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Emergency Department Clinical Quality Indicators: - A CEM guide to implementation

Introduction

The new clinical quality indicators for Emergency Departments in England were announced in December 2010 and will be implemented from April 2011. The quality indicators (QIs) were developed by the Department of Health team in conjunction with clinicians from the College of Emergency Medicine and The Royal College of Nursing, with input from the CEM Lay Advisory Group.

This suite of indicators represents the most important development in emergency care in the past 10 years.

The purpose of this guide is to provide all involved with the delivery of such care with more detail regarding the practicalities of implementing the indicators and the issues which will need to be addressed to ensure compliance. This guide is therefore intended to be of value to clinicians involved in emergency care, Trust Managers and Commissioners.

In May 2010, the Secretary of State for Health indicated that the 4 hour emergency care standard was to be abolished forthwith. CEM expressed great concerns regarding the implications for patient care if the profile of Emergency Care achieved by the 4 hour standard was compromised. This view was accepted and the new indicators represent measures regarding time, quality and the patient experience, which will drive better patient care in Emergency Departments (EDs). Patients will see tangible improvements in their care with earlier initial assessment, prompt treatment interventions, for example pain relief, and optimal patient flow through the Emergency Department, including discharge home, admission to the Emergency Department Clinical Decision Unit or to a hospital bed.

This is a demanding set of measures and success will be dependent on emergency care achieving the highest level of profile and support within the acute Trust. The intention of the measures is to improve the quality of care provided in Emergency Departments with greater consistency.

In order to achieve a successful compliance, the following key points and recommendations should be noted:

- Acute Trusts should consider the appointment of a Director of Emergency Care, preferably a clinician from Emergency Medicine, to provide an informed overview and ensure that Emergency Care achieves the necessary highest profile within the Trust agenda.
- Trusts should review their Emergency Department staffing with a view to increasing Consultant numbers to those recommended by the College of Emergency Medicine i.e. a minimum of 10 whole time equivalent Consultants in Emergency Medicine. The drive towards senior sign-off and early senior clinical involvement identified in the measures requires this level of staffing. There is an increasing body of robust evidence which identifies the clinical and cost benefits of such modest investment.

Excellence in Emergency Care

- Ambulatory care is identified as an important issue. A properly configured Emergency Department Clinical Decision Unit is the key to providing such clinical and cost efficient care.
- The time related incentive that no patient should be in the Emergency Department for more than 6 hours will necessitate pre-emptive hospital capacity planning, particularly in intensive care and high dependency units.
- Monitoring performance will require adequate IT provision. At present, this is variable and there are major concerns regarding the reliability of Emergency Department data. Trusts should review the IT provision in their Emergency Department at the earliest opportunity and upgrade where necessary.
- Please note there are two documents which are subtly different - *data definitions* and *implementation guidance*. It is vital to understand the clinical rationale for each indicator and the philosophy of the set of indicators to successfully implement them which is only described in the implementation guidance.
- Key indicators will be measured by Monitor and by the Department of Health (Performance Management Team).
- It is absolutely crucial that this be regarded as a complete set of indicators rather than individual measures. Successful compliance will be achieved by improving clinical standards across the board.

I hope this guide is useful in navigating the complexities of this important new initiative. Please do let me know directly at prescem@gmail.com if there are any areas of this guide which require greater clarity or detail.

The College of Emergency Medicine will be setting up a forum on the ENLIGHTENme website for all feedback, comments and observations as work commences to implement these indicators.

It is important to note that although intuitively these indicators address key issues in Emergency Department care, they are untested and unproven. It is inevitable that there will be a need to refine and amend the indicators in due course.

Not all these indicators will be immediately achievable. In the interim, the indicators should be regarded as levers to drive improvements in emergency care and not sticks with which to beat clinicians working hard to provide optimal care for their patients, often in challenging circumstances.

Overall, the new quality indicators provide an outstanding opportunity to ensure that all Emergency Departments deliver the consistent high quality care which our patients expect and deserve.

John Heyworth

President

The College of Emergency Medicine

March 2011

1. Ambulatory care

Description

This quality indicator aims to describe the success of managing certain conditions on pathways that require diagnosis, observation and treatment initially in the Emergency Department (ED) or for a short period on an observation medicine unit / Clinical Decision Unit (CDU) and then at home, rather than the traditional hospital bed base or normal outpatient services.

