RCEM
Royal College of Emergency Medicine

Infection Prevention and Control

2022-2023

RCEM National Quality Improvement Programme

National Report

Published: February 2024

Contents

Foreword

Dr Adrian Boyle, RCEM President

I am pleased to report on the performance of Infection Prevention and Control (IPC) measures in UK Emergency Departments from October 2022 to October 2023.

This Quality Improvement Programme (QIP) builds on two previous cycles of the IPC QIP, completed in 2020-21 and 2021-22 by the College. It is the concluding report for this QIP's three-year period; the enclosed report analyses the results from 2022-23 cycle and discusses the QIP's findings across all three years.

The QIP standards were focused on both organisational policies and clinical care, gathering data on over 65,000 patients in its three-year period. The results show that over the QIP's three-year period, performance has dropped across all the QIP's standards and time to isolate patients has increased nationally. In some instances, performance has dropped by over 20% across the three years, highlighting the need for trusts and hospitals to return to placing IPC at the top of their agendas as was done in the COVID-19 pandemic.

The RCEM Quality Assurance and Improvement Committee are committed to continually evaluating the QIPs and improving them to best support you and improve patient care. We welcome your feedback, ideas, and experiences to help us do this. The College is dedicated to improving the quality of care in our Emergency Departments through these important QIPs, undertaking all obligations to ensure the best measures of patient safety are obtained.

Dr Adrian Boyle

RCEM President

Dr Dale Kirkwood

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr Fiona Burton

Co-Chair of Quality Assurance & Improvement Subcommittee

Dr James France

Chair of Quality in Emergency Care Committee

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Topic Team

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EM Consultant at NHS Greater Glasgow and Clyde. Fiona is the IPC topic team lead and co-chair of the RCEM QA&I committee. Fiona is a Scottish Quality & Safety fellow graduating with Cohort XI. She has a passion for QI and improving care for her patients.

Dr Catherine A Ward
Dual EM/ ICM trainee in Glasgow, regional TERN Rep and QA&I beginner

Sarah Chadwick
Antimicrobial Resistance Programme Manager at NHS West Yorkshire Integrated Care Board. Sarah trained as a healthcare scientist and has worked in the NHS over 25 years, with a background in both Medical Microbiology and Clinical effectiveness and audit.

Dr Vanessa Bell
EM Consultant at University Hospital Dorset, QI Fellowship Wessex.

John Stokes
Lay Group Representative. John has been working with the college for the past 6 years on various committees as a lay representative, championing the cause of the patient. He is an organisation development consultant with international experience in public and private sectors.

Alexander Royle
Principal Information Analyst, Public Health Scotland and Data Analyst for RCEM QA&I. Alex has worked in the NHS since 2005 and has worked within Information Management for over 10 years.

Lucas Dalla-Vecchia
Senior Quality Officer at RCEM. Lucas has been working at the college for almost four years and is the current administrator for the QA&I Committee.

Hazel Grant

Quality Officer at RCEM. Hazel has been working at the college for a year and supported the IPC topic team's report writing.

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Introduction

Infection Prevention Control: Year Three Final Report

This Year three final report has been generated to provide a national picture across the agreed IPC standards for both 2022-23 and the entire three-year lifespan of the QIP. Our aim is to show the trends over this time-period and allow ED's to reflect on these in the context of the local and national challenges facing our specialty.

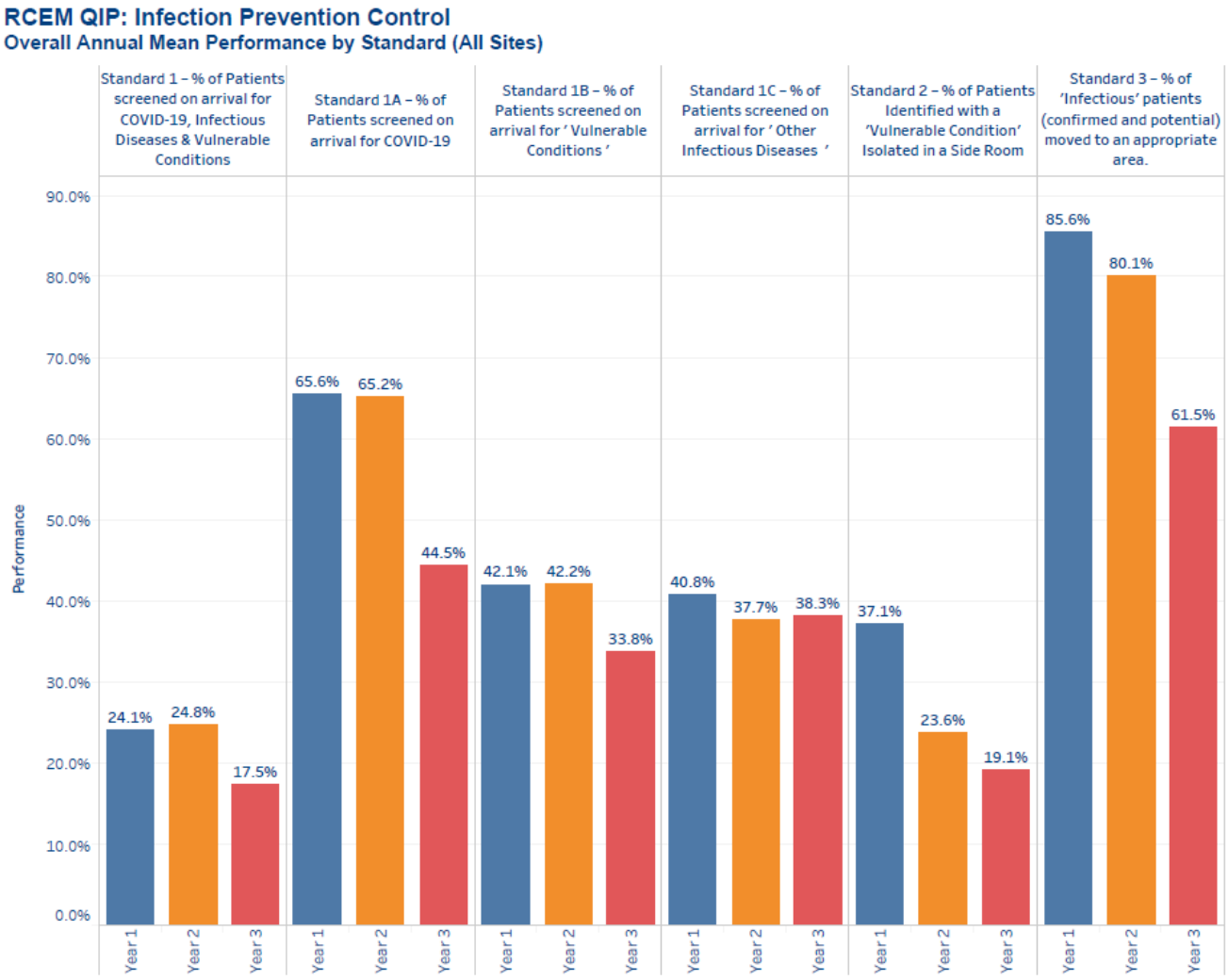
To this end in addition to presenting our normal National SPC charts and Inter-Quartile Range (IQR) charts, we have developed visualisations that will show the overall mean performance per standard over the three-year period and similarly full three-year weekly trend for each individual standard.

It is hoped these new views will help generate discussion within the individual site QIP Team as it means that they will be able to visualise their journey over the three-year QIP.

Our hope is that this will help sites to identify what has worked and what their challenges were, not only in IPC, but in trying to conduct quality improvement. We want to continue focusing on mechanisms to share this learning within the EM community. We aspire to consistently contact centres in the bottom and top inter-quartile ranges to learn more about their processes, how they've achieved their outcomes, encourage them to share their patient stories/learning and support as we can.

Our national QIP programme is new and will continue to develop. We hope you find this report useful and please feel free to contact us on RCEMqip@rcem.ac.uk with any suggestions or questions. We want to thank everyone who has participated and congratulate you on what you've achieved.

Executive Summary - Final Report 2022-23



These are exceptional times in Emergency Departments across the four nations; the fact any Quality Improvement is being conducted is remarkable as staff struggle to get through the day.

Overview

RCEM would like to thank all 127 Emergency Departments (ED) that participated in Year three of this Quality Improvement Project (QIP).

Infection prevention and control (IPC) has always been a key element of high quality and safe care. The topic became even more relevant to our healthcare service due to the COVID-19 pandemic. The aim of this national QIP was to support EDs in maintaining and improving high standards of patient care whilst improving staff experience and outcomes through preventing occupationally acquired infections.

Key Findings

Over the three-year period:

- There has been a decrease in the numbers achieving all the standards except for the percentage screened for other infectious diseases and vulnerable conditions, which has remained relatively static.
- This is most noticeable with a drop of approximately 20% in:
  - Standard 1A - Percentage of patients screened on arrival for COVID-19.
  - Standard 2 - Percentage of patients with a vulnerable condition isolated in a side room.
  - Standard 3 - Percentage of infectious patients moved to an appropriate area.

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Discussion

Recording of relevant negative results is often sub-optimal, making it difficult to identify if an examination/screening has been done when reviewing clinical notes. This can lead to the perception that something has not been done when in fact it has, but not been documented. We believe that this may contribute to the low recorded performance against Standard 1.

For Standard 1A we wonder if the percentage documented in the first two years was higher due to the prevalence of COVID-19 in our departments, IPC measures in place and COVID-19 being woven into every aspect of life. With downgrading of PPE and the focus moving towards other issues, perhaps screening is not as well documented as previously. It is also possible that we are not screening as robustly as COVID-19 is no longer at the front of our minds.

We are seeing a rise in hospital attendances at our EDs with COVID-19. Alongside this rise in presentations, there has been a decrease in the number of healthcare staff receiving vaccinations for both COVID-19 and Flu. It is unclear why this is happening, but we have an increasingly concerning situation for both patients and staff. Staff are still at risk of contracting COVID-19 and long COVID-19 with resultant sickness absence. Vulnerable persons are still at risk from infective people in their environment. Is it possible the population no longer views COVID-19 as a risky virus?

A drop in the performance of Standard 2 and 3 is likely multi-factorial. Routine COVID-19 screening stopped in the UK on the 31st of August 2022, with data collection for year three beginning in October 2022. Departmental footprints changed. In a bid to create more side-rooms during the pandemic, we saw radical changes in configuration, often with expansion out-with normal areas. The 'restorative' phase correlated with year three and departments began to shrink, and side-rooms have disappeared.

It has also been recognised that across the four nations our performance against the four-hour target is at an all-time low. Previously a patient remaining in the ED more than 12 hours was a rare event but now it is a daily occurrence and has been somewhat normalised. Corridor care has returned and, in some departments, call buzzers have been installed in the corridors. The intention is well meaning to enhance patient safety, but it may also be viewed as organisational normalisation of deviance by mandating their EDs must do so. Having any space, let alone appropriate areas/rooms for our infectious and vulnerable patients is a luxury currently. Crowding in the ED '*represents the greatest threat to the timely delivery of emergency care in the UK*'. We cannot ignore the potential impact that being unable to provide adequate IPC measures may have on patient mortality. A recent publication in the EMJ estimated that there is one additional death for every 82 admitted patients whose time to inpatient bed transfer is delayed beyond 6-8 hours. This delay is now commonplace, and patients are coming to harm.

Key Recommendations

- We must continue to raise awareness that COVID-19 is present and real risk to both patients and staff.
- Staff should be encouraged to undertake screening and document the outcomes.
- We must encourage staff to accept vaccinations.
- IPC teams must use their local intelligence to work with each ED to guide PPE and departmental configuration to try and ensure appropriate areas are available to maximise staff and patient safety.
- Organisations must be made aware of:
  - Mortality Data for Long Waits in the ED
  - 'Right Place, Right Care – Learning the lessons from the UK crisis in Urgent and Emergency Care - RCEM, 2022'.
  - 'The Management of Emergency Department Crowding - RCEM, 2024'.
- RCEM recommends sharing this report with the clinical audit and/or quality improvement department, departmental governance meeting, ED Clinical Lead, Head of Nursing and Medical Director as a minimum. Without having visibility of the data and recommendations we cannot expect to see improvements in practice.

