NHS England

A&E Attendances and Emergency Admissions Monthly Return Definitions

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A&E attendances and emergency admissions monthly return definitions

Definitions and FAQs

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

Introduction

This document sets out the definitions for the A&E Attendances and Emergency Admissions Monthly Return. It should be noted that this data set used to be called the “Weekly A&E Situation Report”. We have decided to change the name due to the fact that data is collected on emergency admissions and is collected from trusts that don’t have an A&E department, but do admit emergency patients. In addition, the data is now collected on a monthly rather than a weekly basis.

Section 4 covering delays for emergency admissions via A&E from decision to admit to admission has been revised to include disposal code 7 (transfer to another provider). This is to ensure that such patients are counted in the number of patients spending more than 4 or more than 12 hours from decision to admit to admission. This change does not affect sections 3 and 5 which focus purely on disposal code 1 (the same healthcare provider).

The A&E Attendances and Emergency Admissions Monthly Return has been approved by the Review of Central Returns (ROCR) Steering Committee (Ref: ROCR/OR/2214/001MAND)

The A&E Attendances and Emergency Admissions Monthly Return is to be reported by via Unify2 from all organisations providing NHS funded emergency care services. This includes:

- All providers admitting at least 40 emergency patients per month
- All emergency care providers averaging more than 200 attendees per month, including Type 1, 2, 3 and 4 A&E departments and urgent care centres.

1 A&E Activity

A&E in this context means all types of A&E provision including Type 1, Type 2, Type 3, Type 4 department and urgent care centres that average more than 200 attendances per month. This average should be calculated over a quarter.

Types of A&E service are:

- Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

- Type 2 A&E department = A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients

- Type 3 A&E department / Type 4 A&E department / Urgent Care Centre = Other type of A&E/minor injury units (MIUs)/Walk-in Centres (WiCs)/Urgent Care Centre, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it 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 a number of patients with minor illness or injury.

Potential patients must be aware of A&E departments and perceive the service as an urgent and emergency care service. As a result, for a department to be classified under the above A&E nomenclature it must average over 200 attendances per month.

All data should be submitted against the 3 character provider code for NHS trusts and data should be aggregated to organisational level. For other types of organisation such as GP Practices, other types of provider codes will be accepted.

2 A&E Attendances

Events overlapping months
If an attendance starts in one month and ends in the second month, both the arrival and departure should be recorded in the later month.

Follow up attendances
Include unplanned follow up attendances but do not include planned follow up attendances (e.g. to an A&E clinic or a planned follow up to remove sutures).

An A&E attendance is defined as an unplanned attendance when the A&E attendance category = 1 or 3. This excludes planned follow up attendances.

Planned follow up attendances are defined as having an A&E attendance category of 2.

Follow up attendances must be for the same condition as the first attendance. If a patient makes two visits to A&E for two different conditions, they should be recorded as two first attendances.

A1i) Number of A&E attendances – Type 1

Defined as:
All unplanned attendances in the reporting period at Type 1 A&E departments, whether admitted or not.

A1ii) Number of A&E attendances – Type 2

Defined as:
All unplanned attendances in the reporting period at Type 2 A&E departments, whether admitted or not.

A1iii) Number of A&E attendances – Other A&E department

Defined as:
All unplanned attendances in the reporting period at Type 3 A&E departments / Type 4 A&E departments / Urgent Care Centres, whether admitted or not.

3 A&E Performance Measures

A2i) Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge – Type 1

A2ii) Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge – Type 2

A2iii) Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge – Other A&E department

The following guidance applies to all three data items above.

The clock starts from the time that the patient arrives in A&E and stops when the patient leaves the department on admission, transfer from the hospital or discharge.

Patients should be counted where their total time in A&E is 04:00:01 hours or greater. Patients with a total time of 04:00:00 hours or lower should not be counted.

Please note that any patient who spends time in A&E should have their time in A&E recorded and should be reported under data items A2i to A2iii if appropriate as well.

Time of Arrival
The time of arrival should be recorded using the 24 hour clock.

For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to hand over 15 minutes after arrival that patient is nevertheless deemed to have arrived and the total time clock started.

Time of Departure
Total time in the Department ends when the patient is discharged home, transferred, or admitted.

i) Discharged home. Time of discharge home is defined as when the patient's clinical episode is finished, unless they are waiting for hospital arranged transport or social care/social service support. In these cases, the time of departure is the time the patient actually leaves the department. Patients awaiting family or 'private' transport or who wish to make their own arrangements should be considered discharged once the clinical episode is complete whether or not they have actually left the department.

ii) Transferred. Transfer is defined as transfer to the care of another NHS organisation or other public/private sector agency (for example social services). Time of transfer is defined as when the patient leaves the department.

iii) Admitted. An emergency admission via A&E is defined as an A&E attendance disposal under code 01. Time of admission is defined as 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 en route 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.