Two conditions have been chosen in the first year to focus on - namely *Cellulitis* and *Deep Vein Thrombosis (DVT) assessment*. This indicator class is a new concept and experience will develop during 2011/2012 to stimulate further debate and refinement for future years.

What does it mean and how will it be measured?

Emergency Departments have a vital role to play in ensuring that patients with certain key high volume, low risk conditions are placed on and managed using efficient ambulatory care pathways wherever possible. By making sure that a high proportion of these conditions can be managed in this way it will ensure fewer avoidable admissions to hospital. The result will be to increase efficiency, effectiveness and also improve patient experience.

During the first year of measuring this indicator, it will take time for EDs to configure their healthcare informatics systems appropriately. Hospital Episode Statistics (HES) data indicates a wide variation in the number of admissions for Cellulitis per 1000 weighted head of PCT register population (0.75-1.80 across PCT) with a median value of 1.2 admissions per 1000. For DVT assessment the range is 0.12-1.17 with a median of 0.42 admissions per 1000 head. Evidence suggests that there is a high potential for ambulatory care for Cellulitis cases (60-90% of traditional admissions) and a very high potential for ambulatory care for DVT assessment (> 90% of traditional admissions). Developing and refining local data gathering and audit systems will improve the ability to more accurately prove success in these key areas.

Why has it been chosen?

The aim of the indicator is to ensure that clinicians in the ED consider the importance of ambulatory care pathways and embed them into their daily practice. These two conditions have been chosen for their potential high impact. In future years other conditions will be added to this indicator.

What will this mean for my Emergency Department?

It will be vitally important to look at your ED pathways to review the way in which you assess and manage these two conditions. It may be that you already have robust ambulatory care pathways embedded into either departmental practice or in an observation medicine /CDU area. If not, it will help to develop a project plan to introduce this. Linked to this will be a need to review departmental informatics systems to collect relevant data easily and prove the success of your ambulatory care strategy.

What are the benefits?

The indicator will benefit the patient by avoiding hospital admission unless absolutely necessary. It will also go some way towards helping your local healthcare economy to be more effective and efficient in its use of the hospital bed base.

What are the challenges?

Aspects of ambulatory care may well be already embedded in your departmental practice. The focus on these two conditions in this indicator is an important first step to providing consistency of practice for other conditions as well. The challenges focussed on DVT assessment and Cellulitis will also apply to other conditions in the future.

The challenges include:

- Is there an evidence based ambulatory care pathway for managing these conditions in the ED and /or observation medicine/CDU?
- If not, how can it be developed and delivered into ED practice?
- How can key stake holders (clinicians, diagnostic support, and commissioners) be best engaged to help develop the pathway?
- How can the key metrics be embedded into ED informatics systems so that they can be easily measured? And also how do you identify sub groups that require to be appropriately admitted into hospital due to co- morbidities or social factors?
- If ambulatory care development is constrained by a lack of systems support in the hospital or community - how can this be corrected?
- Data - some locations may record CDU as an admission and so admission rates appear artificially high.

How should clinicians and managers prepare for April 2011?

- Develop an ambulatory care change management team as part of a Quality Indicator delivery programme.
- Make maximum use of available resources:
 - The NHS institute for Innovation and Improvement have launched a Directory of Ambulatory Emergency Care for Adults. This contains many helpful approaches to aid development and delivery. <https://www.institute.nhs.uk/index.php>
 - The College of Emergency Medicine will be launching an Observation Medicine and Ambulatory Emergency Care on the site on its ENLIGHTENme platform at www.ENLIGHTENme.org in April 2011 in order to share good practice between centres.

2. Unplanned re-attendance

Description

This indicator describes the unplanned re-attendance rate to the ED within 7 days of the original attendance. The aim is to make sure that the patient gets the best possible care at first attendance and that issues related to their care are clearly communicated to them. It is important to understand that the percentage re-attendance rate should not be zero, but ideally would fall within a range of 1-5%.

What does it mean and how will it be measured?

The reasons that patients re-attend an ED are multi-factorial. A proportion of patients will re-attend if their condition suddenly worsens or if they have an unrelated second condition. In addition there will be patients with complex mental health needs and/or be related to substance abuse who will attend frequently. Evidence suggests that case managing this last group by involving relevant agencies and creating good case management strategies can help reduce re-attendance. The indicator should be viewed as being reflective of practice across the whole primary-secondary interface and so may be low if good systems are in place in the community. There will also be a narrative that will be provided with the indicator that will help to set it in the local context of services provided or being developed.

