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# Commissioning Data Set v6.2.1

## Introduction of CDS Type 011 Emergency Care Data Set

### Change Specification

# Document management

## Revision History

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0.1	28/09/2016	First draft for comment to include ECDS
0.2	04/10/2016	SCCI and NHS Digital Rebranding
0.3	10/10/2016	Confirmation of new CDS Type 011 Emergency Care Dataset
0.4	27/10/2016	Inclusion of implementation dates and changed data items
0.5	03/11/2016	Initial internal development team comments
0.6	04/11/2016	Additional review
0.7	09/11/2016	Inclusion of Legal Status (s136) data items
0.8	09/11/2016	Final review
0.9	17/11/2016	Update following SCCI review on 16/11/2016, and title change from Change Request to Change Specification
0.10	21/11/2016	Inclusion of updated ECDS v5.0 (Technical Output Specification)
0.11	08/12/2016	Inclusion of comments from ISAS review
0.12	15/12/2016	Additional comments from ISAS review included
0.13	17/01/2017	Further comments from ISAS review included
0.14	19/01/2017	Final comments from ISAS review
0.15	20/01/2017	Reference to Impact Assessment included
0.16	23/01/2017	Inclusion of new ECDS Technical Specification Data Set tables
0.17	08/02/2017	Inclusion of SNOMED CT subset evidence
0.18	13/02/2017	Final review
0.19	23/02/2017	Final update following comments from SCCI Developers (SS)
0.20	31/03/2017	Final SCCI comments
0.21	05/04/2017	Development team review
0.22	06/04/2017	Inclusion of data flow diagram
0.23	12/04/2017	Updated following feedback from SCCI review
1.0	19/04/2017	Publication copy

## Reviewers

This document must be reviewed by the following people:

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The Department of Health has approved this information standard (SCCI0092-2062) for publication under [section 250 of the Health and Social Care Act 2012](#).

Assurance that this information standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Standardisation Committee for Care Information (SCCI), a sub-group of the National Information Board.

This information standard comprises the following documents:

- Requirements Specification
- Change Specification
- Implementation Guidance
- Technical Output Specification.

An Information Standards Notice (SCCI0092-2062 Amd 17/2015) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

The controlled copies of these documents can be found on the [NHS Digital website](#). Any copies held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

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## Glossary of Terms

Term	Abbreviation	Description
Accident and Emergency	A&E	Also referred to as Accident and Emergency Departments. These may be either major units, providing a 24 hour service seven days a week to which the great majority of emergency ambulance cases are taken, or small units commonly called casualty departments, in which services are often only available for limited hours and which may not deal with emergency ambulance cases
Accident and Emergency Department Type		<p><b>Type 1:</b> Emergency departments are a <b>CONSULTANT</b> led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency <b>PATIENTS</b></p> <p><b>Type 2:</b> Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of <b>PATIENTS</b></p> <p><b>Type 3:</b> Other type of A&amp;E/minor injury <b>ACTIVITY</b> with designated accommodation for the reception of accident and emergency <b>PATIENTS</b>. The department may be doctor led or <b>NURSE</b> led and treats at least minor injuries and illnesses and can be routinely accessed without <b>APPOINTMENT</b>. A <b>SERVICE</b> mainly or entirely <b>APPOINTMENT</b> based (for example a <b>GP Practice</b> or <b>Out-Patient Clinic</b>) is excluded even though it may treat a number of <b>PATIENTS</b> with minor illness or injury. Excludes NHS walk-in centres, but will include Urgent Care Centres</p> <p><b>Type 4:</b> NHS walk in centres</p>
Commissioning Data Sets	CDS	<p>The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is currently designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Accident and Emergency Attendances, Outpatient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data etc.</p> <p>CDS v6.2 includes CDS Type 010 A&amp;E</p> <p>CDS v6.2.1 supports the introduction of CDS v6.2.1 Type 011 - ECDS, which will ultimately replace CDS Type 010</p>
Electronic Data Transfer	EDT	Electronic Data Transfer (EDT) is used to transfer batch data securely to SUS.
Emergency Department Information System	EDIS	An electronic health record system used to manage data in support of Emergency Department patient care and operations.
Hospital Episode Statistics	HES	National statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals
Messaging Exchange for Social Care and Health	MESH	An upgraded message exchange service to transfer batch data securely to Secondary Uses Service (SUS) which will replace EDT.
National Tariff		A set of prices and rules to help providers of NHS care and commissioners provide best value to their patients. <a href="https://www.gov.uk/government/publications/nhs-national-tariff-">https://www.gov.uk/government/publications/nhs-national-tariff-</a>

