

## Accident and emergency July 2005



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# The Healthcare Commission

**The Healthcare Commission exists to promote improvement in the quality of healthcare and public health in England. We are committed to making a real difference to the delivery of healthcare and to promoting continuous improvement for the benefit of patients and the public. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.**

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and takes over some responsibilities from other commissions.

The Healthcare Commission:

- replaces the Commission for Health Improvement (CHI), which ceased to exist on March 31<sup>st</sup> 2004
- takes over responsibility for the independent healthcare functions previously carried out by the National Care Standards Commission, which also ceased to exist on March 31<sup>st</sup> 2004
- carries out the elements of the Audit Commission's work relating to efficiency, effectiveness and economy of healthcare

We have a statutory duty to assess the performance of healthcare organisations, award annual performance ratings for the NHS and coordinate reviews of healthcare with others.

We have created an entirely new approach to assessing and reporting on the performance of healthcare organisations – our annual health check – which will look at a much broader range of issues in our assessments, enabling us to focus on what really matters.

# Preface

The acute hospital portfolio is a collection of reviews of key services, resources or issues that are of national concern and that are important to patients, NHS trust managers and clinicians.

The portfolio currently includes 16 topics ranging from accident and emergency services to pathology and facilities management. Together, these reviews provide a unique source of diagnostic guidance, advice, in depth investigation tools, and information that can be used to compare performance across similar trusts and to help trusts improve.

Previous findings and experience have taught us that poor performance is often linked to management and resource issues. One of the key strengths of the portfolio is its capacity to identify drivers of performance, and to delve deeply into problems affecting performance to find their root causes.

This was reflected in a survey<sup>1</sup> of trust chief executives and directors, which found that more than two-thirds of respondents considered the portfolio a valuable or very valuable tool in helping them to make better use of resources.

The Healthcare Commission took over the acute hospital portfolio from the Audit Commission on April 1<sup>st</sup> 2004 and has continued the programme of work. Trusts have received individual reports from Audit Commission performance auditors, who continue to deliver the local work on our behalf. The three topics reviewed in 2004/2005 are ward staffing, accident and emergency (A&E) and day surgery. This national report summarises the main findings from the review of accident and emergency services and separate reports are published on the other two topics. The report also shows the progress that has been made since 2000/2001, when these topics were first reviewed as part of the portfolio.

Further portfolio reviews of admissions to hospital, diagnostic services and medicines management are planned for 2005/2006. The portfolio already embodies much of the Healthcare Commission's vision for its future work, including promoting improvement, focusing on outcomes and emphasising the experiences of patients. Eventually, the portfolio reviews will merge with the Healthcare Commission's new improvement reviews. Full details are included in the separate publication *Assessment for improvement: the annual health check*, published in March 2005. More information is also available on our website:

**[www.healthcarecommission.org.uk/acutehospitalportfolio](http://www.healthcarecommission.org.uk/acutehospitalportfolio)**

<sup>1</sup> Unpublished survey of NHS acute trust chief executives and directors (2003) Audit Commission – responses received from approximately 200 chief executives and directors.

# Executive summary

Accident and emergency services were reviewed by the Audit Commission in 2001. That report highlighted the issue of long waits and showed that they had been getting steadily longer during the preceding four years. Since then, NHS trusts and the Department of Health have made a determined effort to improve matters.

## Introduction

The Department of Health has established the target of a maximum of four hours for patients to spend in A&E, which has been backed up with a range of incentives and support.

This report sets out the results of a major review of A&E services carried out by the Healthcare Commission in 2004/2005. It recognises the improvements in times spent in A&E that have been made since 2001 on a national scale. It also extends the consideration of performance beyond times spent in A&E, to measures of clinical care and also to the perceptions and experiences of patients using A&E. The result is a more comprehensive and balanced assessment of A&E than has previously been possible.

There are 202 major A&E departments in England, which are open 24 hours a day, have the resources to deal with all emergency cases and have access to a complete range of medical and surgical specialties. They are attended by more than 13 million people every year and range in size from 20,000 patients per annum to over 100,000 patients.

In the last few years, there has been major expansion in the provision of minor injuries units and walk-in centres. These can normally deal with the less severe cases that do not need to be admitted to hospital.

## Quality of clinical care

Clinical audits were carried out as part of the review in A&E departments in 2004 using three 'tracer' conditions:

- children in pain from broken elbow or wrist
- hip fracture
- patients who have taken an overdose of paracetamol

Departments were also given the opportunity to audit their services a second time prior to this publication (March 2005), so that any improvements that were carried out as a result of the first audit and already implemented could be recognised.

The quality of clinical care for the three tracer conditions was found to be very variable and often did not meet the standards set out by the British Association of Emergency Medicine.

For children in pain, only 60% on average received analgesia within 60 minutes of arrival, but this improved to 70% on the second audit. The recording of pain scores improved quite markedly, from only 10% to 42%.

For patients with hip fracture, 46% were offered or received analgesia within 60 minutes of arrival, which rose to 57% on the second audit. Pain scoring was much better for this group at 39% rising to 45%. Patients with hip fractures also need to be x-rayed shortly after arrival, but only 33% were x-rayed within one hour of arrival and this hardly improved on the second audit.

The results of the treatment of paracetamol overdose were less conclusive. Again, results were very variable and revealed some shortcomings in treatment, and while some departments improved in the second audit, others did not.

All concerned in A&E services now need to build on these measures and ensure that monitoring of the quality of service becomes a core part of day to day management of A&E departments.

### Perception of care by patients

Clinical measures of quality of care go together with the perceptions of patients. The national survey of patients showed that on average 71% of patients rated their overall standard of care as being excellent or very good. This varied from over 80% of patients in the best trusts to only 50% of patients in the least favourably viewed trusts.

The overall perception of care by patients is strongly associated with their recollection of the time they spent in A&E, but they also associate better care with smaller departments and lower levels of nurse vacancies.

### Times spent in A&E

The portfolio review collected data on the initial waiting time to see a doctor (or emergency nurse practitioner) and also the times for admission in 2000 and 2002 as well as 2004, so that trends could be identified.

Both of these measures show marked improvement, particularly the admissions within four hours. Between 2000 and 2002, admission times were becoming longer, but since 2002, they have become shorter than they were in 2000. This applies particularly for the previously poorer performing departments and departments in London. The initial wait to see a doctor also improved, but to lesser extent.

Since the collection of the portfolio data in 2004, times spent by patients in A&E departments have continued to improve. In the period April to June 2004, the Department of Health reported that an average of 95% of patients left departments within four hours and this had risen to 98% for April 2005 – the latest published data. Although apparently small, these last few percentage points can be the most difficult for departments to achieve and show that there is a continuing need to monitor performance.

The perceptions of patients of times spent in A&E also show improvement over time. In 84% of trusts, patients surveyed in 2004 perceived shorter times compared with patients in 2003, with a median improvement of 8.5 percentage points.

Patients who are admitted to hospital spend more time in A&E than discharged patients. In 2004, the portfolio data showed that the percentages leaving within four hours were 83% and 96% respectively. Adults aged over 65 are far more likely to be admitted, so for this reason they tend to spend longer in A&E than other patients. Initial waits to see a doctor are quicker for patients who are subsequently admitted, indicating that the more seriously ill or injured patients are given priority.

### Children

In the average A&E department, children up to and including the age of 15 comprise 22% of all patients, and in four departments more than 30% of patients are children. Overall, children are treated and admitted slightly more quickly than average; 61% see a doctor in one hour against 56% of all patients, and 95% are admitted within four hours against 83% for all patients.

Approximately 40% of general A&E departments have separate facilities for children that are staffed 24 hours a day. A further 20% have separate facilities, but which are only staffed for part of the day. The remaining 40% of departments report no separately staffed facilities for children. Small departments are just as likely to have special facilities as large ones and they are just as likely to be open 24 hours a day.

In the average department, 6% of nurses are specially trained children's nurses, but there are some departments treating children with no specialist children's nurses.