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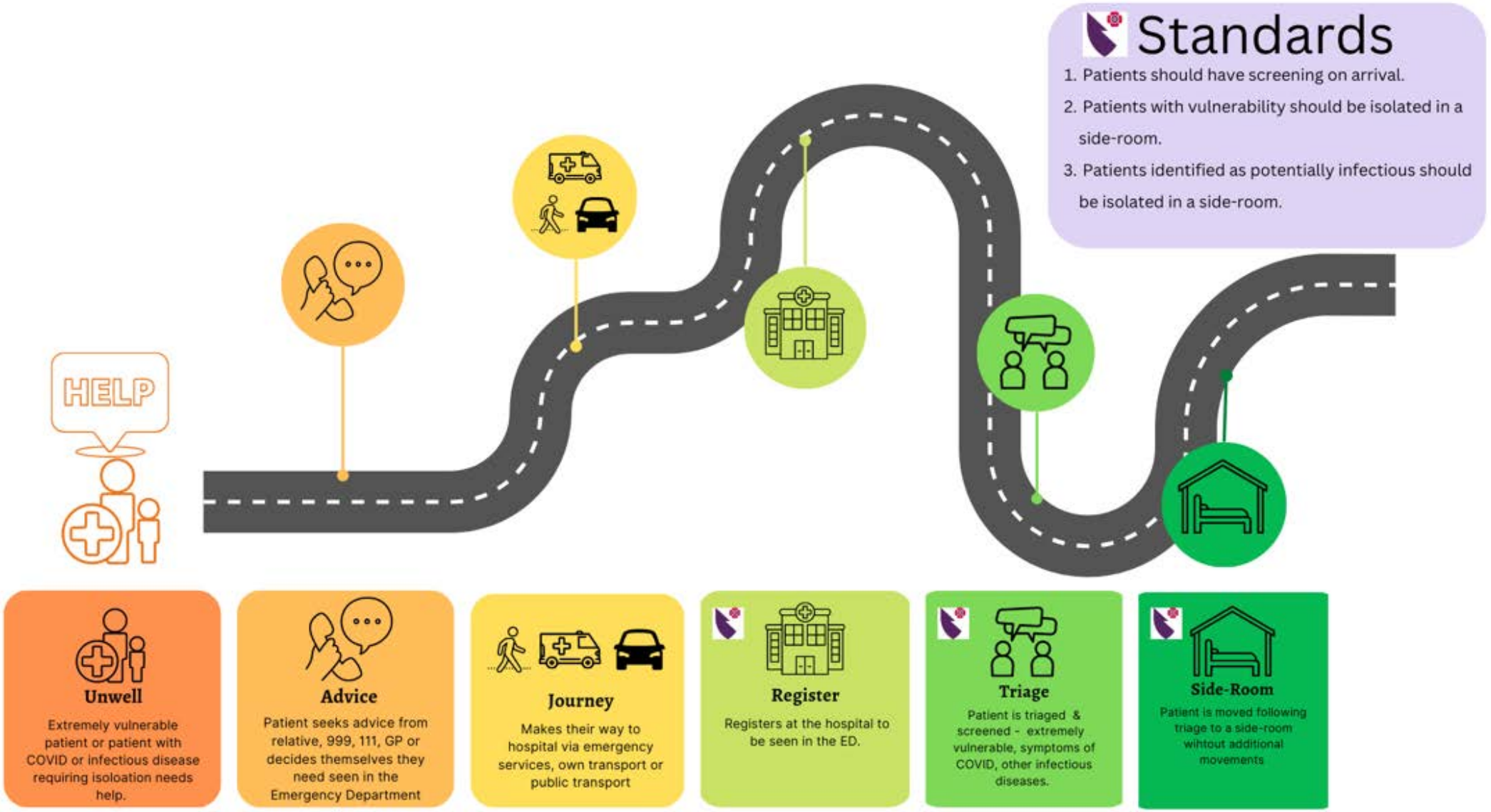
Patient Journey



Case Study – Helen's Story

Based on real patient experiences in UK emergency departments.

Helen, a 32-year-old pregnant woman, arrived at the emergency department in January 2022. She presented with symptoms of altered mental state, headache, and mild diarrhoea. She had gestational diabetes and recently experienced cold-like symptoms with shortness of breath.

When Helen arrived, isolation cubicles for high risk and vulnerable patients were full, so she was directed to wait in the communal waiting area for triage. She had received her first COVID-19 vaccine well over a year ago but had not completed the regime or received any boosters. Despite the hospital's request to wear masks in clinical areas, there was now no national requirement to wear a mask and Helen chose not to.

Whilst the department was busy, Helen was triaged within an hour, and her medical history revealed hypertension and obesity. She was tested for COVID-19 and admitted to a side room on a ward, where a 'screened for COVID-19 symptoms' checkbox on the triage screen was completed. Within 75 minutes of arrival, Helen was being monitored within a bay; and was admitted to a side room on a ward after 3 hours.

Helen's COVID-19 PCR test came back positive, and her condition worsened over time, eventually requiring intubation and ventilation due to respiratory muscle fatigue.

What could have gone better?

- Capacity and Resources in Emergency Departments
    - During the COVID-19 pandemic, the ED Helen attended had measures in place for the triage and streaming of patients to COVID-19 and non-COVID-19 pathways in department spaces. This aided in reducing the risk of spreading COVID-19 and other infections between patients in the ED.
    - However, by 2022, like many EDs it had merged back into one department. Suspected cases and vulnerable patients were still being isolated in new improved cubicles, but with less capacity in busier times and potentially infectious or vulnerable patients waiting together in shared areas.
- Promoting Understanding of Infection Prevention
    - Early in the COVID-19 pandemic, Infection Prevention was prioritised and promoted to both EDs and the public. Information on shielding, PPE, and vaccinations was widely available and patient awareness of potential vulnerabilities was promoted by the UK Government's shielding letter service.
    - Helen would be classed as clinically vulnerable due to her pregnancy, and would have benefitted from information on her vulnerable status, access and encouragement to routine vaccinations for COVID-19, and protective measures such as masks and side rooms when attending the ED.
    - However, shielding advice was paused on 1 April 2021 and over time patients were less aware of potential vulnerabilities, less likely to have accepted a vaccine or wear PPE, and facing longer waits in busy emergency departments.

Summary Charts of Standards

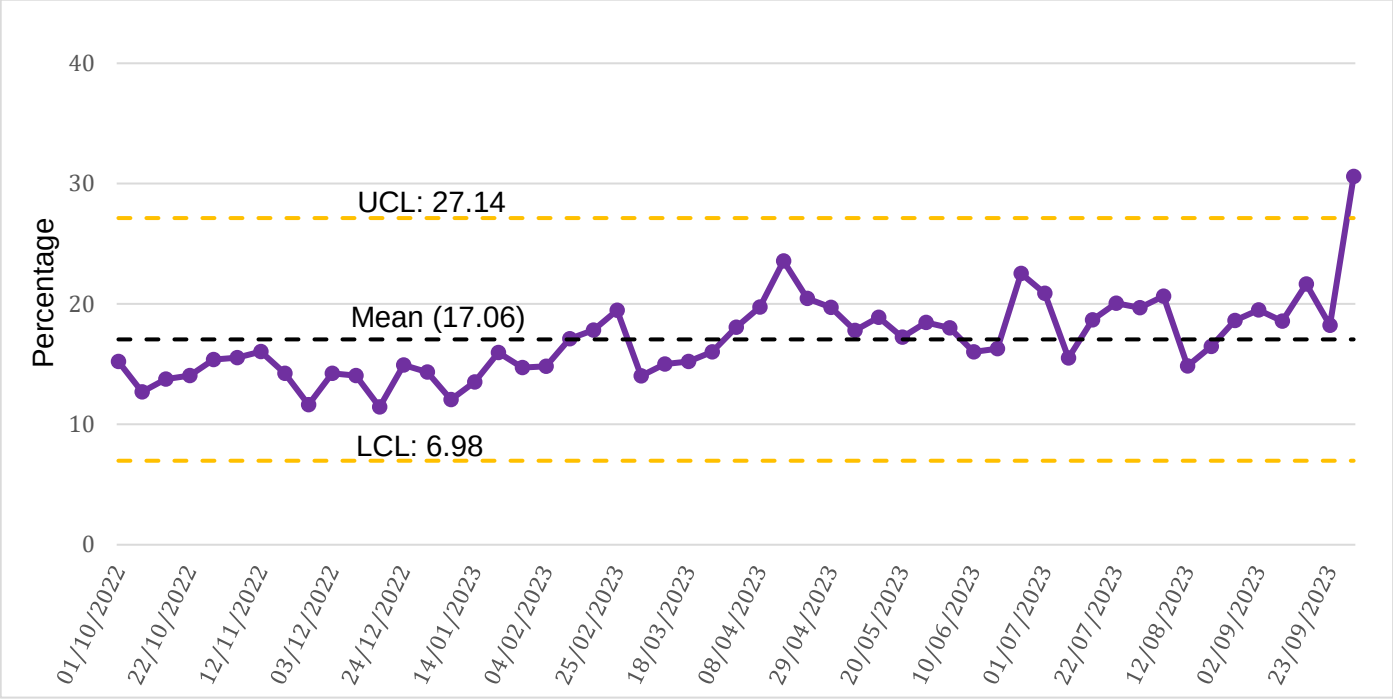
Year Three – 3rd October 2022 – 3rd October 2023

Standard 1 - % of patients screened on arrival (all three specified conditions)

Sample Size = 23144

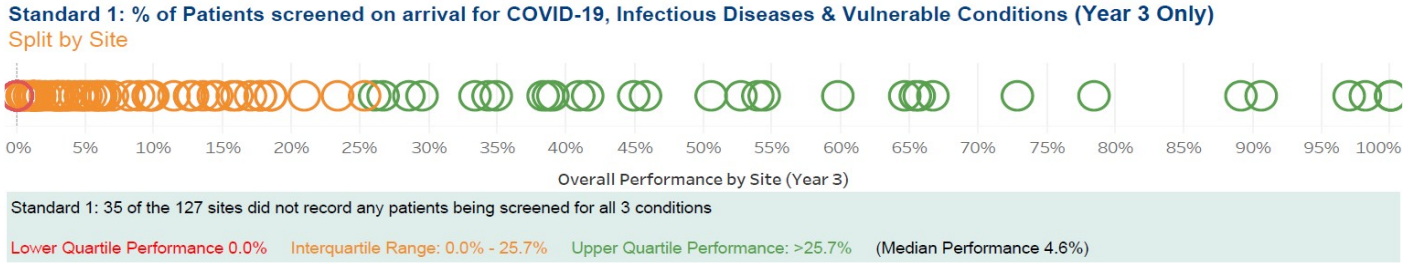
Cases that met the standard = 3906

For inclusion/exclusion criteria, please see the [QIP information pack.]



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

- National average performance was 17% which is a decrease from 25% in 21-22.
- The national weekly trend slightly improved as the year progressed, but from a very low base.
- However, 35 of the 127 sites did not record any patients being screened for all three conditions.
- It is also noted that for 50% of the EDs less than 1 in 20 Patients were recorded as being screened for all three conditions. As per our key recommendations, the importance of record keeping of screening should be highlighted to all staff.
- We know from other QIPs that the last week of data in the collection period is often anomalous and therefore it would be best not to overinterpret this.

