



# **A&E Clinical Quality Indicators**

*Implementation Guidance*

## A&E Clinical Quality Indicators Implementation Guidance

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<b>Description</b>	This is the implementation guidance for the new A&E clinical quality indicators, which will be introduced in April 2011, replacing the 4-hour standard. The measures will provide a comprehensive view of the quality of care across the A&E departments in England, including outcomes, clinical effectiveness, safety, experience and timeliness.
<b>Cross Ref</b>	N/A
<b>Superseded Docs</b>	N/A
<b>Action Required</b>	Providers of A&E services should take steps to ensure that they are able to publish data against the clinical quality indicators. In particular this will require reviewing the coverage and quality of data submitted via A&E SUS. Commissioners of A&E services will want to consider how they can best use the indicators to encourage local service improvements.
<b>Timing</b>	<b>A&amp;E performance from 1 April 2011 will be measured using the clinical quality indicators.</b>
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## *Implementation Guidance*

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## ***Preface by National Clinical Director for Urgent and Emergency Care***

As an emergency medicine consultant, my job is to provide the best care for my patients so they recover quickly. To help me achieve this I need some evidence of the impact of the care I deliver and of that given within my department.

Until now the only national driver and measure of performance in the emergency care system has been time targets, particularly the standard which requires a patient arriving at A&E to be seen and discharged, admitted or transferred within four hours of arrival in 95% of cases. This standard has reduced delays in A&E departments and time matters because research shows that patients who are diagnosed and treated more quickly have better clinical outcomes and experience.

However, there are dangers in focusing too heavily on just the time spent in the A&E department. The four-hour standard has been a blunt instrument that does not differentiate the time when someone is receiving active treatment from the time when they are just waiting for the next step in their care. The four-hour standard has provided an incentive to move patients through A&E quickly, but does nothing to counterbalance this to ensure that patients are receiving the highest quality care.

Urgent and emergency care is changing. With advances in diagnostic testing, medicines and technology, far more people can now be treated in their homes. A few years ago having a clot in your leg would have meant several days in hospital. Now it can mainly be treated at home with occasional visits to the hospital as an out-patient for scans and to monitor treatment. In A&E, we now undertake far more investigation and care before a patient is admitted and we are more able to safely discharge people for community care or self care.

The White Paper *Equity and excellence: Liberating the NHS* signalled a new approach from the Government. It proposes to remove process targets without clinical justification and replace them with a focus on outcomes. A new National Outcomes Framework would include a set of national outcome goals against which the NHS would be held to account.

Now is therefore the right time for the NHS to move on and take a new, more balanced approach to measuring the quality of care provided by A&E departments.

The work to develop this new approach has been based on three key principles:

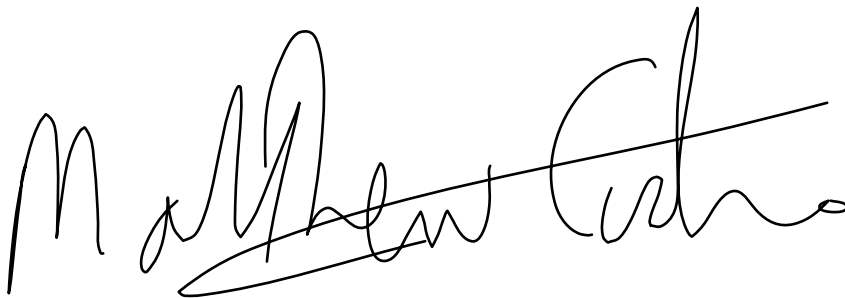
Firstly, we have used the best available research and evidence to underpin our approach. An important element of this has been the involvement of experienced clinicians. I would like to thank those who have been involved and in particular Alan Dobson and Rob Crouch (Royal College of Nursing) and

John Heyworth (College of Emergency Medicine), as well as Suzanne Shale who led the lay input.

Secondly, our aim has been to encourage a spirit of continuous improvement that goes on driving up quality of care, rather than simply achieving targets. It is important to be clear about what I mean by 'quality'. Fundamentally, quality involves getting the best clinical outcomes and experience for patients and their carers. To deliver the best outcomes the NHS needs to provide the right clinical care for each individual and do so in a safe and timely manner. A key indicator of whether the NHS has achieved this will be the experience reported by patients.

Thirdly, information on the quality of clinical care in A&E needs to be easily available and easy to understand so that patients can see and assess for themselves the quality of care provided and staff can see where they are doing well and where to concentrate their improvement efforts. Collecting information is not difficult. The NHS Information Centre's Hospital Episode Statistics dataset already contains lots of useful data, which, with some effort to improve quality and coverage, can be used as the principal source for recording and reporting A&E attendance information.

The result of this work is a set of clinical quality indicators which provides a broader picture of the impact of the care I deliver, of that given within my department and of that given by other departments throughout the country. I hope these indicators will stimulate continuous improvement and a more sophisticated debate about the care delivered in A&E and the wider system of urgent and emergency care, but this is not the end of the story. The indicator set will be reviewed annually to ensure that it remains relevant and useful, and I therefore welcome your feedback.

A handwritten signature in black ink, appearing to read 'Matthew Cooke', written in a cursive style.

**Professor Matthew Cooke**  
**National Clinical Director for Urgent and Emergency Care**  
[urgent&emergency@dh.gsi.gov.uk](mailto:urgent&emergency@dh.gsi.gov.uk)

## Statements of Support

### College of Emergency Medicine

The fundamental role of any health service is the provision of guaranteed high quality safe emergency care for patients at all times. The College of Emergency Medicine welcomes these new indicators as the next step in driving the agenda to ensure such care. The combination of measures reflecting timeliness, senior review and quality represent a powerful synergy. Patient care will be enhanced and patient flow through the Emergency Department maintained. This suite of indicators will inform discussions involving commissioners and Emergency Medicine clinicians to secure the support required for continued improvement and delivery of the excellent Emergency Department care which our patients expect and deserve.

John Heyworth, President, College of Emergency Medicine

### Royal College of Nursing

The Royal College of Nursing Emergency Care Association are pleased to have worked closely with the DH to develop this suite of quality indicators for emergency care. At times of acute injury or illness patients and their carers are often under considerable stress; it is reassuring to know that they can be treated in units that are committed to delivering high quality care in a timely manner. The suite of clinical quality indicators are patient focused and will instil confidence in patients, carers and staff that high quality care is being delivered. The suite of measures recognises the importance of the multidisciplinary team. We look forward to seeing the implementation of these indicators in the delivery of excellent emergency care.

Alan Dobson, Royal College of Nursing

### College of Emergency Medicine's Lay Advisory Group

We welcome the introduction of new indicators as a basis for continuing improvement in emergency care. These indicators capture what is most important to those who need medical help, which is timely treatment by trustworthy clinical teams. We are pleased that performance management measures remain in place to support services at a time of challenge and change for the NHS. Looking to the future, we value the prominence given to further efforts to understand the experience of those seeking medical assistance in an emergency. We know that clinical teams and their managers already work hard to provide the best possible care; the indicators will serve as an important guide towards this common goal.