## Staffing

Since 2000, there has been a substantial increase in staffing levels in A&E departments. On average this has been 20% for nurses, 27% for doctors and 37% for consultants, recorded cumulatively over the four year period. Not only have the numbers increased, but the seniority of staff has also increased. But departments still have vacancies for nurses - the average is 8% rising to 16% in London.

Common sense would suggest that a large part of the improvements in times spent in A&E departments since 2000 has been due to the increases in staff. However, when comparisons are made at individual department level, there is no association between relative increases in staff and improvement in times spent in A&E. This indicates that when extra staff are appointed, it should only be to fulfil a specific purpose and the results should be monitored.

In 2000, only 16 departments treated more than 10% of their patients using emergency nurse practitioners, but this has increased to 76 departments treating 10% or more of their patients this way. However there are still many departments who treat none, or very few of their patients using emergency nurse practitioners, so there is still a lot of opportunity to develop this practice.

## Minor injuries units and walk-in centres

Minor injuries units and walk-in centres have grown in numbers and importance in recent years as part of the Department of Health's strategy of providing a variety of emergency services to meet the needs of different patients. The units surveyed accounted for more than 20% of attendances at main A&E departments.

In general, they provide an effective service with good performance. Waiting and total times compare very favourably with main A&E departments, but this is to be expected, bearing in mind that they treat less complex

patients. Virtually all patients leave units within four hours of arrival and 94% see an emergency nurse practitioner within one hour of arrival, against the equivalent figure for a main department of 56%. However, there are still some poor performers. In the lowest 10% of departments, only 57% of patients, on average, see an emergency nurse practitioner within one hour.

## Conclusions

The indicators for quality of clinical care for pain in children, hip fracture and paracetamol overdose show widely varying performances between trusts, with many failing to meet the standards set out by the British Association of Emergency Medicine. Nevertheless, very useful improvements took place as a result of carrying out the audits.

In general, perceived levels of satisfaction are high. There is evidence that patients perceive higher satisfaction with departments that are smaller than average and which have lower than average nurse vacancies. London departments are viewed somewhat less favourably than those elsewhere in England.

Times spent in A&E are also very important to patients. They have improved significantly since 2000. The departments that had the longest times in 2000 have improved the most, including marked improvement for those in London. Many A&E departments are now meeting the Department of Health standard that 98% of all patients should leave departments within four hours of arrival. However, patients who are admitted are still at higher risk of a long stay in A&E. This risk is highest where the department's performance against the four hour target falls below 98%.

Children are treated more quickly than adults. The quality of care for them is better in specialised departments but, in general, waiting times are similar.

Employing more staff does not, on its own, necessarily lead to improved performance. Many departments, particularly in London, are under-staffed and may lack particular skills such as those held by emergency nurse practitioners and children's nurses

Minor injuries units and walk-in centres have become a significant force in emergency care, accounting for more than 20% of all attendances and provide a rapid, low cost service for non complex care. However, in a few units patients can still experience delays of more than one hour to be seen before treatment starts.

### Recommendations

NHS trusts responsible for A&E services should undertake regular monitoring of clinical care along the lines of the methods and indicators developed in this review that cover pain in children, hip fracture and paracetamol overdose.

The scope of these measures could also be extended to other conditions such as asthma, major trauma and fever in children, based on the standards set by the British Association of Emergency Medicine.

Waiting times are also important to patients and the **Department of Health** should continue to monitor times spent in A&E and ensure that the recent improvements are consolidated, as also recommended by the Public Accounts Committee. Performance management of A&E at all levels (carried out by **strategic health authorities and NHS trusts**) should include both quality and time spent in the department. The measures of times should include waiting time to see a doctor (or emergency nurse practitioner) and the total times spent in A&E by those patients who are admitted, as well as the percentage of all patients leaving the department within four hours.

For minor injuries units and walk-in centres, measures should be established for the times spent by patients that better reflect the services they provide. A measure of waiting time to see a doctor or nurse practitioner applies equally in these units, but the four hour total time in the department standard does not discriminate adequately between good and poor performers because most patients are treated and discharged much sooner than this. There is also a need to further develop budgeting and performance monitoring systems in these units.

**NHS trusts** should review their services for children if they do not provide separate children's facilities, to ensure that the special needs of children in A&E are being met fully. Where the numbers of children attending do not justify specialist children's nurses in the A&E department, there should at least be access to general nurses who are trained and experienced in dealing with children.

**Strategic health authorities and NHS trusts** need to ensure that additional staff employed in A&E are deployed efficiently and effectively. When funding is made available for extra staff, it should be to fulfil a specific purpose. Achievement of this purpose should be monitored subsequently. Trusts should also seek to fill vacancies as quickly as possible and minimise the use of bank and agency nurses or locum doctors. Emphasis should be given to recruiting and training for particular skills that may be lacking, for example emergency nurse practitioners and nurses trained to treat children.

# Introduction

More than 13 million people attend A&E departments in England every year and those people expect high quality and timely care within easy travelling distance of wherever they happen to be.

A&E departments have to ensure that they make the very best use of their resources to meet these rigorous demands.

Services provided by A&E departments were reviewed by the Audit Commission<sup>2</sup> in 2001. That report highlighted the issue of long periods of waiting and showed that these times had been getting steadily longer during the preceding four years. Since then, and after the publication of *Reforming Emergency Care* by the Department of Health in the same year, there has been a determined effort to improve matters. This latter document re-emphasised the target, as first set out in the *NHS Plan*<sup>3</sup>, that the maximum time that any patient (whether major or minor) should spend in A&E is four hours. It has since been recognised that a small number of patients may need to remain in A&E for more than four hours for clinical reasons, and so a minimum standard of 98% was set.

The Department of Health has demonstrated its determination to improve performance by increasing the resources available to A&E departments, principally by providing more doctors and nurses, and also promoting a culture of more analytical performance management backed up by financial incentives and encouragement from the NHS Modernisation Agency.

This report sets out the improvements in times spent in A&E that have been made since 2001 on a national scale. In addition, it extends the consideration of performance beyond just times spent in A&E, to measures of clinical care and also to perceptions and experiences of patients using A&E departments. The result is a more comprehensive and balanced assessment of A&E than has previously been possible.

## A&E departments

There are 202 major A&E departments in England that are open 24 hours a day, have the resources to deal with all emergency cases and have access to a complete range of medical and surgical specialties. They range in size, seeing between 20,000 to 130,000 patients per year. A typical department sees 60,000 patients per year, which translates into approximately 10 patients arriving per hour at the peak times between 9am and 7pm. NHS acute trusts are responsible for the management of A&E departments, but mergers of trusts in recent years mean that 40 of them have more than one department and five acute trusts have three or four A&E departments. Overall, there are 155 acute trusts in England with major A&E departments. Box 1 highlights some of the basic features of A&E departments.

### Box 1: Features of A&E departments

To give an impression of the numbers of staff involved in A&E, the average department has 44 nurses and 17 doctors (measured as whole time equivalents), which can rise to over 100 nurses and 40 doctors in the largest departments.

A&E departments are complex to run, and they draw on the skills and resources from elsewhere in the hospital. Therefore, if they are to be able to cope with any kind of emergency at any time of the day or night, they need to have a 'critical mass' to remain viable and safe. This also applies to the supporting hospital, which must provide access to a complete range of specialties. There are thus considerable problems in balancing the provision of services locally that the public might like, against their cost and quality.

<sup>2</sup> Review of national findings – accident and emergency (Audit Commission, 2001)

<sup>3</sup> The NHS Plan (Department of Health, 2000)



The two principal time intervals that have most impact on patients are shown in figure 1; they are the initial wait to see a doctor or emergency nurse practitioner, and the total time spent in the department before admission, transfer or discharge. The latter is the basis of the Department of Health target and will be discussed further in the section on waiting and total times.

## About this report

This report is a summary of the main national messages that have emerged from the Healthcare Commission's review of A&E service at all relevant main A&E departments and large minor injuries units and walk-in centres in England during 2004.