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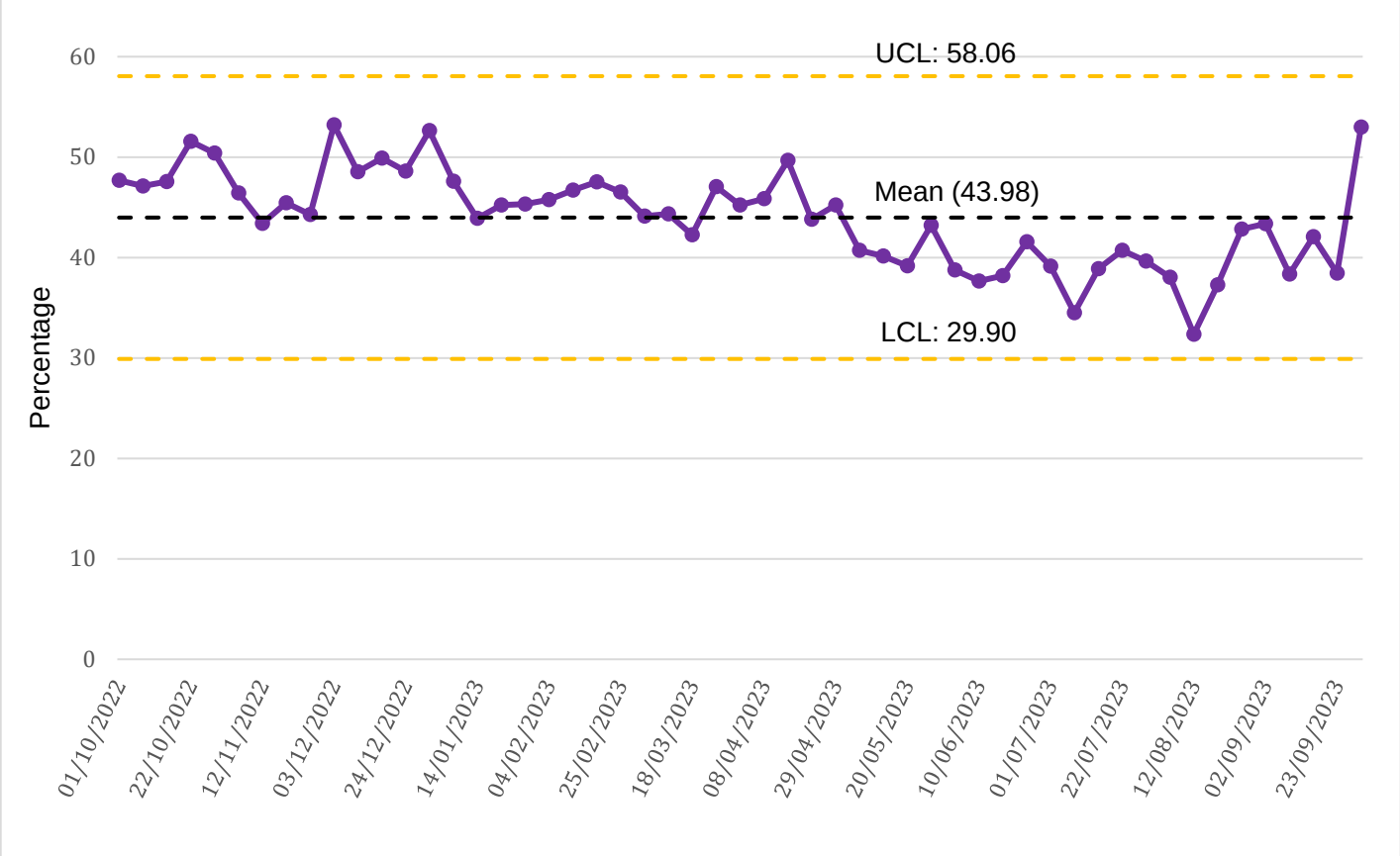
Standard 1a - % of patients screened on arrival for COVID-19.

Sample Size = 23144

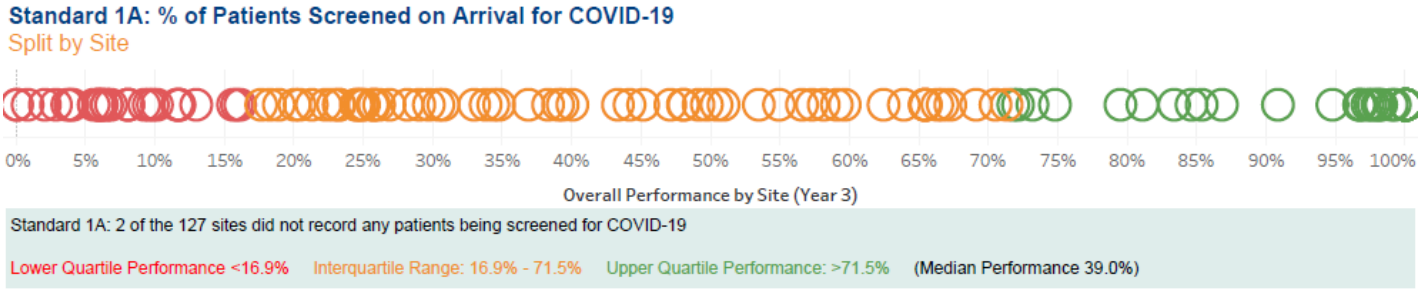
Cases that met the standard = 10398

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

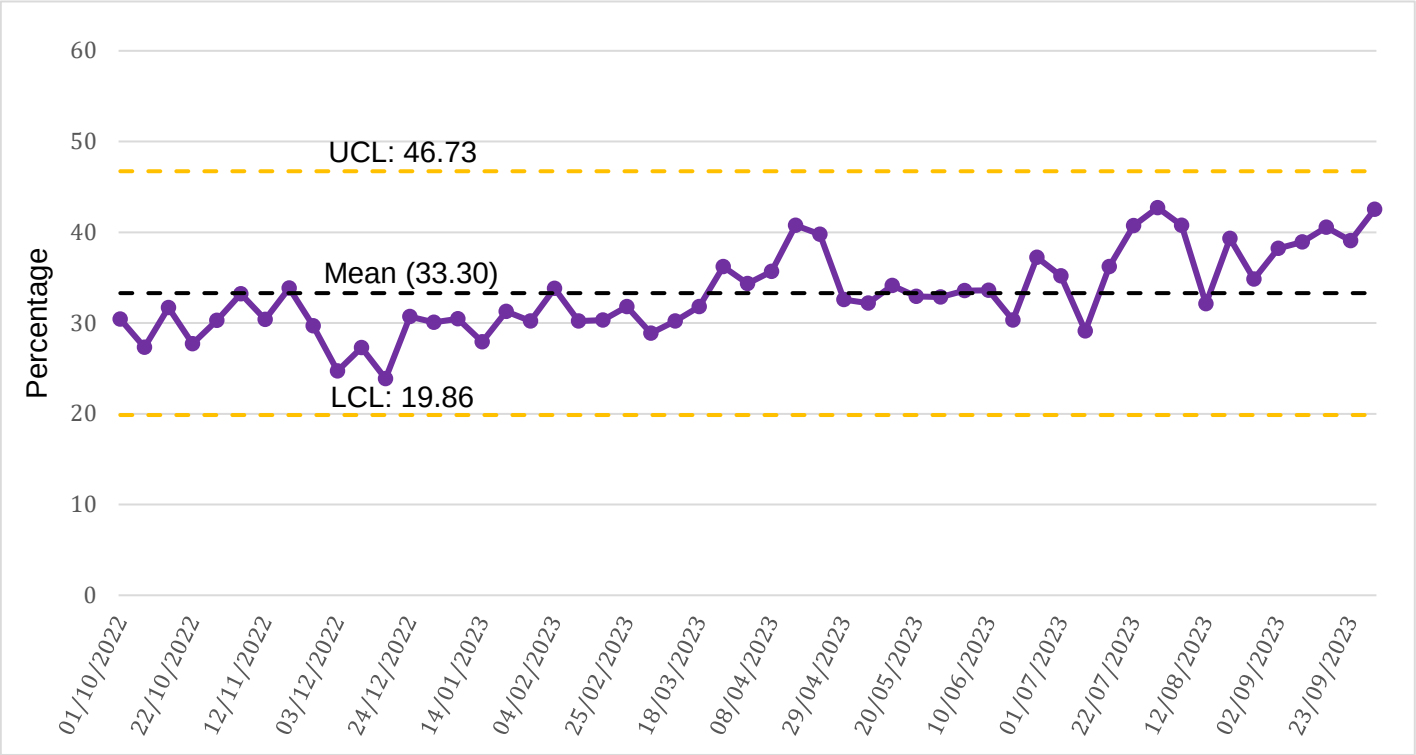
- National average performance was 44%, this is less than 65% in 21-22.
- The national weekly performance trend shows that performance for this standard generally reduced as the year progressed.
- Median performance was 39%, this is less than 69% in 21-22.
- The upper quartile was 72% which means that 25% of the ED's were screening at least 7 out of 10 patients for COVID-19.

Standard 1b - % patient screened on arrival for vulnerable conditions.

