

Process and definitions for the daily situation report web form

November 2017

The daily situation report (sitrep) indicates where there are pressures on the NHS around the country in areas such as breaches of the four-hour waiting time, ambulance handover delays and general and acute bed capacity. This guide outlines how to complete the sitrep web form and includes an example escalation framework.

Process

The template will need to be populated throughout the year by all trusts with a type 1 A&E department.

Daily reports must be signed off by a duty director, or other senior manager, appointed to this role by the trust's chief executive. It is the responsibility of each trust to ensure its return is accurate and reflects the real position in terms of pressure for that time period.

Each collection will cover the **previous 24 hours**.

The collection portal for the daily sitrep collection includes a function to amend previous daily submissions for the current and previous week. The collection will need to be **submitted by 11am each morning** and the collection portal will close each afternoon to collate the daily sitrep report.

Note: if an incident (as in the Emergency Preparedness, Resilience and Response Framework (EPRR) framework) has been declared at any time over the reporting period (ie the period to 8am on the day of reporting, even if stood down within that period), it should be recorded in the comments box along with type, severity level, and brief details including when declared and stood down.

Reporting period

The 24-hour reporting period is defined as midnight (00:00:00) to 23:59:59 on the day before reporting.

The bed figures provided should relate to the latest position on each day of reporting. The time of this snapshot should be taken at 8am on the day of reporting.

For A&E performance data the reporting period should be from midnight to midnight, so that data submitted by 11am on a Wednesday, for example, should relate to the period 00:00:01 on Tuesday morning to 23:59:59 on Tuesday night, covering the whole of Tuesday.

On a Monday, each day of the weekend (Friday, Saturday and Sunday) should be reported retrospectively to provide a daily breakdown of the data, unless otherwise advised.

Guidance notes on data items: A&E performance

A&E attendances (and four-hour breaches)

Count all unplanned attendances in the reporting period at A&E departments, whether admitted or not.

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. They should be counted only once in the following categories:

- Type 1 A&E department: a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for A&E patients. (See below for further information.)
 - 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.
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The data dictionary currently describes WiCs as type 4 departments, but for sitreps these should be included under type 3.

Each **type 1** attendance should be categorised by acuity, based on the patient's condition on the Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Time. The Emergency Care Acuity may be determined by a formal triage process, or by physically allocating the patient to a specific clinical area such as resuscitation. The categories are minor, major, resus or paediatrics.

Emergency departments have historically used a variety of ways to measure acuity. Sometimes this is done explicitly using a scoring system – eg 'triage' – and at other times implicitly, by a member of staff allocating the patient to a specific treatment area. There is a need for emergency care to standardise the acuity measurement of patients attending across a range of emergency care services, as this will help inform optimum use of resources in the provision of emergency care.

To understand the value added by any system (including healthcare), it is important to be able to measure inputs and outputs. In the case of urgent and emergency care, there are two elements to the patient presentation: acuity and chief complaint. There is direct patient benefit to being able to capture and communicate a consistent measure of patient acuity, at both a clinical and operational level.

How to collect

Emergency care acuity is a measure of the urgency and severity of the condition with which the patient has presented to the emergency care facility, as defined by the first clinician who assesses the patient.

'Clinician' in this context could be any member of staff registered by the General Medical Council, Nursing and Midwifery Council or Health and Care Professions Council who has appropriate training and support for this role and who is authorised to treat patients independently – in practice this is usually a nurse. In this context 'clinician' does not include trainees or healthcare assistants.

In CDS Type 011 – emergency care dataset (ECDS) acuity is represented by an integer (number) between '1' and '5', '1' being the most serious/time sensitive and '5' the least.

Each attendance should only be counted in one of these categories:

- 1, 2 = Resus
 - 3 = Majors
 - 4, 5 = Minors
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The first member of clinical staff assigns a number 1 to 5 reflecting acuity after assessing the patient.

(Acuity 4 patients will tend to have broken bones etc, which may need more treatment; so it is helpful to sort these – the ratio varies considerably between institutions.)

Paediatrics: all patients under 16 years of age – there is no need to split paediatric patients between the other categories.

Where there is no existing formal system of acuity measurement, acuity is defined by the physical area of treatment in which the clinician decides the patient should be treated.

- Category 1 = (immediate care area) – resuscitation area
- Category 3 = (high acuity area) – majors/high acuity area (including majors 'chairs')
- Category 4 = (low acuity area) – minors/ambulatory/low acuity (including waiting room).

NB The treatment area is defined by the patient's needs, not the resources available: eg if a patient is a Category 3 patient but due to resource issues is treated in a Category 1 or Category 4 clinical area, they remain a Category 3 patient. Emergency care acuity should be recorded by the first clinician who sees the patient, and must be the initial assessment of acuity. If this subsequently changes – eg the patient deteriorates – this may be recorded locally, but only the first value should be submitted as emergency care acuity.

