**NHS**

# Process and definitions for the daily situation report web form

25 October 2021

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.

Changes since the previous version are highlighted in yellow.

# Contents

# Process

The online return will need to be populated throughout the year by all NHS acute trusts.

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.

# Reporting period

The 24-hour reporting period is defined as midnight (00:00:00) to 23:59:59 on the day before reporting, so that data submitted by 11am on a Wednesday, for example, should relate to the period 00:00:00 on Tuesday morning to 23:59:59 on Tuesday night, covering the whole of Tuesday.

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.

During the winter period, over bank holiday weekends and during periods of extreme pressure on the NHS, submissions are required on a 7 day per week basis. During other times data in respect of Saturday and Sunday can be submitted retrospectively on Monday.

**Events overlapping days**

If an attendance starts on one day and ends on a later day, both the arrival and departure should be recorded on the later day.

For example, if a patient arrives at 11pm on a Tuesday and is discharged at 3am on Wednesday, both the attendance and breach should be recorded in Wednesday's data.

# Attendances

This guidance has been taken from A&E Attendances and Emergency Admissions, published monthly collection guidance, all data items reported in the UEC Daily SitRep should be consistent with that collection, found here – please refer to this guidance for FAQs https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

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 the reception of A&E patients. (Increasingly referred to as an Emergency Department)

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

- Type 3 A&E department. These are now Urgent Treatment Centres (UTCs).  These are GP-led, open at least 12 hours a day, every day, offer appointments that can be booked through 111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for.

  Non-UTC Type 3 or 4 facilities that continue to operate as MIUs, UCC, WICs because of ongoing service reconfiguration and/or being given a time limited exemption should continue to report as Type 3 facilities until planned changes are implemented.

An appointment-based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone/video 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.

However, the collection will now include some booked appointments in A&E departments, including the following:

- Appointments booked at UTC via NHS 111 or via GPs
- Appointments booked at A&E services set up as a response to the Covid-19 pandemic
- Appointments booked as part of NHS 111 First pilots

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.

# A&E attendances (and four-hour breaches)

<u>Follow up attendances</u>

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.

<u>Telephone, video or internet consultations do not count as an A&E attendance.</u>

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.  Exclude booked appointments.

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. Exclude booked appointments.

Number of A&E attendances – Type 3
Defined as:
All unplanned attendances in the reporting period at Type 3 A&E departments / Urgent Treatment Centres, whether admitted or not.  Exclude booked appointments.

# Booked appointments

Number of Booked A&E appointments – Type 1
Defined as:
All booked appointments that are attended at a type 1 A&E department, such as bookings made via 111 (including the NHS 111 First programme) or arrangements put in place as a

response to the Covid-19 pandemic.  Exclude any appointments where the patient does not attend.  Do not include planned follow ups.

Number of Booked A&E appointments – Type 2
Defined as:
All booked appointments that are attended at a type 2 A&E department, such as bookings made via 111 (including the NHS 111 First programme) or arrangements put in place as a response to the Covid-19 pandemic.  Exclude any appointments where the patient does not attend.  Do not include planned follow ups.

Number of Booked A&E appointments – Other departments
Defined as:
All booked appointments that are attended at a type 3/ Urgent Treatment Centres, such as bookings made via 111 (including the NHS 111 First programme) or arrangements put in place as a response to the Covid-19 pandemic.  Exclude any appointments where the patient does not attend.  Do not include planned follow ups.

**General note on booked appointments**

If a patient arrives at an A&E department and is then requested to attend a booked appointment at a later time, the original visit should NOT count as an A&E attendance.

Telephone or video consultations should NOT be counted as A&E attendances or booked appointments.

# Type 1 attendances acuity split

Each **type 1** attendance should be categorised by acuity, based on the patient's condition at the time of assessment. 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 – e.g. '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

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: e.g. 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 – e.g. the patient deteriorates – this may be recorded locally, but only the first value should be submitted as emergency care acuity.

## Patients streamed to co-located primary care led streaming service

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.

For examples, please see A&E Attendances and Emergency Admissions, published monthly collection guidance, found here: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

## 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.

# 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 (e.g. for outpatient clinics or tertiary care).

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 because 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.

# Ambulance handover delays of 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.

# Ambulance handover delays of 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.

# Admissions

## Number of admissions

Admissions should not be counted for maternity, mental health or day cases.

