

### **A&E Quality Indicators – Statement of Purpose**

A new set of clinical quality indicators for A&E services were introduced following the proposal from the Secretary of State in December 2010. Since the proposal was announced BHRUT has been working hard across all clinical services to develop clinical pathways to support the implementation of the new indicators. From April 2011 we have been collecting information to determine how we are progressing against the indicators and we are now required to publish this data.

The purpose of the clinical quality indicators is to provide a more balanced and comprehensive view of the quality of care. This includes outcomes, clinical effectiveness, safety and service experience, as well as timeliness. These indicators remove the isolated focus on achieving faster care at the expense of higher quality care. The clinical quality indicators also aim to stimulate a more sophisticated discussion and debate about quality of care to support a culture of continuous improvement. Each A&E department will present data on performance against the indicators on their website, as well as some narrative text to explain what their performance means and how they plan to continuously improve their service.

We will use the results of the indicators to benchmark ourselves against other sites with similar profiles, to our gauge performance and identify improvements.

There are eight Quality Clinical Indicators which are set out in the table, alongside the indicator's aim, demonstrating how they will impact quality of care for the emergency patient. These indicators have been developed by Professor Matthew Cooke, National Clinical Director for Urgent and Emergency Care working with the College of Emergency Medicine, the Royal College of Nursing and lay representatives.

Of the eight indicators all A&E departments are currently measured against five which are:

- unplanned re-attendance at A&E (within 7 days of discharge from A&E)
- left without being seen (by a decision making clinician)
- time to initial assessment (by a decision making clinician)
- time to first definitive treatment
- total time spent in the department (non admitted and admitted patients)

We are developing the methodology to implement the remaining three in order to be able to implement and record against them when we are required to which are:

- ambulatory care for emergency conditions (DVT and cellulitis)
- service experience
- Consultant sign off

## **A&E Clinical Quality Standards**

### **Effectiveness of care**

- **1. Ambulatory care for emergency conditions (DVT and cellulitis)**

To reduce avoidable hospital admissions by improving the provision of ambulatory care.

- **2. Unplanned re-attendance rate at A&E (within 7 days of discharge from A&E)**

To reduce avoidable re-attendances at A&E by improving the care and communication delivered during the original attendance

- **3. Total time spent in the A&E department**

To improve the timelessness and monitoring of care to ensure patients do not have excessive waits in A&E before leaving the department.

### **Patient experience**

- **4. Left without being seen rate by a decision making clinician**

To improve patient experience and reduce the clinical risk to patients who leave A&E before receiving the care they need.

- **5. Service experience**

To improve the experience of patients who use A&E services and their carers.

### **Patient safety**

- **6. Time to initial assessment**

To reduce the clinical risk associated with the time the patient spends unassessed in A&E

- **7. Time to treatment**

To reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in A&E

- **8. Consultant sign-off**

To improve clinical processes and outcomes and reduce the risk patients are exposed to.