The indicator will measure re-contact of the same ED facility in its first year of operation. A rate above 5% unplanned re-attendance is likely to be reflective of poor quality care and would trigger a central performance management review under the 2011/2012 Operating Framework.

Why has it been chosen?

The evidence base both nationally and internationally suggests this indicator is a very useful surrogate marker of the quality care that an ED delivers.

What will this mean for my ED?

Most departmental systems collect unplanned re-attendance data. It may be of use to identify two cohorts of patients in your department: those that have a single re-attendance and those who re-present frequently with multiple attendances.

Strategies can then be developed to manage these two cohorts in different ways, some of which will have common themes and others will require more tailored solutions. This indicator will be a vital component of the NHS operation framework for 2011/2012. This should help significantly in engaging relevant stakeholders to take responsibility especially for the group of patients who attend frequently with mental health and substance abuse issues.

What are the benefits?

Identifying the specific needs of patients who have unplanned re-attendance to hospital is likely to improve quality of care overall. By better management of the key issues (especially in the group with complex needs) solutions can be developed that will link greater accessibility of community services, improved care pathways in the ED, better education of juniors with regard to communications skills, and discharge advice. In addition, by being able to review unplanned re-attendance in those who do not re-attend frequently areas of clinical practice may be found that can be improved upon.

What are the challenges?

The key challenges will be:

- Reviewing departmental informatics systems to make sure that un-planned re-attendance within 7 days is collected and can be sub- divided into those with single re-attendances versus multiple re-attendances.
- Engaging other stakeholders in the community (especially mental health) to share in the responsibility for multiple re-attendances. These will be recognised in the NHS Operating Framework for 2011/12.

- Reviewing rates of re-attendance that are very low (e.g. <1%) as this level may reflect a very risk averse approach to care and be associated with an inappropriately high admission rate or be reflective of good community systems of care delivery for patients who re-attend with 'complex' needs.
- Creating solutions in the ED for development of appropriate clinical care pathways and communication strategies to ensure that patients are well informed prior to discharge.

How should clinicians and managers prepare for April 2011?

- Optimise ED and informatics systems to collect the right data.
- Develop a multi-disciplinary group (with commissioner/PCT involvement) to define the scale of the problem and develop shared solutions for patients with multiple re-attendances per year who have complex needs.
- Developing effective clinical audit with feedback to decrease misdiagnosis and suboptimal treatment
- Review local data to optimise departmental pathways and make patients better informed at the first attendance.

3. Total time spent in the Emergency Department

Description

This measure recognises the fundamental importance of monitoring total time in the Emergency Department as a driver to maintain patient flow, whether being admitted to a hospital bed, ED Clinical Decision Unit or discharged home. The measure reflects the benefits which have accrued from the 4 hour emergency care standard whilst minimising the adverse consequences of a single time related measure of care.

It is crucial to note that a 95 centile of waiting above 4 hours will be a trigger for intervention.

The measure includes the additional statement “the single longest wait should be no more than 6 hours”. The implications of the latter statement have not yet been fully appreciated.

What does it mean and how will it be measured?

The Clinicians contributing to the development of these new QIs emphasised the absolute necessity to maintain the infrastructure, support and investment which were put in place to deliver the previous 4 hour standard. The investment in staff in the ED, hospital bed management, and the improved processes in the Emergency Department which have transformed ED flow during the past decade must therefore be continued. Any withdrawal or reduction in the level of support for the Emergency Department will inevitably impair a compliance with the required measure.

All Emergency Departments must have adequate IT provision to ensure accurate and reliable measuring of this time interval.

Why has it been chosen?

Experience during the past 10 years has established a body of evidence indicating that in a properly staffed Emergency Department, supported by prompt access to diagnostics and well managed flow into inpatient beds, then more than 95% of patients will complete their ED care within 4 hours. If the Department is under resourced or in-hospital bed capacity is inadequate, then compliance with the time requirement becomes difficult.