Dr Suzanne Shale, Lay Advisory Group Chair, College of Emergency Medicine

## Overview

### *Why are the new clinical quality indicators being introduced?*

1. The new clinical quality indicators are being introduced in April 2011 to replace the four hour A&E operational standard. The purpose of the new set of A&E indicators is to provide a balanced and comprehensive view of the quality of care, including outcomes, clinical effectiveness, safety and experience, as well as timeliness, and to remove the isolated focus on faster care. This will allow everyone to easily see the quality of NHS emergency care. Because the indicators aim to give a balanced view of the quality of care, it is vital that they are seen as a single set, and that no one indicator is considered in isolation. The indicators will therefore be a barometer of the quality of A&E care across the NHS in England.
2. These clinical quality indicators aim to stimulate the discussion and debate in health communities that is needed in a culture of continuous improvement. In order to have continuous improvement we need to move away from a culture of achieving a specified target and move to looking at how we can get closer to perfection.
3. The indicators have been developed by the Department of Health working with the College of Emergency Medicine, the Royal College of Nursing and informed lay representatives. Other stakeholders have also been consulted. This has resulted in large numbers of clinicians working in emergency care being able to contribute to and influence the indicators.

### *How will the indicators fit with other initiatives to demonstrate quality?*

4. This set of indicators is part of a project to develop system indicators across the whole of urgent and emergency care. Ambulance indicators are also being developed with the same domains as the A&E indicators. With continuing development, a system will evolve that also covers the other components of urgent and emergency care including hospital based assessment units. Work is also being undertaken relating to urgent primary care and telephone-based health services. These indicators will have a commonality of topics and will help to promote greater integration and a consistent and improving level of service across the whole urgent and emergency care system.
5. The indicators will complement National Institute for Health and Clinical Excellence (NICE) Quality Standards and the NHS Outcomes Framework to give a comprehensive overview of quality of emergency care. At a more local level, clinical audit will still be important for monitoring standards of care. Commissioners will find further guidance is available from many sources that can be used for supporting improvements in local structures and processes in urgent and emergency medicine (e.g. The Royal College of Paediatrics and Child Health and College of Emergency Medicine *Services for Children in Emergency Departments*<sup>1</sup>; the British Geriatric

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<sup>1</sup> <http://www.rcpch.ac.uk/Policy/Emergency-Care>

Society guide on *The Older Person in the Accident & Emergency Department*<sup>2</sup>; *College of Emergency Medicine Professional Standards in Emergency Medicine*<sup>3</sup>). Peer review processes are also starting in some areas<sup>4</sup> and have particular value – they not only allow more discussion and debate but also facilitate shared learning to promote continuous improvement. Process measures will still be important locally, particularly to measure the impact of improvement interventions where more specific information is required. Such projects should however aim to measure outcomes and experience as well as structure and process.

*To whom will these indicators apply?*

6. Initially these indicators will be used in the same sites which have been included in the 4 hour standard, that is Type 1 (Major), Type 2 (Specialist) and Type 3 (e.g. Minor Injury Units and Walk-in Centres) A&Es. Where possible, other facilities accepting emergency patients, e.g., medical/surgical/paediatric assessment units, should adopt them if they are able. Otherwise these facilities should be developing systems, as it is our intention to take steps to include such facilities formally in the national data collection from April 2012. Ultimately, we must measure the quality of care received by patients with urgent and emergency care needs regardless of where these patients present and have indicators that reflect the whole patient pathway.

*How will the clinical quality information be presented?*

7. Data will be presented in a manner that is most meaningful to the patient and most helps professionals to see areas of improvement and success. Each individual site (rather than NHS organisation) will publish data against the indicators, because sites are what matters to patients. This may mean data from different organisations being combined, e.g. where there is an A&E department and a walk-in centre managed on the same site or campus by different organisations. Sites will publish data on the internet so that it is available to the general public. The NHS Information Centre for Health and Social Care will collate and publish the majority of the national indicator data to allow for benchmarking of performance.
8. The data will be presented so that changes over time can be seen, while a narrative will enable sites to explain what the data means and what actions are planned in light of the indicator data. A template and publication guide will be provided to healthcare organisations in early 2011 so that results are presented in a consistent way to allow the public to make fair comparisons.

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<sup>2</sup> [http://www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm)

<sup>3</sup> <http://www.collemergencymed.ac.uk/Shop-Floor/default.asp>

<sup>4</sup> West Midlands Quality Review Service-Urgent Care  
<http://www.wmqi.westmidlands.nhs.uk/wmqrs/review-programmes/view/urgent-care>



*What is good and what could indicate poor quality or unsafe care?*

9. This guidance describes what is best and gives national benchmarking data as well as referring to international research evidence. Where appropriate, expert opinion from clinicians is also stated. Data alone rarely tells you the quality of the service, but data with observation and understanding of the quality-adding steps in the process will usually enable informed discussions involving clinicians, managers and commissioners, leading to true improvement in the quality of care and the patient experience. For each indicator we have discussed what is good and what could indicate poor quality or unsafe care. Local situations will vary and so local communities may want to define this more closely for their circumstances but should be able to justify why such variation is for the benefit of their community.
10. “Good” care will invariably satisfy four criteria:
  1. Patient-focussed with reports of good experience
  2. Best health outcomes with minimal risk
  3. Timely care in the best location
  4. Correct first time

*How will the indicators be managed?*

11. The indicators are *not* the goal in themselves. The NHS should utilise the results of the indicators to stimulate continuous improvement in care. The indicators have been designed to present a comprehensive and balanced view of care, so they should be used as a single set and the NHS should therefore avoid initiatives which aim to improve performance against a single indicator without considering the effect on the other indicators.
12. Sites, provider organisations and networks will want to use the results of the indicators, benchmarking their own site(s) against other sites with similar profiles, to gauge performance. Sites, provider organisations and networks should use the indicators as levers to further understand their service and see where improvements to patient outcomes can be made. How this is done is for local determination, but might involve, for example, regularly reviewing the data, and reporting it to the board. Boards will no doubt want to take responsibility for ensuring service improvements.
13. Commissioners may use them to set goals for improvements in the quality of the care they are commissioning. Commissioners will want to monitor and review them and, where performance levels as a whole are below expectations, to agree improvement incentives, actions and timescales.
14. Organisations may have their own historical data for many of the existing indicators and it would be expected that they share these with their commissioners to allow historical benchmarking so that improvement can be recognised. By using statistical process control techniques it would be expected that significant changes could be identified in the indicator performance and normal variation better understood (further details will be in the publication guide).

