NHS
North East and North Cumbria

NENC Urgent Emergency Care Quality and Safety process

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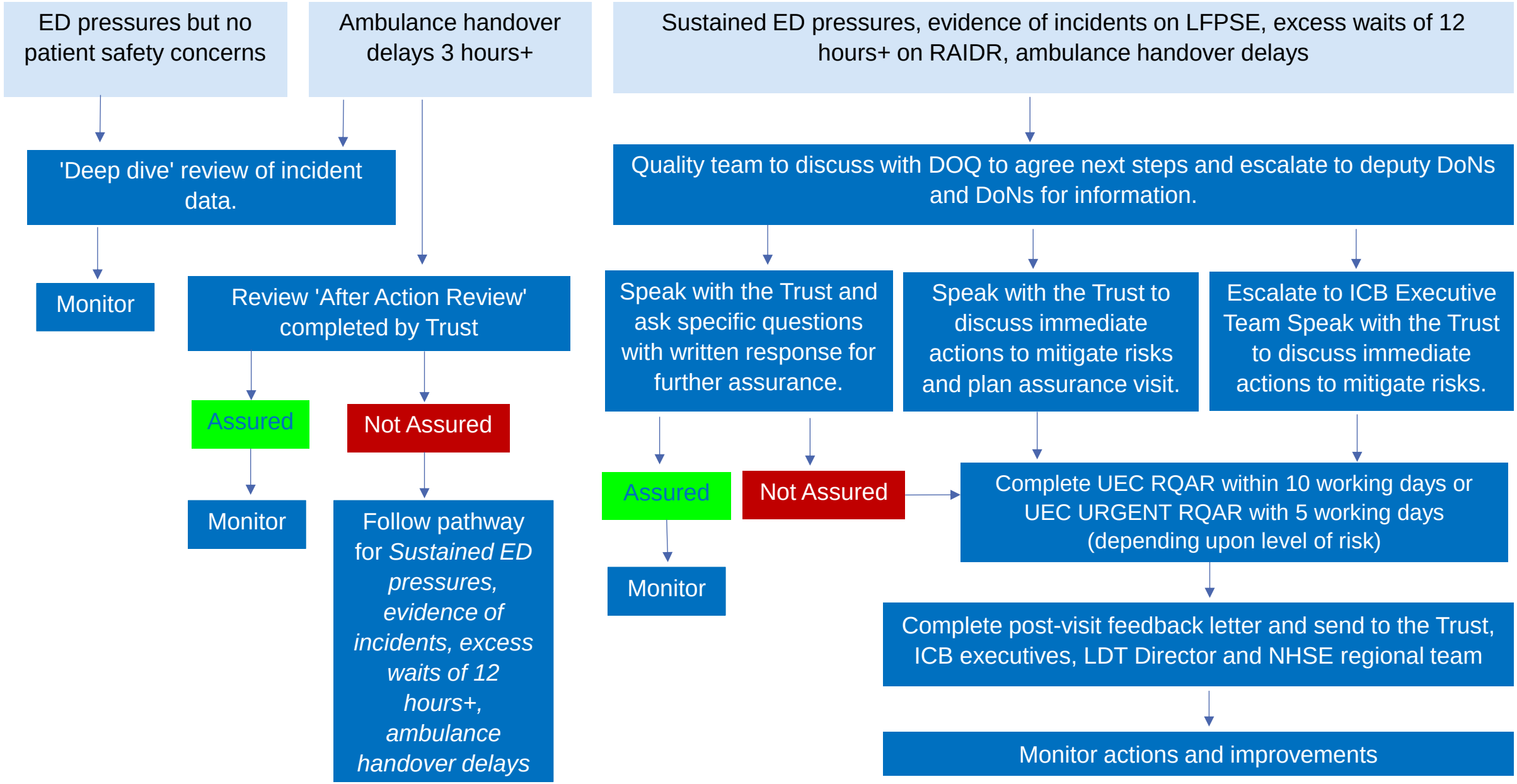
High quality and safe care for all

Context

- Since July 2024 monitoring incidents through learning from patient safety events (LFPSE) system
- Weekly executive summary of incidents
- Developed a patient safety incident dashboard
- Joint working between our system co-ordination and quality teams
- Royal College of Emergency Medicine (RCEM) data- 12 hour waits in ED.
- Nationally quality and safety in ED identified as an absolute priority area.

Urgent Emergency Care Process



Themes

Trusts not always incident reporting – 12 hours stays in ED– exposed risks of harm.

- Treatment delays, privacy, and dignity, management of deterioration.
- Lack of treatment in emergency departments before transfer to wards
- Ambulance delays impacting on risks to patients at home
- Significant capacity issues within departments
- Flow out of departments because of challenging discharge processes.
- High acuity of patients.
- Infection – Flu, norovirus.
- Staffing – sickness, no availability of impact nurses, staff from other areas.

Sharing the process and our learning

- Weekly executive summary report of incidents
- Shared in the system with Chief Nurses and Urgent Emergency care network strategic board.
- Summary of key themes and trends from incidents,
- Weekly meetings, with trusts to share early learning and good practice,
- ICB shared our approach with NHSE and the other ICB’s in Yorkshire and Humber
- Seen as an exemplar of good practice