As highlighted above, no patient should be in the Emergency Department for more than 6 hours, which applies to those few patients who may be delayed in the Emergency Department, often whilst awaiting a bed in the Intensive Care or High Dependency Unit. This measure should therefore act as a prompt to adequate bed availability for this group of patients to ensure that delays of greater than 6 hours never occur.

What will this mean for my Emergency Department?

These measures will be introduced in April 2011. It is therefore essential that discussions occur at the earliest opportunity with senior Trust management and Commissioners to identify the areas in which compliance may be challenging and the steps required to ensure consistent delivery against this measure.

It is probable that this will involve the following two initiatives:

- A review of the Emergency Department workforce, particularly Emergency Medicine Consultant numbers.
- Enhancing the bed management programme to ensure that pre-emptive capacity planning is undertaken to manage the mostly predictable demand throughout the 24 hour period 7 days a week.

What are the benefits?

High quality safe emergency care can be delivered within 4 hours by an adequately resourced Emergency Department supported by the necessary in-hospital capacity and an Emergency Department Clinical Decision Unit.

The patient experience will be significantly enhanced as care is delivered promptly in the Emergency Department and prolonged delays whilst waiting for in-hospital beds no longer occur.

What are the Challenges?

Sustained compliance with the total time measure will require continued high level engagement across the system and individual organisations.

In this regard, the College of Emergency Medicine recommends the appointment of a Director of Emergency Care in each acute Trust to ensure that the key axes between the Emergency Department and the community and the Emergency Department and the in-hospital specialties are optimised.

However, where the Emergency Department is under resourced or in-hospital capacity is not available, then compliance with this measure will be challenging. It is possible that the gaming tactics which were reported during the implementation of the previous 4 hour standard will recur with these new measures. Similarly, the exodus of patients from the Emergency Department at 3.50 must be avoided. Resorting to such manoeuvres results in significantly increased risk and the safety agenda is compromised, Clinicians are unable to deliver the care required and patients find themselves pawns in such misguided manoeuvres. Any such events should please be reported to the College of Emergency Medicine (prescem@gmail.com).

The key challenges for the acute Trust and the Commissioners is to recognise that emergency care is a fundamental component of the Health Service and the public expect the highest quality of care to be available 24/7. This measure in particular should be regarded as a catalyst to drive the support and investment required, with the immense returns available for delivering care to the huge numbers of patients who attend Emergency Departments each year.

How should clinicians and managers prepare for April 2011?

- Arrange meetings involving Emergency Medicine Clinicians, Trust Managers and Commissioners at the earliest opportunity to discuss the local situation and take whatever urgent action is required to comply with the required measures by April 2011.
- Recognise the Emergency Department is the hub of the delivery of emergency care and ensure that the necessary workforce is in place.
- Review the processes to ensure flow which will involve early access to senior clinical decision makers, supported by prompt access to diagnostics including pathology and imaging and to undertake a careful bed requirement analysis to ensure that the pre-empted capacity is available to meet anticipated demand.

4. Left without being seen

Description

This measure is designed to capture the numbers of patients who leave the Emergency Department before a proper and thorough clinical assessment has been undertaken. Patients in this group will already have been registered at the ED Reception and, depending on local processes, undergone a varying form of triage/ assessment.

However, the causes of patients leaving before being seen are multifactorial and, in the early stages at least, attempting to disentangle the varied issues may prove elusive.

As a principle, a rate of greater than 5% of ED attendances leaving before the full clinical work up has been undertaken should be considered to be an area of risk which requires careful local review and improvement.

What does it mean and how will it be measured?

Where the ED has adequate IT provision, then this measure should already be part of the routine data collection exercise undertaken on a daily basis.

However, where IT is inadequate, then urgent improvement should be undertaken to ensure the ability to measure this and other groups.

Determining the exact nature of any triage or other early assessment which has been undertaken may prove difficult. The best approach would be, in the first instance, to consider those patients who leave a waiting room or a clinical area before their planned full clinical work up has been completed constitute of patient who has left without being seen.

It is important to note that this is one of the 5 indicators which will be monitored centrally and rates at well above 5% may trigger intervention from the centre.

Why has it been chosen?

Internationally, patients who leave the Emergency Department before the required detailed formal clinical process is completed are known to be at risk of adverse events.

What will this mean for my Emergency Department?

Although the factors contributing to a patient's decision to leave without being seen are multifactorial, in general terms EDs with prompt processes, good patient flow, good patient communication and adequate staffing to ensure the above will achieve compliance within the expected 5% limit.