15. Any deterioration from present performance should be studied by commissioners and incentives developed locally for driving real improvement across the whole set of indicators. Spending longer in A&E is only acceptable for a small number of patients who have complex needs and replacement of the four hour standard must not lead to delays in service provision. Many patients still experience long delays in receiving initial care and while waiting for a bed and we must still reduce such clinically inappropriate delays.
16. The NHS Operating Framework for 2011/12 describes the Department of Health's proposed approach to performance during 2011/12. In respect of A&E, all eight clinical quality indicators are included in the NHS Operating Framework under national oversight. Elements of five of the A&E clinical quality indicators are included as headline measures to assess organisational and system health (see table below). All remaining indicators, for example the longest wait and median total time in A&E, are included as supporting measures.
17. Full details on the performance measures are included in the underpinning Technical Guidance to the NHS Operating Framework 2011/12, but in summary the elements that will be headline measures are:

Indicator	Title	Performance management trigger
2	Unplanned re-attendance rate	A rate above 5%
3	Total time spent in the A&E department	A 95th percentile wait above 4 hours for admitted patients and with the same threshold for non-admitted
4	Left without being seen rate	A rate at or above 5%
6	Time to initial assessment	A 95th percentile time to assessment above 15 minutes for ambulance cases
7	Time to treatment	A median wait above 60 minutes

18. These five headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor quality care. The Operating Framework will be reflected in the national contract. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below national minima.
19. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at. There is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance.

20. The five indicators are included in the Operating Framework as headline measures in order to assess organisational and system health. The five indicators have partly been chosen because these have more robust historical data. The fact that five have been chosen does not indicate that these five have a greater importance than the remaining indicators which are new, qualitative, or developing collections (for example Consultant Sign-Off, Service Experience, Ambulatory Care). The aim is for these indicators to stimulate debate and discussion of A&E performance which should always be considered across all eight indicators.

*Will these indicators change in the future?*

21. There will be an annual review of the indicators to ensure they continue to promote best standards of care and remain applicable as systems develop.

22. The real test of the indicators and their presentation is whether the users of the information can easily interpret and use it. These A&E clinical quality indicators should therefore:

- a) present a clear picture of performance to patients and the public;
- b) provide a basis for benchmarking across the system;
- c) provide data for commissioners and sites on which to base quality improvement activity;
- d) demonstrate continuous improvement.

We therefore welcome feedback on these indicators via [urgent&emergency@dh.gsi.gov.uk](mailto:urgent&emergency@dh.gsi.gov.uk) .

## The Indicators

The indicators are:

Number	Indicator	Page
1	Ambulatory care	13
2	Unplanned re-attendance rate	16
3	Total time in the A&E department	19
4	Left without being seen (LWBS) rate	23
5	Service experience	26
6	Time to initial assessment	29
7	Time to treatment	32
8	Consultant sign-off	35

**Indicator:** [1]  
**Short title:** Ambulatory care  
**Full title:** Ambulatory care sensitive conditions: the number of admissions for cellulitis and deep vein thrombosis (DVT) per head of weighted population

Ambulatory care for emergency conditions: the percentage of A&E attendances for cellulitis and deep vein thrombosis (DVT) that end in admission

<b>Aim</b>	To reduce avoidable hospital admissions by improving the provision of ambulatory care.
<b>Rationale</b>	<p>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; the healthcare setting may vary, but optimal clinical care will often require prompt access to diagnostic support for clinical assessments.</p> <p>Ambulatory care sensitive conditions, such as chronic obstructive pulmonary disease (COPD), are those where improved preventative healthcare or improved long-term condition management in community care settings can result in decreased risk of an acute event occurring. These can be distinguished from the provision of ambulatory care for emergency conditions, such as cellulitis and DVT, where an acute event has already developed but the delivery of acute care is feasible without requiring an admission for overnight stays in hospital. Patients suffering from those conditions have traditionally been managed in an inpatient environment but many can now be managed without a hospital stay.</p> <p>Providing effective ambulatory care for conditions such as cellulitis and DVT will allow for better patient care and case management, care delivered closer to home, and a reduction in avoidable emergency admissions which are costly and also expose patients to otherwise avoidable clinical risks such as healthcare-acquired infections. These two conditions of cellulitis and DVT have been chosen because we know there is a large variation in admission rates, they are common conditions and they require a whole systems approach.</p> <p>To better reflect the specific role of A&amp;E departments in improving patient care and reducing avoidable admissions to hospital, the preferred measure is the proportion of patients attending A&amp;E for cellulitis and DVT who are then admitted. However, to recognise that not all A&amp;E departments are able to fully clinically code attendances for these two specific</p>

	<p>conditions, a broader measure of admission rates per weighted head of registered population has been included. This also supports whole system planning and encourages patient focus.</p> <p>Evidence<sup>5</sup> supporting ambulatory emergency care and a guide to implementation is available from the NHS Institute for Innovation and Improvement. Provisional Hospital Episode Statistics for 2009/10 indicate that the number of emergency admissions for cellulitis per 1,000 weighted head of PCT registered population ranges between 0.75 and 1.80 across PCTs, with a median value of 1.20 admissions per 1,000 head. For DVT, the range in emergency admissions per 1,000 weighted head across PCTs is 0.12 to 1.17, with a median of 0.42 admissions per 1,000 head. These ranges are significant despite appearing relatively small in absolute terms due to the scale of the denominator, and improving the provision of ambulatory emergency care will result in several thousand fewer costly emergency admissions, and several thousand more patients receiving more appropriate clinical care.</p>
<b>Patient Perspective</b>	<p>I want to receive the care I need and avoid being admitted into hospital if I do not need to. If my condition is less serious then it would be more convenient to be treated closer to home, or within A&amp;E rather than within a hospital ward, and I would like to receive the level of care and support I need to prevent my condition worsening to the level where I have to be admitted to hospital.</p>
<b>What is good?</b>	<p>When it is safe and effective 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.</p>
<b>What could indicate poor quality or unsafe care?</b>	<p>Admitting patients to hospital unnecessarily.</p> <p>It is vital that accepted guidelines are followed to ensure that ambulatory care is only undertaken in clinically safe and indicated cases.</p>
<b>Discussion and Debate</b>	<p>Admission rates are not only determined by the diagnosis, and when studying admission rates it is important to understand the relative impact of patient and system factors. Patient related factors such as co-morbidity, social</p>

<sup>5</sup> NHS Institute for Innovation and Improvement. Ambulatory emergency care - manage your emergencies as day case .  
[http://www.institute.nhs.uk/quality\\_and\\_value/high\\_volume\\_care/ambulatory\\_emergency\\_care.html](http://www.institute.nhs.uk/quality_and_value/high_volume_care/ambulatory_emergency_care.html)

	<p>circumstances may also result in legitimate variation between different sites; there may also be some variation related to the relevant local community characteristics such as deprivation and health needs. Other factors may however be amenable to change such as availability of other health services.</p> <p>One aspect of this indicator is measured at PCT level and is a reflection of how the whole health system is set up to promote ambulatory care. High admission rates may be the result of non-availability of services or pathways at any point in the whole system of care. It is therefore important to explore all potential barriers to implementation before looking at the individual patient factors.</p>
<p><b>Bottom Line</b></p>	<ol style="list-style-type: none"> <li>1. Healthcare systems should explore how they can safely treat as many people as possible in the community by exploring existing system based barriers.</li> <li>2. Benchmarking against systems in other localities will demonstrate the capacity for improvement.</li> <li>3. Evidence suggests there is a high potential for ambulatory care for cellulitis cases (i.e. 60-90% of admissions) and a very high potential for ambulatory care for DVT (i.e. &gt; 90% of admission)<sup>17</sup></li> </ol>

