

A&E Clinical Quality Indicators

Best Practice Guidance for Local Publication

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Introduction

1. The effective presentation of high quality clinical information is a powerful driver for continuous improvement in patient care and health outcomes.
2. This document sets out best practice guidance for the presentation and publication of the A&E clinical quality indicators. A&E sites following this guidance will ensure that locally published information on the indicators provides an accurate, transparent and comparable reflection of their performance.
3. This clinical information should be used to improve decision making processes; identify emerging issues and areas where immediate targeted decisions can benefit patients; improve the quality and coverage of local data through the frequent use of real time information; and facilitate improvements in patient care through comparison with the best performing providers.
4. The information published will also be used by commissioners for managing the performance of the services they commission, and the public for assessing the quality of the A&E services they use.

Background to the indicators

5. The Operating Framework for the NHS in England 2011/12 announced that a set of clinical quality indicators would be introduced to provide a comprehensive and balanced view of the care delivered in A&E.
 - 1) The eight A&E clinical quality indicators are:
 - 2) Ambulatory Care
 - 3) Unplanned re-attendance rate
 - 4) Total time spent in A&E
 - 5) Left without being seen rate
 - 6) Service experience
 - 7) Time to initial assessment
 - 8) Time to treatment
 - 9) Senior consultant sign-off
6. These quality 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 informed lay representatives.
7. Details of the data definitions and implementation guidance for the A&E clinical quality indicators, which set out what data should be collected and how the indicators should be used to improve the quality of care delivered

in A&E were published on 17 December 2010¹. Further detailed information and FAQs to allow consistent production of the indicators will be released shortly, as part of the work the Department of Health are undertaking with the NHS Information Centre for Health and Social Care.

8. The collection of data for the A&E clinical quality indicators has been approved by the Review of Central Returns Steering Committee (ROCR)².
9. We welcome feedback on these indicators via urgent&emergency@dh.gsi.gov.uk

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

² The ROCR reference number for these data is ROCR/OR/2079/FT6/001MAND. The ROCR licence is for an ongoing mandatory collection from PCTs, Care and Acute Trusts (including Foundation Trusts). The initial licence expiry/renewal date for this collection is 2 February 2012.

General notes on publication

What information should be locally published?

10. Data for the A&E clinical quality indicators should be presented in a manner that is most meaningful to the patient, and most helps professionals to see areas of improvement and success. It is recommended that sites publish more accessible information specifically for non-clinical audiences, in addition to the detailed information supplied for clinicians and commissioners. Annex B (What might a clinical dashboard look like?) includes both a high level summary alongside more detailed information presented in a clinical dashboard.
11. This document does not prescribe the exact content and format for making information on the indicators locally available; this best practice guidance includes expectations of the type of information that should be reported, and a template which sets out how the information might be reported.
12. Based on feedback from senior clinicians, A&E sites are encouraged to locally publish information on the A&E indicators in the form of a clinical dashboard. The broad characteristics of this dashboard are set out below.

<i>What is the purpose of the dashboard?</i>	To promote accountability, transparency and choice to patients and the public by publishing accessible and timely information on A&E performance. To inform discussions between providers, commissioners and patients by providing detailed and validated information on A&E performance
<i>Who is the audience for the dashboard?</i>	Patients and the public, who will want to understand the quality of the services they use Providers, who will want to accurately reflect and better understand how to improve the quality of the services they provide Commissioners, who will want to use the information to assess the quality of the services they commission
<i>What information should be presented?</i>	An overall assessment of performance across the indicators An accessible narrative summary of performance on each indicator Detailed graphical information on the indicators See Annexes A and B for further details
<i>What are the main data sources for the information in the dashboard?</i>	Local A&E IT and Patient Administration Systems Provisional Hospital Episode Statistics (HES) data from the A&E Commissioning Data Set (CDS) (for national benchmarks)
<i>Who will provide data for the dashboard?</i>	Local A&E sites The College of Emergency Medicine
<i>Who will publish the dashboard?</i>	Local A&E sites
<i>How often should the dashboard be published?</i>	Monthly

<i>When should the dashboard be published?</i>	The dashboard should be made available to the public with minimal delay; organizations should aim to publish the dashboards during the month following the month of activity
<i>Where should the dashboard be published?</i>	Local trust websites In the A&E department or hospital itself Interactive new media Local data on the indicators may also be reflected on the NHS Choices website in the future

How should the information be displayed?