Trusts have already received individual reports from auditors on their own performance, which has given them the opportunity to look closely at their data and to correct any inaccuracies that might have become apparent (see box 2 for data sources). This early receipt of reports by trusts also means that they will already be able to identify any problems and be working on action plans, if needed, to address them.

Data has therefore been amended where necessary and certain items have been brought right up to date, namely:

- the measures of total times spent in A&E departments, published by the Department of Health
- the clinical audit data where trusts have been given the opportunity to re-audit and identify improvements resulting from changes in policy put in place after the first audit

The review and this report have benefited greatly from close links with several organisations, but in particular:

- The British Association of Emergency Medicine (BAEM), who have provided the clinical lead to establish the clinical quality audits (see box 2).
- The National Audit Office, which carried out a study of emergency care in England during 2004 and reported in October 2004<sup>4</sup>. The Committee of Public Accounts published its own report on the topic in 2005<sup>5</sup>. The National Audit Office study assessed national performance and put A&E services at department level into the wider context of the functioning of hospitals as a whole and of local emergency care networks. It therefore complements this detailed review of A&E services. In line with the Concordat between healthcare inspection bodies<sup>6</sup>, the Healthcare Commission and the National Audit Office liaised closely throughout their respective projects to avoid overlaps and unnecessary burden on trusts.
- The Audit Commission, who collected the data and delivered the local reports to trusts on our behalf.
- The Medical Care Research Unit at Sheffield University, which is conducting a study into organisational characteristics of A&E departments that can affect their performance, commissioned by the National Coordinating Centre for NHS Service Delivery and Organisation R&D. It is expected to report in 2006. All data has been shared between us – a further example of cooperation to prevent duplication of data collection and additional burden on trusts.

<sup>4</sup> *Improving Emergency Care in England* (National Audit Office London: The Stationery Office 2004 [HC 1075, Session 2003-04]).

<sup>5</sup> 16th Report of 2004-05, Committee of Public Accounts, HC 445, Session 2004-05.

<sup>6</sup> The Concordat, between bodies that inspect, regulate and audit healthcare, is a code of objectives and practices aimed at: delivering more consistent and coherent programmes of inspection, improving services for patients, clients and their carers and reducing unnecessary burdens of inspection on staff providing healthcare.

### Box 2: Sources of data

- The acute hospital portfolio review in which data was collected in July 2004 and fed back to A&E departments from November 2004 – comprising 202 major departments in England and 136 minor units (referred to as the 'portfolio').
- Clinical audits of treatment for three tracer conditions (pain in children, hip fracture and paracetamol overdose) in A&E departments. This was collected along with the portfolio, but with a second audit in early 2005 to identify improvements.
- The Healthcare Commission's survey of A&E patients carried out in the autumn of 2004. For each trust the number of patients surveyed varied but averaged around 300. Referred to as the 'national survey of patients'. A similar earlier survey was carried out in spring 2003 and is used for trend analysis.
- The Department of Health data on times spent in A&E, by trust, which are updated quarterly.

This report begins by examining the quality of care in A&E departments (including indicators of clinical effectiveness, the perceptions of patients of quality and times spent in A&E, plus a separate section on services for children). Where possible, links between these indicators and a department's use of its resources are highlighted. The report then looks more specifically at the use of staff. The final section considers the role of minor injuries units and walk-in centres.

# Quality of care

## Indicators of clinical care

In their 2004 report, the National Audit Office observed that 'national benchmarking of quality of care in A&E departments has been very limited compared with inpatient services'. A significant step in filling this gap has been taken by the British Association of Emergency Medicine (BAEM)<sup>7</sup>. It has established treatment standards for a number of important conditions for which patients attend A&E departments. Three conditions were selected for inclusion in this review on the basis that they were common and that they encompassed three distinct vulnerable groups of patients – children, the elderly and those with a mental health problem. The conditions were:

- children in pain from broken elbow or wrist
- hip fracture
- patients who have taken an overdose of paracetamol

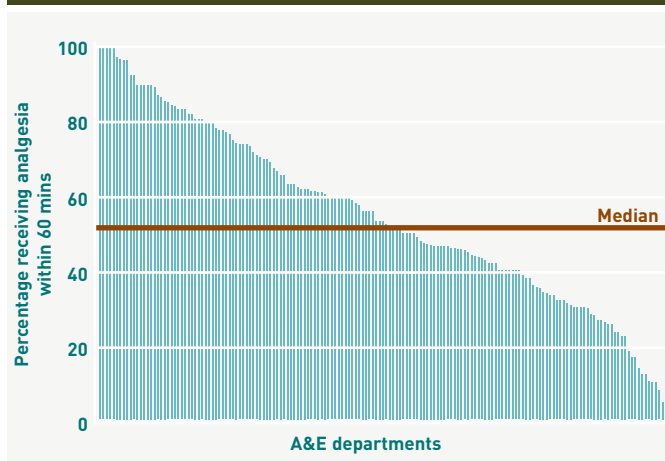
Clinical audit tools were developed jointly by the BAEM and the Healthcare Commission, specifically for this review, and each A&E department audited retrospectively its treatment of up to 50 patients in each of these three patient groups who presented in the period up to December 2003. Departments have been given the opportunity to re-audit their services immediately prior to this publication, so that any improvements already implemented could be recognised. The results of this aspect are discussed at the end of this section.

### Children in pain

The audit was confined to patients in moderate or severe pain as a result of a fractured arm or wrist and recorded the administration of analgesia in intervals of 20, 30 and 60 minutes from arrival. The standards recommended by the BAEM are set out in box 3.

Administration at 20 minutes was so low that the results for administration after 60 minutes of arrival are more indicative.

**Figure 2: Percentage of children in pain receiving analgesia within 60 minutes of arrival**



Source: A&E portfolio, 2004, England

### Box 3: BAEM guidelines on treating children in pain

Patients in severe pain (pain score of 7 to 10) should receive appropriate analgesia, according to local guidelines, within 20 minutes of arrival.

Patients with moderate pain (pain score of 4 to 6) should be offered analgesia at triage.

90% of patients with severe pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic.

75% of patients with moderate pain should have documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic.

<sup>7</sup> The professional association for specialist emergency medicine and affiliated to the Royal College of Surgeons



The results (figure 2) show that:

- on average, only 53% of children received analgesia within one hour of arrival
- there was extreme variation in performance between departments with no obvious explanation

One of the problems revealed by the audits was that despite the BAEM recommendations, very few departments systematically recorded pain scores, so the assessment of pain levels had to be deduced from the treatment recorded in the patient's notes. Most departments recorded pain scores for some of their patients but a third did not record any.

### Hip fracture

This is usually known to clinicians as 'fractured neck of femur'. The BAEM standards are set out in box 4.

Results similar to those for children in pain were found for the administration of analgesia for hip fracture, but in this case the average was slightly lower with only 42% of patients receiving (or being offered) analgesia within 60 minutes of arrival.

#### Box 4: BAEM Guidelines on treatment for hip fracture

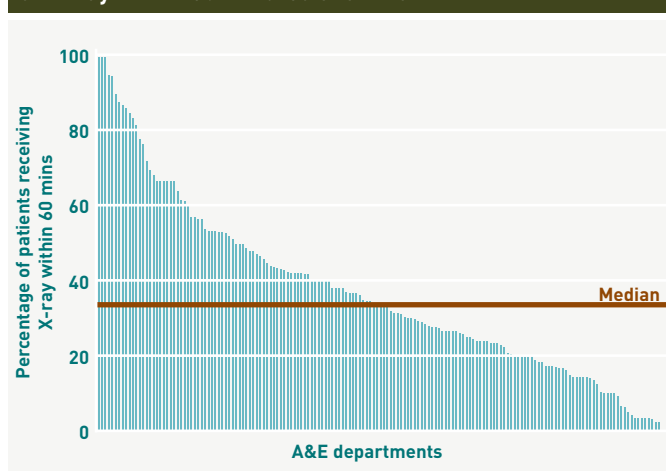
Patients in severe pain (pain score of 7 to 10) should receive appropriate analgesia, according to local guidelines, within 20 minutes of triage or arrival, whichever is the earlier.

