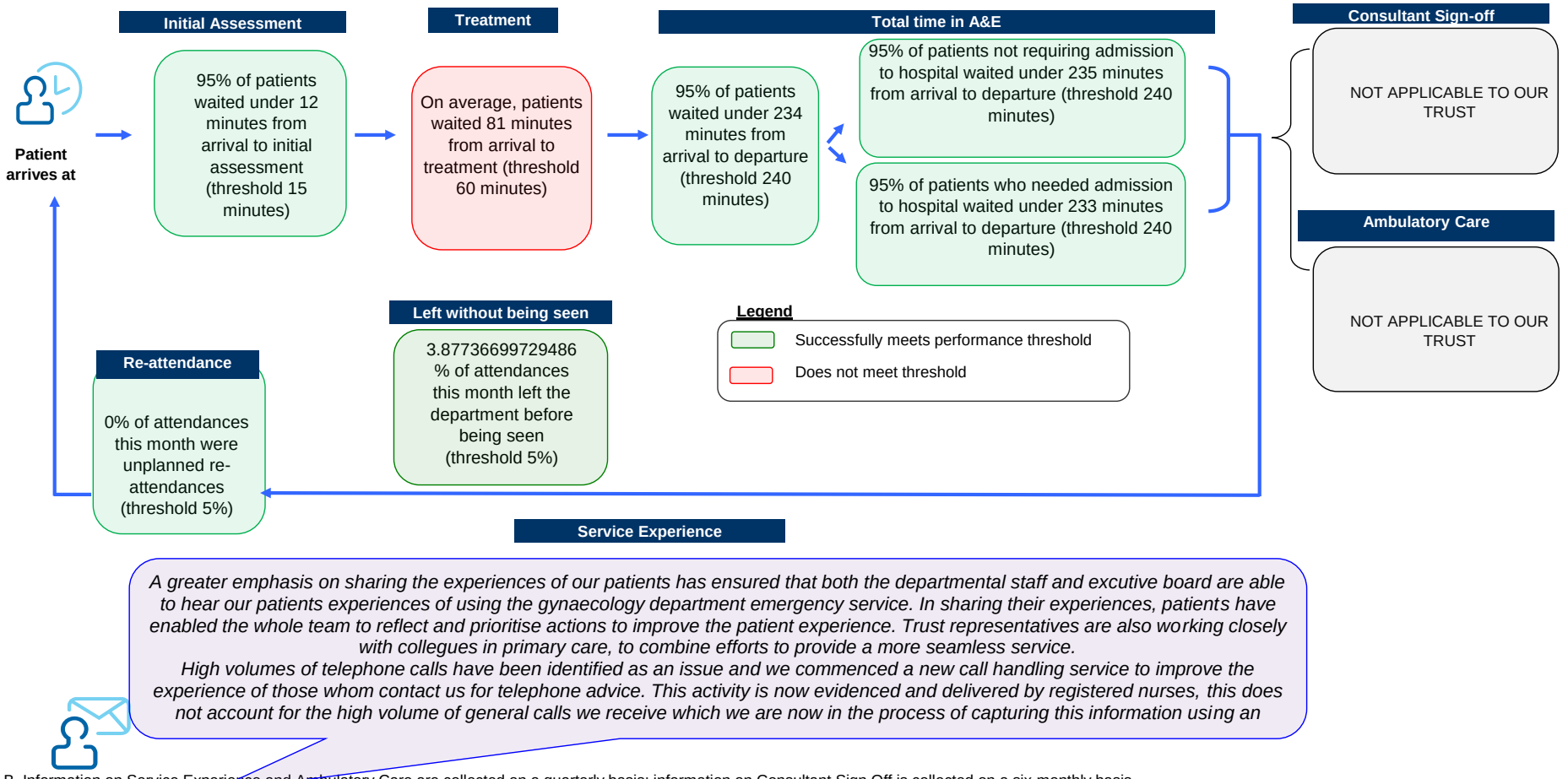
Overview

This dashboard presents a comprehensive and balanced view of the care delivered by our A&E department, and reflects the experience and safety of our patients and the effectiveness of the care they receive. These indicators will support patient expectations of high quality A&E services and allow our department to demonstrate our ambition to deliver consistently excellent services which are continuously improving.

General Information

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	- A&E site name and organization code
Type 2 (Specialist)	- A&E site type
Hayley McCabe, Ext 4213	- Contact details for further information
January 2017	- The time period the data in the dashboard relate to

Summary of performance - January 2017



N.B. Information on Service Experience and Ambulatory Care are collected on a quarterly basis; information on Consultant Sign Off is collected on a six-monthly basis

For further information on performance for individual indicators, please view the main dashboard