Note that in the NHS Data Model & Dictionary, patients waiting following a decision to admit are known as 'Lodged Patients', and they remain in the A&E department from the decision to admit to their Lodging End Time. The lodging end time is defined as follows:

'The time that the responsibility for nursing care is transferred from an accident and emergency department to a ward thus ending the period as a lodged patient. This will be the same as A&E departure time if the patient was lodged as a result of an accident and emergency attendance.'

‘The transfer of responsibility may occur when the patient is received into a bed in an appropriate ward, an operating theatre or another setting for immediate treatment (e.g. an X-ray Department) before being received into a bed in an appropriate ward. A bed in an A&E observation and assessment ward may be a transfer of responsibility but a trolley, bed or chair in a corridor would not.’

<u>Patients who need more than 4 hours observation/assessment</u>
For a few patients, a period of assessment and/or observation of greater than 4 hours before a decision to admit or discharge is made will be beneficial. This group would include some patients awaiting results of investigations, CT, reduction of fractures/dislocations, clinical observation for improvement, time critical diagnostics etc.

Every effort should be made to accommodate these patients, for their comfort, away from the main A&E in a dedicated observation/assessment ward. If this observation/assessment ward meets the criteria set out in FAQ 6.5, the patient should be treated as admitted for the period required for observation. In most cases, the admission will be very short – often much less than 24 hours. However the criteria for deciding if the patient is admitted and the time of admission applies in the same way it would to any other patient being admitted for a 24 hour or longer stay in the hospital.

However where these patients remain in A&E or are accommodated in an environment that not does meet the criteria set out in FAQ 6.5, they should remain within the total time count until they are admitted, transferred or discharged.

4 Waits for Emergency Admission via A&E from decision to admit to admission

A3i) Total number of patients who have waited 4-12 hours in A&E from decision to admit to admission – Type 1

A3ii) Total number of patients who have waited 4-12 hours in A&E from decision to admit to admission – Type 2

A3iii) Total number of patients who have waited 4-12 hours in A&E from decision to admit to admission – Other A&E department

A4i) Total number of patients who have waited over 12 hours in A&E from decision to admit to admission – Type 1

A4ii) Total number of patients who have waited over 12 hours in A&E from decision to admit to admission – Type 2

A4iii) Total number of patients who have waited over 12 hours in A&E from decision to admit to admission – Other A&E department

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

Defined as:

The waiting time for an emergency admission via A&E is measured from the time 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.

i) 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.

ii) 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:

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 en route 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 Trust will end when the ambulance crew collect 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.

For data items A3i, A3ii and A3iii include patients whose waiting time for an emergency admission is between 04:00:01 hours and 12:00:00 hours inclusive.

For data items A4i, A4ii and A4iii include patients whose waiting time for an emergency admission is 12:00:01 hours or longer.

5 Emergency admissions

The following data items should be completed by all providers that admit at least 40 emergency patients per month.

B1i) Number of emergency admissions via A&E - Type 1

Defined as:

All emergency admissions in the reporting period via Type 1 A&E departments. The "admission method" code for emergency admission via A&E is code 21 = Accident and emergency or dental casualty department of the Health Care Provider. Please include all patients who spend time in a Type 1 A&E department before being admitted as an emergency to the same healthcare provider.

B1ii) Number of emergency admissions via A&E - Type 2

Defined as:

All emergency admissions in the reporting period via Type 2 A&E departments. The "admission method" code for emergency admission via A&E is code 21 = Accident and emergency or dental casualty department of the Health Care Provider. Please include all patients who spend time in a Type 2 A&E department before being admitted as an emergency to the same healthcare provider.

B1iii) Number of emergency admissions via A&E – Other A&E department

Defined as:

All emergency admissions in the reporting period via Type 3 A&E departments / Type 4 departments / Urgent Care Centres. The "admission method" code for emergency admission via A&E is code 21 = Accident and emergency or dental casualty department of the Health Care Provider. Please include all patients who spend time in a Type 3 A&E department / Type 4 A&E department / Urgent Care Centre before being admitted as an emergency to the same healthcare provider.

B1iv) Number of emergency admissions - other

Defined as:

All emergency admissions in the reporting period that are not via any type of A&E department belonging to the same healthcare provider, e.g. patient admitted directly by GP. The following "admission method" codes will apply to these patients:

- 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 mean
- 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

6 Frequently Asked Questions

6.1 What does the monitoring of total time spent in A&E cover?

The monitoring covers all attendances at A&E departments, including Minor Injury Units, Urgent Care Centres or Walk-in Centres. It also covers those services that are provided by the independent sector for NHS patients and commissioned by CCGs.