Patients in moderate pain (pain score of 4 to 6) should be offered analgesia at triage.

X-ray should be performed within 60 minutes.

90% of patients should be admitted within two hours of arrival and 100% of patients should be admitted within four hours of arrival.

**Figure 3: Percentage of patients with hip fracture receiving an x-ray within 60 minutes of arrival**



Source: A&E portfolio, 2004, England

Only 33% of patients on average were x-rayed within one hour of arrival (see figure 3).

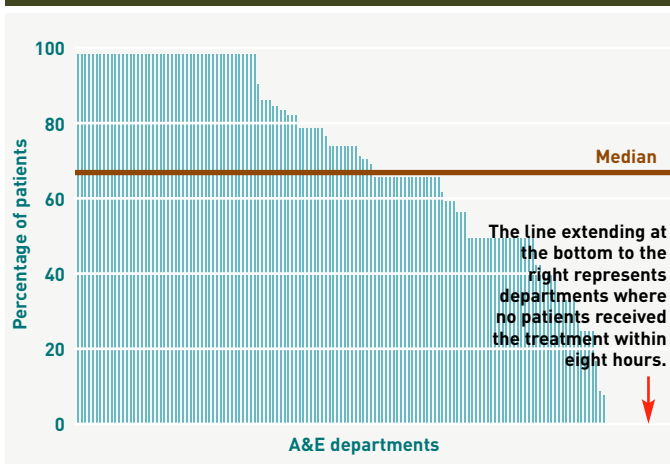
The BAEM recommendation for 90% of patients to be admitted within two hours of arrival is ambitious, compared with the Department of Health's target of four hours, but the recommendation that 100% of hip fracture patients should be admitted within 4 hours is entirely consistent with it and should certainly apply to all patients in this vulnerable group. In the first audit, which referred to patients in 2003, 72% of patients were admitted within four hours.



## Paracetamol overdose

The BAEM recommendations are set out in box 5. Treatment for these cases varies, depending on the circumstances in which the patient took the overdose, and therefore each of the indicators is based on a subset of the original sample. As an example, figure 4 shows those patients who received the antidote after presenting within eight hours of ingestion and where their blood tests revealed that treatment was required.

**Figure 4: Percentage of patients with a level of paracetamol overdose requiring treatment and receiving that treatment within eight hours of ingestion**



Source: A&E portfolio, 2004, England

## Improvements already achieved

The clinical audits were very well received by consultants in A&E departments and many of them said they would welcome the opportunity to re-audit, particularly if they had changed procedures to improve performance as a result of the original audits.

In response to this, departments were asked to carry out second audits in February 2005 and submit results by April 2005. Fifty departments were able to complete results within this short timeframe and showed

significant improvements in performance. In the discussion that follows, the original and second audit results are compared for only those departments who participated in both stages.

### Box 5: BAEM Guidelines on treatment of paracetamol overdose

Patients arriving within one hour of ingestion: 75% should receive activated charcoal within 30 minutes of arrival.

Staggered overdoses: treatment should be started within one hour of arrival.

Patients should not have blood plasma levels measured earlier than four hours after the estimated ingestion time.

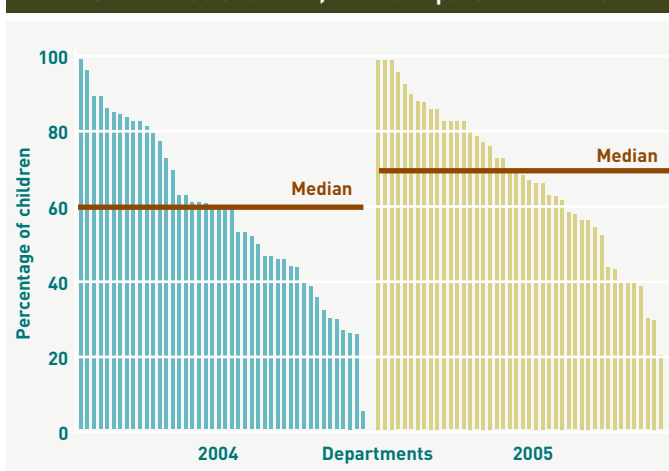
Patients arriving within eight hours after ingestion: treatment given appropriately, as judged by presentation time and the treatment guidelines from National Poisons Information Service (NPIS) 2003.

Patients arriving eight to 24 hours after ingestion. Treatment started before blood results available if there is a clear history of greater than 12g ingestion (or 150mg/kg, whichever is the smaller).

## Children in pain

The recording of pain scores showed a marked improvement. In the original audit, only 10% of patients had pain scores recorded in their notes and a third of departments did not record any pain scores. In the second audit, this had improved to 42% of cases and only four departments failed to record any scores. Recording pain scores is important because it provides a systematic base for carrying out the proper treatment.

**Figure 5: Percentage of children in pain receiving analgesia within 60 minutes of arrival, 2004 compared with 2005**



Source: A&E portfolio, 2004, England

The speed of treatment itself also improved significantly. For those departments that responded to the second audit, the median percentage of children receiving analgesia within 60 minutes of arrival increased from 60% to 70% (figure 5). Although this is a very rewarding improvement over a short time, it also shows that there is still much need to go further.

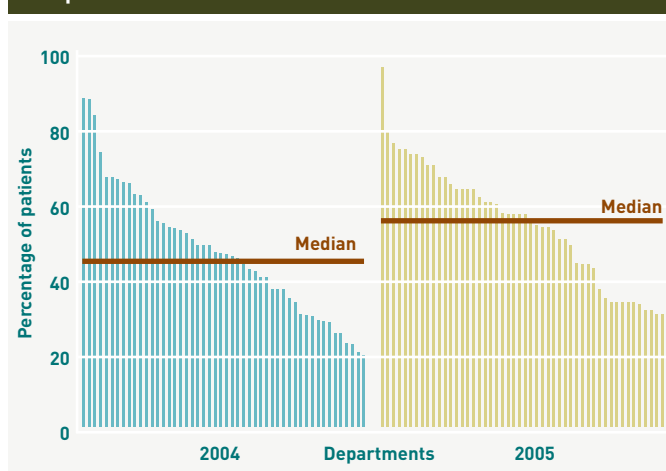
### Hip fracture

The recording of pain scores is generally better for hip fracture than for children in pain, but there was still a useful improvement from 39% of patients to 45% between the first and second audits.

Significant improvements were shown in the administration (or offering) of analgesia to patients within 60 minutes of arrival, where the median increased from 46% to 57% (figure 6).

There was, however, little improvement in the percentage of patients with hip fracture being x-rayed within one hour of arrival, although this factor would often be outside the control of A&E department staff.

**Figure 6: Percentage of hip fracture patients receiving, or being offered, analgesia within 60 minutes of arrival, 2004 compared with 2005**



Source: A&E portfolio, 2004, England

There was a major improvement in the percentage of patients with hip fracture who were admitted within four hours of arrival, which increased from 75% of patients in 2004 to 91% in 2005.

### Paracetamol overdose

In contrast to the previous two tracer conditions, there was very little change in performance between the two audits for any of the indicators, so for paracetamol overdose we have not shown any change charts. The audits did not reveal any major problems of treatment, but there is room for improvement in the number of patients where four hours was not allowed before taking a blood plasma test.

## Putting quality on the agenda

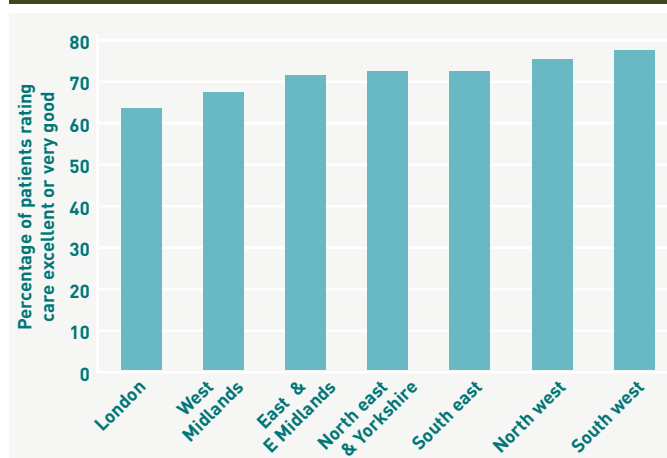
Recent reports, including this one, have recognised the considerable improvement achieved by trusts in times spent in A&E, so it is disconcerting to identify such widely variable quality of care. However, we recognise that this is the first truly national data available on quality of care. Trusts should now monitor these indicators regularly as part of their management of A&E and we are encouraged by their very positive response to the audits, already bringing about significant improvements.