		<a href="#">payment-system-201617</a>
<b>Public Health England</b>	<b>PHE</b>	An executive agency, sponsored by the Department of Health to protect and improve the nation's health and wellbeing, and reduce health inequalities
<b>Role Based Access Control</b>	<b>RBAC</b>	RBAC is the process through which a national set of job roles, activities and workgroups can be applied to grant users access to functionality and indirectly to data within NHS national (Spine) services. <a href="http://systems.digital.nhs.uk/rsmartcards/planning/rbacoutline">http://systems.digital.nhs.uk/rsmartcards/planning/rbacoutline</a>
<b>Referral to Treatment</b>	<b>RTT</b>	Waiting Times measurement policy for consultant led and Allied Health Professional activity, which monitors the waiting time between the referral of a patient to a service, to the time they receive first definitive treatment for their condition
<b>Standardisation Committee for Care Information</b>	<b>SCCI</b>	The Committee that oversees the development, assurance and approval of information standards, data collections and data extractions
<b>Secondary Uses Service</b>	<b>SUS</b>	Single source of comprehensive data to enable a range of reporting and analysis. SUS supports the NHS and its partners in the areas of planning, commissioning, management, research, audit, public health and a number of national initiatives, such as National Tariff and the reimbursement mechanism for acute care.
<b>Treatment Function Code</b>	<b>TFC</b>	A division of clinical work based on Main Specialty, but incorporating approved sub-specialties and treatment interests used by lead care professionals including but not limited to Consultants
<b>Extensible Markup Language</b>	<b>XML</b>	XML is a markup language designed to carry data, not to display data. It is the CDS XML schemas which carry data in the Commissioning Data Set format between health care providers and the Secondary Uses Services (SUS).

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# 1 Overview

## 1.1 Summary

Standard	
Standard Number	SCCI0092-2062
Standard Title	Commissioning Data Sets (CDS)
Release	
Release Number	Amd 17/2015
Release Title	Version 6.2.1: Addition of CDS Type 011 - ECDS
Description	<p>This change outlines the introduction of CDS Type 011 Emergency Care Data Set, within the existing CDS v6.2.</p> <p>The submission of CDS v6.2.1 Type 011 - ECDS will apply to all Accident and Emergency Department Types, explicitly, Types 1, 2, 3 and 4.</p> <p>Providers must continue to submit all other CDS Types within the current CDS v6.2, using the existing mechanisms to do so, but replace the current submission of CDS Type 010 A&amp;E, with the new CDS v6.2.1 Type 011 - ECDS.</p> <p>Once CDS v6.2.1 Type 011 - ECDS has been implemented by a particular site, CDS Type 010 A&amp;E will no longer be accepted by SUS for that site. CDS v6.2 will continue to be supported via the Secondary Uses Service (SUS), and any changes to SUS will also be applicable for CDS v6.2.1 Type 011 - ECDS, as and when this occurs.</p> <p>CDS v6.2.1 Type 011 - ECDS will initially be a weekly feed at least, from October 2017, moving ultimately to a daily feed from April 2018.</p> <p>When submitting CDS v6.2.1 Type 011 - ECDS on a daily basis, this should be automated from the Emergency Department Information System.</p> <p>CDS v6.2.1 Type 011 - ECDS data set includes code sets represented as NHS Data Dictionary-defined National Codes or SNOMED CT concepts.</p> <p>The changes outlined following this introduction will support the following areas:</p> <ul style="list-style-type: none"> <li>• Continued support for National Tariff</li> <li>• Accident and Emergency Clinical Quality Indicators (CQIs)</li> <li>• Mental Health</li> <li>• Improving Quality and Value of Hospital Data</li> <li>• Injury Surveillance</li> <li>• Changes to support local analysis by providers and commissioners</li> <li>• Maintenance updates to ensure alignment with NHS Data Dictionary editorial policy and to address known issues.</li> </ul> <p>The current CDS Type 010 A&amp;E data will be withdrawn from 1<sup>st</sup> April 2019.</p>
Implementation Completion Date	<p>ED Types 1, 2, 3 and 4 <b>MAY</b> flow CDS Type 011 - ECDS from 1<sup>st</sup> Aug 2017</p> <p>ED Types 1 and 2 <b>MUST</b> flow CDS Type 011 - ECDS from 1<sup>st</sup> October 2017</p> <p>ED Types 3 and 4 <b>MUST</b> flow CDS Type 011 - ECDS from 1<sup>st</sup> October 2018</p>

