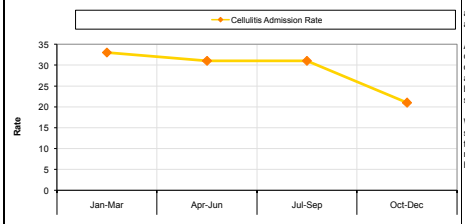
Accident & Emergency Department Clinical Quality Indicators - Good Hope Hospital

Ambulatory Care

Cellulitis Admission Rate



Rationale

The aim is to reduce avoidable hospital admissions by improving the provision of ambulatory care.

Ambulatory care is clinical care for urgent conditions, which may include diagnosis, observation, treatment and rehabilitation that are not provided within the traditional hospital bed base or within traditional outpatient services.

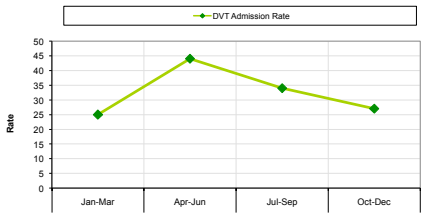
When it is safe and effective to do so a patient should be treated at home or in settings where the delivery of acute care is feasible without requiring an admission for overnight stays in hospital.

Narrative

Good Hope Hospital has a defined Cellulitis pathway which we manage via our Clinical Decisions Unit whereby appropriate patients are managed on the same day and safely discharged where clinically appropriate rather than traditionally admitting this patient group . CDU medicine is seen as best practice in ambulatory care and supports emergency departments to manage patients who need more than four hours but not more than a 24 hour stay if aggressively managed. We are also developing our Ambulatory Emergency Care service in conjunction with acute medicine colleagues to further enhance ambulatory services. The overall trend for performance is positive and an ongoing review process will endeavour to keep this consistent in future months.

21%	This quarter (cellulitis)

DVT Admission Rate



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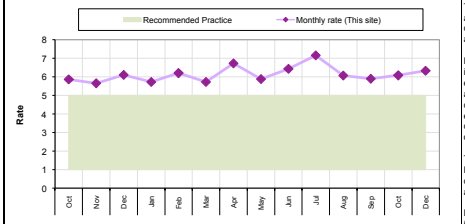
When it is safe and effective to do so a patient should be treated at home or in settings where the delivery of acute care is feasible without requiring an admission for overnight stays in hospital.

Narrative

We currently manage this patient group via our CDU and we continue to develop our Ambulatory Emergency Care services in conjunction with acute medicine colleagues to further enhance ambulatory services. Whilst performance is positive, ongoing monitoring across the department is designed to ensure consistent performance.

27%	This quarter (DVT)

Unplanned re-attendance



Rationale

The aim is to reduce avoidable re-attendances at A&E by improving the care and communication delivered the during the first attendance.

Patients may re-attend A&E because of a wrong initial diagnosis, wrong treatment or poor explanation by clinicians. A subset of re-attendances at A&E may be due chronic conditions. Effective case management and ensuring patients receive the right care first time can improve patient experience and health outcomes.

The optimum re-attendance is *not zero*. Patients may be expected to re-attend if their conditions unavoidably worsens, or if they re-attend for unrelated conditions.

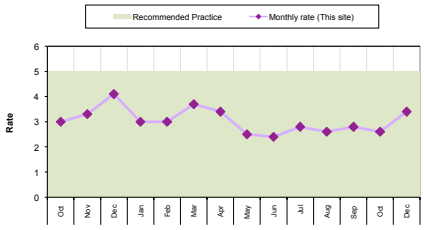
Expert opinion suggests levels should be below 5% and levels less than 1% may reflect a risk averse approach to care.

Narrative

To manage the re-attending group of patients we have convened a multidisciplinary group consisting of ED consultants, primary care, commisioners and mental health teams. This MDT group review the patients who frequently attend and will agree a case management approach for the highest attending patients. Current analysis shows us that patients with drug / alcohol and psychiatric issues make up a significant number of those who re-attend. Nationally the average re-attending rate was 7.4% with the approach currently being deployed within HEFT used as an example of best practice nationally. The overall trend regarding this measure is challenging, therefore, ongoing work is underway to ascertain the causes of the rising trend. Once established remedial action planning will take place.

6%	Rate this month

Left without being seen



Rationale

The aim is to improve patient experience and reduce the clinical risk to patients with high risk conditions who leave A&E before receiving the care they need.

Patients who decide to leave the A&E department after they have been initially received, but before being seen by a clinical decision maker, may have health conditions that will deteriorate without treatment.