However, not all departments improved and in a few cases, a deterioration of performance was experienced between the two audits. When approached, these departments cited particular factors such as over reliance on locum doctors or changes in admission policy, so that all patients were now routed through A&E. These instances illustrate just how difficult it is to manage and sustain improvements in A&E departments, and how vulnerable they are to the unforeseen consequences of organisational change.

## Quality of care perceived by patients

Measures of the quality of clinical care tie in with the perceptions of patients. The national survey of patients<sup>8</sup> collected, amongst other things, the perceptions of patients of the times spent in A&E departments, together with demographic information such as age, sex, ethnic mix and level of education. It also collected data on their perception of aspects of quality, asking questions such as 'Did you have enough time to discuss your health or medical problem with the doctor or nurse?' and 'Overall, how would you rate the care you received in the emergency department?' The results for all the questions on quality were closely correlated, and so patients' rating of the overall quality of care has been taken as the marker indicator.

**Figure 7: Regional variation of patients' perception of overall quality**



Source: National survey of patients, 2004

On average (median), 71% of patients rated their overall standard of care as being excellent or very good. This varied from 85% of patients in the best trust to only 39% of patients in the least favourably viewed trust and showed a regional pattern. The region rated the worst by patients was London, where the median rating was only 63% and the best rated was the South West with 77% (figure 7).

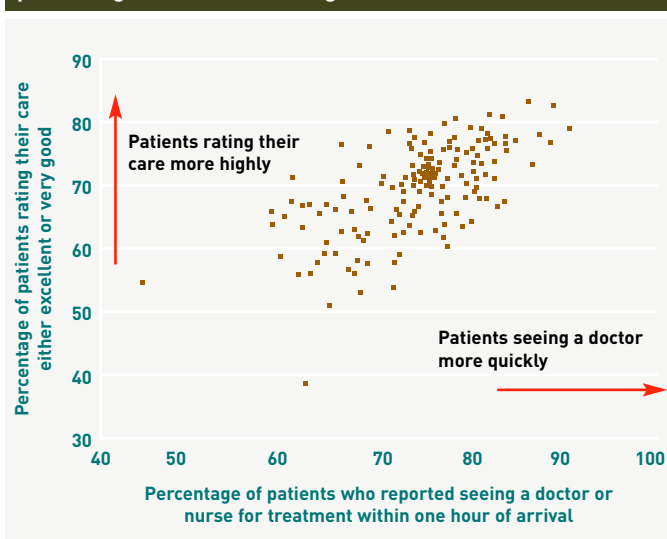
## Factors affecting perception of care

There is a tendency for A&E departments with higher levels of nurse vacancies to be viewed less favourably. This could reflect that where there are high vacancy levels, there will be staff shortages or there will be a higher use of bank and agency staff, who are unfamiliar with the department. In either case, this would result in the permanent staff being more stretched. This is similar to the findings in the accompanying portfolio report on ward staffing<sup>9</sup>, where high levels of bank and agency staffing are clearly associated with lower patient satisfaction.

<sup>8</sup> This is accessible on the Healthcare Commission website via [www.healthcarecommission.org.uk/PatientSurveyAandE2004](http://www.healthcarecommission.org.uk/PatientSurveyAandE2004). The survey refers to adults aged 16 and over.

<sup>9</sup> *Acute hospital portfolio review, Ward staffing* (Healthcare Commission, 2005)

**Figure 8: Patients rating their overall care vs the percentage who recall seeing a doctor within one hour**



Source: National survey of patients, 2004  
Significance:  $R^2=0.45$ ,  $p<0.01$

There is a similar association with the total number of people attending departments; small departments are perceived to provide a better quality of care.

However, the factor particularly associated with the overall perception of quality of care is the recollection of patients of how long they waited to see a doctor (figure 8). Waiting times and, by implication, total times, are therefore good proxy measures for perceived quality, as well as being important in their own right, so it is worth discussing them in some detail.

## Waiting and total times spent in A&E

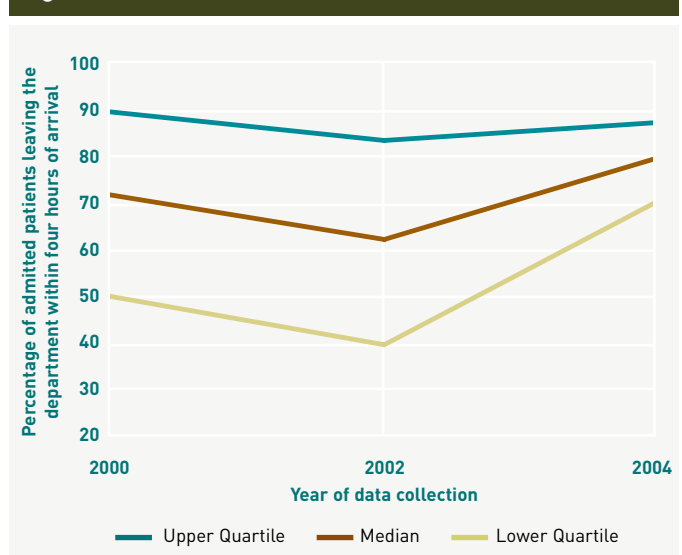
### Trends in performance

The portfolio data on times spent in A&E, collected when the A&E review was first carried out in 2000 and subsequently in 2002, measured the percentage of patients who saw a doctor or nurse within one hour of arrival, and the percentage of patients who left the

department for admission within four hours of arrival. Data was therefore collected for these two indicators in 2004, allowing trends in performance to be identified.

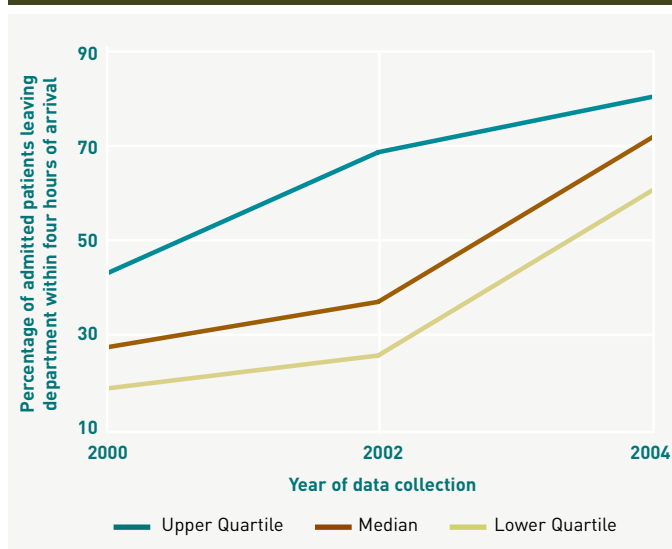
Both of these measures show a marked improvement, particularly the admissions within four hours. Between 2000 and 2002, admission times were becoming longer, but since 2002, they have become shorter than they were in 2000, (see figure 9). The most noticeable and encouraging feature is that those trusts in the lower quartile of performance in 2000 show the most marked improvement, so that the difference between the best and the worst departments is much less than it was previously. The improvement is particularly noticeable for A&E departments in London, which have improved consistently and rapidly since 2000, albeit from a low base, (see figure 10.)