## 1.2 Supporting Products

Reference	Title
SCCI0092-2062	Requirements Specification
SCCI0092-2062	Implementation Guidance
SCCI0092-2062	Technical Output Specification

## 1.3 Related Standards

Ref #	Reference	Title
1	ISB 0092 Amd 16/2010	CDS Type 6.2 Information Standard
2	SCCI0034 Amd 35/2016	SNOMED CT Information Standard
3	SCCI1605 Amd 8/2013	Accessible Information Standard
4	ISB0149	NHS Number
5	ISB0149-02	NHS Number Standard for Secondary Care (England)
6	ISB 1588 Amd 11/2012	A&E Clinical Quality Indicators (in development)
7	ISB 1596 Amd 31/2012	Information Sharing to Tackle Violence (ISTV)

## 2 Change Request

### 2.1 Overview

The Commissioning Data Sets (CDS v6.2) is the primary mechanism for the national reporting of secondary care activity which is either NHS funded, and/or provided by NHS Organisations.

Commissioning Data Sets are patient level data sets intended to deliver robust, comprehensive, nationally consistent and comparable person-based information on activity to support a variety of secondary use purposes (i.e. not for the direct care of the patient).

These include:

- Monitor and manage NHS service agreements
- Develop commissioning plans
- Support the Payment by Results processes
- Support NHS Comparators
- Monitor Health Improvement Programmes
- Underpin clinical governance
- Understand the health needs of the population

The Department of Health requires accurate data for the following types of patient activity:

- Accident and Emergency attendances (within CDS Type 010 A&E)
- Outpatient Appointments (including Did Not Attends)
- Admitted Patient Care (Hospital Admissions)
- Elective Admission Lists

This includes all secondary care activity of this nature undertaken by NHS Hospital Providers, including patients receiving private treatment, and NHS patients treated electively in the independent sector (including Any Qualified Provider) and overseas.

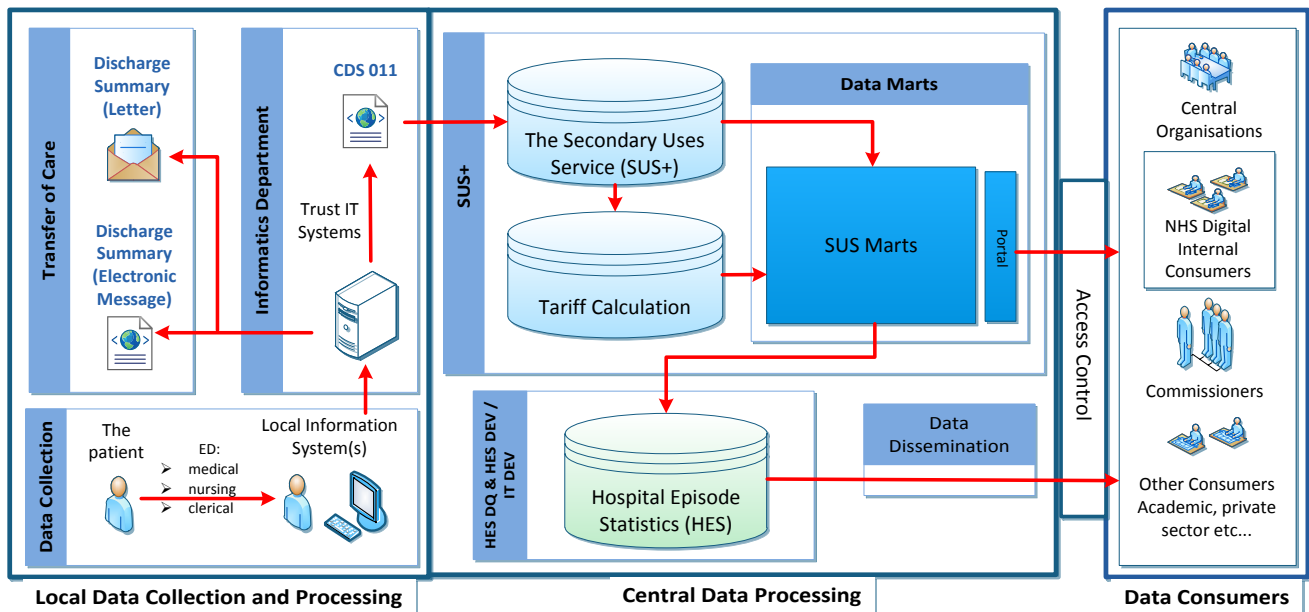
Commissioning Data Sets are securely submitted to the Secondary Uses Service (SUS) in XML format, and form the basis of the Hospital Episode Statistics (HES) data set.