13. A&E sites are encouraged to locally publish information on the indicators in the form of a clinical dashboard. Clinical dashboards are frequently used in clinical practice and offer the benefits of:

- Being clear and accessible
- Presenting information with high visual impact
- Displaying information for a series of different time periods
- Consolidating information from a range of different data sources and clinical areas
- Presenting locally relevant information and allowing comparisons with national data sets
- Allowing users to drill down where appropriate to show more detailed data, allowing decision-making to be as close to the patient as possible
- Encouraging clinicians, providers, commissioners, and patients to view performance as a balance of all the measures on the dashboard, rather than focussing on only a few aspects of performance presented in isolation (e.g. time)

14. It is crucial that this clinical dashboard is more than an interesting representation of readily available information, and providers should ensure that they are using the information to improve patient care.

15. More detailed information on the material that might be included in the dashboard is set out in Annex A (Checklist of clinical dashboard information) and Annex B (What might a clinical dashboard look like?). The dashboard template in Annex B does not incorporate all the best practice elements discussed in this guidance document (e.g. statistical process control and funnel plots are not included), but it does set out a design for presenting comprehensive information on all eight clinical quality indicators.

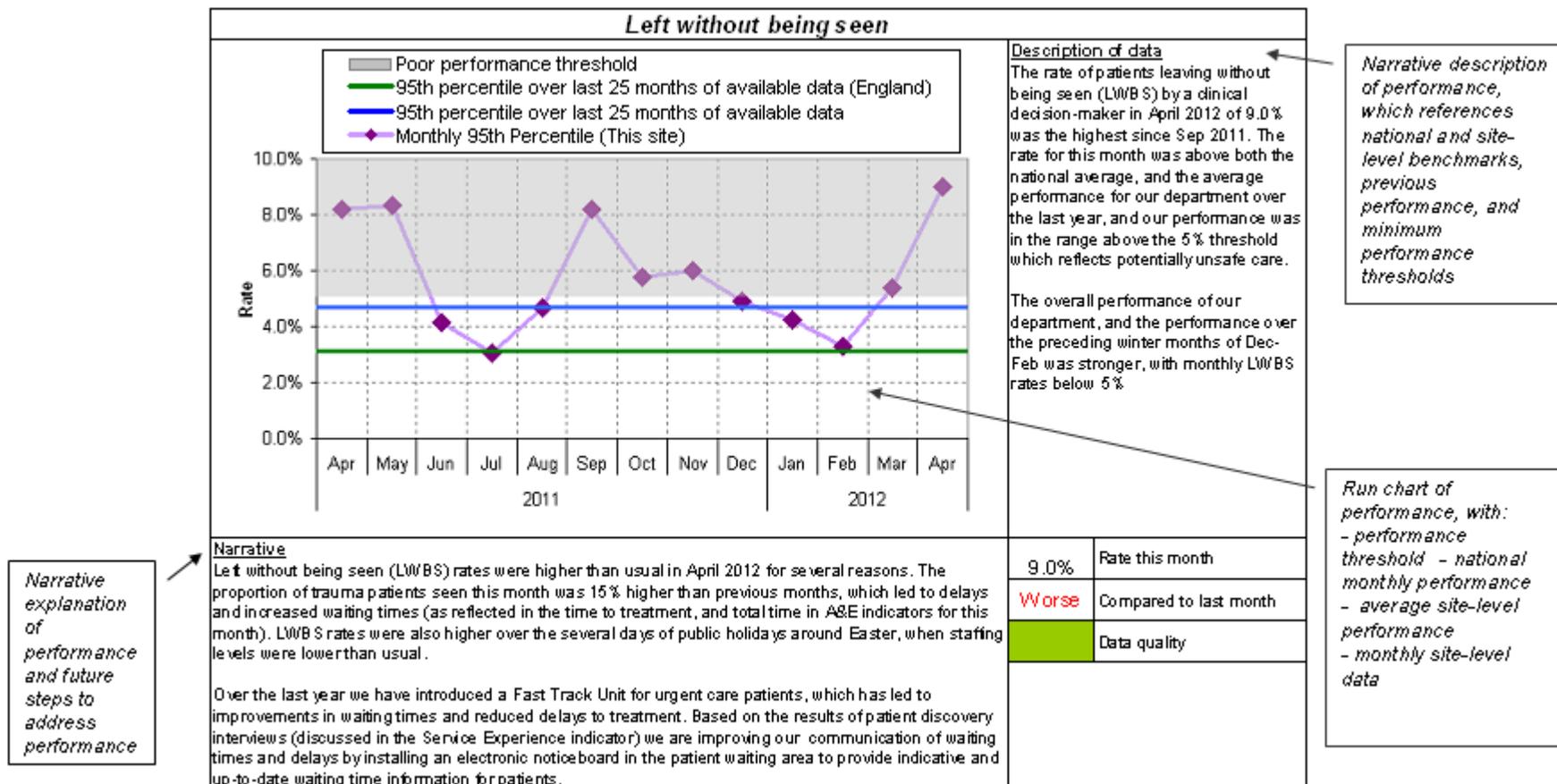
16. When presenting information in their clinical dashboards, providers should also refer to Quality Accounts Toolkit³ notes on best practice in presenting information.