**Figure 9: Trend in times for admission**



Source: A&E portfolio, 2004

**Figure 10: Trend in times for admissions in London departments**



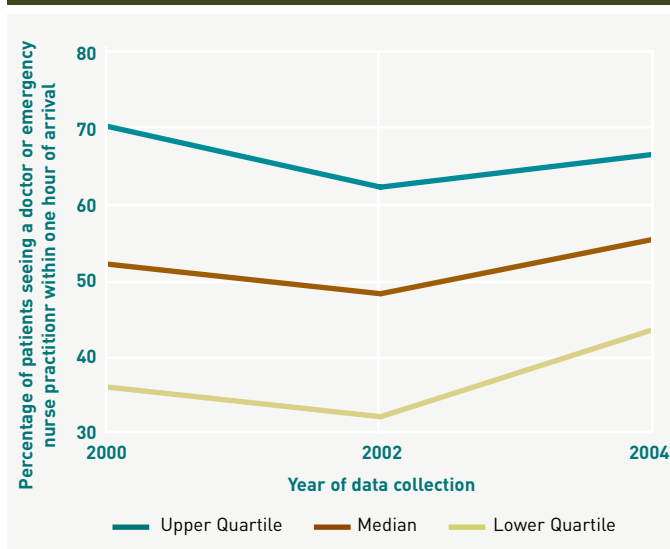
Source: A&E portfolio, 2004, England

Although not so marked, the initial wait to see a doctor or emergency nurse practitioner has also improved, and the difference between the best and the worst departments has reduced (see figure 11). Again, the worst performers have shown the greatest improvement and the figures for London have shown a greater than average improvement.

These favourable results undoubtedly reflect the emphasis on improvement in the local portfolio reviews in 2000, particularly in London, and also the much more extensive Reforming Emergency Care initiative implemented by the Department of Health since 2002 and the combination of associated policies identified in the introduction.

All of these factors contribute to increasing the priority accorded to performance in A&E departments. As reported by the National Audit Office in their 2004 report: 'we found much evidence that the focus on the

**Figure 11: Trend in percentage of patients seeing a doctor or emergency nurse practitioner within one hour of arrival**



Source: A&E portfolio, 2004, England

four hour target has increased the amount of senior management attention devoted to managing this part of the hospital'.

Since the portfolio data was collected, times spent by patients in A&E departments have continued to improve. From April to June 2004, an average of 95%<sup>10</sup> of patients left departments within four hours and this had risen to 98% for April 2005 – the latest published data. Although apparently small, these last few percentage points can be the most difficult for departments to achieve.

This is based on the Department of Health's measure that comprises the total times spent by all patients in a department – not just those who are admitted – and has become widely accepted as described in the National Audit Office report. However, a higher percentage of patients who are admitted still spend over four hours in major A&E departments. The relatively higher risk of a

<sup>10</sup> Department of Health figures include minor injuries units and walk-in centres. Available at: [www.performance.doh.gov.uk/hospitalactivity](http://www.performance.doh.gov.uk/hospitalactivity)

stay of longer than four hours for those who are admitted can be masked within the overall measure, as identified in the earlier report on A&E by the Audit Commission in 2001 and discussed below.

A key assumption underlying these results is that the data on which they are based is accurate and reliable. It is reassuring that the detailed information we have collected is generally very consistent with the Department of Health's published figures, but the Healthcare Commission, in partnership with the Audit Commission, has been carrying out separate investigations of data quality in several areas of acute care, including A&E. The findings of this work will be published in due course.

The perceptions of patients of times they spend in A&E also show improvement over time. In 84% of trusts, patients surveyed in 2004 perceived shorter times compared with patients in 2003, with a median improvement of 8.5 percentage points.

### Times spent in A&E by departure category and age group

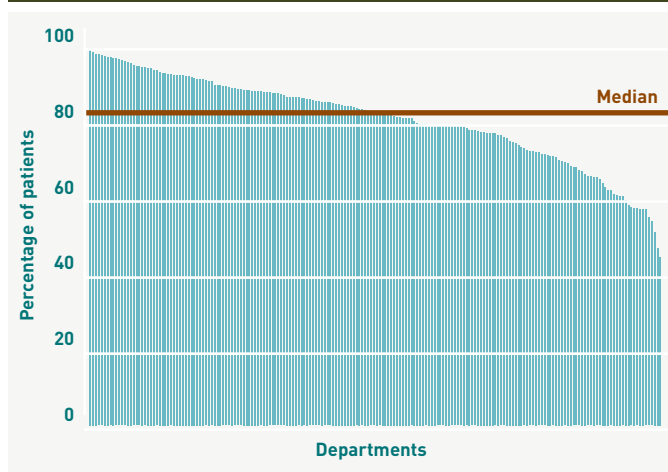
The 2004 portfolio data collection allowed times in A&E to be analysed separately for the three departure categories, that is whether patients were admitted, discharged or transferred.

The median figure for all patients who left A&E departments within four hours in April to June 2004 was 93%. However, when separated, this becomes 96% for discharged patients but only 83% for those patients who needed to be admitted because they were more seriously ill or injured. The best departments admitted all of their patients within four hours, but a few departments were only admitting 40% of patients within four hours (see figure 12). The difference was much reduced in departments meeting the 98% standard.

A&E departments whose results were close to the Department of Health standard generally admitted patients faster than other departments, but the variation is still significant enough to merit separate consideration of total times spent in A&E for admitted patients only.

The extra time spent in A&E departments by patients who are admitted was graphically demonstrated in the paper published by Mason and Locker from Sheffield University<sup>11</sup>. This showed that discharged patients mostly left departments within one to two hours. However, admitted patients were spread over a longer time and showed a peak in the 20 minute interval immediately preceding the four hour target, suggesting that departments are making particular efforts to ensure that patients, who would otherwise take longer than four hours, are admitted within that time.

**Figure 12: Percentage of admitted patients leaving departments within four hours**



Source: A&E portfolio, 2004, England

<sup>11</sup> *Analysis of the distribution of time that patients spend in emergency departments*, (T Locker and S Mason, Medical Care Research Unit, Sheffield University, British Medical Journal, 2005;330;1188-1189)

The portfolio also separates total times spent in departments according to three age groups - children up to and including 15, adults aged 16 to 64 and elderly adults aged 65 or over. Children take less time than adults (see section on children below), but elderly patients take longer, with only 87% leaving departments within four hours, compared to 94% of other adults. However, elderly patients are far more likely to be admitted (nearly 50%) compared with other adults (18%). When this is taken into account, the differences are much smaller and show that 81% of elderly patients are admitted within four hours – almost as much as the 83% for other adults. The principal factor that affects time spent in A&E is more to do with whether patients need to be admitted, rather than their age.

When the initial one hour wait figures are examined, patients who are subsequently admitted are seen somewhat more quickly than discharged patients – 62% and 56% respectively are seen within one hour. This suggests that more serious patients are being given some priority. There is no difference between the time taken to see elderly patients and other adults. This indicates that the slightly longer times that the elderly subsequently spend in A&E departments are more to do with the complexity of assessing and treating them, rather than any possible neglect.

### Observation wards and clinical decision units in A&E departments

Many A&E departments have their own wards usually referred to as observation wards or clinical decision units<sup>12</sup>. The aim of such units depends on local policy, but is usually to allow patients to be fully assessed on arrival and, where possible, discharged directly from the unit after 24 or 48 hours or so, but if necessary to

be admitted to an inpatient ward. There is evidence<sup>13</sup> that such units help to shorten the total length of stay. Since 2003, all short stay units that patients are admitted to from A&E have to be of an equivalent standard to main inpatient wards. The Department of Health has issued guidance on the standards to be met, known as 'SITREP' standards. These standards stipulate, amongst other requirements, that they must have catering facilities and provide adequate privacy and dignity for patients.

Approximately 45% of A&E departments have their own wards or units and in one third of these units, more than 10% of patients stay for longer than 48 hours. Also, in a third of units, 50% or more of their patients are admitted into a hospital bed rather than discharged. Such units will be most effective in trusts that have a good bed management system, and those trusts with long lengths of stay or higher admissions than planned, should examine their overall bed management policy.

