Guidance notes for completing the extra data items in the full (including the winter) daily situation report 2016/17

November 2016

This guidance will help trusts that do not achieve the four-hour performance standard for accident and emergency (A&E) to complete the required extra metrics. Sections 9 to 12 cover new experimental areas of data collection.

1. Accident and emergency activity (attendances and four-hour breaches)

In this context A&E means a type 1, type 2 or type 3 A&E department. Each patient should be counted as a type 1, 2 or 3 attendance if they receive care in an A&E department and they should be counted in one of the ‘other’ categories if they are streamed on arrival to an alternative service. They should be counted only once in the following four categories:

- **Type 1 A&E department**: a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for A&E patients.

- **Type 2 A&E department**: a consultant-led single specialty A&E service (eg ophthalmology, dental) with designated accommodation for patients.

- **Type 3 A&E department**: other type of A&E/ minor injury unit (MIU)/walk-in centres (WiCs), primarily designed for receiving A&E patients. A type 3 department may be doctor led or nurse led; co-located with a major A&E department or sited in the community. A type 3 department treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment-based service (for example an outpatient clinic), or one mainly or entirely accessed via telephone or other referral (for example most out-of-hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a type 3 A&E service even though it may treat some patients with minor illness or injury.
The data dictionary currently describes WiCs as type 4 departments but for situation reports (SITREPs), these should be included under type 3.

- **Other**: Patients who would have previously gone through A&E and are now seen and treated in other secondary care services provided by the same healthcare provider; for example ambulatory care clinics, frailty clinics, and so on. This is a new experimental area of data collection, and different trusts will have different services that have been created to divert patients away from A&E. Trusts are not required to report a breach rate for this measure as the patient is not treated in A&E.

Where a figure has been entered in the ‘other’ section detailed above, list the services/clinics that make up each of these numbers.

### 2. Patients arriving by ambulance

Count all accident, emergency and urgent patients if destined for A&E (type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E.

Do **not** count non-emergency patients or patients being transported between locations/trusts/hospitals (eg for outpatient clinics or tertiary care).

**Ambulance handover delays of over 30 minutes**

Report the number of handover delays of longer than 30 minutes for patients arriving according to the definition above.

The 30 minutes includes the 15 minutes allowed under SITREP guidance if an ambulance is unable to unload a patient immediately on arrival at A&E because the A&E department is full.

The start time of the handover is defined as the time of arrival of the ambulance at the A&E department. The end time of the handover is defined as the time of handover of the patient to the care of A&E staff.

Do not count the time required for crews to complete record forms, clean or re-stock vehicles or have a break.

Delaying ambulances outside A&E as a result of a temporary mismatch between A&E/hospital capacity and numbers of elective or emergency patients arriving is not acceptable. Well before the majors side of A&E becomes so full that significant queuing begins, the full hospital escalation plan (including cancelling routine operations and increasing consultant rounds to check for those ready for discharge) should have been implemented and the local clinical commissioning group (CCG) alerted.
As with 12-hour trolley waits (see below), if a significant delay still occurs, it indicates a failure of planning by the acute trust (and by implication wider health community) to meet the needs of patients requiring emergency admission to A&E/hospital alongside planned elective work. By definition, the local escalation plan has also failed, since allowing ambulance queues to build up is not an appropriate management response to a spike in demand.

3. Number of 4–12 hour trolley waits and number of over 12-hour trolley waits

The following guidance applies to all data items above relating to waits for emergency admissions.

Definitions

The waiting time for an emergency admission via A&E is measured from when the decision is made to admit, or when treatment in A&E is completed (whichever is later), to the time when the patient is admitted.

Time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in A&E before admission is complete – whichever is the later.

An emergency admission via A&E is defined as an A&E attendance disposal under code 1 or code 7 (transfer to another healthcare provider). Time of admission is defined as outlined below:

- For disposal code 1, the time when such a patient leaves the department to go to:
  - an operating theatre
  - a bed in a ward
  - an X-ray or diagnostic test or other treatment directly on the way to a bed in a ward (as defined below) or operating theatre. However, leaving A&E for a diagnostic test or other treatment does not count as time of admission if the patient then returns to A&E to continue waiting for a bed.

- For disposal code 7, the time when such a patient is collected for transfer to another provider. Where a patient is transferred to another hospital, it is expected that they will be taken immediately to a bed in an appropriate ward on arrival. The waiting period at the first hospital will end when the ambulance crew collects the patient for transfer.
If further assessment and/or treatment is necessary in the A&E department of the second (receiving) trust, a fresh waiting period begins when assessment and/or treatment is completed in that A&E department.

Data items between 4–12 hour waits include patients whose waiting time for an emergency admission is between 04:00:01 hours and 12:00:00 hours inclusive.

For data items over 12 hours, include patients whose waiting time for an emergency admission is 12:00:01 hours or longer.

4. Delayed transfers of care

Note: only the trust that is transferring the patient should report the transfer on their SITREP – the trust receiving the patient does not need to.