**Indicator:** [2]  
**Short title:** Unplanned re-attendance rate  
**Full title:** Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)

<b>Aim</b>	To reduce avoidable re-attendances at A&E by improving the care and communication delivered during the first attendance.
<b>Rationale</b>	<p>Patients may re-attend A&amp;E because of the wrong initial diagnosis, wrong treatment or poor explanation by clinicians<sup>6</sup>. A subset of re-attendances at A&amp;E may be due to chronic re-attendance for conditions such as mental health problems and substance abuse. Effective case management and ensuring patients receive the right care first time can improve patient experience and health outcomes. If re-attendances within 48 hours are monitored this may miss many cases, whereas two thirds will be detected by looking at re-attendances within seven days<sup>7</sup>.</p> <p>The optimum re-attendance is <i>not zero</i>. Patients may be expected to re-attend if their conditions unavoidably worsen, or if they re-attend for unrelated conditions; discharging patients on consideration of the clinical risk, with appropriate safety-netting advice can be good care; and a low re-attendance rate may also reflect unnecessarily high admission rates and longer stays in hospital. For these reasons, only avoidable re-attendances should be reduced, and the re-attendance rate should be balanced by investigating admission rates and lengths of stay where appropriate to ensure that these are not increasing at the expense of a low re-attendance. It is suggested that when change occurs in re-attendance rates then commissioners should study these countermeasures and understand how reductions in re-attendance have been achieved to ensure this reflects good practice.</p>
<b>Patient Perspective</b>	After my first visit to A&E, if things do not go as I expect then I will go back or seek help elsewhere. This may be because of clinical mistakes being made during the first attendance or explanations not being made clear to me.
<b>What is good?</b>	Patients should be correctly diagnosed, treated and advised on their first visit. Some complications will occur after acute illness or injury but these can be minimised by best care on

<sup>6</sup> Sturch P, Cooke MW. Reattendances at Emergency Departments (literature review undertaken for this work and awaiting publication)

<sup>7</sup> Id.



	<p>the first visit. These unplanned re-attendances are to be reviewed by a senior clinician where appropriate.</p> <p>Those with chronic conditions may have multiple re-attendances because of the nature of their disease but evidence<sup>8</sup> suggests that most can have the number of acute episodes reduced by good case management in primary care.</p> <p>Nationally, at present, unplanned follow-up attendances account for 2.1% of all attendances, with different sites reporting rates of between 0 and 22%.</p> <p>International literature on re-attendance reports very variable rates and also measures re-attendance over a varying length of time and with varying definitions. Most reports report 2-3% in 72 hours with studies at one week varying from 2-13%. These are also from a variety of health systems. The only UK study specifying entry criteria demonstrated a rate of 3% in one month but limited it to cases with associated symptoms.<sup>9</sup></p> <p>Expert opinion suggests that levels should be below 5% but that levels less than 1% may reflect a risk averse approach to care.</p> <p>Re-attendance rates may vary according to case mix. It may therefore be appropriate to benchmark against units with similar case mix (there is no easy measure of case mix but admission rates, proportion brought by ambulance, age distribution may be useful indicators).</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Having a high number of patients re-attending the A&amp;E department because they have continuing problems.</p> <p>Falsely reducing this figure by referring excessive numbers to planned clinics or admitting to assess is also poor clinical practice.</p>
<p><b>Discussion and Debate</b></p>	<p>In analysing these figures, organisations may want to split these in to those with a single re-attendance and those who have had multiple attendances over the last year.</p> <p>A high re-attendance rate does not only reflect the standard of</p>

<sup>8</sup> Chapter 4.3.8 of Cooke MW, Fisher JD, Dale J, McLeod E, Szczepura A, Walley P, Wilson S. Reducing Attendances and Waits in Emergency Departments: A Systematic Review of Present Innovations. A report to the NHS Service Delivery and Organisation R&D Programme. SDO: London 2005.

<sup>9</sup> Sturch P, Cooke MW. Reattendances at Emergency Departments ( literature review undertaken for this work and awaiting publication)

	<p>care in the A&amp;E. It may reflect a lack of accessible community services. It is therefore important that a root cause analysis approach is taken to detecting the reasons for a high re-attendance so that the true cause is addressed. Organisations may want to regularly audit unplanned re-attendances to understand the causes, the impacts and the solutions. Sites will in particular want to consider how they handle vulnerable patients.</p> <p>Too low a re-attendance rate can however be an issue. It may reflect excellent initial care but could reflect poor patient care such as being too risk averse and admitting patients unnecessarily, or patients who are dissatisfied with their care seeking subsequent care elsewhere. Monitoring admission rates may be a useful countermeasure, and where possible sites should attempt to investigate re-attendance of their patients at other A&amp;E sites within 7 days. Some of the re-attendances within 7 days may be in the group of individuals who have very high usage of the service. It has been demonstrated that case management can reduce their A&amp;E usage. Maximum benefit is obtained if they are detected in the early stages of their high usage period.</p> <p>We are working towards measuring re-contacts made at any point in the urgent and emergency care system, but for the moment, re-contacts at the same facility can be counted.</p>
<p><b>Bottom Line</b></p>	<ol style="list-style-type: none"> <li>1. 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 re-attending patient to be seen by a different and more senior clinician.</li> <li>2. Rates above 5% are likely to reflect poor quality care but rates below 1% may reflect excessive risk aversion.</li> <li>3. A rate above 5% may trigger intervention as this is one of the five A&amp;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.</li> </ol>

**Indicator:** [3]  
**Short title:** Total time spent in the A&E department  
**Full title:** The median, 95<sup>th</sup> percentile and longest total time spent by patients in the A&E department, for admitted and non-admitted patients

<b>Aim</b>	To improve the timeliness and monitoring of care to ensure patients do not have excessive waits in A&E before leaving the department.
<b>Rationale</b>	<p>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, patients leaving without being seen, and financial effects<sup>10</sup>. It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly.</p> <p>Monitoring the median, 95th percentile and longest time spent by patients in A&amp;E departments will allow departments to understand the entire distribution of waiting times of the patients they care for. This will prevent patients being ignored as they spend more time in A&amp;E, and will give sites more flexibility in providing care to patients as they need it, rather than attempting to see all patients within the same time period irrespective of the severity or requirements of the patients' conditions. There is professional agreement that some patients need prolonged times in A&amp;E. However, these exceptions are rare and unlikely to account for more than 5% of attendances.</p>
<b>Patient Perspective</b>	Making me wait a long time for a hospital bed or discharge makes me anxious and uncomfortable and these delays can pose a clinical risk. Moving me as quickly as possible to the right care in the right setting will minimise my discomfort and improve the chances of my condition improving.
<b>What is good?</b>	Patient delays should be minimised but care should not be hurried. Changes in the practice of emergency medicine in some departments mean that more is being done for patients in the A&E, which may take longer but is for the benefit of the patient. Commissioners need to understand the model of care before deciding who to benchmark against. A decreased