This analysis refers solely to units in A&E departments that are within the scope of this review. However, patients who need to be admitted to a hospital bed in an emergency (or those who may need to be admitted) can follow various pathways, depending on their needs, the facilities available in the trust and the trust's policies. Many trusts have assessment or admission units to which patients are admitted directly, without passing through A&E, often when referred by their GP. These units are usually outside the control of the A&E department and are beyond the scope of this report. The various routes taken by patients who are admitted will be examined in detail next year in the portfolio review on admissions to hospital, particularly with reference to the quality of care.

<sup>12</sup> The terms 'ward' or 'unit' are used interchangeably in this context. We have used the term 'unit' because it is more frequently used and it distinguishes this kind of facility from an inpatient ward.

<sup>13</sup> *Reducing Attendances and Waits in Emergency Departments: A systematic Review of Present Innovations (draft report)*, (University of Warwick 2004)



# Treatment of children in A&E departments

Approximately 40% of general A&E departments have separate facilities for children that are staffed 24 hours a day. A further 20% have separate facilities, but are only staffed for part of the day. The remaining 40% of departments report no separately staffed facilities for children.

There are separate issues that apply to children, because they require more specialised facilities and skills if they are to have access to a high quality service. There are only a few specialised children's A&E departments. Some are separate children's departments in a general trust, for example the Children's Hospital, Lewisham, which is part of Lewisham Hospital NHS Trust, and some are A&E departments in trusts catering exclusively for children, for example Sheffield Children's Hospital. However, as most children are treated in general A&E departments, the analysis below covers all departments but compares them with the specialist departments where appropriate.

In the average A&E department, children up to and including the age of 15 comprise 22% of all patients and in four departments, more than 30% of patients are children. At the other extreme, there are 10 departments with children comprising less than 5%, which tend to be in areas served by a specialist children's A&E, for example Sheffield Teaching Hospitals NHS Foundation Trust. Overall, children are treated and admitted slightly more quickly than average - 61% see a doctor in one hour against 56% of all patients, and 95% are admitted within four hours against 83% for all patients. Admission rates are lower at 11% against an average of 19%, showing that children are less likely to require admission than adults.

There is some evidence that the specialist departments provide a better service for children. The clinical audits for children in pain reported above showed that in these departments, 83% of children in pain received analgesia within one hour of arrival, whereas in other departments only 52% did. On the other hand, the figures for waiting times to see a doctor and the time spent in the A&E department waiting to be admitted were virtually identical with those found in general A&E departments. Admission rates are also very similar between specialist and general A&E departments. Approximately 40% of general A&E departments have

separate facilities for children that are staffed 24 hours a day. A further 20% have separate facilities, but are only staffed for part of the day. The remaining 40% of departments report no separately staffed facilities for children. It might be expected that large departments would find it easier to provide special facilities for children, but there is no evidence from the data that special facilities for children are more prevalent in large departments. Small departments are just as likely to have special facilities as large ones and they are just as likely to be open 24 hours a day.

It might also be expected that departments seeing a high percentage of children would make a point of having special facilities and keeping them open. Most departments having children comprising more than 25% of their patients do have facilities open 24 hours a day. However, six such departments do have separate facilities, but they are only opened when required and not at set hours. It is therefore important that these departments ensure that they are fully meeting their demand.

The 2004 National Audit Office report on emergency care expressed concern that many A&E departments have gaps in the availability of specialist staff to treat children. We found that in the average department, 6% of the nurses are specialist children's nurses, and there was a tendency for departments with a high proportion of children to have more children's nurses. However, despite the general trend, four departments with children comprising more than 25% of their patients reported having no specialist children's nurses. Departments may be deploying general nurses who have received additional training for treating children, and who are not covered in the survey; this would be in accordance with the National Service Framework for Children.

In specialist departments, all nurses are specially trained children's nurses, but their overall levels of nursing staff are similar to the levels for general departments in relation to the number of patients.



# Staffing

Small departments appear to be just as efficient with regard to staffing as large departments.

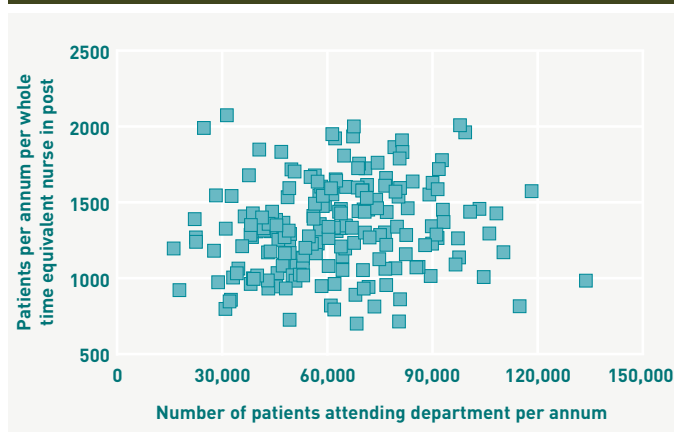
## Current performance

A shortage of resources, in particular of clinical staff, is a frequently cited reason for poor performance and quality from A&E departments. The key staff are mainly doctors and nurses, but they need support from a range of other people such as clerical staff, porters and other professional staff. This section looks at staffing in departments and ways in which this might affect performance.

Larger departments tend to have more staff on average than smaller ones, as one would expect. But for comparability, staffing levels need to be expressed as a ratio between actual staff numbers and the numbers of annual attendances (a reasonable measure of the size of a department). When expressed in this way, there is no relationship between times spent in A&E and staffing levels. Tightly staffed departments perform as well as generously staffed departments. This is consistent with the findings in the 2000 review.

There is also no association between staffing ratios and the size of department. Large departments have just as many staff, relative to the numbers of patients, as small ones (see figure 13). Thus, small departments appear to be just as efficient with regard to staffing as large departments.

**Figure 13: Size of department vs workload of nurses**



Source: A&E portfolio, 2004, England

## Absence and sickness

The absences of nurses due to sickness are on average 5.1% of total time, which is lower than the 6.8% for nurses in general, reported in the companion acute hospital portfolio report on ward staffing. This may be at least partly explained by the richer than average skill mix found in A&E departments who have, on average, 88% qualified nurses.

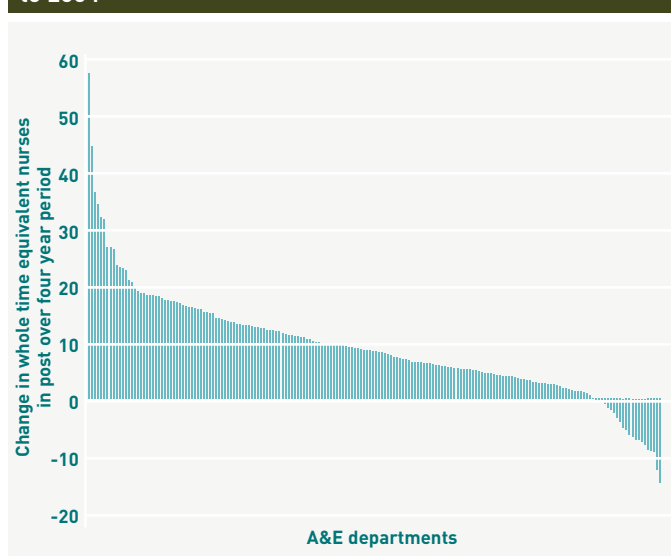
There is no regional variation for sickness absence, but there is a variation for vacancy levels. On average, 8% of established posts were not filled at the time of the survey, but in London this rises to 16%, which is consistent with the ward staffing report. The high vacancies would imply higher uses of bank and agency staff, which may account for the poorer perceived quality of care and performance in London A&E departments. This relationship is examined in detail in the companion report on ward staffing.

## Trends in staffing

Since 2000, there has been a substantial increase in staffing levels in A&E departments. On average this has been 20% for nurses, 27% for doctors and 37% for consultants, cumulatively over the four year period. Not only have the numbers increased, but the seniority of staff has also increased. The number of doctors has been increasing for many years, so this continues and even accelerates the trend. However, the increase in the numbers of nurses is a new and welcome feature, but it should be noted that despite the overall trend, a few departments report having fewer nurses than in 2000 (see figure 14).