Sample Size = 23144

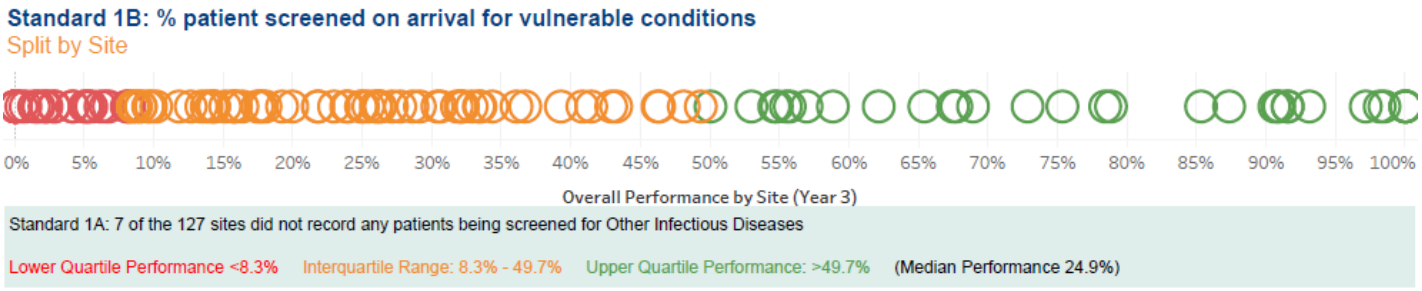
Cases that met the standard = 7681

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

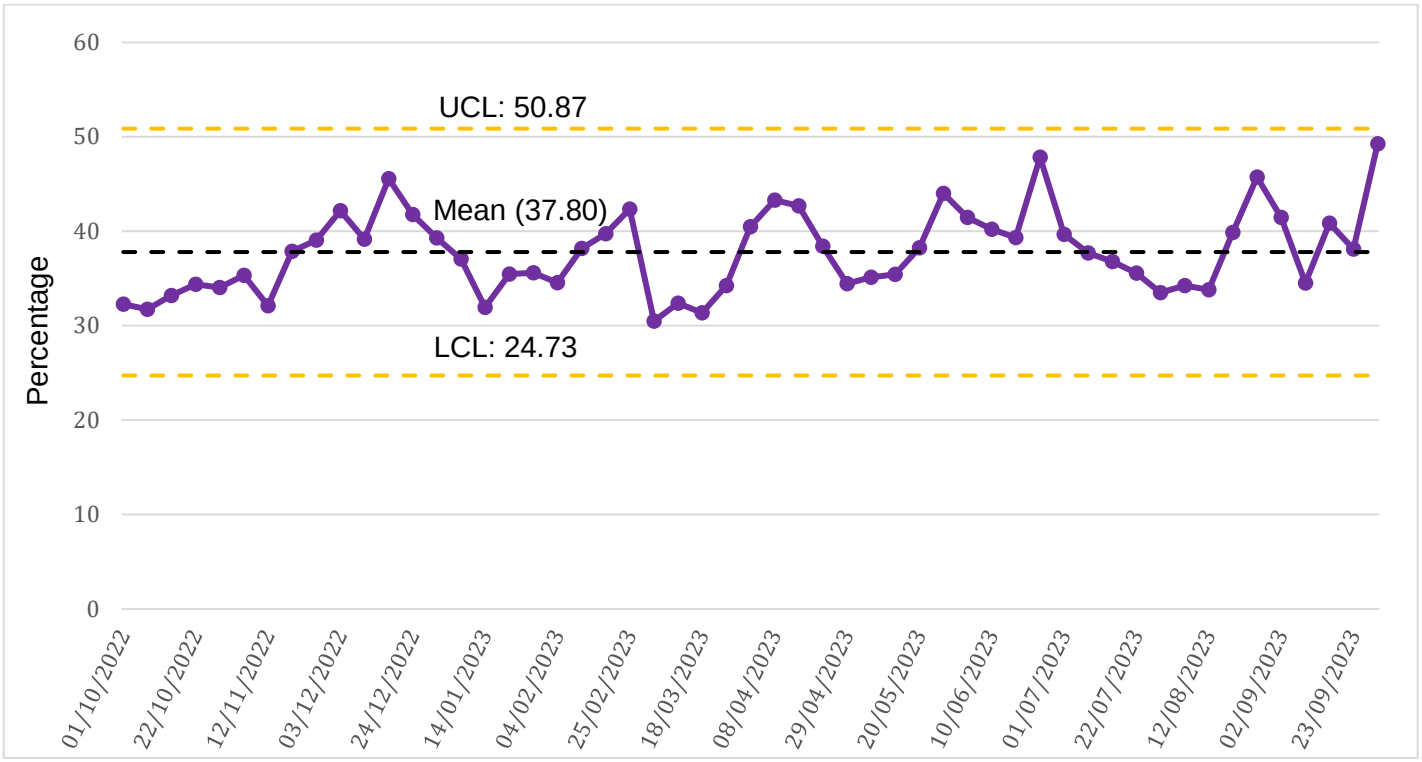
- National average performance was 33%, this is less than 43% in 21-22.
- The national weekly performance trend shows that performance for this standard slightly improved as the year progressed.
- However, it is noted that the median performance of 25% for this year is lower than the 34% in the previous year. This means that for 22-23 at 50% of ED Sites only 1 in 4 patients were recorded as being screened for vulnerable conditions.

Standard 1c - % of patients screened on arrival for other infectious diseases.

Sample Size = 23144

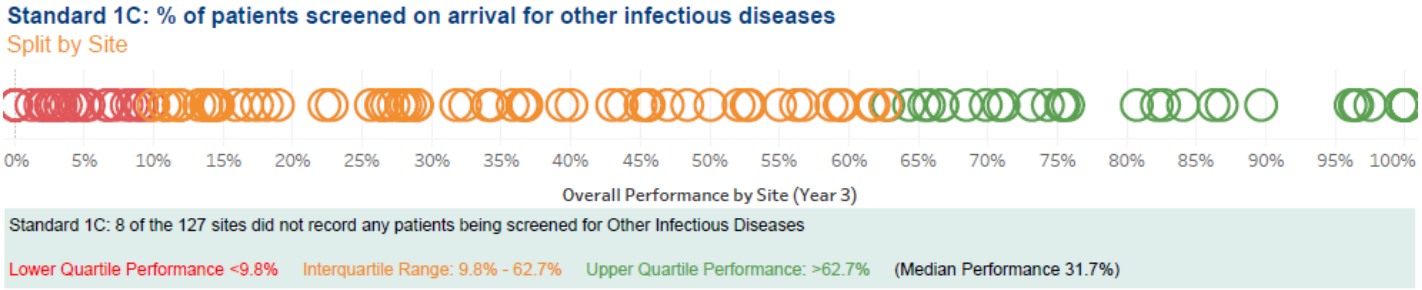
Cases that met the standard = 8783

For inclusion/exclusion criteria, please see the [QIP information pack.]



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

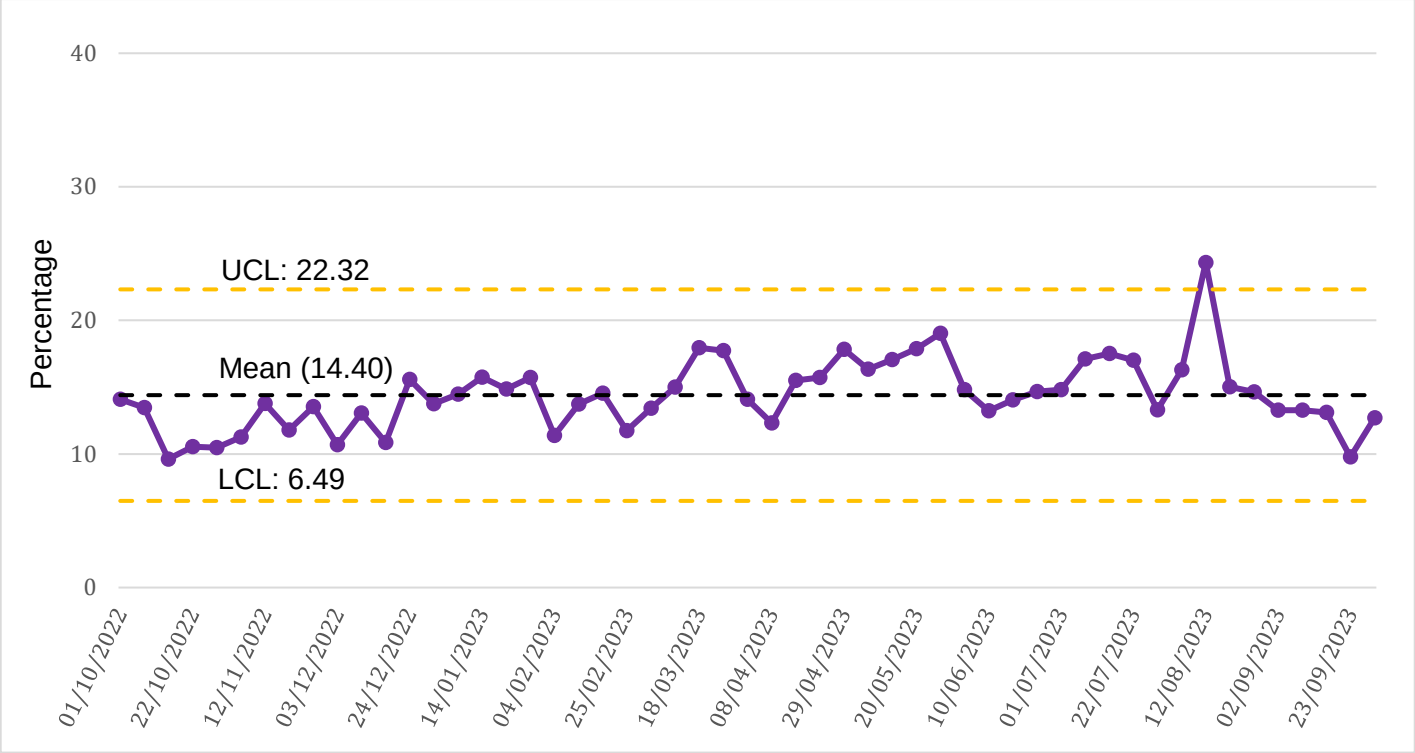
- National average performance was 38% which is the same as 21-22.
- Median performance was 32% which is more than 25% in 21-22.

Standard 1 – No screening undertaken for any of the three conditions.

Sample Size = 23144

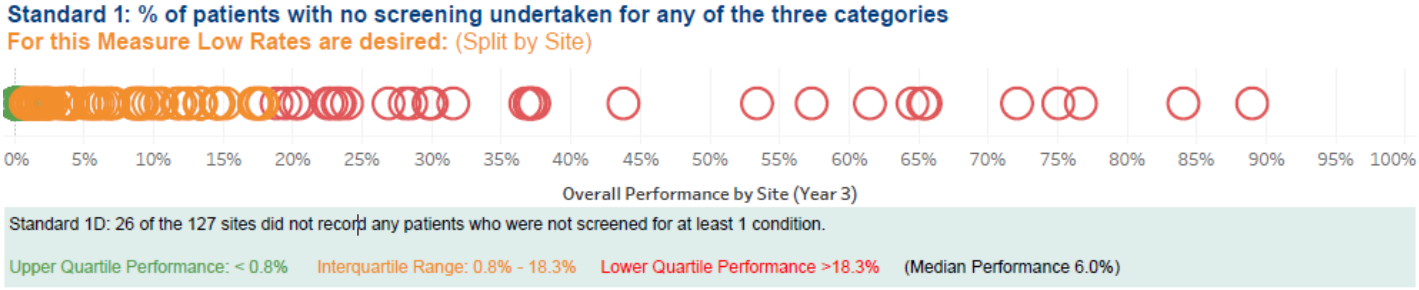
Cases where no screening undertaken = 3283

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

- National average performance was 14%, which is higher than 8.1% in 21-22. For this measure low rates are desired.
- This may indicate that less people are undergoing screening.

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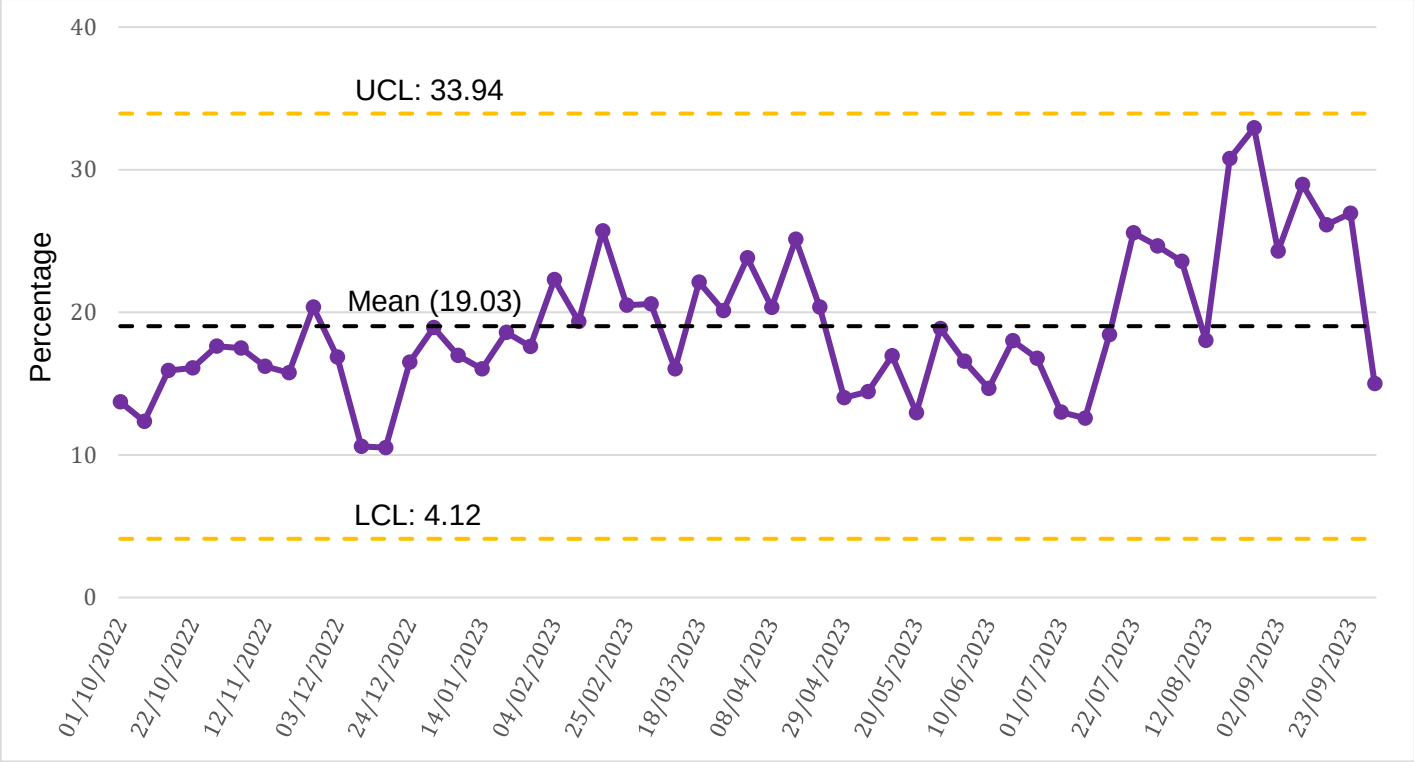
Standard 2 - % patients with identified vulnerability isolated in a side room.