Expert opinion suggests that the rate should be below 5% in good UK practice.

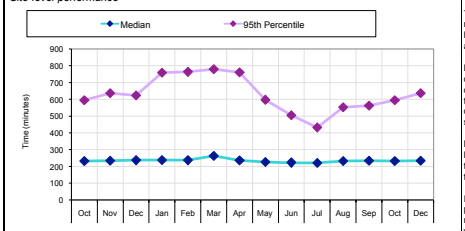
Narrative

The numbers of patients leaving before being seen continues to remain well within recommended levels.

3.4%	Rate this month
	Data quality

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

Site-level performance



Rationale

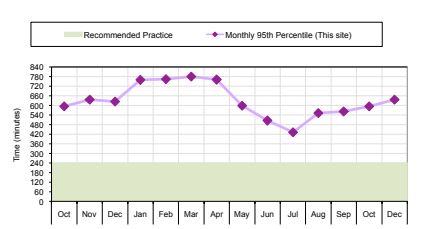
The aim is to improve the timeliness and monitoring of care to ensure patients do not have excessive waits in A&E before being admitted.

Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion and patients leaving without being seen.

Monitoring the median, 95th percentile and longest time, allows departments to understand the distribution of waiting times of the patients they care for.

In England, the median time spent in A&E for a patient being *admitted* is approximately 205 minutes with 95% of patients being admitted within 340 minutes.

Site performance against performance thresholds)



Bottom Line

1. Excessive total time in the A&E is linked to poor outcomes, but decreasing delays must not be confused with faster care

2. Clinical advice suggests that a 95th percentile wait above four hours is not good practice

3. The single longest wait should be no more than six hours

The median is the middle time, so half the patients waited less and half of the patients waited more.

The 95th percentile is essentially a method of separating the majority from the insignificant few, in simple terms it looks at what happened for 95% of patients.

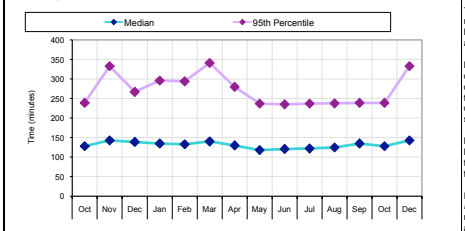
Narrative

This indicator includes patients who are critically unwell and require stabilisation before safe transfer. This includes patients going to Intensive Care or directly to Theatre. However, this group also includes patients who simply require inpatient treatment but are awaiting beds. The Good Hope site team continues to focus on hospital processes to reduce the total time for admissions from the ED. The recent deterioration rwhich is mirrored on the Heartlands site has been recognised by the board with additional steps being taken to maintain and improve patient flow in the hospital. This work is ongoing.

636mins	95th percentile this month
	Data quality

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

Site-level performance



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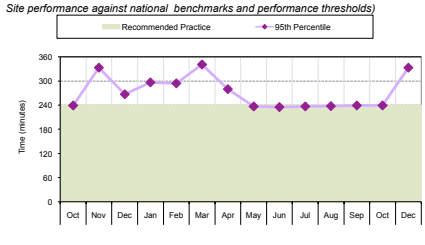
Monitoring the median, 95th percentile and longest time, allows departments to understand the distribution of waiting times of the patients they care for.

In England, the median time spent in A&E for a *non-admitted* patient is approximately 105 minutes with 95% of patients being non-admitted within 235 minutes.

Site performance against national benchmarks and performance thresholds)



Bottom Line

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3. The single longest wait should be no more than six hours

The median is the middle time, so half the patients waited less and half of the patients waited more.

The 95th percentile is essentially a method of separating the majority from the insignificant few, in simple terms it looks at what happened for 95% of patients.

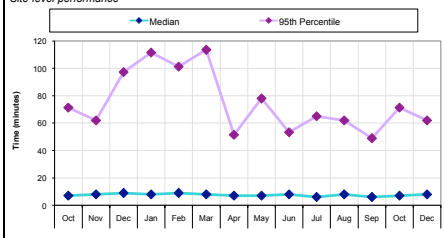
Narrative

The patient cohort included within this metric are mostly made up of patients with minor injury and illness reflected by the median waiting time. However the 95th percentile often represent patients who have been aggressively treated to the point they do not require admission which is better for the patient but is reflected as longer than expected waiting times for patients who are not admitted. Renewed focus on the embedding of Rapid Assessment and Treatment will facilitate reductions in waiting times. Ongoing discussions to introduce a new primary care front end service will also support this performance measure. This work is ongoing.