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122545

17. There are five themes that influence how data should be presented in the clinical dashboards, and Figure 1 below illustrates how information might be presented for the left without being seen rate in line with these themes.

- i. **Figure 1** Example of how information might be presented in the clinical dashboard for the left without being seen rate



ii.

(i) Continuous improvement

18. In keeping with the ethos of continuous improvement for the A&E clinical quality and outcome indicators, and to demonstrate system-resilience and the maintenance of a high quality service year-round to patients, data should be presented as run charts that set out a running time series of monthly data for the most recent 25 months⁴, rather than point charts which show activity or performance for only the most recent month.
19. It is entirely appropriate to include additional information and data that further explore the most recent month of performance, but this performance should be understood in the context of previous performance, to promote a culture where more considered and targeted plans are developed, implemented and monitored to deliver improvements in patient care.

(ii) Placing performance in context

20. A single number, percentage or indicator cannot capture or reflect the range, complexity and quality of the care delivered in A&E. Similarly, simply reporting quantitative performance on a range of different indicators does not go far enough in allowing A&E sites to demonstrate the quality of care that is delivered.
21. Therefore, in addition to publishing quantitative information on these indicators, A&E sites should provide a narrative explanation of what their performance on each indicator means, how this performance should be interpreted, what factors have driven performance over the latest period of activity, and what action will be taken to ensure continuing improvement.
22. Sites should take this opportunity to provide greater context and understanding around their past performance (including reflecting on positive performance and improvements that have already been realised), note what further improvements can be made, and explain the targeted steps that are planned to improve performance in the future. This is an opportunity for A&E sites to enter into a real, open and honest dialogue with clinicians, stakeholders and the public regarding the quality of care in their organization.
23. The narrative should reflect on what makes good clinical care and how the site has delivered this. As such it should be written in co-operation with clinicians. Best practice is for the narrative to be signed off by the organisation's Medical Director. A&E Sites should refer to the A&E Clinical Quality Indicators Implementation Guidance⁵ which sets out the available empirical evidence of "what good looks like" for each indicator.

⁴ 25 months inclusive of the most latest month; for example, if the latest month of available data is for April 2013, then data should be provided by month for the period April 2011 to April 2013.

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

24. In line with the guidance for producing Quality Accounts, A&E sites should aim to ensure that the content of their narrative explanation of performance is produced with involvement from stakeholders where possible; the content should be presented in accessible language; and care should be taken to not disclose information that would allow the identification of individual patients (particularly when discussing longest wait information). To make the information in the dashboard accessible to all, sites might also wish to include a glossary of terms; and information on the what the indicator measures, why this is important, and how good care is reflected on the indicator.
25. Organizations are also encouraged to use the richness of their A&E data to analyse and present data that can be disaggregated by the equality protected characteristics defined by the Equality Act 2010 (for example, presenting data for different age, gender and ethnic groups where available); and to explore presenting their data in a way that aids understanding of the issues affecting particular clinical groups (for example, investigating attendances for patients with mental health issues).
26. The Service Experience indicator is fully narrative in nature, therefore no additional narrative or meta-narrative is needed for this indicator.

(iii) Learning from best practice

27. The minimum thresholds set out in the A&E Clinical Quality Indicators Implementation Guidance and the NHS Operating Framework are not targets or the levels sites should aim to, or be commissioned to, operate at.
28. In addition to the evidence set out in the Implementation Guidance on “what is good” for each of the indicators, A&E sites should also seek to learn from best practice by comparing their performance against suitable benchmarks and peer groups. For this reason, A&E sites should reflect the national performance figures alongside their own performance information. As more robust and granular data become available from the data centrally collected via the A&E Commissioning Data Set, A&E sites will be encouraged to use more relevant benchmarks such as regional benchmarks or benchmarks for different types of A&E site.
29. Benchmarking should not simply involve comparing a particular A&E site with the national average to see if the site is above or below average; This information will be of use and interest to stakeholders and the public, but this information alone will be of limited use to the A&E site itself in developing specific plans for continuous improvement. Trusts should instead use the national comparison as the first step to stimulate further focussed discussions on how to identify the best performing A&E sites, determine how these sites achieve their performance, and use this information to improve their own performance.