However, the measure is a reasonable surrogate for departments which are functioning well in each of these domains.

Achieving compliance should prompt a detailed review of all aspects of the Emergency Department staffing, processes and flow to establish any variable which requires urgent work.

What are the benefits?

Optimal processes, staffing, communication and patient flow will significantly enhance the patient experience and will inevitably reduce the percentage of patients who leave before their full clinical assessment has been completed. This will lead to significant improvements in the safety agenda and the risks associated with incomplete assessment of patients across the range of case mix will be avoided.

What are the challenges?

- Ensuring that the Emergency Department has adequate IT to capture the data
- Managing patient flow, particularly amongst the less seriously ill and injured group which comprises of many of the LWBS patients, will demand equal prioritisation amongst the various measures to be introduced from April 20th 2011.

5. Service experience

Description

This quality indicator describes (i) the steps that have been taken to regularly assess experience of the emergency or urgent care services provided, and (ii) what has been done to improve services in light of the results of assessment.

What does it mean and how will it be measured?

It is important to note three features of this quality indicator. First, it is not simply a patient satisfaction indicator, but an indicator of overall service experience reflecting the 24 hour nature of emergency and urgent care. Second, it requires data on service experience to be gathered and analysed on a regular basis. The minimum requirement is for quarterly review. Third, the indicator requires clear evidence of the action that has been taken to respond to the findings from the review.

There are significant differences between a patient satisfaction indicator and this service experience indicator. A patient satisfaction indicator asks patients to evaluate their care. Patient evaluations vary according to patient expectations, are inclined to be favourable, and do not supply sufficient data to support quality improvement. Coulter et al ("Measures of patients' experience in hospital: Purpose, methods and uses" Kings Fund – see below) summarize the focus on experience as follows: "Instead of asking patients to rate their care using general evaluation categories (e.g., excellent, very good, good, fair, poor), they are asked to report in detail about their experiences of a particular service, hospital episode, general practice, or clinician. Such questions ask respondents to report whether or not certain processes or events occurred during a particular visit, a specific episode of care, or over a specified period. These types of questions are intended to elicit reports on what actually occurred, rather than the patient's evaluation of what occurred."

This service experience indicator is not restricted to patient experience, but may also include carer, staff or others' perceptions of the service. Its aim is not to retrieve satisfaction ratings but to explore more broadly how the service is experienced and therefore how it might be improved.

Unlike the other indicators, this indicator will not permit comparisons between sites. It is intended to support local quality improvement. This affords freedom to clinicians and managers, working with others including users, to develop an approach to understanding local service experience that will be meaningful and supportive of local improvement needs.

At this stage the indicator will be measured by way of a narrative report that is expected to describe the steps taken to assess service experience and the steps taken to improve quality in response. As providers develop and spread good practice in assessing emergency and urgent care service experience, the indicator may in future be measured by reference to agreed best practice. Departments are encouraged to seek and share effective ways of capturing service experience relevant to local circumstances.

Why has it been chosen?

The indicator was chosen because it is essential to understand how a service is experienced if it is to be responsive to the needs of users. Emergency and urgent care services address a wide range of human need beyond the purely clinical, including compassionate care for bereaved family, comfort for the dying, and alleviation of anxiety for all. Overall experience of emergency and urgent care services is therefore as important as clinical outcomes.

A service experience indicator was preferred over narrower patient satisfaction data to permit departments to prioritise local concerns for service experience investigation. It also allows for some sampling of views from people who experience aspects of the service important to quality of care but of which patients are sometimes unaware e.g. ambulance crew handover, communication with GPs, communication with community mental health teams.

A narrative report was chosen in order to emphasize that the purpose of the indicator is to support local improvement and develop approaches to understanding service experience, rather than provide data for national comparison.

What will this mean for my Emergency Department?

All Emergency Departments should review the ways in which they currently gather data respecting experience of their service. Many Emergency Departments already gather data on patient and carer experience, or patient satisfaction data, sometimes in novel and interesting ways.

Departments will need to consider how far their existing data collection allows them to understand different dimensions of service experience, whether to extend data collection to other groups whose perspectives on the service are important, and what mechanisms they have for reviewing and responding to service experience data. Departments are encouraged to involve users and other stakeholders in developing local responses to local issues.