If you have difficulty providing the split above, can you please contact NHSI.returns@nhs.net, with details of the challenges, and we will be able to provide relevant support.

Patients streamed to co-located primary care led streaming service

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. These patients should be a subset of the type 3 attendances.

Taken from the *ECDS user guidance*:

“When the word ‘streaming’ is used in emergency care it implies a contractual arrangement whereby care of a patient who has had a limited assessment is transferred from one (organisation/site) to another (organisation/site) without formal referral. Increasingly these organisations are on the same site and share IT systems, facilitating this process.”

Four-hour wait breaches in co-located primary care led streaming service

Of the patients streamed to a primary care led service, the number of patients who were not admitted, discharged or transferred within four hours.

Time to treatment: type 1 attendances seen within first 60 minutes

Time to treatment is the time from arrival at the A&E department to the time when a patient is seen by a decision-making clinician (someone who can define the management plan and discharge the patient) to diagnose the problem and arrange or start definitive treatment as necessary.

Include a count of all attendances seen within 60 minutes of arrival at the type 1 A&E department.

Number of emergency admissions

All patients who are emergency admissions in the reporting period, via the following ‘admission method’ code:

- 21 = Accident and emergency or dental casualty department of the healthcare provider
 - 22 = Emergency – via GP
 - 23 = Emergency – via bed bureau (including the central bureau)
 - 24 = Emergency – via consultant outpatient clinic
 - 25 = Admission via mental health crisis resolution team
 - 28 = Emergency – other means
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- 2A = Accident and emergency department of another provider where the PATIENT had not been admitted
- 2B = Transfer of an admitted PATIENT from another hospital provider in an emergency
- 2C = Baby born at home as intended
- 2D = Other emergency admission.

Number of emergency admissions (via A&E)

The 'admission method' code for emergency admission via A&E is code 21 = Accident and emergency or dental casualty department of the healthcare provider. Include all patients who spend time in an A&E department before being admitted as an emergency to the same healthcare provider.

Front door

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

The start time of the handover is defined as the ambulance's time of arrival 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 restock 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.

If a significant delay still occurs, it indicates a failure of planning by the acute trust (and by implication, the 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.

- **30 to 60 minutes**

Report the number of handover delays longer than 30 minutes, up to and including 59 minutes 59 seconds for patients arriving according to the definition above.

This time 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.

- **over 60 minutes**

Report the number of handover delays longer than 60 minutes for patients arriving according to the definition above.

This time 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.

Operational issues

Number of 4 to 12-hour waits for admission from decision to admit

The following guidance applies to all data items above relating to waits for emergency admissions following a decision to admit (DTA).

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.

Include patients whose waiting time for an emergency admission following a decision to admit is between 04:00:00 and 12:00:00 hours.

Number of waits for admission over 12 hours from DTA

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

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.

Include patients whose waiting time for an emergency admission following a decision to admit is 12:00:01 hours or longer.

Urgent operations cancelled in the 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 within 24 hours of the cancellation.

Include all urgent operations that are cancelled, including emergency patients (ie non-elective) who have their operations cancelled. In principle, most urgent cancellations will be urgent elective patients, but it is possible that an emergency patient has their operation 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 following the definitions in the guidance from the National Confidential Enquiry into Perioperative Deaths (NCEPOD).

Broadly these are:

I. Immediate – immediate (a) lifesaving or (b) limb or organ-saving intervention. Operation target time within minutes of decision to operate.

II. Urgent – acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate.

III. 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.

IV. Elective – surgical procedure planned or booked in advance of routine admission to hospital.

Broadly, (i), (ii) and (iii) should be regarded as 'urgent' for the purpose of meeting this requirement.

A&E closures

Record any unplanned, unilateral closures of any A&E department (type 1, 2 or 3) to admissions, which occurred without consultation or the agreement of neighbouring trusts or the ambulance trust.

If an A&E department is closed to ambulances without the agreement of its neighbours or ambulance service, it is defined as an 'A&E closure' irrespective of whether the A&E department is still accepting patients arriving on foot.

Temporary closure of an A&E should only occur in exceptional circumstances.

A&E managers should expect never to have to close their departments. Contingency planning should cover all escalations in activity, from situations where patient numbers temporarily exceed resources to specific events. Guidance on major incident planning provides more detailed information on the latter and is available at:

<https://www.gov.uk/government/policies/planning-for-health-emergencies>

If there has been an A&E closure, please also provide information on how long the A&E department was closed in the boxes provided. If the unit was closed more than once, please enter the total time the unit was closed: ie the sum of the times of the individual closures.