The number of beds unavailable due to delayed transfers of care (as at 8am on day of reporting should include all delayed transfers, both acute and non-acute, for any reason.

5. Beds occupied by stranded patients

To understand the impact of poor flow through the urgent and emergency care system this metric looks at the proportion of beds occupied by ‘stranded patients’. These are defined as any patient who is in a hospital bed for seven days or more. Most of these patients will be non-elective but to understand the overall impact, it is important to include the number of elective patients.

Although there will be patients in this number who are expected to have a seven-day or longer stay in a general and acute bed, eg patients who have had a stroke, myocardial infarction, fractured neck of femur, neurorehabilitation, and so on, no patient cohorts are exempt from this measure. The measure is a snapshot taken at either midnight or 8am. It would be preferable to receive this from the midnight timeframe but we are aware of the constraints of various data systems.

We do not advise comparing this metric between providers because hospitals provide significantly different services.

6. Urgent operations cancelled for the second or subsequent time in previous 24 hours

Only count urgent operations that have already been cancelled on one or more occasions.

Provide comments if you report any such cancellations.
7. Urgent operations cancelled in previous 24 hours

Count all urgent operations that are cancelled by the trust for non-clinical reasons, including those cancelled for a second or subsequent time. This should exclude patient cancellations, and only include cancellations where the operation was scheduled to take place in the previous 24 hours.

Include all urgent operations that are cancelled, including emergency patients (i.e. non-elective) who have their operations cancelled. The majority of urgent cancellations will be urgent elective patients but it is possible that an emergency patient might have their operation cancelled (e.g. patient presents at A&E with complex fracture which needs operating on; their operation is arranged and subsequently cancelled).

**Definition of ‘urgent operation’**

The definition of ‘urgent operation’ should be agreed locally in the light of clinical and patient need. However, we recommend you follow the National Confidential Enquiry into Perioperative Deaths (NCEPOD) guidance as outlined below:

1. **Immediate**: immediate (A) life-saving or (B) limb- or organ-saving intervention. Operation target time within minutes of decision to operate.
2. **Urgent**: acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate.
3. **Expedited**: stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Operation target time within days of decision to operate.
4. **Elective**: surgical procedure planned or booked before routine admission to hospital.

Broadly, 1, 2 and 3 above should be regarded as ‘urgent’ for the purpose of meeting this requirement.

8. Patients treated at A&E who did not require hospital treatment

Recording the number of patients who did not require hospital treatment requires the data dictionary definition for the A&E stream metric.

The A&E stream records the classification assigned to an A&E attendance in an A&E department. Streaming is a system that allocates patients to different flows according to their needs. These flows are individually staffed and continue to function whatever the pressures in other streams. In any stream, at any one time, there may be patients with different A&E initial triage assessment categories. An A&E department
will have either simple streaming or full streaming and will use the appropriate classification.

This indicator uses A&E streaming codes ‘d’ and ‘e’ to record the number of patients treated at A&E who did not require hospital treatment:

- **D**: self-care (patients who attend A&E and do not need investigation or hospital treatment. After a thorough assessment the patients are given appropriate advice on self-care and are discharged. They will also be advised on indications for further contact)

- **E**: primary care (patients with conditions that could be treated by a primary care team).

9. **Patients who could have been treated in primary care**

Recording the number of patients who did not need hospital treatment requires the data dictionary definition for the A&E stream metric.

A&E stream records the streaming classification assigned to an A&E attendance in an A&E department. Streaming is a system whereby patients are allocated to different flows according to their needs. These flows are individually staffed and continue to function whatever the pressures in other streams. Within any stream, at any one time, there may be patients with different A&E initial triage assessment categories. An A&E department will have either simple streaming or full streaming in place and will use the appropriate classification.

Recording the number of patients treated at A&E who did not require hospital treatment will use A&E streaming code ‘e’. The code ‘e’ is classified as:

- **E**: primary care (patients with conditions that could be treated by a primary care team).

10. **Patients referred or admitted to ambulatory emergency care service at the same healthcare provider**

An ambulatory emergency care (AEC) service is defined as a dedicated service that diagnoses and treats appropriate patients on the same day and sends them home with ongoing clinical follow-up as required. This should include patients streamed directly to the AEC service on arrival at the healthcare provider and those referred to the AEC following care in a type 1, type 2 or type 3 A&E. This is a new experimental area of data collection.
11. Patients streamed to primary care or urgent care setting

This is the count of patients streamed on arrival at A&E to an onsite GP or primary care setting managed offsite by the same or alternative provider, or to a more appropriate urgent care setting (eg type 3). This is a new experimental area of data collection.

12. Patients discharged through discharge to assess – defined as NHS-run care home or local authority care home for continuing care assessment

This is the number of patients discharged to their own home, NHS-run care home or local authority-run care home for a continuing care assessment (including patients receiving their continuing care assessment in a ‘step-down’ care facility). This is a new experimental area of data collection.

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