<sup>10</sup> Hoot NR, Aronsky D. Systematic Review of Emergency Department Crowding. *Ann Emerg Med.* 2008; 52: 126-136

	<p>admission rate may be evidence of more productive care in A&amp;E that might justify a longer total time.</p> <p>In England, the median time spent in A&amp;E for a patient who is admitted is approximately 205 minutes (95% of attendances admitted in approximately 340 minutes) and the median time for a non-admitted patient is approximately 105 minutes (95% of attendances departing in 235 minutes).</p> <p>International literature suggests increases in adverse outcomes for patients who have been in the ED for more than 4-6 hours.<sup>11</sup></p> <p>Total time in the A&amp;E has been measured for several years and this allows a more clinically orientated focus, but overall time should not deteriorate from existing levels.</p> <p>Benchmarking should be able to be undertaken across all emergency care providers split between admitted and non-admitted patients.</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Large numbers of patients spending a long time in A&amp;E.</p> <p>Compromising the quality of care to achieve fast care; to have a patient waiting for any elements of their care or for transfer to a ward (both of which are associated with adverse outcomes).</p> <p>Moving a patient to a clinically inappropriate area or unit during or before their A&amp;E care is complete in order to improve performance against this indicator is unacceptable. This may be indicated by high numbers of short stay admissions not due to decreased hospital lengths of stay<sup>12</sup>.</p> <p>Under the previous four hour standard, many A&amp;E sites observed a significant increase in the number of admissions as the end of the four hour period approached. As well as ensuring that patients are seen in a timely manner, the total time spent in A&amp;E indicator gives clinicians the freedom to deliver timely care according to the clinical needs of individual patients. Use of this clinical freedom and admission criteria can help avoid unnecessary short-stay admissions simply to</p>

<sup>11</sup> Sprivulis PC, Da Silva J-A, Jacobs IG, Frazer ARL, Jelinek GA (2006) The Association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments MJA 184 (5): 208

<sup>12</sup> Richardson DB (2001) The access-block effect: relationship between delay to reaching an in-patient bed and in-patient length of stay MJA 177:49

	<p>assess the patient and will result in better patient care.</p> <p>The College of Emergency Medicine and Royal College of Nursing agree that there is no good clinical reason for lengths of stay in A&amp;E over 6 hours. These usually reflect delays in transfer to the location of definitive care.</p>
<p><b>Discussion and Debate</b></p>	<p>Total time reflects a summation of a period of both productive clinical time and delays. This indicator aims to reduce the delays without compromising on quality of care.</p> <p>The indicators for admitted and non admitted patients are presented separately as they may have different solutions. If admitted patients have a long median total time, times for investigations and delays for admission should be investigated</p> <p>The non admitted may consist of two groups who should be considered separately:</p> <ol style="list-style-type: none"> <li>1. Those who need only a simple consultation and few investigations who have a very short contact time, and</li> <li>2. Those who need intensive investigation to avoid admission.</li> </ol> <p>In looking for improvement it is important to analyse these situations separately.</p> <p>The College of Emergency Medicine and Royal College of Nursing recommend that this indicator should be discussed locally by analysing the whole patient flow in its component parts and with other indicators of flow through the hospital.</p> <p>This indicator should never be considered in isolation from the other indicators. The flow through the department is reflected by a combination of these indicators and those for initial assessment and time to clinician.</p> <p>If care is too fast then it is likely that care quality will be compromised, adherence to best practice in the senior review of high-risk cases will be reduced, and the re-attendance rate is likely to increase.</p>
<p><b>Bottom Line</b></p>	<ol style="list-style-type: none"> <li>1. Excessive total time in the A&amp;E is linked to poor outcomes but decreasing delays must not be confused with faster care.</li> <li>2. Timeliness of care should not deteriorate from that achieved in the last few years.</li> <li>3. Clinical advice suggests that a 95<sup>th</sup> percentile wait above 4 hours for admitted patients and with the same threshold for</li> </ol>

	<p>non-admitted patients is not good practice.</p> <ol style="list-style-type: none"><li data-bbox="448 264 1356 304">4. The single longest wait should be no more than 6 hours.</li><li data-bbox="448 338 1356 524">5. A 95<sup>th</sup> percentile wait above four hours may trigger intervention as this is one of the five A&amp;E quality indicators included as a headline measure under national oversight to assess organisational and system health under national oversight in the NHS Operating Framework for 2011/12.</li></ol>
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**Indicator:** [4]  
**Short title:** Left without being seen  
**Full title:** The percentage of people who leave the A&E department without being seen

<b>Aim</b>	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.
<b>Rationale</b>	<p>Patients who decide to leave the A&amp;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. Patients who leave without being seen (LWBS) are also likely to have recurrent LWBS episodes in A&amp;E. A recent international literature review (undertaken for this work and awaiting publication) has shown that LWBS is linked with some patient characteristics as well as hospital characteristics. It also demonstrated that up to 49% needed subsequent urgent treatment,<sup>13</sup> and national data for England indicate that over 14% of unplanned follow-up attendances result in admission to hospital<sup>14</sup>.</p> <p>High rates of leaving before being seen by a clinical decision maker are associated with perceptions of excessive waiting times in A&amp;E and overcrowding and poorer patient experience.</p> <p>Although patients may unexpectedly leave A&amp;E for a variety of reasons, as a matter of good practice A&amp;E departments should have arrangements in place to regularly check that patients listed as waiting are still waiting and offer information about why they are waiting and the expected treatment time.</p>
<b>Patient Perspective</b>	I will leave A&E without being seen because something has made me unhappy or uncomfortable and because I have not received the care I felt I needed yet. If I received the care I needed I would not feel the need to leave, ignore my condition, or seek alternative healthcare.
<b>What is good?</b>	If a patient leaves the department, it should be because they have made an informed decision not because they are dissatisfied. Ideally patients should only leave after they have

<sup>13</sup> Clarey AJ, Cooke MW Patients who leave Emergency departments without being seen. ( literature review undertaken for this work and awaiting publication)

<sup>14</sup> Provisional A&E Hospital Episode Statistics (HES), Apr-Jun 2010, NHS Information Centre for Health and Social Care. Further information on the details of these data, including information on data quality and coverage, are available from the NHS Information Website. Figures here have been reported to the nearest minute, but the data quality of A&E HES should be borne in mind when using these data.