30. It is recognized that performance on the indicators will be affected by factors (not all of which are in the control of the A&E site) such as casemix and the provision of other urgent care facilities nearby, therefore services should aim to take this into account before making comparisons with peers. Regional Quality Observatories and Public Health Observatories are useful sources of information and intelligence for benchmarking.

(iv) Freedom to innovate

31. The information contained in the templates in Annexes A and B only set out the suggested minima that A&E sites should provide in order to produce a consistent and comparable view of A&E performance for reporting and accountability purposes.

32. Providers and their stakeholders should not feel that they are restricted to these presentation options if they wish to further explore their data for the purposes of their own continuous quality improvement. For example, providers might wish to provide information at a more granular level⁶, with separate data displayed for the individual high-risk conditions identified in the Consultant Sign-off indicator. In future, providers may also wish to provide additional information such as casemix-adjusted or seasonally-adjusted data to provide greater context to the information presented in the clinical dashboard.

33. When looking at time series data in healthcare settings, Statistical Process Control (SPC) and funnel plots present a practical approach for further investigating and understanding variation in performance levels. SPC is useful for distinguishing “special cause” variation due to unexpected or unplanned situations or events from “common cause” variation in performance which would be expected to occur even when a process is in control or stable. Further information on the use of SPC is available from Quality Observatories, Public Health Observatories, and the NHS Institute for Innovation and Improvement, and providers may wish to explore how SPC can be used to better understand their data.

(v) Balance and weighting of the indicators

34. The eight A&E indicators have been designed to present a balanced and co-ordinated view of the performance of the A&E site, with many indicators being complementary. For example, a high rate of patients leaving A&E before being seen may be better understood by investigating the service experience of patients and the time spent in A&E before initial assessment or treatment.

35. A&E sites may wish to have a more detailed focus on some indicators rather than others in a given month, for example if performance was particularly poor or good that month or if there is a seasonal effect, but

⁶ Though care should of course be taken to always protect patient confidentiality where granular data are published.

sites should ensure that they do not systematically focus on or report on one aspect of care to the neglect of other indicators.

What is the data source for the information in the local dashboards?

36. Of the 8 A&E clinical quality indicators

- (i) The Service Experience indicator uses local narrative information that will not be centrally reported; this information should be included in the local dashboards on a quarterly basis;
- (ii) The Consultant Sign-off indicator uses information that will be made available as part of the College of Emergency Medicine's clinical audit programme; this information should be included in local dashboards as it becomes available;
- (iii) The remaining six indicators (Left without being seen rates, Re-attendance, Time to initial assessment, Time to treatment, Total time in A&E, Ambulatory Care) use information from local A&E IT systems, some of which is centrally reported via the A&E Commissioning Data Set (CDS).

37. It has been reiterated that the NHS should deliver public access to the information they hold as soon as possible, adopting a 'publish and improve' rather than a 'polish and publish' approach. For the six indicators listed in paragraph 19iii, the main data source for the information that is presented locally in the clinical dashboard should be local A&E IT and Patient Administration Systems; though these data may be supplemented by national and regional benchmarks provided from Hospital Episode Statistics (HES) data from the A&E CDS where appropriate (see paragraph 27 below).

What information will be centrally published on the indicators?

38. In addition to local data on the A&E indicators being published in the form of a clinical dashboard, centrally collected monthly information on the A&E indicators listed in paragraph 19iii above will be published on a monthly basis.

39. These data will be sourced from provisional A&E Hospital Episode Statistics (HES) derived from the A&E CDS. Information will be published on each component of each indicator e.g. the median, 95th percentile and longest wait for time to treatment. Information will be published at national level and organization-level (3 digit provider code) routinely; where information is available at site level (5 digit provider code), this information

will also be provided where appropriate. A&E HES data are generally made available with a 3 month data lag e.g. April 2011 activity data available in August 2011.