Elective Admission, when the DECISION TO ADMIT could be separated in time from the actual admission:

- 11 = waiting list
- 12 = booked
- 13 = planned

as well as:

- 81 = Transfer of any admitted PATIENT from other Hospital Provider other than in an emergency.

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
- 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

The number of emergency admissions should be included in your figure for number of 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
- 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 number of emergency admissions via A&E should be included in your figure for number of emergency admissions and the number of admissions.

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.

# Number of discharges

Discharges should relate to the number of admissions above, and should not be counted for maternity, mental health or day cases.

National discharge codes:

- 1 = PATIENT discharged on clinical advice or with clinical consent
- 2 = PATIENT discharged him/herself or was discharged by a relative or advocate
- 3 = PATIENT discharged by mental health review tribunal, Home Secretary or Court
- 4 = PATIENT died.

By collecting admissions and discharges, we intend to show the net gain or loss of available beds each day.

It is therefore essential that the cohort of patients reported in the admissions' metric matches the cohort of patients reported in the 'discharges' metric.

# 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 decision to admit

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 (i.e. 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' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) should be followed. 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: i.e. 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 (i.e. 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 – i.e. 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)

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 because 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.

<u>Only the trust that has diverted should report, not the trust receiving the diverted ambulances.</u>

# General and acute beds

The following lines on beds relate to general and acute beds, using relevant definitions from the KH03 beds return. Which can be found here:

https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

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.

In order to better understand the occupancy pressures facing acute trusts, general and acute beds will now be split between adult and paediatric beds.

## Core adult general and acute beds open

The number of adult 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.

## Adult general and acute escalation beds open

The number of adult general and acute escalation beds open on day of reporting. This would include areas opened for winter periods, which are intended to stay open for some time – i.e. not areas which are opened on the day to resolve extreme pressures (e.g. theatre space).

## Total adult general and acute beds open

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

## Of total adult general and acute beds open, number occupied

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

## Core paediatric general and acute beds open

The number of paediatric 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.

# Paediatric general and acute escalation beds open

The number of paediatric general and acute escalation beds open on day of reporting. This would include areas opened for winter periods, which are intended to stay open for some time – i.e. not areas which are opened on the day to resolve extreme pressures.

# Total paediatric general and acute beds open

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

# Of total paediatric general and acute beds open, number occupied

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

# Infection Control

## D&V/Norovirus-like symptoms

**Total number of beds** closed due to diarrhoea and vomiting (D&V)/norovirus-like symptoms (occupied and unoccupied)

This will be a sum of the adult beds closed and paediatric beds closed. *This metric is the same as we have historically collected for beds closed due to D&V.*

Of these beds closed due to D&V, number unoccupied

This will be a sum of the adult beds closed and unoccupied and paediatric beds closed and unoccupied. *This metric is the same as we have historically collected for beds closed and unoccupied due to D&V.*

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

Number of beds closed due to D&V/norovirus-like symptoms only. In the example below, 10 beds would be reported in this section.

*The definition for this metric has not changed from the historic collection, but we are splitting adult and paediatric beds.*

Of these beds closed due to D&V, number unoccupied

Unoccupied / empty beds which are unavailable to new admissions. In the example below, you would report 4 beds for this metric.

**For example:** if there are 10 beds in a bay, with 6 patients with D&V/norovirus-like symptoms, the rest are closed for infection control. Record all 10 beds in the category above and the four empty beds in this category.

The 4 empty beds should not be counted in the number of G&A beds open, if these beds will not accept any patient at the time of the snapshot.

*The definition for this metric has not changed from the historic collection, but we are splitting adult and paediatric beds.*

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

Number of paediatric beds closed due to D&V/norovirus-like symptoms only. In the example below, 10 beds would be reported in this section.

*The definition for this metric has not changed from the historic collection, but we are splitting adult and paediatric beds.*

### Of these beds closed due to D&V, number unoccupied

Unoccupied / empty paediatric beds which are unavailable to new admissions. In the example below, you would report 4 beds for this metric.

**For example:** if there are 10 paediatric beds in a bay, with 6 patients with D&V/norovirus-like symptoms, the rest are closed for infection control. Record all 10 beds in the category above and the four empty beds in this category.

The 4 empty beds should not be counted in the number of G&A beds open, if these beds will not accept any patient at the time of the snapshot.

*The definition for this metric has not changed from the historic collection, but we are splitting adult and paediatric beds.*

# Covid

## Number of adult beds closed due to Covid (occupied and unoccupied)

When patients are subject to infection control measures related to Covid-19 which would result in beds in the same bay being closed for new admissions with the possible exception of patients with the same infection. In the example below, you would report 10 beds for this metric.