Sample Size = 10738

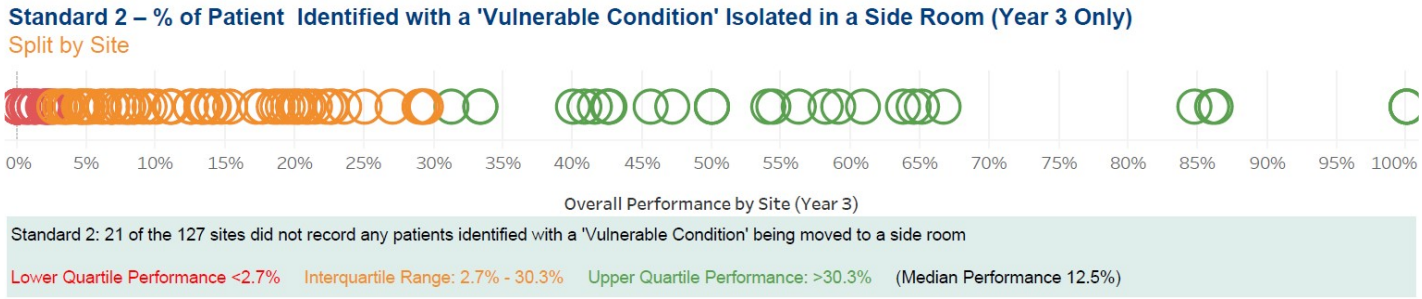
Cases that met the standard = 2015

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

- National average performance was 19%, which is less than 24% in 21-22.
- Median performance has dropped from 17% to 13%
- 5038 cases had 'no evidence' recorded on their data returns. Some of these were potentially in a side room but no evidence could be found.
- For 50% of sites only 1 in 8 patients identified as vulnerable were recorded as being moved to a side-room.

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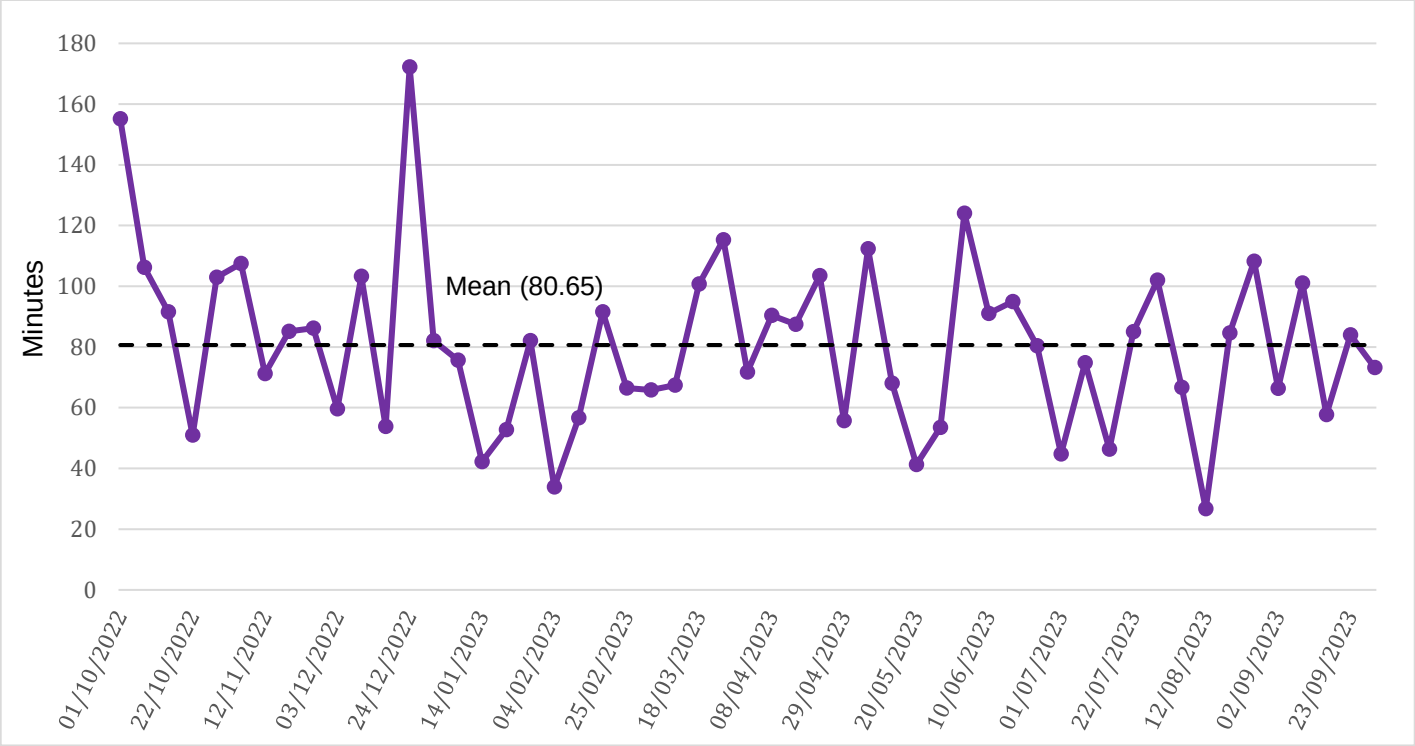
Standard 2 – Average time taken to isolate patient with identified vulnerability in a side room.

Sample Size = 1628

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Commentary

- 1650 of 2015 eligible cases had both the time of isolation and of arrival recorded. Patients were excluded if the recorded time difference exceeded 24 hours; out of 1650 cases, 22 cases were excluded for the time difference exceeding 24 hours. Potentially we have excluded some 'real' waits in excess of 24 hours.
- For 1096 cases the patient was identified as vulnerable, but they were not isolated, and in 171 cases the patient was isolated after being identified as vulnerable, but the time was not known.
- National average performance: 81 minutes, which is higher than 61 minutes in 21-22 and significantly higher than 18 minutes in 20-21.
- Our data is derived from a relatively small number of returns, however this remains concerning.

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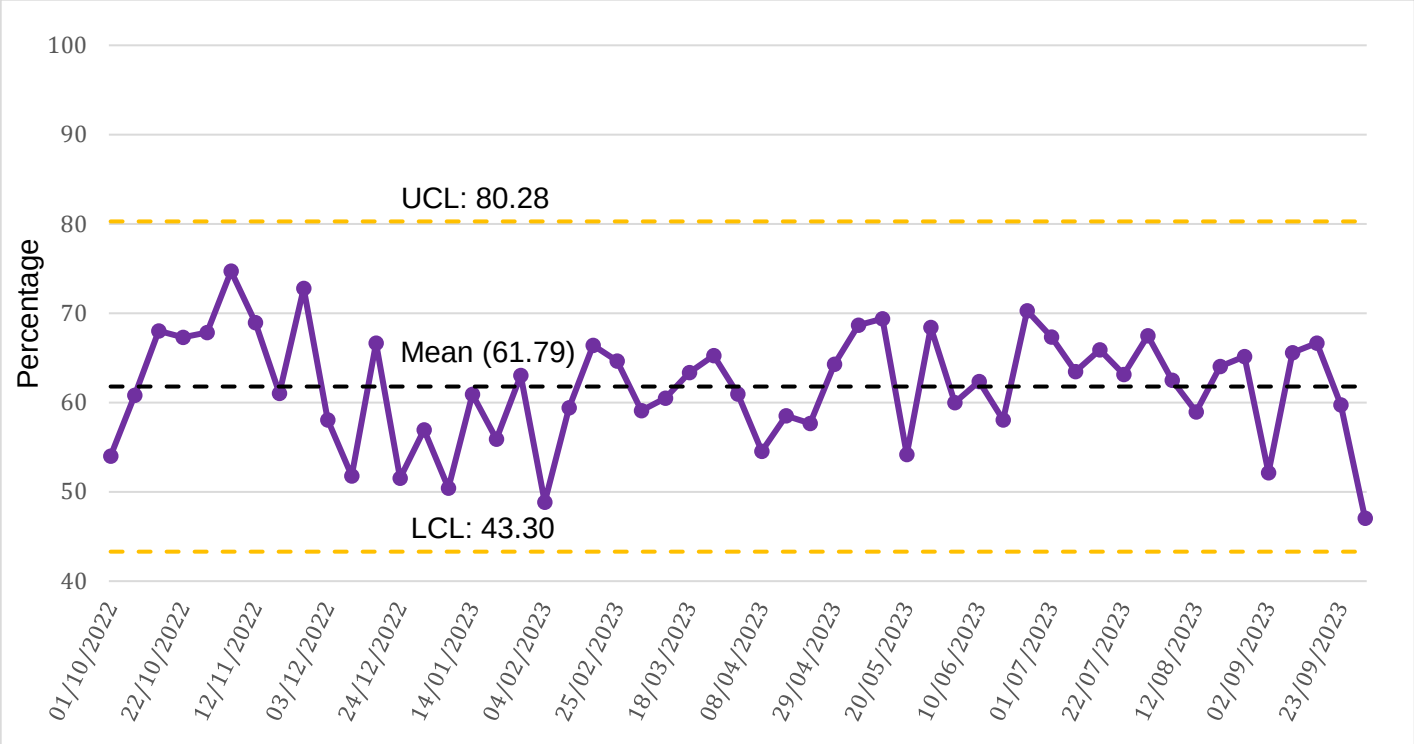
Standard 3 - % of patients identified as potentially infectious moved to an appropriate area.

Sample Size = 4617

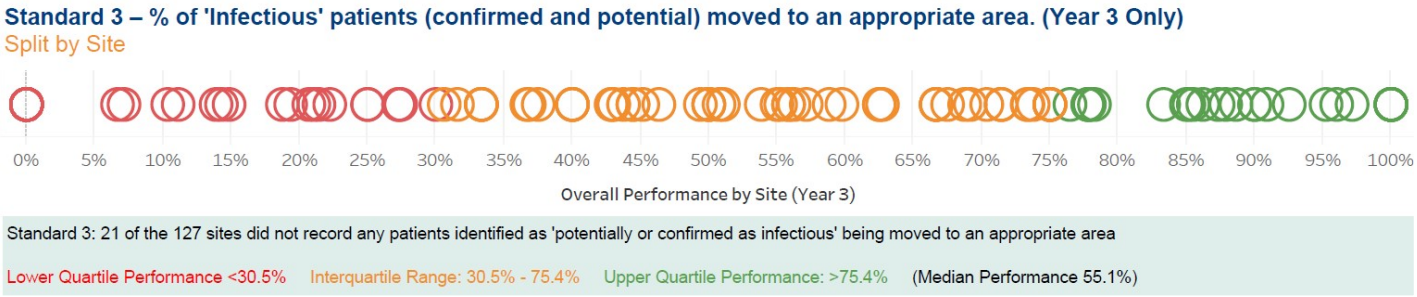
Cases that met the Standard = 2875

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Site Performance



Understanding IQR Charts

Commentary

- National average performance was 62%, which is less than 80% in 21-22.
- Median performance was 55%, which is less than 81% in 21-22.
- This means that 50% of sites were able to move 1 in 2 patients identified as potentially infectious to an appropriate area.