333mins	95th percentile this month
	Data quality

Time to initial assessment in A&E

Site-level performance



Rationale

Time from arrival to start of full initial assessment, which includes a pain score and an early warning score, for all patients arriving by ambulance.

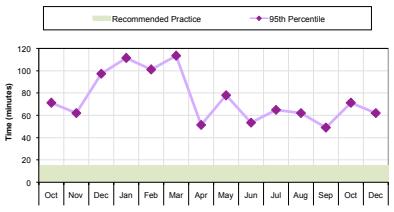
The aim is to reduce the clinical risk associated with the time a patient spends unassessed in A&E.

Many urgent and emergency conditions are time sensitive and the period before a patient is seen by a health professional represents clinical risk.

Major case patients waiting more than 20 minutes for initial assessment could indicate poor quality or unsafe care.

The College of Emergency Medicine has issued a standard for vital signs measurement in the majors area of A&E departments.

Site performance against national benchmarks and performance thresholds)



Bottom Line

1. 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

2. Patients should be assessed as soon as possible; good practice would be to have all patients assessed within 20 minutes of arrival

The median is the middle time, so half the patients waited less and half of the patients waited more.

The 95th percentile is essentially a method of separating the majority from the insignificant few, in simple terms it looks at what happened for 95% of patients.

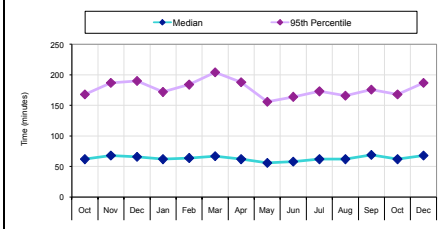
Narrative

The Rapid Assessment and Treatment initiative has been in place since November 2013. This, along with an increased focus on process efficiency should deliver shorter times to initial assessment within the deparment for all patients on average overall. This should become apparent when the Rapid Assessment service has been underway and fully established for some months/

62mins	95th percentile this month
	Data quality

Time to Treatment in A&E

Site-level performance



Rationale

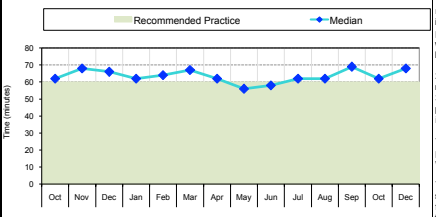
Time from arrival to see a decision making clinician (someone who can define the management plan and discharge the patient).

The aim is to reduce the clinical risk and discomfort associated with the time a patient spends before their treatment begins in A&E.

The decision-maker should be someone who can define the management plan and has the ability to discharge a patient.

Large numbers of patients waiting more than 60 minutes to be seen by a clinical decision maker could indicate poor quality or unsafe care.

Site performance against national benchmarks and performance thresholds)



Bottom Line

1. Time to the start of treatment should be minimised but not at the expense of other 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

2. 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

The median is the middle time, so half the patients waited less and half of the patients waited more.

The 95th percentile is essentially a method of separating the majority from the insignificant few, in simple terms it looks at what happened for 95% of patients.

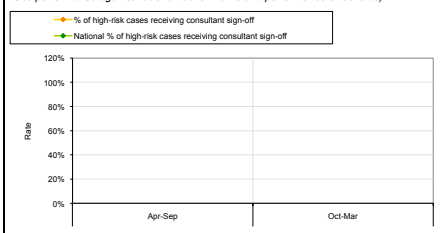
Narrative

This indicator reports the time from arrival to clinician, the directorate continues to develop its workforce according to its workforce strategy so we can optimise our decision making capacity against demand. As the departments become less crowded with patients waiting for beds our clinicians are able to see the new patients more quickly. Introduction of new services such as ambulatory care and primary care front end services will further support timely decision making

68mins	Median this month
	Data quality

Consultant Sign-off

Site performance against national benchmarks and performance thresholds)



Rationale

The percentage of patients presenting at major A&E departments within certain high-risk patient groups (below), that are reviewed by an emergency medicine consultant before being discharged.

*Non-traumatic chest pain
*Febrile children less than 1 year old
*Patients making an unscheduled return visit with the same condition within 72 hours of discharge

The aim is to improve clinical processes and outcomes and reduce the risk patients are exposed to.

This is measured by the College of Emergency Medicine, every six months.

Narrative

N/A	Oct-Mar performance

Overall Summary of performance

HEFT is currently significantly challenged with overall waiting times within the departments. Detailed action plans are in place to improve internal processes within the department as well as system wide changes. Significant investment into the nursing and medical workforce has recently been released to support the effective and safe functioning of the department.