This increase in staff numbers has been partly offset by increases in attendances at A&E departments. However, it still leaves a significant reduction in average numbers of patients treated per nurse or doctor.

**Figure14: Change in numbers of nurses in post, 2000 to 2004**



Source: A&E portfolio, 2004, England

The 2001 Audit Commission report on accident and emergency recommended that greater use should be made of emergency nurse practitioners (ENPs) to ease the load on doctors, allowing them to concentrate on the more serious cases, and to improve care for those with less serious conditions. In 2000, there was very little deployment of ENPs – only 16 departments treated more than 10% of their patients this way. However, since then, pressure to speed up treatment of all patients, including the more minor cases, has prompted departments to make more use of ENPs, so that now 76 departments treat 10% or more of their patients using ENPs. However, there are still many departments who treat none, or very few, of their patients in this way, so there is still a lot of opportunity to develop this practice.

## Does staffing affect performance?

Common sense would suggest that a large part of the improvements in times spent in A&E departments since 2000 has been due to the increases in staff. However, when comparisons are made at individual department level, there is no association between relative increases in staff and improvement in times spent in A&E.

Anecdotal evidence suggests that increases in staff can improve performance, but the fact that this relationship is not general shows that extra staff are only likely to yield beneficial results where the purpose of the extra staff is very tightly focused, for example where a particular problem or bottleneck has been identified.

# Minor injuries units and walk-in centres

Ninety four per cent of patients in minor injuries units and walk-in centres see an emergency nurse practitioner within one hour of arrival, compared to the equivalent figure of 56% for a main A&E department.

Minor injuries units and walk-in centres have grown in numbers and importance in recent years as part of the Department of Health's strategy of providing a variety of emergency services to meet the needs of different patients. Data was collected from 115 units in England with a minimum threshold of 10,000 patients per year. The median number of attendances was 20,000 per year and the largest was 50,000 – comparable with a medium sized main A&E department. These numbers testify to the significance of these units in overall emergency care provision, accounting for more than 20% of total attendances.

Thirty eight units are minor injuries units managed as part of an acute trust. They are either attached to the main A&E units, in which case they see the patients in that A&E with relatively minor needs or they may be separate from the main A&E department, providing emergency access in locations where there is no main A&E nearby. The other 77 units are self standing and are financed directly by their primary care trust. Although separately financed and independently managed, they may still work closely with their local A&E department and may be co-located with it.

Minor injuries units and walk-in centres treat relatively more adults than main A&E departments. Children and the elderly each account for only 10% of patients, about half the proportion in main departments. Thus, not only do these units treat less serious conditions, their patients are probably less complex as well.

## Times spent in units

In general, minor injuries units and walk-in centres provide an effective service with good performance. Waiting and total times compare very favourably with main A&E departments, but this is to be expected bearing in mind that they treat less complex patients. Virtually all patients leave units within four hours of arrival (the Department of Health target applies to them as well), and 94% see an emergency nurse

practitioner within one hour of arrival, against the equivalent figure for a main department of 56%. However, there are still some poor performers. In the lowest 10%, only 57% of patients, on average, see an emergency nurse practitioner within one hour.

## Staffing

Staffing seems to be less of a problem in these units than in main departments. Vacancies average only 4% and absence due to sickness is only 3.6%. The mix of skill in these units is high – 82% of the nurses are F grade or above compared with 34% in main departments. In most units, the clinical lead is a nurse. Very few doctors are employed – when they are it is typically a GP on a sessional basis.

## Costs

The average cost per patient treated in one of these units is £20, approximately a third of the average for a main department, which is at least £60 per patient. It is not possible to separate the cost of treating patients with minor problems in a main A&E department, but this figure indicates that minor units are likely to be cost effective.

## Management

Many of these units welcomed this review because it helped to make them more visible and for the first time, has provided some performance figures that can be used to make comparisons both amongst themselves and with main departments. Bearing in mind the increasing contribution that minor injuries units and walk-in centres are making to emergency care and that they are subject to the Department of Health's four hour target, continuing this monitoring is essential – they must be brought into the main stream.

Some of these units were quite unaccustomed to gathering and reporting any data of this kind routinely and, while often appreciating its value, had great difficulty in providing the limited data requested. Moreover, some units did not have their own budgets, making it impossible to assess the cost of providing their service. There is a need for primary care trusts to examine their procedures and ensure that all units providing emergency care have separately identified budgets and are monitored for activity and performance, in line with the recommendation of the 2004/2005 report of the Public Accounts Committee.

# Conclusions

The indicators for quality of clinical care for hip fracture, paracetamol overdose and pain in children show widely varying performances between trusts, with many failing to meet the standards set out by the British Association of Emergency Medicine. Nevertheless, very useful improvements took place as a result of the audits.

The perceptions of patients of the quality of care in A&E were assessed from the national survey of patients. In general, perceived levels of satisfaction are high. There is evidence that patients perceive higher satisfaction with departments that are smaller than average and which have lower than average nurse vacancies. London departments are viewed somewhat less favourably than those elsewhere in England.

Times spent in A&E are also very important to patients. They have improved significantly since 2000. The departments with the longest times in 2000 have improved the most, including marked improvement in London departments. Many departments are now meeting the Department of Health standard that 98% of all patients should leave departments within four hours of arrival. However, patients who are admitted are still at higher risk of a long stay in A&E. This risk is highest where the department's performance against the four hour target falls below 98%.

Children are treated more quickly than adults. The quality of care for them is better in specialised departments but in general, waiting times are similar. However, some departments that treat significant numbers of children lack specific facilities or do not have children's nurses.

Employing more staff does not, on its own, necessarily lead to improved performance. Many departments, particularly in London, are under-staffed and may lack the particular skills such as those held by emergency nurse practitioners and children's nurses.

Minor injuries units and walk-in centres have become a significant force in emergency care, accounting for more than 20% of all attendances and provide a rapid, low cost service for non complex care. However, in a few units patients can still experience delays of more than one hour to be seen before treatment starts. Many of them have further to go in embedding systematic performance monitoring and budgeting.

# Recommendations

**NHS trusts** responsible for A&E services should undertake regular monitoring of clinical care along the lines of the methods and indicators developed in this review that cover pain in children, hip fracture and paracetamol overdose.

The scope of these measures could also be extended to other conditions such as asthma, major trauma and fever in children, based on the standards set by British Association of Emergency Medicine.

Waiting times are also important to patients and the **Department of Health** should continue to monitor times spent in A&E and ensure that the recent improvements are consolidated, as also recommended by the Public Accounts Committee. Performance management of A&E at all levels (**strategic health authorities and NHS trusts**) should include both quality and time spent in the department. The measures of times should include waiting time to see a doctor (or emergency nurse practitioner) and the total times spent in A&E by those patients who are admitted, as well as the percentage of all patients leaving the department within four hours.

For minor injuries units and walk-in centres, measures should be established for the times spent by patients that better reflect the services they provide. A measure of waiting time to see a doctor or nurse practitioner applies equally in these units, but the four hour total time in the department standard does not discriminate adequately between good and poor performers because most patients are treated and discharged much sooner than this. There is also a need to further develop budgeting and performance monitoring systems in these units.

**NHS Trusts** should review their services for children if they do not provide separate children's facilities to ensure that the special needs of children in A&E are being fully met. Where the numbers of children attending do not justify specialist children's nurses in the A&E department, there should at least be access to general nurses who are trained and experienced in dealing with children.

**Strategic health authorities and NHS trusts** need to ensure that additional staff employed in A&E are deployed efficiently and effectively. When funding is made available for extra staff, it should be to fulfil a specific purpose. Achievement of this purpose should then be monitored subsequently. Trusts should also seek to fill vacancies as quickly as possible and minimise the use of bank and agency nurses or locum doctors. Emphasis should be given to recruiting and training for particular skills that may be lacking, for example emergency nurse practitioners and nurses trained to treat children.

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