What are the benefits?

The indicator will benefit patients, carers, staff and those who may become users of emergency and urgent care by encouraging continuous improvement effort based on a wider understanding of what people need or want and what they think they are currently getting.

Clinicians, managers and users should benefit from freedom to adopt local initiatives and local solutions in response to local needs.

What are the challenges?

The scale of the challenge depends upon what your Trust and department already does to collect data on service experience, and what your Trust and department already do to develop a response to findings from service experience data. The challenges include:

- Does the Trust have a strategy for patient experience of which the ED is a part? If so, is the Trust's strategy consistent with the requirements of this indicator?
- Does the ED already have effective systems for regularly gathering and responding to data on service experience?
- If not, how can a system be developed and delivered into practice? Is there scope to learn from other organizational or departmental initiatives?
- Is there scope for embedding a focus on service experience into clinical audit activity?
- How can key stake holders (e.g. service users, PALS, local HealthWatch, commissioners) be engaged to help develop and implement approaches to gathering service experience data, and develop responses to findings?

How should clinicians and managers prepare for April 2011?

- For an excellent overview including the difference between patient satisfaction, patient experience and PROMs, and a comprehensive summary ways of gathering data, read Coulter, Fitzpatrick and Cornwell "Measures of patients' experience in hospital: Purpose, methods and uses" 32pp Downloadable free from <http://www.kingsfund.org.uk/publications/measures.html>
- The NHS Institute for Innovation and Improvement Patient Experience Network http://www.institute.nhs.uk/share_and_network/pen/welcome.html has many useful resources to guide data collection and developing a response through 'Experience Based Design'. Use their 'High Impact Actions for Improving Patient Experience' as a checklist to assess your current practice.
- Your Trust may have responded to *The Next Stage Review* by developing a Trust-wide patient/service experience strategy, including an executive board lead for patient/service experience and departmental champions. If it hasn't, identify an ED clinical champion who is a patient experience enthusiast (or prepared to become one) and ensure they have senior clinical and managerial support. Lobby for a Trust-level approach to patient/service experience.

6. Time to initial assessment

Description

This quality indicator records the time from arrival in the ED to full initial assessment for cases arriving by ambulance. Initial assessment must include a pain score and physiological early warning score for all patients arriving by ambulance.

This indicator aims to reduce the time the patient spends without assessment by staff. Serious untoward events have been noted where there have been significant delays in formal assessment.

What does it mean and how will it be measured?

Patients have traditionally been 'triaged' when they have been brought to the ED by ambulance. However, the nature of this triage assessment is not necessarily consistent across England. This indicator defines the elements that should be included in a full assessment. The minimum elements include a brief history, pain score and recording of vital signs leading to the completion of a physiological early warning score.

The phrasing of this indicator around those brought by ambulance was adopted because of the challenges associated with defining 'majors' patients and pragmatically avoiding extra steps in the management of patients with more 'minor' presentations that could be 'seen and treated'. However, the implementation of this indicator should not exclude those presenting with 'major' type presentations that self-present.

Time to initial assessment should be within 20 minutes of arrival or handover by ambulance crew (which may be up to 15 minutes after they have arrived at the ED) whichever is earlier. If the ambulance handover includes the parameters defined in this indicator then this indicator can be achieved at the same time as ambulance handover. Time to initial assessment is included as one of the 5 QIs for national oversight in the NHS Operating Framework 2011/2012.

Why has it been chosen?

Adopting this approach will help to identify those with the most time critical need for early intervention; improve health outcomes and patient experience. Early focused assessment should reassure the patient that their needs are identified and particularly that the need for analgesia is identified and acted upon early.

What will this mean for my Emergency Department?

There will be a need to focus experienced nursing staff on the initial assessment of patients. This QI is intrinsically linked to improving ambulance handover times and on time to treatment. Investing focus on getting this indicator right will pay dividends in ensuring that the patient pathway is safe, focused on clinical need of high quality. Given the nature and pattern of patient presentation by ambulances this may require more than one nurse or other clinician to be allocated to this role at times. Understanding attendance patterns will be important in planning the numbers of staff required.

Attention should also be focused on communication and interventions associated with this QI. Just identifying those who need early intervention, either because of altered physiological scores or the need for analgesia, does not equate to quality. Enabling pathways will be required for instance ensuring that nurses are able to provide adequate analgesia and request appropriate investigations early are fundamental to the whole care pathway.