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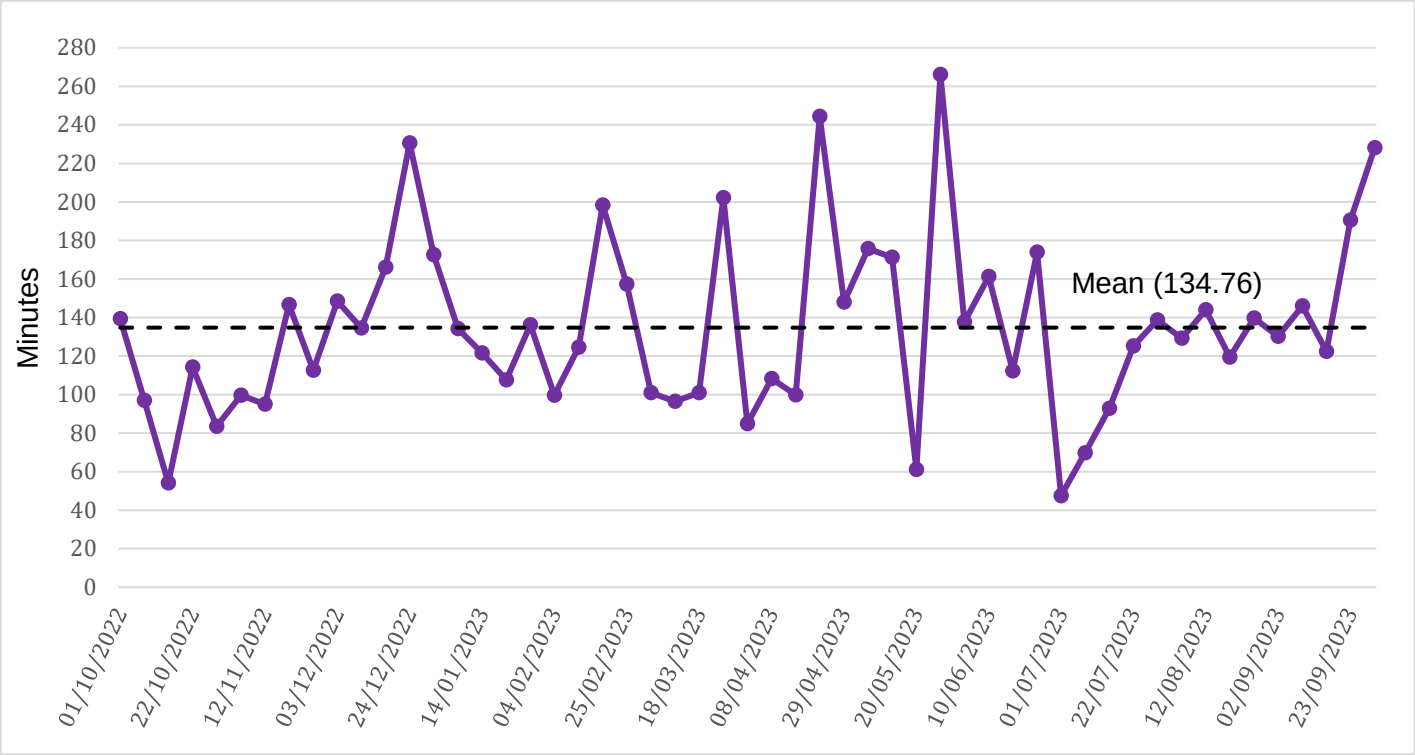
Standard 3 – Average time to move potential or confirmed infectious patient to an appropriate area.

Sample Size = 2409

For inclusion/exclusion criteria, please see the QIP information pack.



Understanding SPC Charts

Commentary

- Included in this sample size is all patients who were identified as potentially or confirmed as infectious and the time of isolation was recorded.
- 2461 of 2875 eligible cases had both the time of isolation and of arrival recorded. Patients were excluded if the recorded time difference exceeded 24 hours; out of 2461 cases, 52 cases were excluded for the time difference exceeding 24 hours. Potentially we have excluded some 'real' waits in excess of 24 hours.
- National average performance: 135 minutes which is significantly higher than 83 mins in 21-22 and 46 minutes in 20-21.

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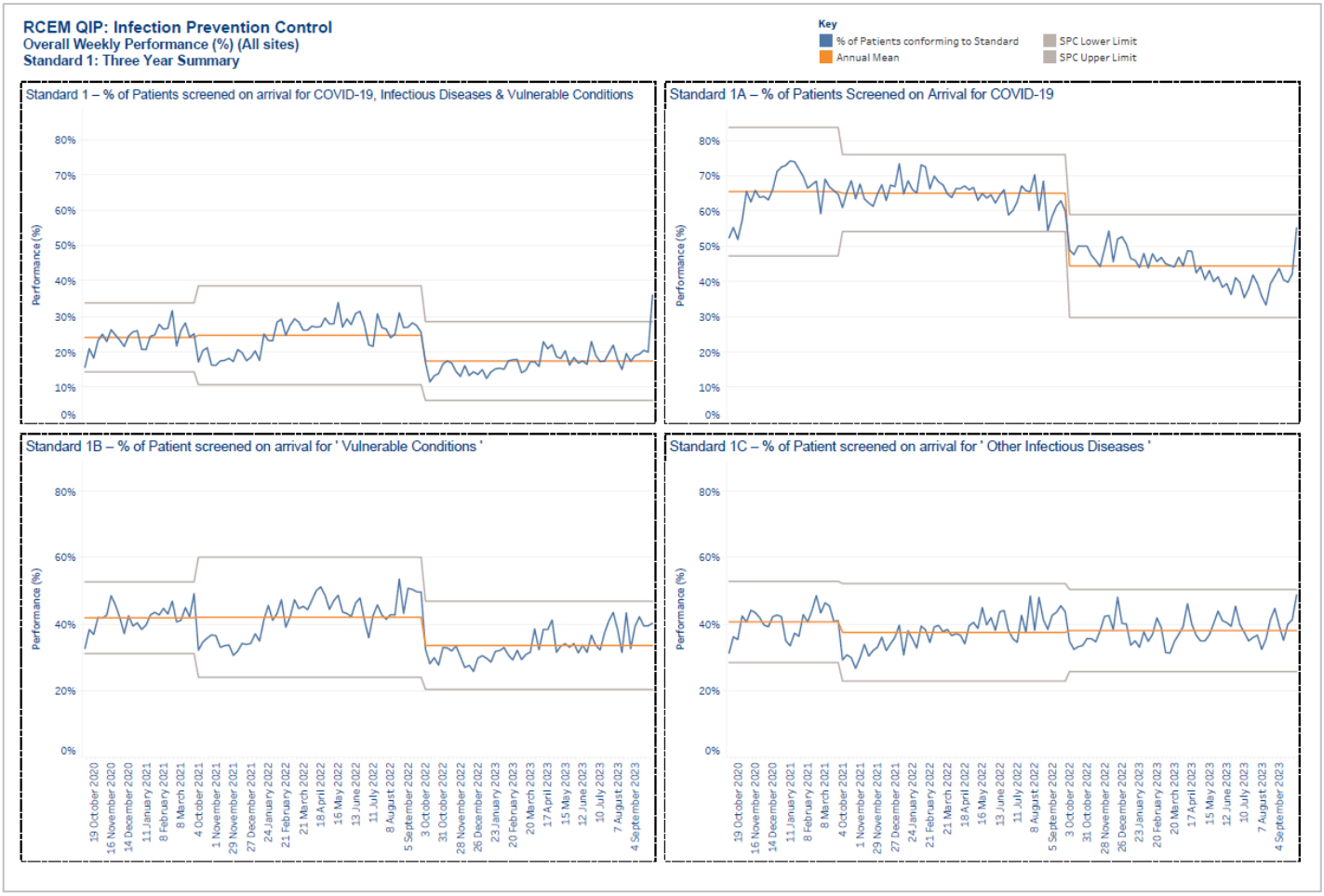
Three Year Summary of QIP

Year 1 - 5 October 2020 – 2 April 2021
Year 2 – 4 October 2021 – 2 October 2021
Year 3 – 3 October 2022 – 3 October 2023



[Understanding SPC Charts]

Commentary

- Over the three-year period the national performance has dropped, most noticeably in the percentage of patients screened for COVID-19 on arrival but also for those with vulnerable conditions. Both have dropped off in year three, which may be linked. In the earlier years of the pandemic there was strong messaging about the importance of identifying those with vulnerable conditions. The vulnerability list itself was being continuously reviewed and updated with not infrequent bulletins from respective governments to raise awareness. With the introduction of the successful vaccination programme the messaging has lessened and perhaps screening for vulnerable conditions at the front door is not as prominent in individual's minds especially as other system pressures mount.