	<p>had a meaningful clinical assessment. Inevitably some patients will leave without being seen.</p> <p>At present 3.6% of patients leave without being seen, but individual departments range from 0-22%<sup>15</sup> using A&amp;E HES data (this may currently overestimate due to data quality and poor coding, e.g., planned re-attendances to clinics).</p> <p>The published literature mostly shows rates under 9% with a few outliers.</p> <p>Expert opinion suggests that the LWBS rate should be below 5% in good UK practice</p> <p>At present we do not know the local factors that influence LWBS rates so initially benchmarking will be against all other type 1/2/3 departments. Further experience may allow us to develop more refined benchmarking comparator groups.</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Poor quality will be reflected by a high rate of LWBS (generally accepted as above 5%).</p> <p>Variation in data collection and definition may account for some variation. Once a patient has seen a clinician they are not considered as being “LWBS” but this must have been a meaningful assessment and the patient should be making an informed decision about leaving. It would be unsafe practice to regard patients who receive a non-meaningful clinical assessment as exempt from this indicator i.e. patients who leave after receiving a non-meaningful clinical assessment should be regarded as having left without being seen.</p>
<p><b>Discussion and Debate</b></p>	<p>When looking to reduce the LWBS rate it is necessary to understand the reasons for people leaving and also the consequences, for example by investigating results on the re-attendance rate indicator and time to initial assessment, treatment and departure indicators. A common reason for patients leaving is that they perceive the wait as too long and so looking at the waits for these patients will be important. The clinical risk and therefore the priority for action can be determined by looking at patients’ presenting diagnosis, their re-attendance rates and their re-attendance diagnosis. When studying the LWBS rate it is important to understand the</p>

<sup>15</sup> Provisional A&E Hospital Episode Statistics (HES), Apr-Jun 2010, NHS Information Centre for Health and Social Care. Further information on the details of these data, including information on data quality and coverage, are available from the NHS Information Website. Figures here have been reported to the nearest minute, but the data quality of A&E HES should be borne in mind when using these data.



	<p>variation by day of week and time of week to focus improvements appropriately.</p> <p>These patients may also present at other NHS facilities so in the long term we should also aim to collect data on their representation elsewhere.</p>
<b>Bottom Line</b>	<ol style="list-style-type: none"><li>1. LWBS reflects the satisfaction of patients with the initial management and experience they receive in A&amp;E.</li><li>2. The left without being seen rate should be minimal and it appears that best practice would be to have level below 5%.</li><li>3. A rate at or above 5% may trigger intervention as this is one of the five A&amp;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.</li></ol>

**Indicator:** [5]  
**Short title:** Service experience  
**Full title:** Narrative description of what has been done to assess the experience of patients using A&E services and their carers, what the results were, and what has been done to improve services in light of the results

<b>Aim</b>	To improve the experience of patients who use A&E services and their carers.
<b>Rationale</b>	<p>Service experience is a marker of the quality of care received in the A&amp;E department, and can be influenced by service user expectations, the approach of staff, the information and clinical care staff provide, and the delays in receiving the timely care patients need. The three most frequently identified service factors are: interpersonal skills/staff attitudes; provision of information/explanation; and perceived waiting times<sup>16</sup>. Listening to and addressing the views of patients can guide providers in raising the quality of the services they provide to patients.</p> <p>More timely and frequent service experience information is required specifically for A&amp;E departments to drive this improvement in services. The focus of this indicator should not be restricted to simply recording and reporting quantitative levels of service satisfaction (e.g. the percentage of patients/carers who reported that they received a good service in A&amp;E); a good A&amp;E department will obtain a deep understanding of what patients think of the service that has been provided and how they believe it can be improved, and will act upon this feedback to improve their service.</p>
<b>Patient Perspective</b>	I want an NHS that meets not only my physical needs but my emotional needs too. This means getting good and timely treatment in a comfortable, caring and safe environment, and being treated with honesty, respect and dignity. I want to feel safe and cared for while I am under the care and responsibility of the A&E department. If the hospital does not ask for my opinion on the experience I have had of A&E then how will they improve the service for me and other patients?
<b>What is good?</b>	A good service will respond to the needs of the user as an individual. It will search out and listen to feedback, it will encourage users to suggest improvements and it will discuss this feedback across the whole health economy and will act upon it promptly to deliver measurable improvements.

<sup>16</sup> C Taylor, J R Benger, Patient satisfaction in emergency medicine. Emerg Med J 2004;21:528-532 (systematic review)

	<p>Because this indicator is reported as narrative, it cannot be benchmarked but there will undoubtedly be learning applicable to many departments.</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Developing and running a service without involving service users. Simply using complaints and litigation to guide developments may create ‘workarounds’ that do not address the root cause of problems and create overly complex systems. Using service user satisfaction surveys alone does not provide a deep understanding of the views of service users and does not empower service users to suggest how a service can be improved.</p>
<p><b>Discussion and Debate</b></p>	<p>This indicator's key aim is to promote discussion between commissioners, service providers and service users. Reliable means of collecting service experiences (not just satisfaction surveys) are the first step in improving services but action must result from the information obtained. We hope that organisations will experiment with various means of obtaining this feedback, perhaps including focus groups, discovery interviews, web-based feedback or written questionnaires. To be most helpful results will need to be from a representative cross section of users and their carers and in large enough numbers for this sample to be representative; this feedback process will also need to be undertaken regularly if not continuously to be able to observe changes.</p> <p>Locally we hope that the results of such information gathering will be discussed and explored so that key areas for service improvement can be determined. Equally, it is important to regularly revisit these issues to ensure that improvement is occurring in the eyes of the service users. Many of our staff will be aware of the issues that cause service users and their carers concern, so ensuring that information from staff is obtained and acted upon is also important. Various toolkits are available to support this analysis of experience data<sup>17 18</sup> and to support user based redesign of services.<sup>19</sup></p>

<sup>17</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091660](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091660)

<sup>18</sup> <http://www.pickereurope.org/usingpatientfeedback>

<sup>19</sup> [http://www.institute.nhs.uk/quality\\_and\\_value/introduction/experience\\_based\\_design.html](http://www.institute.nhs.uk/quality_and_value/introduction/experience_based_design.html)

<b>Bottom Line</b>	<ol style="list-style-type: none"><li>1. Quarterly feedback from patients, carers and staff relating to experience is important for improving the service and we need to show how commissioners and service providers have considered and acted upon it.</li><li>2. Information on the experience of a wide range of patients, carers and staff, reflecting the 24 hour<sup>20</sup> nature of the service, over the whole of the previous quarter, must be collected, analysed and acted upon by providers and commissioners.</li></ol>
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<sup>20</sup> Sites will need to ensure that feedback reflects the whole of the period the site is open. For type 1 and type 2 services, this will be 24 hours. Some type 3 services may have shorter operating hours.