40. It is recognized that not all A&E sites and organizations currently submit A&E Commissioning Data Set information to the Secondary Uses Service (SUS) which underpins A&E HES. SUS is a mandated national collection and all A&E providers should ensure they have appropriate reporting capabilities, in line with the direction set out the Operating Framework: “The NHS should use the Secondary Uses Service (SUS) as the standard repository for performance, monitoring, reconciliation and payments by April 2012, operating in shadow form from October 2011.”
41. A&E sites and organizations that are unable to centrally submit A&E CDS data at present should still aim to produce and self-publish their clinical dashboard and have this information available to commissioners and the public. However, this local reporting is not a long-term substitute for central reporting of the data, and organizations that do not submit data to the A&E CDS will be included in the national performance management programme. It is noted that trends in performance levels derived from centrally collected A&E HES data will be affected by improvements over time in the coverage and quality of data supplied via the A&E CDS. It is also recognised that as both local data and provisional A&E HES data may be revised in-year, the data published for a given month may not match the data that are available for the same month later on in the year.
42. It is acknowledged that the data which are centrally published on the six indicators listed in paragraph 19iii will not exactly match the data which are locally available and published on these same indicators over the same period (i.e. A&E HES data on performance for April 2011 may not exactly match locally-held data on performance for April 2011). There will be variance between these two data sets as
 - (i) The locally published data will be made available at site level, while the majority of data supplied to A&E HES is at organization level;
 - (ii) A number of organizations and sites, particularly Type III (minor injury units, walk in centres, other types of A&E) do not report data via the A&E CDS but may report data locally on the indicators. It is noted that this may affect national averages calculated from A&E HES data.
 - (iii) Data centrally supplied via the A&E CDS in line with current A&E CDS data definitions will not exactly match the data definitions for the A&E clinical quality indicators, and local data in this scenario may give a more accurate reflection of performance on the indicators (e.g. the total time in A&E recorded in A&E HES may include time spent in Medical Assessment Units or time spent in A&E awaiting private transport from the department even though the clinical episode has concluded).

- (iv) Data submitted centrally via the A&E CDS undergo further data cleaning and validation checks before being released as A&E HES data.

43. The Department of Health is working with the Information Standards Board in order to bring the A&E CDS data definitions more in line with the A&E clinical quality indicator data definitions. In advance of these changes being implemented, both the presentation of the centrally collected A&E HES data on the indicators and the use of these A&E HES data for the purposes of performance management will acknowledge that locally available data on the indicators need to be taken into account before making definitive assessments of performance on the A&E clinical quality indicators.

44. A&E sites are encouraged to use and incorporate published national benchmark information from the centrally published A&E HES data into their dashboards as these data become available. It is recognised that the benchmarks used from A&E HES will not exactly match the local data in the dashboard (e.g. A&E HES undergo different cleaning routines, will be provided with greater time lags, have lower coverage of Type III units and are based on slightly different data definitions to the A&E indicators at present); nevertheless, the context provided by national trends will still be of interest and use to commissioners and the public.

How often should the dashboards be published?

45. The clinical dashboard should be published locally on a monthly basis.

46. Three indicators are collected and reported on quarterly or six-monthly basis (i.e. Ambulatory Care, Service Experience and Consultant Sign-off); for example, Service Experience indicator information may be collected over April to June, and the results for this activity would be reported in the July clinical dashboard. For these indicators that are not collected on a monthly basis, A&E sites should present the latest available charts and information, even if this information has been included in previously published clinical dashboards; A&E sites may however wish to update the narrative accompanying the charts to incorporate more timely information.

47. It is recognised that due to data lags and different data collection periods, all of the data contained in the clinical dashboard for an A&E site in a given month may not refer to the same activity period across all indicators.

When should the dashboards be published?

48. The summary clinical dashboard should be published during the month following the month of activity (e.g. July data published in August)

49. We would strongly encourage organisations to publish their data, where it is robust, as soon as possible, with an expectation that all organisations

will be publishing local data by the time July 2011's data is available (in August 2011). Sites should aim to include historical local information for earlier months where available.

Where should the dashboards be published?

50. A&E sites should primarily aim to self-publish the clinical dashboard on their own website. A&E sites are also encouraged to physically publish the information within the A&E department or hospital itself, to make the material more accessible to their own patients.
51. Data should be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. organization level).
52. However, to appropriately reflect the patient's perspective, we would strongly encourage organisations to publish their local data at site level. We would also encourage organisations where there are integrated services on the same site but provided by two or more different providers to agree for such activity to be reported by a single provider..
53. Where it is not possible to publish information on the website of an A&E site, the dashboard for individual A&E sites should be published instead on the trust website.
54. Trusts are encouraged to discuss the indicators with local stakeholders and patient groups. Where there is an expressed need to do so, trusts should consider making the dashboard available in other more accessible formats including hardcopies and different community languages.
55. In the future, the clinical dashboards may be reflected on the NHS Choices website, to provide a portal where patients can more easily assess and compare the performance of different A&E services in their local area