## Of these beds closed due to Covid, number unoccupied

This has also been referred to as "void beds": unoccupied / empty beds which are unavailable to NON-Covid patients. In the example below, you would report 3 beds for this metric.

**For example:** if there are 10 beds in a bay, with 7 patients who are confirmed as Covid positive, the rest of the beds are unavailable to new admissions, unless that newly admitted patient is covid positive. Those 3 beds would be counted as closed and unoccupied in this section.

If these 3 beds will accept Covid positive patients at the time of this snapshot, they should be counted in your G&A beds open figure.

Number of paediatric beds closed due to Covid (occupied and unoccupied)

When paediatric patients are subject to infection control measures related to Covid-19 which would result in beds in the same bay being closed for new admissions with the possible exception of patients with the same infection. In the example below, you would report 10 beds for this metric.

Of these beds closed due to Covid, number unoccupied

This has also been referred to as "void beds": unoccupied / empty beds which are unavailable to NON-Covid patients. In the example below, you would report 3 beds for this metric.

**For example:** if there are 10 beds in a bay, with 7 patients who are confirmed as Covid positive, the rest of the beds are unavailable to new admissions, unless that newly admitted patient is covid positive. Those 3 beds would be counted as closed and unoccupied in this section.

As long as these 3 beds will accept Covid positive patients at the time of this snapshot, they should be counted in your G&A beds open figure.

# Other infection control

Number of adult beds closed due to other IPC reasons (occupied and unoccupied)

When patients are subject to other infection control measures which would result in beds in the same bay being closed for new admissions with the possible exception of patients with the same infection.

Of these beds closed due to other IPC reasons, number unoccupied

This has also been referred to as "void beds": unoccupied / empty beds which are unavailable to new admissions.

Number of paediatric beds closed due to other IPC reasons (occupied and unoccupied)

When paediatric patients are subject to other infection control measures which would result in beds in the same bay being closed for new admissions with the possible exception of patients with the same infection.

Of these beds closed due to other IPC reasons, number unoccupied

This has also been referred to as "void beds": unoccupied / empty beds which are unavailable to new admissions.

# RSV

## Number of paediatric beds closed due to RSV (occupied and unoccupied)

When paediatric patients are subject to infection control measures related to RSV which would result in beds in the same bay being closed for new admissions with the possible exception of patients with the same infection. In the example below, you would report 10 beds for this metric.

## Of these beds closed due to RSV, number unoccupied

This has also been referred to as "void beds": unoccupied / empty beds which are unavailable to NON-RSV patients. In the example below, you would report 2 beds for this metric.

**For example:** if there are 10 beds in a bay, with 8 patients with a confirmed RSV diagnosis, the rest of the beds are unavailable to new admissions, with the possible exception of patients with the same infection. Those 2 beds would be counted as closed and unoccupied in this section.

As long as these 2 beds will accept paediatric patients with an RSV diagnosis at the time of this snapshot, they should be counted in your G&A beds open figure.

# Metrics relating to influenza

- Daily census of the number of patients in the hospital (each day at 8am) with laboratory-confirmed influenza in HDU and ITU beds

- daily census of the number of patients in the hospital (each day at 8am) with laboratory-confirmed influenza in all other inpatient beds

- of these patients in hospital, the number who are newly diagnosed (laboratory-confirmed) in the last 24 hours.

# Long stay patients

## Beds occupied by long-stay patients: 7+ days
**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 'long-stay patients'. These are defined as any patient, meeting the criteria below, 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.

There will be patients in this number who are expected to have a seven-day or longer stay in a general and acute bed – e.g. patients who have had a stroke, myocardial infarction, fractured neck of femur or neurorehabilitation. The methodology is as follows:

- Acute activity only
- 18+ only
- Excludes regular day and night attenders, day cases and zero length of stay (LOS) admissions
- Acute trusts only
- Count long-stay days only (i.e. day 7 onwards).

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 long-stay patients: 14+ days
**beds occupied by patients with a length of stay of 14 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 'long-stay patients'. These are defined as any patient, meeting the criteria below, who is in a hospital bed for **14 days or more**.

The methodology is as follows:
- Acute activity only
- 18+ only
- Excludes regular day and night attenders, day cases and zero length of stay (LOS) admissions
- Acute trusts only

- Count long-stay days only (i.e. day 14 onwards).