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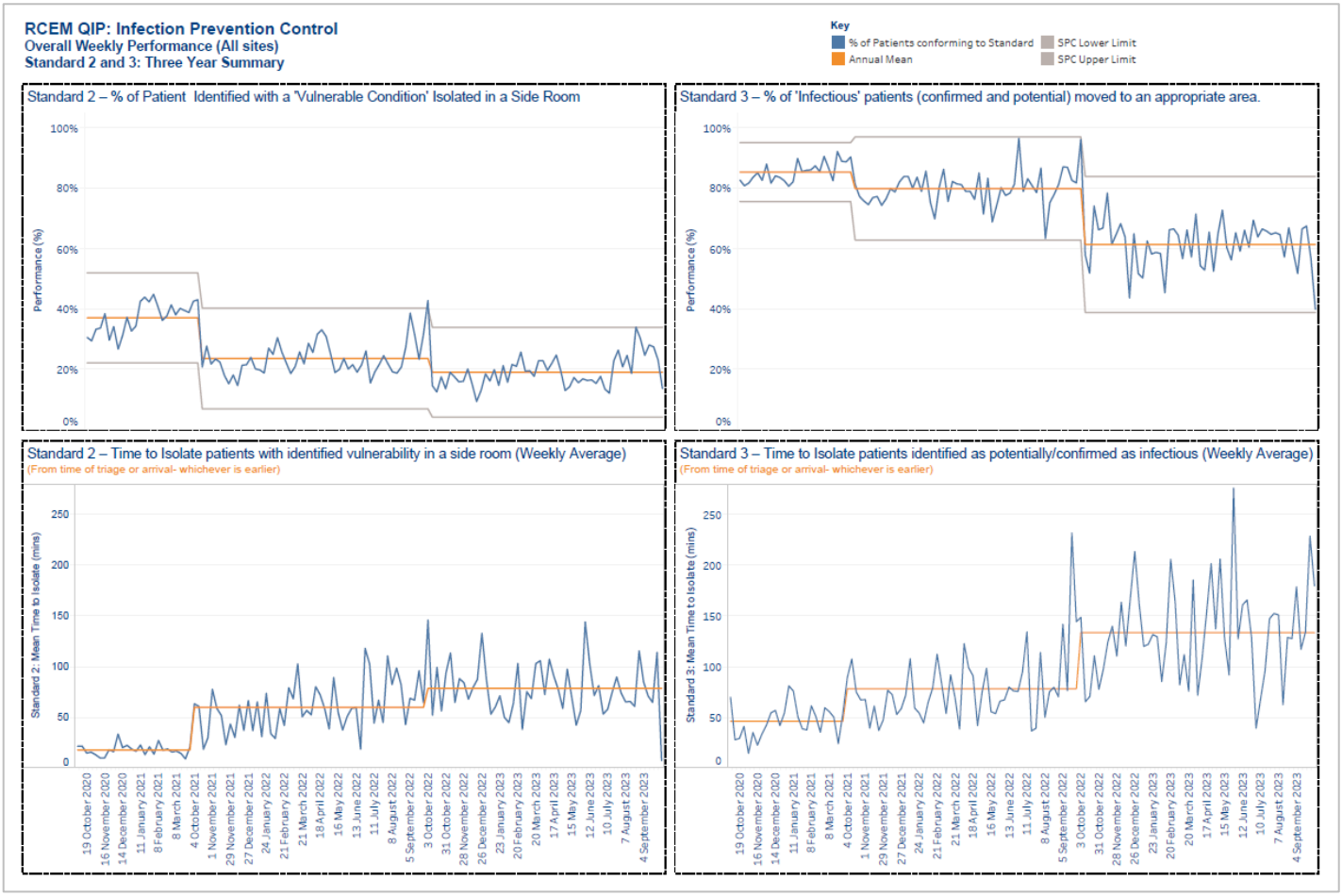
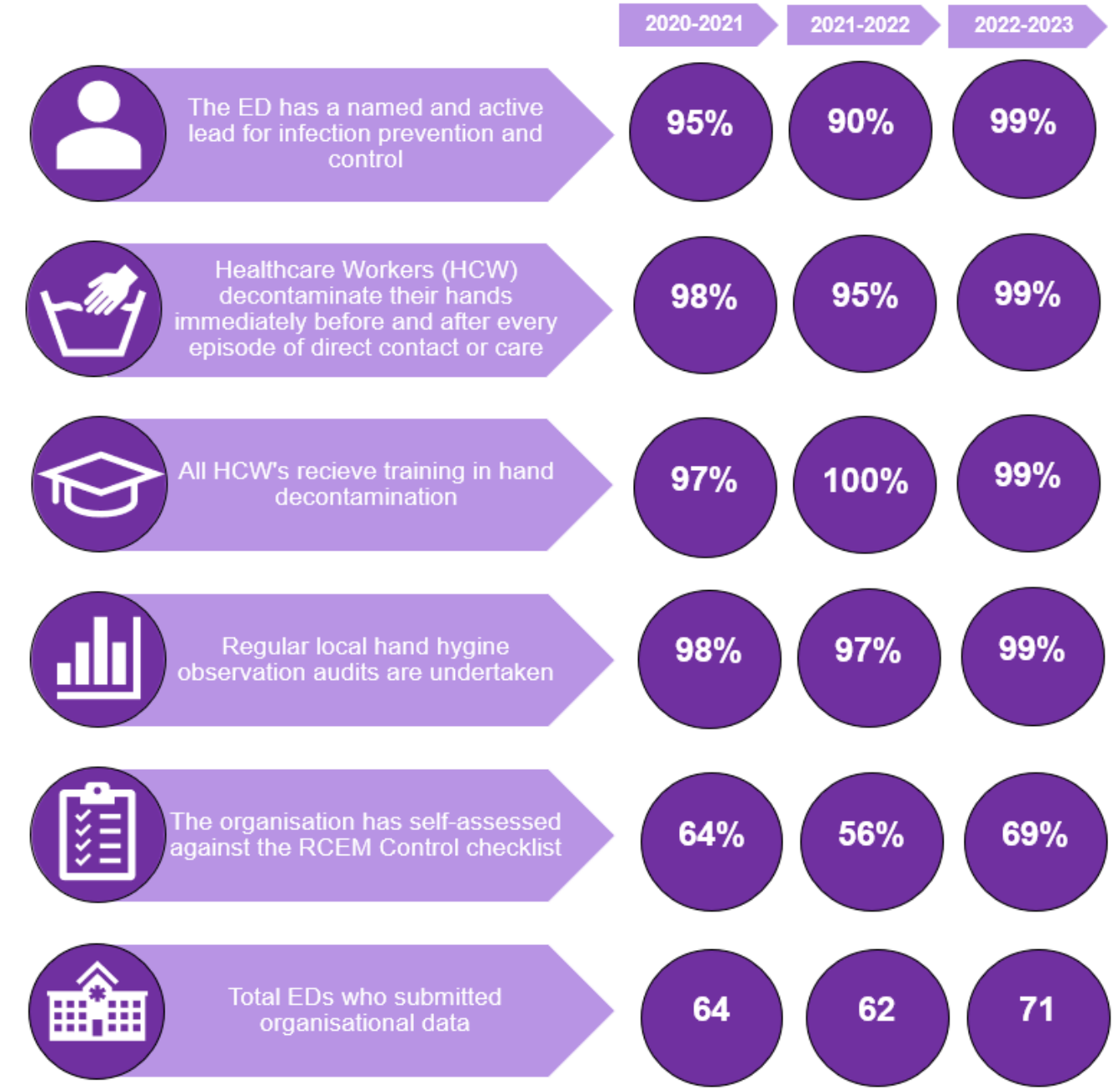


Understanding SPC Charts

Commentary

- Standard 2 and 3 have shown similar trends, with a reduction each year in those requiring appropriate areas getting them. This is concerning as this is a potential risk to both patients and staff.
- Whilst the numbers analysed for the time taken in the respective groups to get to the appropriate areas are small, they are again showing a similar trend with an increase in the time taken to get to the appropriate areas.

Organisational Audit



Commentary

It is not surprising that compliance with the first four standards is in the 90's, given that hand hygiene features on each of the four nations national strategies with audits mandated monthly. As it has been assigned such a high priority centrally, it would be unusual for a department not to have an IPC lead and to perform so well.

What we were initially surprised at were the number of participating centres who completed the organisational audit, with only 71 out of 127 in 22-23 submitting a completed entry. Our intention for the organisational audit was to give departments the ability to show their organisations what their ED needed to improve in the standards outlined in the QIP.

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Upon reflection, given the priority assigned centrally, the questions asked likely failed to help ED's improve standards but rather became a data collection burden. This is something we are mindful of for future QIPs and will aim to make the questions useful for ED's in their improvement activities.

We also acknowledge that the RCEM Control Checklist needs to be updated. Whilst some of the standards are applicable as are the guiding principles, not all are still in place and definitions of patient groups have changed. Given the perception it may be outdated by departments, we appreciate why departments may not be using the checklist and have opted out of completing the organisational audit.

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Appendices

Appendix 1: Number of Participating Centres/Cases per Nation

Country	Number of Participating EDs			Number of cases *		
	2020-21	2021-22	2022-23	2020-21	2021-22	2022-23
Total	154	129	127	17500	24128	24133
England	145	122	120	16615	23477	22313
Scotland	2	1	0	283	24	0
Wales	4	4	6	412	349	611
Northern Ireland	3	2	1	190	278	220
Isle of Man / Channel Islands	0	0	0	0	0	0

* Analysis includes complete cases only. Please note 20-21 was for a six-month cycle (Oct-Apr)

Data excluded post-validation.

The data used to create the charts in this report contains only the cases that have been submitted within the data entry period. The records submitted were also validated to ensure poor quality data was excluded to prevent distortion of the means and charts. Some of the cases submitted during the data collection period have been removed due to incomplete information and data entry errors that were not identified by the data entry system.

Appendix 2: Queries and Feedback

Thank you for taking part in this QIP. We hope that you find the process of participating and results helpful.

If you have any queries about the report, please e-mail RCEMQIP@rcem.ac.uk.

Details of the RCEM QIP Programme can be found on RCEM - Quality Improvement.

Give Your Feedback

We would like to know your views about this report and participating in this QIP. Please email RCEMQIP@rcem.ac.uk or complete our anonymous feedback form linked below.

RCEM QIPs - Your Thoughts and Feedback

We will use your comments to help us improve our future topics and reports.

Useful Resources

- Site-specific report – available to download from the QIP portal (registered users only)
- Online dashboard charts – available from the QIP portal (registered users only).
    - The dashboard remains open after the end of the national QIP project so you can keep monitoring local performance and doing PDSA cycles.
- Local data file – available from the QIP portal (registered users only)
- RCEM Quality Improvement Guide – guidance on PDSA cycles and other quality improvement methods

Appendix 3: New National Quality Improvement Programmes

Overview

At the college, we have moved from an annual audit programme to a national Quality Improvement Programme (QIP). Life cycles of our QIPs will now be three years, with the committee having spent up to a year in advance of the launch of each QIP designing the programme and engaging with our members.

Each Emergency Department that takes part in each QIP is provided with access to an online reporting portal that allows data collection/recording and monitoring of performance against agreed standards over time. Functionality is included that allows PDSA cycles to be highlighted and that identifies changes in performance. Real time benchmarking of performance against peers is also included.

In addition to this RCEM will provides a range of online Quality Improvement resources and to further support sites running QIPs it is planned to develop regular online project surgeries where anyone involved can join in, ask questions, share stories, improvement experiences and suggestions. Details will be circulated centrally by RCEM communications team.

It is intended that after year one of a QIP, a Baseline Report showing performance against the identified standards will be shared. An Interim Report will be generated following year two of the QIP with a final report produced at the end of Year three. We have developed new visualisations for inclusion in these reports to help centres understand their own data in more detail. One of these is the new Inter-Quartile Range (IQR) visualisation for each of the standards to show the range of performance for the individual sites involved in this QIP.

Future

We appreciate that QI may feel like an additional burden to teams. We want to ensure that it is not met with a sigh of relief when it is finished or perceived as a tick box exercise. We want members to see the benefit of taking part in the national programme and to sign up willingly. We believe the national QIP programme provides opportunities for teams to partake in QI, make sustainable improvements, learn new skills, and hopefully enjoy the process.

Taking part in the three-year programme allows focused use of departmental resources on a topic deemed important by the membership. Traditionally the topics for the annual audits were set by the RCEM. We have moved to identifying topics that are deemed to be of importance to the wider membership by asking for entries in an annual competition.

We will be working with other committees in RCEM to increase awareness of the programmes and how they will satisfy the learning needs of individuals. We will share resources to help teams visualise how each member can work in a team and achieve the leadership/QI experience that they need.

We recognise that people with lived experience have not been involved from the beginning of the QIPs and this is something that we are looking to rectify promptly. We are working with various patient groups and charities to identify how we can involve this group from the outset.

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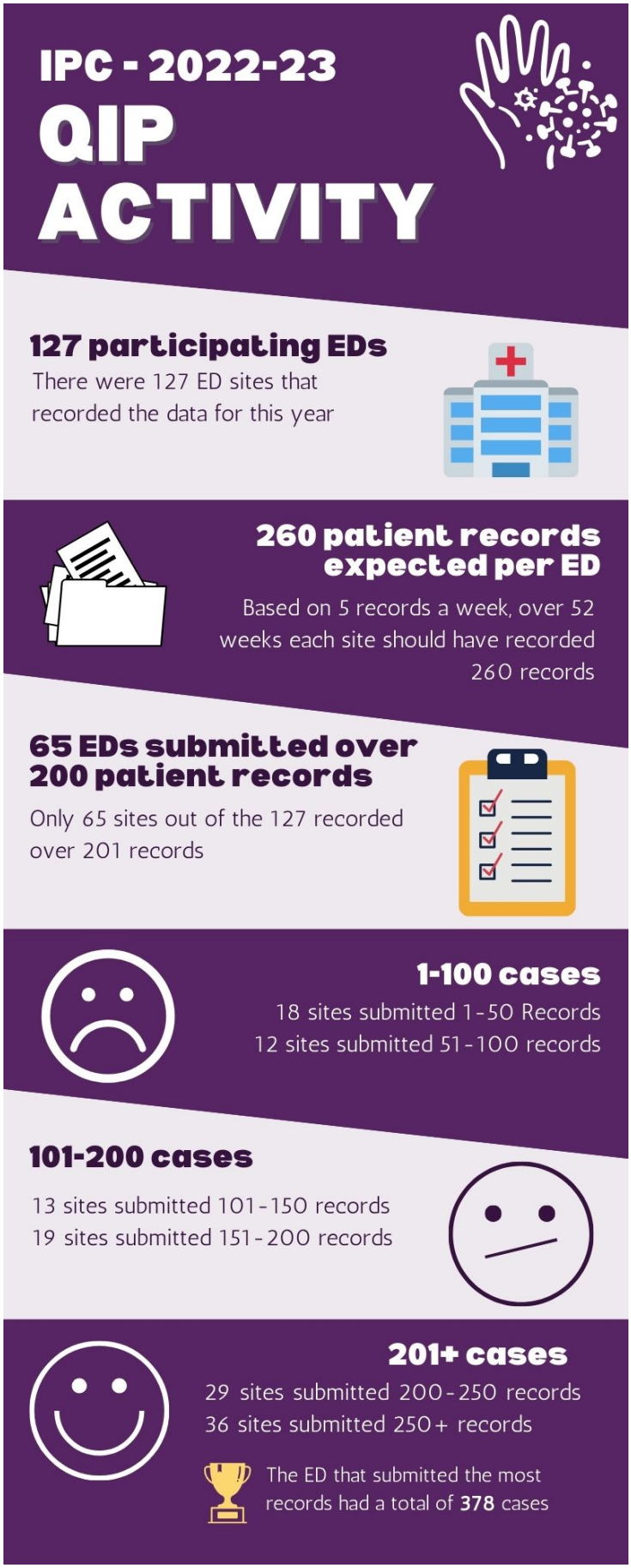
Appendix 4: Data Returns from Each Centre



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Appendix 5: EDI Monitoring

Equality, Diversity, and Inclusion statement: We have integrated ethnicity data monitoring into our platform to form the start of a data set containing thousands of cases which can then be analysed to detect differences in care quality along sex, race, and age lines. We have representation from the EDI committee at our programme development meetings and attend theirs to update on this body of work.

