NHS Improvement

# How to complete the winter daily situation report 2016/17

The daily winter situation report (SITREP) will indicate where there are winter pressures on the NHS around the country such as A&E closures or diverts, cancelled operations and pressure on beds. This guide outlines how to complete the sitrep with an annex outlining an example escalation framework.

## Process

The template will only populate questions the trust needs to complete, depending on whether it is achieving or failing the A&E four-hour performance target of 95%:

- Trusts that have previously encountered heightened operational pressure so that they have not met the A&E performance target for four consecutive weeks will need to complete the whole return.
- Trusts that have achieved the A&E four-hour performance for four consecutive weeks will only need to complete a subset of data items in the daily return.

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 their return is accurate and fit for purpose.

Once the web portal is closed for the reporting day there will be no retrospective data submissions for the day or any previous submissions.

Each collection will cover the previous 24 hours up until 8am that day (with the exception of A&E performance data submitted after a weekend or bank holiday – see below).

**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 detail including when declared and stood down.

## Reporting period

The 24-hour reporting period is defined as 8am on the day before reporting to 7:59:59 am on the actual day of reporting.

The bed figures provided should relate to the latest position on each day of reporting. The time of this snapshot is flexible, but should be 8am or 9am.

For A&E performance data the reporting period ideally should be from midnight to midnight, so that data submitted by 11.00 am on a Wednesday, for example, should relate to the period 00:00:00 on Monday night to 23:59:59 Tuesday night. If systems make it difficult to submit on this basis you may use a different 24-hour period (eg 8am to 8am) but must submit the data consistently each day, ensuring the majority of the 24 hours relate to the day being reported. For example, 8am Monday to 8am Tuesday should appear in the return submitted on Tuesday (about Monday).

On a Monday, or following a bank holiday, each day should be reported retrospectively to provide a daily breakdown of the data.

Christmas period: to be confirmed.

## Guidance notes on data items: operational issues/pressures

### A&E attendances

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

Follow the latest guidance for the monthly A&E return about which services should be included: www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

Note: A&E, in this context, means a type 1, type 2 or type 3 A&E department/minor injury (MIU) service department:

- Type 1 A&E department: a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for accident and emergency 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 types of A&E/ MIUs/walk-in centres, 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 or sited in the community. A defining characteristic of 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 (eg 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 patients with minor illness or injury.

Note: The data dictionary currently describes walk-in centres as type 4 departments but for sitreps, they should be included under type 3.

**Number of emergency admissions**

Defined as the sum of:

A: All emergency admissions in the reporting period via 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 healthcare provider. Include all patients who spend time in an A&E department before being admitted as an emergency to the same healthcare provider.

and B: Number of emergency admissions - other

All emergency admissions in the reporting period that are not via any type of A&E department belonging to the same healthcare provider, eg 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 means
- 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 A&E closures**

Record any unplanned, unilateral closures of an A&E department (type 1, 2 or 3) to admissions without consultation, which occurred without agreement from neighbouring trusts or from 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 it is still accepting patients arriving on foot.

Temporary closure of an A&E should only be done 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 planning for the latter and is available at: www.gov.uk/government/policies/planning-for-health-emergencies

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

**Number of A&E diverts**

Count the number of occasions when 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 (including ambulance trusts)/commissioners (where applicable) affected**. If there has been an A&E divert, also provide information on how long the divert lasted and where patients were diverted to, in the extra boxes provided. If there was more than one divert, enter the total time of the diverts, ie the sum.

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

1. agreement/discussion with the receiving A&E departments/acute trusts
2. agreement/discussion with local ambulance service
3. discussion/agreement with the local commissioners (this may be delayed until after the closure in situations which meet predetermined criteria agreed in advance with the commissioner).

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 agreed with neighbouring trusts. Robust network-wide escalation planning and internal planning should mean that any increase in activity can be managed internally, by for example diverting staff from elsewhere in the hospital. Therefore, diversion of patients for respite should only happen in exceptional circumstances, where internal measures have not solved the underlying problem.

Review plans periodically and develop protocols with neighbouring trusts and the ambulance trust for the area. Take an overall total view of system capacity including community response, intermediate care, community in-patient capacity, elective work

and acute resource, etc. The local emergency care network should be the usual forum for drawing up such protocols.

**Serious operational issues: Given the answers above, and any other relevant factors (eg staffing issues, adverse weather conditions), has the trust experienced serious operational problems during the past 24 hours? If 'yes', please provide further information in the relevant text boxes below.**

If the trust is at operational pressures escalation levels (OPEL) 3 or 4 (please refer to page 7) and has therefore has experienced serious operational problems, select 'Yes' from the dropdown box and complete the text box on actions being taken.

If it has not experienced serious operational problems, select 'No'. No further information will be required.

Note: If an incident (as in the 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), record it along with type, severity level and brief detail including when declared and stood down.

**General and acute (G&A) beds**

The following lines on beds relate to general and acute beds, using relevant definitions as in 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**. The time of this snapshot is flexible, but should be 8am or 9am.

5a. Total G&A 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 6 are occupied and 4 empty – exclude the 4 empty beds..

5b. Total G&A escalation beds open: The number of general and acute escalation beds open on day of reporting.

5c. Total G&A beds available: The form will automatically calculate the total number of beds available.

5d. Of total G&A beds open, number occupied

5e. Number of beds closed due to diarrhoea and vomiting (D&V)/norovirus-like symptoms

5f. Of these beds closed, number unoccupied

### Critical care beds

Adult critical care beds: Count all adult critical care (intensive therapy unit, 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 can be determined locally (eg 8am or 9am). 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 two counts should be consistent with those provided for the monthly sitrep return:

6a. Adult critical care beds available

6b. Adult critical care beds occupied

### Paediatric intensive care (PIC)

6c. Paediatric intensive care beds available

The total number of available paediatric intensive care (Level 2, Level 3 and Level 4) beds on day of reporting

6d. Paediatric intensive care beds occupied

The total number of occupied paediatric intensive care (Level 2, Level 3 and Level 4) beds on day of reporting

### Neonatal intensive care

6e. Neonatal intensive care cots (or beds) available

6f. Neonatal intensive care cots (or beds) occupied

## OPEL guidance

The OPEL guidance below is taken *Operational Pressures Escalation Levels Framework* by NHS England and NHS Improvement, available at: www.england.nhs.uk/resources/resources-for-ccgs/#operational-pressures

To enable local A&E delivery boards to align their escalation protocols to a standardised process, the national framework has been built on work already done across the four regions.

The levels mirror systems already in use around the country, and aligns with the national Resource Escalation Action Plan2 (REAP) used by ambulance trusts.

## Operational Pressures Escalation Levels

### OPEL 1

The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.

### OPEL 2

The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.

### OPEL 3

The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms

### OPEL 4

Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Local A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

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## About NHS Improvement

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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