NHS

A&E Attendances and Emergency Admissions Monthly Return Definitions

NHS England and NHS Improvement

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Introduction

This document sets out the definitions for the A&E Attendances and Emergency Admissions Monthly Return.

This version has been updated in July 2019 and reflects coding changes from A&E CDS to ECDS. It has also clarified when the A&E waiting time clock stops on admission.

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

- 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.
- All providers admitting at least 40 emergency patients per month.

This average should be calculated over a quarter.

It is expected that all data reported to this collection will also flow as part of the provider's ECDS return.

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[1]:

- 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/Urgent Treatment Centre (UTCs)/ 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 an appointment. From December 2019 the majority of Type 3 and Type 4 services will be designated as GP-led UTCs or will change their function to become other primary health care services, with any exemptions to be agreed with the Regional Director.

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 the A&E department 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.

[1]https://www.datadictionary.nhs.uk/data_dictionary/attributes/e/emergency_care_department_type_de.asp?shownav=1

A&E Attendances

Events overlapping days
If an attendance starts on one day and ends on the next, both the arrival and departure should be recorded in the later period. This is also true of attendances spanning month ends.

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, 2, or 3. This excludes planned follow up attendances.

Planned follow up attendances are defined as having an A&E attendance category of 4.

Follow up attendances must be for the same (or related) 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.

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 it 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 / Clock Start

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 / Clock Stop

Total time in the Department ends when the patient is discharged, transferred, or admitted.

i) Discharged from the provider. Time of discharge from the provider 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 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 leaving the A&E department with the a valid CDS admission code

Time of admission is defined as the time when such a patient leaves the A&E department and ceases to be under the care of the A&E consultant. The patient may 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
- A Same-Day Emergency Care (SDEC) unit

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.’

If a patient leaves the A&E and is admitted to a temporary bed in an inpatient ward, the time of admission should be the time the patient left the A&E and ceased to be under the care of the A&E consultant. In this scenario, the patient should consider themselves admitted and have a similar experience to the lodged patients within the same ward.

<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 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 5, they should remain within the total time count until they are admitted, transferred or discharged.

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

A3) Total number of patients who have waited 4-12 hours in A&E from decision to admit to admission

A4) Total number of patients who have waited over 12 hours in A&E from decision to admit to admission

The following guidance applies to both 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 with a valid admission disposal code. Time of admission is defined as:

For admitted patients, the time when such a patient leaves the department to go to:

- An operating theatre; or
- A bed in a ward; or
- 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 transfers, 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 item A3 include patients whose waiting time for an emergency admission is between 04:00:01 hours and 12:00:00 hours inclusive.

For data item A4 include patients whose waiting time for an emergency admission is 12:00:01 hours or longer.

Clinical Streaming

Patients that attend an A&E department and are subsequently streamed to another department on the same site, for example a GP service, should only be counted as a single attendance (and breach if the attendance exceeds 4 hours). The attendance should be counted against the final department the patient attended using a start time of when they arrived at the first department.

If a patient attends an A&E department and is streamed to same-day emergency care (SDEC) on arrival, then this is not a reportable A&E attendance. If a patient receives care in the A&E department before later being streamed to SDEC then this should be recorded as an A&E attendance with the clock stopped at the point at which they were transferred to SDEC.

Example A

A patient attends Type 1 A&E and is streamed to a co-located Type 3 A&E. The attendance (and any breaches) should be counted as a single Type 3 attendance.

Example B

A patient attends Type 1 A&E and is streamed to a co-located Type 3 A&E. The patient then deteriorates and is subsequently transferred back to the Type 1 A&E. The attendance (and any breaches) should be counted as a single Type 1 attendance.

Example C

A patient attends Type 1 A&E and is streamed to SDEC on arrival. The attendance is not counted as an A&E attendance.

Example D

A patient attends Type 1 A&E and tests and/or treatment are undertaken in the A&E. It is later decided to transfer the patient to SDEC. The attendance (and any breaches) should be counted as a single Type 1 attendance with the clock stopped at the point at which the patient is transferred to SDEC.