Without accurate data, establishing care disparities is more challenging, hampering efforts to target resources and find solutions in priority areas. We have nested these questions to establish the interhospital variability of ethnicity data recording and better understand the barriers to this data set. This exercise will take 15-20 minutes but provides a significant insight into this issue. Please encourage your team locally to input this data and show them how to find it to improve the collection process.

This data is only going to be used nationally however we do encourage local systems to better capture this data so insights and research can be undertaken in this important space.

Standard 1 - % of patients screened on arrival (all three specified conditions).

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	304	16.78%	83.22%
Any Other Asian Background	473	17.55%	82.45%
Any Other Black Background	218	19.72%	80.28%
Any Other Ethnic Group	784	15.69%	84.31%
Any Other Mixed Background	199	19.60%	80.40%
Any Other White Background	1127	17.92%	82.08%
Bangladeshi	186	15.59%	84.41%
Caribbean	171	15.79%	84.21%
Chinese	59	10.17%	89.83%
Indian	479	16.49%	83.51%
Not Stated	4145	16.50%	83.50%
Pakistani	525	16.76%	83.24%
White And Asian	76	15.79%	84.21%
White And Black African	134	17.91%	82.09%
White And Black Caribbean	71	15.49%	84.51%
White British	13906	16.90%	83.10%
White Irish	287	19.16%	80.84%

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Standard 1 – No screening undertaken for any of the three conditions.

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	304	8.55%	91.45%
Any Other Asian Background	473	9.51%	90.49%
Any Other Black Background	218	9.17%	90.83%
Any Other Ethnic Group	784	8.04%	91.96%
Any Other Mixed Background	199	11.06%	88.94%
Any Other White Background	1127	10.03%	89.97%
Bangladeshi	186	11.29%	88.71%
Caribbean	171	10.53%	89.47%
Chinese	59	8.47%	91.53%
Indian	479	5.85%	94.15%
Not Stated	4145	13.46%	86.54%
Pakistani	525	13.14%	86.86%
White And Asian	76	10.53%	89.47%
White And Black African	134	10.45%	89.55%
White And Black Caribbean	71	8.45%	91.55%
White British	13906	16.21%	83.79%
White Irish	287	4.53%	95.47%

Standard 2 - % patients with identified vulnerability isolated in a side room.

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	115	14.78%	85.22%
Any Other Asian Background	208	23.08%	76.92%
Any Other Black Background	76	13.16%	86.84%

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Any Other Ethnic Group	281	14.95%	85.05%
Any Other Mixed Background	79	10.13%	89.87%
Any Other White Background	436	16.74%	83.26%
Bangladeshi	91	9.89%	90.11%
Caribbean	67	17.91%	82.09%
Chinese	25	8.00%	92.00%
Indian	264	14.77%	85.23%
Not Stated	2067	12.00%	88.00%
Pakistani	277	10.11%	89.89%
White And Asian	35	31.43%	68.57%
White And Black African	37	21.62%	78.38%
White And Black Caribbean	22	4.55%	95.45%
White British	6554	21.83%	78.17%
White Irish	104	26.92%	73.08%

Standard 3 - % patients identified as potentially infectious moved to an appropriate area.

Population	Sample Size	Conforming to standard (% of specific population)	Not conforming to standard (% of specific population)
African	64	54.69%	45.31%
Any Other Asian Background	95	64.21%	35.79%
Any Other Black Background	42	57.14%	42.86%
Any Other Ethnic Group	205	52.20%	47.80%
Any Other Mixed Background	40	42.50%	57.50%
Any Other White Background	229	56.33%	43.67%
Bangladeshi	49	38.78%	61.22%
Caribbean	39	61.54%	38.46%
Chinese	15	46.67%	53.33%

Indian	126	61.11%	38.89%
Not Stated	725	58.62%	41.38%
Pakistani	124	42.74%	57.26%
White And Asian	20	65.00%	35.00%
White And Black African	16	56.25%	43.75%
White And Black Caribbean	17	64.71%	35.29%
White British	2770	64.30%	35.70%
White Irish	95	87.37%	12.63%

Appendix 6: Understanding your IQR Visualisation

Inter-Quartile Range Visualisations

Although this report is focussing on the overall national picture, it was felt that it would be useful to show the range of performances for the individual sites involved in this Quality Improvement Programme.

These IQR visualisations provide a benchmarked view of how all sites compare to each other across the full period. It is coloured to show the quartile range for the sites. The bottom 25% performing sites have been coloured red, the top 25% performing sites are green, with the remaining sites orange, (which means they performed within the inter-quartile range).

It is hoped these new views will help generate discussion within the individual sites QIP team, as it means that they will be able to benchmark their performance against all other sites.

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Appendix 7: Participating Emergency Department

England

Addenbrooke's Hospital
Airedale General Hospital
Alexandra Hospital
Arrowe Park Hospital
Barnet Hospital
Barnsley Hospital
Basildon University Hospital
Bassetlaw Hospital
Bedford Hospital
Birmingham City Hospital
Blackpool Victoria Hospital
Bradford Royal Infirmary
Bristol Royal Infirmary
Broomfield Hospital
Calderdale Royal Hospital
Charing Cross Hospital
Chelsea and Westminster Hospital
Colchester Hospital
Countess of Chester Hospital
Cumberland Infirmary
Darent Valley Hospital
Darlington Memorial Hospital
Diana, Princess of Wales Hospital
Doncaster Royal Infirmary
Ealing Hospital
Fairfield General Hospital
Frimley Park Hospital
Furness General Hospital
George Eliot hospital
Good Hope Hospital
Heartlands Hospital
Hillingdon Hospital
Hinchingbrooke Hospital
Homerton University Hospital
Huddersfield Royal Infirmary
Hull Royal Infirmary
Ipswich Hospital
James Cook University Hospital
James Paget Hospital
King George Hospital
King's College Hospital
Kingston Hospital
Leeds General Infirmary
Leighton Hospital
Lincoln County Hospital
Luton and Dunstable University Hospital
Macclesfield District General Hospital
Manchester Royal Infirmary
Medway Maritime Hospital
Milton Keynes University Hospital
Musgrove Park Hospital
North Devon District Hospital
North Manchester General Hospital
North Middlesex University Hospital
Northampton General Hospital
Northern General Hospital
Northumbria Specialist Emergency Care Hospital
Northwick Park Hospital
Ormskirk and District General Hospital
Peterborough City Hospital
Pilgrim Hospital
Princess Alexandra Hospital
Princess Royal University Hospital - King's College Hospital NHSFT
Queen Alexandra Hospital
Queen Elizabeth The Queen Mother Hospital
Queen's Hospital - Barking, Havering and Redbridge University Hospitals NHST
Queen's Medical Centre
Rotherham District General Hospital
Royal Berkshire Hospital
Royal Blackburn Teaching Hospital
Royal Bolton Hospital
Royal Cornwall Hospital
Royal Hampshire County Hospital
Royal Liverpool Hospital
Royal Shrewsbury Hospital
Royal Surrey County Hospital
Royal Sussex County Hospital
Royal Victoria Infirmary
Russells Hall Hospital
Salford Royal
Salisbury District Hospital
Sandwell General Hospital
Scarborough Hospital
Scunthorpe General Hospital
South Tyneside District Hospital
Southend University Hospital
Southport and Formby District General Hospital
St George's Hospital (Tooting)
St James' University Hospital
St Peter's Hospital
Stepping Hill Hospital
Tameside General Hospital
The Maidstone Hospital
The Princess Royal Hospital - Shrewsbury and Telford Hospital NHST
The Royal Free Hospital
The Royal Lancaster Infirmary

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The Royal London Hospital

The Royal Oldham Hospital

The Tunbridge Wells Hospital

University Hospital Aintree

University Hospital - University Hospitals Coventry and Warwickshire NHST

University Hospital Lewisham

University Hospital of North Durham

University Hospital of North Tees

Walsall Manor Hospital

Warrington Hospital

Warwick Hospital

West Cumberland Hospital

West Middlesex University Hospital

West Suffolk Hospital

Wexham Park Hospital

Whipps Cross Hospital

Whiston Hospital

Whittington Hospital

William Harvey Hospital

Worcestershire Royal Hospital

Worthing Hospital

Wythenshawe Hospital

Yeovil District Hospital

York Hospital

Northern Ireland

Ulster Hospital

Wales

Glan Clwyd Hospital

Grange University Hospital

Prince Charles Hospital

Princess of Wales Hospital

Royal Glamorgan Hospital

Ysbyty Gwyne

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Appendix 8: Useful Resources

Quality Improvement

Link to RCEM QI resource page - https://rcem.ac.uk/quality-improvement-resources/

Link to RCEM curriculum - https://rcem.ac.uk/wp-content/uploads/2022/04/Generic_QIAT_How_to_Guide_v3.pdf

Link to NES Turas Improvement Zone - https://learn.nes.nhs.scot/741/quality-improvement-zone

Link to Making Data Count- https://www.england.nhs.uk/wp-content/uploads/2019/12/making-data-count-getting-started-2019.pdf

Link to Sonia Sparkles - https://qi.elft.nhs.uk/tag/sonia-sparkles/ and https://soniasparkles.com/improvement/

IPC

SCT - Link to Scottish Gov site - https://www.nss.nhs.scot/browse/antimicrobial-resistance-and-healthcare-associated-infection

WLS - Wales https://phw.nhs.wales/services-and-teams/harp/healthcare-associated-infections-hcai/

NI - https://www.publichealth.hscni.net/directorate-public-health/health-protection/healthcare-associated-infections

NI - https://www.nisra.gov.uk/statistics/cause-death/healthcare-associated-infection

ENG - Link to National Infection prevention and control manual for England https://www.england.nhs.uk/wp-content/uploads/2022/04/C1636-national-ipc-manual-for-england-v2.pdf

Link to RCEM IPC standards - https://rcem.ac.uk/wp-content/uploads/2021/10/RCEM_BPC_Guideline_COVID_IPC_090620.pdf

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Appendix 9: Stakeholder

Below is a table of stakeholders that we believe would be interested in this QIP topic and are in a position that they can help support improvement within EDs. If you have any others that you think should be included, please contact us at RCEMqip@rcem.ac.uk.

Stakeholder
Antimicrobial Resistance & Healthcare Associated Infection Scotland
Northern Ireland Statistics and Research Agency
Public Health Agency, Northern Ireland
Public Health Wales
UK Health Security Agency (UKSHA)
FutureNHS – AMR IPC workstream

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