A&E diverts

Count the number of occasions/periods during which there was an agreed temporary divert of patients to other A&E departments to provide temporary respite (ie not to meet a clinical need). To be included in the count, the divert must be agreed between the trusts affected, including ambulance trusts (and commissioners where applicable). If there has been an A&E divert, please also provide information on how long the divert lasted and where patients were diverted to, in the box provided. If there was more than one divert, please enter the total time of all of the divert periods – ie the sum.

A temporary divert should be made only as part of the local health system's escalation policy and be preceded by:

- agreement/discussion with the receiving A&E departments/acute trusts
 - agreement/discussion with local ambulance service
 - agreement/discussion with the local commissioners (this may be delayed until after the divert in situations which meet predetermined criteria agreed in advance with the commissioner).
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All diverts between A&E departments at geographically separate hospitals are subject to the above arrangements. This includes diverts between hospitals that are part of the same trust but geographically separate.

Diversion of patients as a result of lack of physical or staff capacity to deal with attendances or admissions should be an action of last resort and should be agreed with neighbouring trusts. Robust network-wide escalation planning together with trusts' own internal planning should mean that any increase in activity can be managed internally: for example, by diverting staff from elsewhere in the hospital. Therefore, diversion of patients for respite reasons should only need to happen in exceptional circumstances, where internal measures have not succeeded in tackling the underlying problem.

Plans should be reviewed periodically and agreed protocols developed with neighbouring trusts and the ambulance trust for the area. A total view of system capacity should be taken including community response, intermediate care, community inpatient capacity, elective work and acute resource, etc. Therefore the local emergency care network should be the usual forum for such protocols to be drawn up.

General and acute beds

The following lines on beds relate to general and acute beds, using relevant definitions from the KH03 beds return. They exclude maternity and mental health beds. The figures provided should relate to the latest position **on the day of reporting**. This snapshot should be taken at 8am on the day of reporting.

Total general and acute core bed stock open

The number of general and acute bed beds available on the day of reporting. Note this figure should show your core bed stock including beds that are closed but occupied. Beds that are closed but empty should be subtracted from the core bed stock number.

For example: if there are 10 beds closed for infection control of which six are occupied and four empty, exclude the four empty beds.

Total general and acute escalation beds open

The number of general and acute escalation beds open on day of reporting.

Total general and acute beds open

This should be the total number of beds available: core beds open plus escalation beds open.

Of total general and acute beds open, number occupied

Total number of beds that are occupied at the time the snapshot is taken.

Number of beds closed due to diarrhoea and vomiting (D&V)/norovirus-like symptoms

Number of beds closed due to D&V/norovirus-like symptoms.

Of these beds closed, number unoccupied

For example: if there are 10 beds closed for infection control of which six are occupied and four empty, record the four empty beds in this category.

Delayed transfers of care

Note: only the trust that is transferring the patient should report the transfer on its 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 the day of reporting) should include all delayed transfers, both acute and non-acute, for any reason.

Beds occupied by stranded patients – beds occupied by patients with a length of stay of seven or more days

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 or neurorehabilitation – no patient cohorts are exempt from this measure. The measure is a snapshot taken at midnight.

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

Beds occupied by extended length of stay patients – beds occupied by patients with a length of stay of 21 or more days

To understand the impact of poor flow through the urgent and emergency care system this metric looks at the proportion of beds occupied by ‘extended length of stay patients’. These are defined as any patient who is in a hospital bed for **21 days or more**.

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

Critical care beds

Adult critical care beds: count all adult critical care (ITU, HDU or other) beds that are funded and available for critical care patients (levels 2 and 3). The figures provided should relate to the latest position on the day of reporting. The time of this snapshot should be consistent with the general and acute beds. Note that this should be the actual number of beds at that time and not the planned number of beds. Beds funded but not available due to staff vacancies should not be counted unless the vacancies have been filled by bank or agency staff. Beds that are not funded but are occupied should be counted.

The following counts should be consistent with those provided for the monthly sitrep return:

Adult critical care beds available

The total number of available adult critical care beds on day of reporting.

Adult critical care beds occupied

The total number of occupied adult critical care beds on day of reporting.

Paediatric intensive care beds available

The total number of available paediatric intensive care (level 2, level 3 and level 4) beds (or cots where applicable) on day of reporting.

Paediatric intensive care beds occupied

The total number of occupied paediatric intensive care (level 2, level 3 and level 4) beds (or cots where applicable) on day of reporting.

Neonatal intensive care cots available

The total number of available neonatal intensive care cots (or beds) on day of reporting.

Neonatal intensive care cots occupied

The total number of occupied neonatal intensive care cots (or beds) on day of reporting.