**Indicator:** [6]  
**Short title:** Time to initial assessment  
**Full title:** Time from arrival to start of full initial assessment, which includes a pain score and early warning score, for all patients arriving by ambulance

<b>Aim</b>	To reduce the clinical risk associated with the time the patient spends unassessed in A&E.
<b>Rationale</b>	<p>Many urgent and emergency conditions are time-sensitive, and the period before a patient is seen by a health professional represents clinical risk. In the past, many serious untoward incidents have related to patients who deteriorate rapidly before being assessed.</p> <p>Full assessments of major cases that include a brief a history, pain and early warning scores (including vital signs) are a marker of higher quality patient care. This initial assessment should be able to detect those who need emergency intervention. Reducing delays in assessment can improve health outcomes and patient experience, and the focus on major cases has been made to make sure patients with the greatest clinical risk are given the attention they need. We also want to avoid placing unnecessary additional steps in the care pathways of minors patients where see and treat without initial assessment may be more appropriate<sup>21</sup>.</p> <p>As there is no commonly accepted and consistent definition of major cases at present, the indicator will apply to cases arriving by ambulance but best practice is to also undertake full initial assessment for those who self present with major conditions.</p>
<b>Patient Perspective</b>	Not knowing whether I am seriously ill means I am worried and possibly in pain. Not knowing whether the doctors or nurses are aware of my condition will be a further source of anxiety. Assessing me and giving me pain relief when I need it will allow me to feel less anxious and more comfortable.
<b>What is good?</b>	<p>The time to initial assessment should be minimised.</p> <p>In England the median time to initial assessment for ambulance cases is 6 minutes, though over 50 A&amp;E sites report median times to assessment in excess of 20 minutes.</p>

<sup>21</sup> Chapter 4.3.5 of Cooke MW, Fisher JD, Dale J, McLeod E, Szczepura A, Walley P, Wilson S. Reducing Attendances and Waits in Emergency Departments: A Systematic Review of Present Innovations. A report to the NHS Service Delivery and Organisation R&D Programme. SDO: London 2005.

	<p>International literature: most international systems state that the initial assessment should be undertaken immediately or as soon as possible but do not define a time scale. In Canada it is expected that a rapid initial assessment is undertaken within 10 minutes of arrival.</p> <p>Expert opinion suggests that the time to initial assessment should be less than 20 minutes from arrival time. Arrival time is when handover occurs or 15 minutes after the ambulance arrives at A&amp;E, whichever is earlier, and in practice this means that assessment may take place up to 35 minutes after the ambulance arrives. If the handover process includes a full initial assessment as set out in this document and the accompanying data definitions, the clock stops at the point of handover.</p> <p>Benchmarking should be able to be undertaken across all emergency care providers as best care will be the same everywhere.</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Major case patients waiting more than 20 minutes for initial assessment.</p> <p>Undertaking a brief assessment of a major case that does not benefit the patient by providing meaningful information to determine future care and by starting the pain relief process is poor quality care and potentially unsafe.</p> <p>The College of Emergency Medicine has issued a standard for vital signs measurement in the majors area of the A&amp;E department<sup>22</sup>.</p>
<p><b>Discussion and Debate</b></p>	<p>The initial assessment must be meaningful and therefore should include a pain score, physiological early warning scoring and, for the elderly, should include a physiological assessment (vital signs).</p> <p>The College of Emergency Medicine and Royal College of Nursing recommend that this indicator should be discussed in combination with local indicators such as audits of pain scoring, early warning scores and AMT4.</p>
<p><b>Bottom Line</b></p>	<ol style="list-style-type: none"> <li>1. The delay in the A&amp;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:</li> <li>2. Patients should be assessed as soon as possible; good</li> </ol>

<sup>22</sup> <http://www.collemergencymed.ac.uk/Shop-Floor/Clinical%20Standards/Vital%20Signs/>

	<p>practice would be to have all patients assessed within 20 minutes of arrival.</p> <p>3. A 95<sup>th</sup> percentile time to assessment above 15 minutes may trigger intervention as this is one of the five A&amp;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.</p>
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**Indicator:** [7]  
**Short title:** Time to Treatment  
**Full title:** Time from arrival to see a decision making clinician (someone who can define the management plan and discharge the patient)

<b>Aim</b>	To reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in A&E.
<b>Rationale</b>	The period before a patient is seen by a health professional to make a provisional diagnosis and a care management plan represents clinical risk and anxiety <sup>23</sup> . Patients may deteriorate prior to the commencement of treatment, and reducing delays in delivering definitive treatment can improve health outcomes and patient experience. The decision-maker should be someone who can define the management plan and has the ability to discharge the patient.
<b>Patient Perspective</b>	Not knowing whether I am seriously ill or what tests I will have to undergo leads to anxiety. Making a diagnosis and decision about treatment more quickly will reduce my anxiety and discomfort.
<b>What is good?</b>	<p>There are many conditions where the outcome is improved by earlier care. Outcomes are improved if the management plan for the patient is decided earlier and time critical interventions are therefore undertaken as early as possible in the patients care.</p> <p>In England the median time to start of treatment is 57 minutes; however, over 100 A&amp;E sites report median times to treatment in excess of 60 minutes. Data quality issues mean that we do not currently have an accurate picture of 95<sup>th</sup> percentile time to treatment.</p> <p>Expert opinion suggest that patients should be seen by a decision maker within 60 minutes of arrival but that this may be too long for the more serious cases.</p> <p>Benchmarking should be able to be undertaken across all emergency care providers as best care will be the same everywhere.</p>
<b>What could indicate poor quality</b>	Large numbers of patients waiting more than 60 minutes to be seen by a clinical decision maker.

<sup>23</sup> Chapter 1.7 of Cooke MW, Fisher JD, Dale J, McLeod E, Szczepura A, Walley P, Wilson S. Reducing Attendances and Waits in Emergency Departments: A Systematic Review of Present Innovations. A report to the NHS Service Delivery and Organisation R&D Programme. SDO: London 2005.



<p><b>or unsafe care?</b></p>	<p>Rapid review by a decision maker that adds no value for the patient but achieves a rapid time to treatment is not acceptable. Similarly, being seen by a clinician who will inevitably have to ask another more senior person is not best practice.</p>
<p><b>Discussion and Debate</b></p>	<p>Focussing on time to initial assessment and/or treatment should not be at the cost of poorer quality or experience of care or because staff are diverted from later stages of care. This may be detected by looking at the balance between these measures, the re-attendance rate and the total time spent by patients in A&amp;E.</p> <p>The clinical perspective may be detected as part of the clinical audit programme within the department, which could measure delays to time-critical interventions.</p> <p>The College of Emergency Medicine and Royal College of Nursing recommend that this indicator should be discussed in combination with local clinical audit such as:</p> <ul style="list-style-type: none"> <li>• pain relief and reassessment;</li> <li>• time to antibiotics in sepsis/pneumonia;</li> <li>• major trauma standards;</li> <li>• time to catheter lab for acute myocardial infarction;</li> <li>• time to CT for stroke patients.<sup>24</sup></li> </ul> <p>This approach will ensure that those with the most serious illness receive the most urgent care, hence focussing on clinical priorities rather than focussing on the indicator as the measure of success.</p>
<p><b>Bottom Line</b></p>	<ol style="list-style-type: none"> <li>1. Time to the start of treatment should be minimised but not at the expense of other indicators.</li> <li>2. 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.</li> <li>3. 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.</li> <li>4. No 95<sup>th</sup> percentile trigger has been applied because poor data quality and coverage at the time of publication for this guidance means that current data does not provide an</li> </ol>

<sup>24</sup> Pines JM, Hollander JE, Locallo AR. The Association between Emergency Department Crowding and Hospital Performance on Antibiotic Timing for Pneumonia and Percutaneous Intervention for Myocardial Infarction. *Acad Emerg Med.* 2006; 13: 873-878.