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 long stay patients: 21+ days

**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 'long-stay patients'. These are defined as any patient, meeting the criteria below, who is in a hospital bed for **21 days or more**.

The methodology is as follows:
- Acute activity only
- 18+ only
- Excludes regular day and night attenders, day cases and zero length of stay (LOS) admissions
- Acute trusts only
- Count long-stay days only (i.e. Day 21 onwards).

The measure is a snapshot taken at midnight.

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 available for critical care patients (levels 2 and 3 - except paediatrics). 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, guidance can be found here:
https://www.england.nhs.uk/statistics/statistical-work-areas/critical-care-capacity/

## Adult critical care beds open

The total number of open adult critical care beds at 8am on the day of reporting.

## Of your adult critical care beds open, how many are level 3.

The total number of level 3 adult critical care beds open at 8am on the day of reporting.

## Adult critical care beds occupied

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

## Of your adult critical care beds occupied, how many are level 3.

The total number of level 3 adult critical care beds occupied at 8am on the day of reporting.

## Paediatric intensive care beds open

Paediatric intensive care at level 3, also known as paediatric advanced critical care. In order to provide the appropriate level of care for paediatric intensive care (level 3), a minimum nurse to patient ratio of 1:1 is required. There are 21 Trusts who are commissioned to provide Paediatric Intensive care (Level 3) across England (equating to 23 units).

Level 2 beds should be reported as Paediatric G&A beds.

## Paediatric intensive care beds occupied

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

*please note that the Monthly SitRep guidance has been updated in November 2018 to exclude paediatric HDU beds from this count, please check that your daily submission is consistent with this*

# Neonatal critical care cots open

The total number of available neonatal intensive care cots (or beds) on day of reporting. This includes level 2 and level 3 care.

# Of your neonatal critical care cots open, how many are level 3.

The total number of level 3 neonatal critical care cots (or beds) open at 8am on the day of reporting.

# Neonatal intensive care cots occupied

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

# Of your neonatal critical care cots occupied, how many are level 3.

The total number of level 3 neonatal critical care cots (or beds) occupied at 8am on the day of reporting.

# Patients in department for over 12 hours from arrival

The total number of patients who were not admitted, discharged or transferred within 12 hours of their arrival at A&E (all types).

This should relate to the number of attendances declared that day in order that a percentage of patients spending more than 12 hours in A&E can be calculated.

All waits in excess of 12 hours should be counted, regardless of whether the patient is admitted, transferred or discharged.

Queries relating to this metric should be directed to: england.uectransformation@nhs.net

# Elective cancellations

For the data items on elective cancellations, count admissions that were due to take place between 00:00 and 23.59 yesterday and that were cancelled by the trust for non-clinical reasons up to 14 days prior to yesterday's admission date or on the day of admission itself. Exclude patient initiated cancellation and cancellations for clinical reasons.  Include cancellations which are as a result of capacity constraints – beds, staffing or through the need to implement infection control protocols to maintain distancing.

Provide separately the number of ordinary and day case admissions that took place yesterday between 00:00 and 23:59.

For ordinary electives, include those with a patient classification of 1.  For day cases, include those with a patient classification of 2.

For both elective cancellations and elective admissions, include admissions with an admission method of 11, 12 or 13.

Provide the breakdown for Priority (P) Codes 1 to 4. The Priority Code is the standard categorisation for patients waiting for surgery, as part of the National Clinical Prioritisation Programme.

<72 hours          P1

<1 month          P2

<3 months          P3

>=3 months          P4

The P1-P4 categories are based on based on the prioritisation tool produced by the Federation of Surgical Specialty Associations and endorsed by all surgical colleges: https://fssa.org.uk/_userfiles/pages/files/covid19/prioritisation_master_240720.pdf

Further details about the National Clinical Prioritisation Programme can be found at:

1.      Letter from Pauline Philip to the NHS:

https://www.england.nhs.uk/coronavirus/publication/third-phase-of-nhs-response-to-covid-19-clinical-prioritisation-and-validation-of-elective-waiting-lists-letter/

2.      Programme FAQs:
https://www.aomrc.org.uk/wp-content/uploads/2020/11/National_Clinical_Validation_Programme_FAQ_1120.pdf

3.      Document outlining the framework and support tools:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/10/C0760-Clinical-validation-of-surgical-waiting-lists-1-2.pdf

Queries relating to elective cancellations should be directed to:

**england.rtt@nhs.net**

**For UEC Daily SitRep enquiries, contact:** england.dailysitrep@nhs.net

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