What are the benefits?

This indicator encourages earlier identification of those who require intervention. It should help to reduce risk and improve patient safety. It should also help to focus the need for developing enabling pathways for early investigation and intervention. Patients and their carers should be reassured that their needs have been identified and are being met.

What are the challenges?

- Allocating sufficient numbers of experienced nursing staff to front load the assessment process and having insufficient numbers of staff to provide on-going care.
- Developing the enabling pathways to provide adequate analgesia early in the patient journey before full assessment.
- Developing enabling pathways for investigations that are identified at initial assessment.
- Providing the right skill mix of staff.

How should clinicians and managers prepare for April 2011?

- Analysing the nature of attendance patterns and demands, to enable planning for sufficient staffing. Identification of staff that will perform this role.
- Development of enabling pathways to assist with requesting of investigations and administration of early analgesia. Identification of the physiological scoring system to be used and what the actions associated with the acuity triggers will be.
- Plan for data collection ensuring that it is linked to local and national audits such as the CEM vital signs standard.

7. Time to treatment

Description

This quality indicator records the time between ED arrival and the time when the patient is seen by a “decision-making clinician”. In practical terms this clinician is somebody able to discharge the patient from the ED (e.g. a suitably experienced doctor or Emergency Nurse Practitioner). ED arrival time is well defined and measured:

- Time of initial assessment/triage or initial registration, whichever is sooner
- Ambulance handover time or 15 minutes after ambulance arrival, whichever is sooner

The time that the patient is seen by a decision-making clinician is already routinely recorded and reported in many EDs.

What does it mean and how will it be measured?

Many ED presentations have some degree of time sensitivity. This indicator will encourage earlier treatment of ED patients, thereby improving the quality of care and the patient experience.

It is anticipated that this indicator will be reported for all patients on a monthly basis. The median time, 95th centile and maximum (longest) time should all be reported with the expectation that median time will be consistently less than 60 minutes. In some cases data will be missing and therefore no time interval will be calculable, however the rate of missing data should be less than 5%. Ideally the required information should be automatically collected and reported, with further investigation if there are unexpected values or high rates of missing data.

Why has it been chosen?

This indicator reflects the fact that earlier intervention improves outcome in some conditions, and improves the patient experience in all cases. An ED that is achieving well in this indicator is likely to have sufficient decision-making staff seeing patients in a consistently timely way.

What will this mean for my Emergency Department?

In addition to measuring total time in the ED, the time to treatment will need to be robustly measured and consistently reported. Reporting of the 95th centile is a new concept that will require whole-system approaches to improvement, however it will also encourage further investment in the ED to improve staffing levels and patient flows. This is one of the five indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12, and a result it is likely to figure prominently in local commissioning and performance discussions.

What are the benefits?

This indicator encourages earlier patient management which in turn improves outcome and experience. It can be used as a driver for increased ED staffing and resource allocation as well as improvements in ED processes and whole system working. Working with the other two time indicators it encourages a global improvement in flow rather than focussing on the departure time as could occur with the 4 hour target

What are the challenges?

There are four main challenges associated with this standard:

- Avoiding the introduction of a “hello clinician” who technically meets the standard but achieves no additional patient value.
- Excessive use of junior medical staff that may lack the experience to make definitive clinical decisions. This further supports an increase in consultant numbers.
- Failing to rapidly manage the most urgent patients in favour of those with less clinical need but times approaching 60 minutes.
- Excessive front-loading so that the later stages of care are delayed.

The published standard identifies all of these pitfalls, and specifically advises against them. In particular the College recommends that this indicator is combined with local clinical audit to ensure that those patients with the most time-critical conditions are receiving prompt care.

How should clinicians and managers prepare for April 2011?

It is important to ensure that mechanisms are in place to robustly collect and report these data on a monthly basis from April.

8. Consultant Sign-Off

Description

This quality indicator is adapted from the recently released CEM standard for “consultant sign-off”. It identifies three high risk presentations that should be reviewed by a consultant prior to ED discharge:

- Non-traumatic chest pain in adults (> 17 years of age).
- Febrile illness in children < 1 year old.
- Unscheduled returns (with the same complaint) within 72 hours.