Exclusions from A&E Attendance and Performance Measures

The following areas should not be reported as A&E attendances, nor included in A&E performance measures:

- Patients attending hospital for an unscheduled early pregnancy-related assessment, for an example via an Early Pregnancy Unit (EPU). EPUs are considered outside the scope of emergency care and therefore should not be counted as an A&E attendance.
- Genitourinary medicine (GUM) and Sexual Health Clinics. Genitourinary medicine and Sexual Health are considered outside the scope of emergency care and therefore should not be counted as an A&E attendance.
- Emergency Inpatient Clinics or Wards. Any clinics where patients are admitted directly and bypass the A&E department should be counted as emergency admissions and not A&E attendances.

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 a 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

Frequently Asked Questions (FAQs)

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 (MIUs), Urgent Care Centres (UCCs) or Walk-in Centres (WiCs). It also covers those services that are provided by the independent sector for NHS patients and commissioned by CCGs.

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.

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.

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 leaves the care of the A&E consultant and is received into:

- a bed in a ward (see FAQ 5); or
- 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; or
- an ambulance for transfer to another provider (disposal code 7); or
- An SDEC unit (see FAQ 12)

Also see FAQ 6 for further details on waiting times for patients transferred to another provider. This measurement is not the same as measuring for total time spent in the A&E.

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".

A&E clocks can only stop upon admission to an inpatient ward or equivalent. 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" that is equivalent to an inpatient 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 list below gives the minimum criteria for managers and clinicians to take into account when considering whether the patient experience is likely to be similar to that of an inpatient ward and therefore whether an environment constitutes a ward within the meaning of this guidance. This list is not meant to be exhaustive but provides a checklist of things patients could reasonably expect to find in an inpatient ward on admission to hospital.

- The same privacy and dignity as other inpatient 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 provides a similar patient experience to that in an inpatient ward. 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. 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 the 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 and such organisations will need to implement suitable methods for data sharing. Should the patient's overall stay exceed 4 hours then **both** organisations should record the breach on their return.

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 FAQ 5.

However, if the patient must 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 (e.g. Type 1 to Type 3 or vice versa).

8. We are an acute trust. Can we record attendances at a nearby Type 3 A&E in our return?

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

- The acute trust is clinically responsible for the service delivered in the Type 3 A&E. This will typically mean that the service is operated and managed by the acute trust, with the majority of staff being employees of the acute trust. An acute trust should not assume responsibility for reporting activity for an operation if the acute trust's involvement is limited to clinical governance or oversight.
- The Type 3 A&E service is run by an Independent Sector (IS) provider on the same site as a Type 1 A&E unit run by the acute trust. This would need to be agreed by the parties involved, and only one organisation should report the activity as Type 3.
- Where patients are streamed to an off-site externally-commissioned service it must be recorded only once, and by the site at which the clinical responsibility for the patient's care is located.

9. Who should record the time of arrival?

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

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

GP referrals to a 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).

11. How should we record time of departure for a patient that dies in the department?

If a patient dies within the A&E department, the time of death should be used as the departure time. If this time is greater than 4 hours after arrival it should be reported as wait of over 4 hours.

12. How should we record time of departure for a patient that is transferred to same-day emergency care (SDEC)?

Any patients that undergo further assessment/treatment in the A&E but are then transferred to SDEC (where it is appropriate to do so) should be counted as an A&E attendance with the clock stop being defined as the point at which the patient leaves the A&E department and ceases to be under the care of the A&E consultant. In cases where SDEC is located within the A&E and the patient does not leave the department, it is when the responsibility of care is passed from the A&E consultant to the SDEC consultant.

Patients that are streamed to SDEC on arrival should not be counted as an A&E attendance.

Contact Details

If you have a question not covered by the form guidance or the FAQ, please contact us via e-mail – england.nhsdata@nhs.net