6.2 How should we record patients who leave the A&E department without informing staff?

For patients who leave A&E before being treated the discharge time should be recorded as the time when it is found that the patient is no longer in the department. As a matter of good practice Trusts should have arrangements in place to regularly check that patients listed as waiting are still waiting and offer information about why they are waiting and the expected treatment time.

6.3 What does the monitoring of emergency admissions through A&E cover?

The monitoring covers all A&E attendances who need to be admitted, including patients referred by GPs for hospital admission who are assessed in the A&E department.

6.4 When does the waiting time for an emergency hospital admission start and finish

The waiting time for an emergency hospital admission is measured from the time when the decision is made to admit or when treatment in A&E is completed, whichever is the latest, to the time when the patient is received into:

i. a bed in a ward (see FAQ 6.5); or
ii. an operating theatre; or
iii. another setting for immediate treatment (eg an X-ray department) before being received into a bed in an appropriate ward; or
iv. an ambulance for transfer to another provider (disposal code 7)

Also see question 6.6 for further details on waiting time when patient is transferred to another provider. This measurement is not the same as measuring for total time spent in A&E.

6.5 The A&E clock can stop upon admission to a ward. What qualifies as a ward?

The NHS Data Dictionary definition of a “ward” is “a group of beds with associated treatment facilities managed by a senior nurse”.

In this instance, a ward is defined as an inpatient ward. This includes any interface ward (including observation wards, medical/surgical assessment wards and short stay admission wards) if they meet the guidance set out below on what constitutes a “ward”.

It is recognised that short stay wards will not be identical in every respect to longer stay inpatient wards. However, for patients in these wards to be treated as admitted, the environment needs to be such that the patient experience is similar to other inpatient wards.

The criteria below list minimum criteria for managers and clinicians to take into account when considering whether the patient experience is likely to be similar and therefore whether an environment constitutes a ward within the meaning of this guidance. The list is not meant to be exhaustive, but it is a checklist of things patients could reasonably expect to find in a ward on admission to hospital. These include:

- The same privacy and dignity as other in patient wards in the hospital
- Patients must have access to toilet and washing facilities
- No staff or public thoroughfare through the area
- Facilities for patients to securely store their belongings
- Sufficient space between beds to allow visitors to be seated in comfort
- Provision of hot meals and appropriate access to refreshments

Interface wards are expected to offer appropriate levels of nursing and clinical cover. Local managers in discussion with clinicians will need to decide whether or not a ward meets the criteria described. The onus will be on local managers where they are in any doubt to seek external advice and involve patients' representatives (through the Patients' Forum).

6.6 What if the patient is transferred to another trust?

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 Trust will end when the ambulance crew collect 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.

The exception to this is where a patient is transferred to another A&E Department, which may be run by another organisation, and is on the same campus. In this scenario the clock will **not** stop. The receiving organisation will report the combined wait, the forwarding organisation should ensure that sufficient data is forwarded to

the receiving organisation to allow accurate returns to be made. Should the patient's overall stay exceed 4 hours then **both** organisations should record the breach on their Sitrep.

For those organisations that will now fall under these new arrangements will need to implement methods of data sharing.

6.7 What if the patient is transferred to another department in the same trust?

Where a patient is transferred to another A&E Department, which is run by the same organisation, and is on the same campus then the clock will **not** stop. This is covered in question 6.5.

However, if the patient has to attend an A&E Department that is not on the same campus then a fresh waiting period should start when a patient is transferred to a different A&E department within the same Trust. This would normally involve attending a different type of A&E Department (eg Type 1 to Type 3 or vice versa)

6.8 We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?

Such attendances can be recorded by the trust in the following circumstances

a) The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust's involvement is limited to clinical governance.
b) The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.

6.9 Who should record the time of arrival?

The time of arrival should be recorded by the clinician (nurse or doctor) carrying out initial triage/assessment or A&E reception, whichever is earlier.

6.10 Should patients who are sent by their general practitioner directly to a Medical Assessment Unit (MAU) be counted?

GP referrals to an MAU for assessment or admission should not be counted as an A&E attendance. However, if the patient is subsequently admitted, this should be counted as an emergency admission (B1iv - other).

6.11 Should patients who are sent by their general practitioner directly to a drop in clinic be counted?

If the service is commissioned as a type 2 A&E service (for example, a type 2 eye walk in service), then the activity should be recorded as an A&E attendance. However, if the service is commissioned as an outpatient clinic then the activity should not be recorded as an A&E attendance.

7 Contact Details

If you have a question not covered by the form guidance or the FAQ please contact us via e-mail – unify2@dh.gsi.gov.uk.