If a consultant is not immediately available on the “shop floor” then review may be undertaken by an experienced trainee in Emergency Medicine (ST4 or above) or a staff grade or similar substantively appointed doctor who has been designated to undertake this role by the EM consultant staff.

What does it mean and how will it be measured?

This indicator will encourage a process of formal senior review for high risk patients being discharged from the ED, and will also act as a driver for progressive consultant expansion. The included conditions will be reviewed at an early stage, as will the overall impact on a wide range of Emergency Departments.

CEM is planning to audit this indicator during the latter part of 2011, including a selection of EDs in the first instance. Ultimately the expectation is that this indicator will be reported by all EDs every March and October. Ideal practice would be for every patient in these high risk groups to be reviewed by a consultant prior to discharge, but initially this will be possible in only a handful of EDs. Early audit will establish a benchmark by which similar EDs can be compared, and from which progressive improvement can be measured. Data should be collected continuously on all eligible patients, but where this is not possible a sampling approach is acceptable, providing those sampled are compared to those not sampled and any differences explained.

Why has it been chosen?

This indicator has been chosen to improve patient safety and enhance the quality of clinical care, thereby complimenting the process-related and time-based indicators. It also acknowledges the importance of senior staff in the ED, and acts as a driver for consultant expansion in order to improve compliance.

What will this mean for my Emergency Department?

Every ED to which these quality indicators apply will need to do the following:

- Establish a mechanism for formal senior review of patients falling into the above groups prior to ED discharge.
- Establish a mechanism for recording and auditing this senior review so that robust data can be readily returned on the number of eligible patients and the number receiving review. It would also be helpful to record how often this review leads to a change in the treatment plan, follow-up, etc.
- Consider how the introduction of this indicator could be used to support increased senior staffing in the ED.

What are the benefits?

This indicator is intended to improve quality and safety in the ED. It also provides support for increased senior presence and consultant expansion.

What are the challenges?

The indicator should not be used as a justification to extend or alter the working hours of existing consultant staff without prior agreement: the best way to improve compliance would be to increase the number of consultant staff and therefore improve their availability and hours of work

on the “shop floor”. The guidance also cautions against diverting senior staff away from other essential functions, which similarly supports an increase in staffing numbers, rather than restructuring of existing posts.

Two important additional challenges are as follows:

- The risk of increasing the admission rate in order to avoid triggering the indicator, particularly overnight.
- The risk of increasing the referral rate to specialty teams, who then discharge. This possibility is explicitly considered in the indicator by recommending consultant review prior to discharge for all patients falling into these groups, including those referred to specialty teams. At the same time, the guidance indicates that ED consultants should not be required to review the patients of other hospital teams.

How should clinicians and managers prepare for April 2011?

This is a new indicator that has not been measured before. It will take time to introduce both the process to achieve consultant sign-off and the reliable recording and audit of this process. EDs with a well-developed IT system are likely to have an advantage, but paper-based recording is also possible.

Clinicians should consider how consultant sign-off will be achieved and who will be designated to undertake this role in the absence of an ED consultant immediately available on the shop floor. They will need to work with managers to introduce this process alongside effective data collection. Where gaps in sign-off are anticipated plans for consultant expansion should be considered.

Funding

To deliver high quality emergency care EDs must be properly resourced. This means that Fellows need to understand how their Trust is paid for ED activity, and also how their Trust distributes this income. There will be a major change in the payment system for EDs from April 2011: the previous system (HRG 3.2), which groups patients according to disposal and investigations, will be replaced by a system using investigations and treatment instead (HRG 4.0).

Coding both investigations and treatments is a significant difference in practice. It is essential that this is done accurately in every ED, and that the data collected is used to correctly group patients into one of five new tariffs that should be paid to hospital Trusts.

Unless senior ED clinicians understand how the system works, and ensure that their EDs activity is accurately coded and then grouped, their departments will miss out on income to which they are entitled. It is therefore essential that Fellows get to grips with this important development. There are also a number of important changes in the new guidance that Fellows should be aware of: for instance around payments for increased activity and readmissions. Further information is available on the College Website at:

[http://www.collemergencymed.ac.uk/Shop-Floor/Casemix and IT/PbR Rules and Tariff/](http://www.collemergencymed.ac.uk/Shop-Floor/Casemix%20and%20IT/PbR%20Rules%20and%20Tariff/)