	<p>accurate picture of current performance.</p> <p>5. 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&amp;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.</p>
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**Indicator:** [8]  
**Short title:** Consultant Sign-off  
**Full title:** The percentage of patients presenting at type 1 and 2 (major) A&E departments in certain high-risk patient groups (adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency medicine consultant before being discharged.

<b>Aim</b>	To improve clinical processes and outcomes and reduce the risk patients are exposed to.
<b>Rationale</b>	<p>Research indicates that the care delivered by senior staff has better clinical outcomes and experience than that by more junior staff working alone<sup>25 26</sup>. Patients in high risk groups can be managed more safely and effectively by reviewing their condition with a consultant, with an improvement in the delivery of care via more rapid identification of clinical risk and more decisive treatment. Initially this indicator will only apply to type 1 and type 2 A&amp;E departments. The high risk groups are:</p> <ul style="list-style-type: none"> <li>• Adults (over 17 years of age) with non-traumatic chest pain;</li> <li>• Febrile children less than 1 year old; and</li> <li>• Patients making an unscheduled return to A&amp;E with the same condition within 72 hours of discharge from A&amp;E.</li> </ul> <p>These patient groups have been selected on the basis that they are important presentations with a risk of life-threatening disease that may not be immediately appreciated by less experienced clinical staff. There are many other presentations that carry a high risk, e.g., headache and abdominal pain, and should be included as the next steps. Individual sites will want to ensure that all high risk presentation groups are monitored so that all patients are given appropriate, safe care.</p> <p>Initially this indicator will only apply to type 1 and type 2 A&amp;E departments, but through further developments of this indicator it is expected that high-risk conditions should receive appropriate senior clinician review regardless of where they present.</p>
<b>Patient Perspective</b>	If I am seriously ill and discharged without seeing a senior clinician then there may be a higher chance of being given a

<sup>25</sup> NCEPOD: Caring to the end. London: National Confidential Enquiry into Patient Outcome and Death, 2009

<sup>26</sup> Chapter 4.9.1 of Cooke MW, Fisher JD, Dale J, McLeod E, Szczepura A, Walley P, Wilson S. Reducing Attendances and Waits in Emergency Departments: A Systematic Review of Present Innovations. A report to the NHS Service Delivery and Organisation R&D Programme. SDO: London 2005.

	<p>misdiagnosis, incorrect or missed treatment, or inappropriate care. Being seen by a more experienced and qualified clinician reduces these risks.</p>
<p><b>What is good?</b></p>	<p>The aim is for every patient to be seen by an experienced senior clinician with early access to a Consultant.</p> <p>This indicator is to be measured using an audit managed by the College of Emergency Medicine. It has never been measured before and so there is no benchmarking information. However, benchmarking information will be made available as soon as the first audit is complete.</p> <p>Expert clinical opinion suggests that all patients with these high risk conditions should be reviewed by a consultant. Some sites, particularly those with lower numbers of consultants, will find this challenging. However, its purpose is to promote continuously improved risk management over time. If, due to insufficient availability of consultant staff, an emergency medicine consultant is not immediately available on the “shop floor”, review may be carried out by a senior trainee in emergency medicine (ST4 or above), or by a staff grade or similar substantive career grade doctor with sufficient experience to be designated to undertake this role by the emergency medicine consultant medical staff, though this should only be done in exceptional circumstances.</p> <p>Benchmarking should be possible across all departments, but it may be worth also comparing with locations with similar numbers of consultants to understand the contribution of that factor.</p>
<p><b>What could indicate poor quality or unsafe care?</b></p>	<p>Inexperienced staff seeing and discharging high risk patients without senior input as this poses a risk to patients.</p>
<p><b>Discussion and Debate</b></p>	<p>Analysis of risk and errors will enable organisations to see where senior staff may need to be deployed. The solutions will vary according to local circumstances but may include:</p> <ul style="list-style-type: none"> <li>• Increased numbers of consultants;</li> <li>• Changing work patterns of consultants;</li> <li>• Looking at consultant workload so it is focussed on those patients who benefit most from senior input (this will include other cases as well as the high risk discharges in this indicator).</li> </ul> <p>The College of Emergency Medicine and Royal College of Nursing recommend that this indicator should be discussed in combination with local indicators such as the numbers of</p>

	<p>hours of consultant presence and to ensure this indicator does not detract from other important senior staff clinical roles. Local communities need to decide how consultant staff are best utilised and how many consultants are required.</p>
<b>Bottom Line</b>	<ol style="list-style-type: none"><li>1. The more high risk patients seen by a senior clinician the safer and more effective the care. This will depend on appropriate staffing levels and usage of those staff but must be balanced against other patients who also benefit from senior care.</li><li>2. All patients in these high risk groups being seen by a consultant would currently be good practice, but sites not able to reach this should aim for continuous improvement.</li></ol>

**Annex – Bottom line quick reference guide**

This table sets out for each of the indicators the ‘bottom lines’ that sites need to be taking into account. This must to be used with caution. The indicators should always be considered as a complete set. The aim of the indicator set is continuous improvement, and not just achieving any of the figures on that page. In any case, the figures are only one element of assessing the quality of care. Improvement will only result by further investigation, debate and discussion of what is best care.

No.	Title	Bottom line
1	Ambulatory care	Healthcare systems should explore how they can safely treat as many people as possible in the community by exploring existing system based barriers.
		Benchmarking against systems in other localities will demonstrate the capacity for improvement.
		Evidence suggests there is a high potential for ambulatory care for cellulitis cases (i.e. 60-90% of admissions) and a very high potential for ambulatory care for DVT (i.e. > 90% of admission).
2	Unplanned re-attendance rate	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 re-attending 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.
3	Total time in the A&E department	Excessive total time in the A&E is linked to poor outcomes but decreasing delays must not be confused with faster care.
		Timeliness of care should not deteriorate from that achieved in the last few years.
		Clinical advice suggests that a 95th percentile wait above 4 hours for admitted patients and with the same threshold for non-admitted patients is good practice.
		The single longest wait should be no more than 6 hours.
		A 95 <sup>th</sup> 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 in the NHS Operating Framework for 2011/12.
4	Left without being seen (LWBS) rate	LWBS reflect 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 it appears that 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.
5	Service experience	Quarterly feedback from patients, carers and staff relating to experience is important for improving the service and we need to show how commissioners and service providers have considered and acted upon it.
		Information on the experience of a wide range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter, must be collected, analysed and acted upon.
6	Time to initial assessment	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.
7	Time to treatment	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.
		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.
		No 95th percentile trigger has been applied because poor data quality and coverage at the time of publication for this guidance means that current data does not provide an accurate picture of current performance.
		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.
8	Consultant sign-off	The more high risk patients seen by a senior clinician the safer and more effective the care. This will depend on appropriate staffing levels and usage of those staff but must be balanced against other patients who also benefit from senior care.
		All patients in these high risk groups being seen by a consultant would currently be good practice, but sites not

## A&E Clinical Quality Indicators Implementation Guidance

		able to reach this should aim for continuous improvement.
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