The primary aim of CDS Type 010 was to support a variety of secondary use purposes. The Emergency Care Data Set (CDS v.6.2.1), which will replace the existing CDS Type 010 A&E, is closely aligned with the care and management of the patient, and the information collected will be dual-purpose, including; for the existing range of secondary uses and in some instances for the direct care of the individual (primary uses).

In ECDS (CDS v6.2.1) the developers have sought to align data collection for primary and secondary uses wherever possible as this ensures data quality that benefits patients, staff, commissioners, researchers and the wider NHS.

The ECDS does not intend to alter clinical practice, rather to streamline already existing practices and to introduce consistency.

The diagram below provides a high level view of the flow of ECDS data:



## 2.2 CDS v6.2.1 Type 011 Emergency Care Data Set (ECDS)

This change focuses exclusively on the introduction of the new CDS v6.2.1 Type 011 – ECDS within the existing CDS v6.2, eventually replacing the existing CDS Type 010 A&E. This document outlines the new data elements within the new CDS v6.2.1 Type 011 - ECDS.

The changes introduce new data items, update data items found in the current CDS Type 010 A&E data set and remove some data items.

The ECDS introduces a requirement for all Emergency Department types, as defined by the NHS Data Dictionary<sup>1</sup> to submit CDS v6.2.1 Type 011 - ECDS. This includes Type 3 and Type 4 departments (including Urgent Care Centres) who may not currently be submitting the CDS Type 010 A&E.

The existing mechanism to flow CDS Type 010 A&E data will remain, as outlined within the existing CDS v6.2. The mechanism to flow the data for CDS v6.2.1 Type 011 - ECDS will be via the Message Exchange for Social Care and Health (MESH).

## 2.3 Changes for Providers

The table below outlines the expected changes for providers, based on their current CDS 6.2 submission status:

Providers current CDS 6.2 Submission Status	Expected Change for Providers
Providers submitting CDS 6.2, within one file, including CDS Type 010, via EDT	<ul style="list-style-type: none"> <li>Separate the CDS Type 010 elements from current CDS 6.2 file pack where submissions are made including all CDS Types within one file</li> <li>Continue to submit remaining CDS Types within CDS 6.2 via Electronic Data Transfer (EDT)</li> <li><b>Submit CDS v6.2.1 Type 011 - ECDS, instead of CDS Type 010, via Message Exchange for Social Care and Health (MESH)</b></li> </ul>

<sup>1</sup>[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/acc/accident\\_and\\_emergency\\_department\\_type\\_de.asp](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp)

Providers submitting CDS 6.2, within separate files or independently of each other, including CDS Type 010, via EDT	<ul style="list-style-type: none"> <li>• Stop submitting CDS Type 010 as a separate file</li> <li>• Continue to submit remaining CDS Types within CDS 6.2 via EDT</li> <li>• <b>Submit CDS v6.2.1 Type 011 - ECDS, instead of CDS Type 010, via MESH</b></li> </ul>
Providers only submitting CDS Type 010 via EDT	<ul style="list-style-type: none"> <li>• Stop submitting CDS Type 010 via EDT</li> <li>• <b>Submit CDS v6.2.1 Type 011 - ECDS via MESH</b></li> </ul>
Providers not required to submit CDS Type 010, but submit other CDS Types within CDS 6.2	<ul style="list-style-type: none"> <li>• No change, continue to submit CDS Types (all others excluding CDS Type 010) via EDT</li> </ul>
Accident and Emergency Departments that currently do not submit any CDS Types within CDS 6.2	<ul style="list-style-type: none"> <li>• <b>Submit CDS v6.2.1 Type 011 - ECDS via MESH</b></li> </ul>

For those providers that already submit CDS Type 010, once they have transitioned to submitting CDS v6.2.1 Type 011 - ECDS, it will no longer be possible to revert to flowing CDS Type 010.

## 2.4 Change Justification

The relative costs and complexity of delivering emergency care have changed over recent years, due to:

- External factors including: increasing demand; access to alternative sources of care; patient preferences; perceived value and consistency of service.
- Internal factors including: pressure to avoid admitting patients unnecessarily; the front-loading of testing and decision making, which is now performed in Accident and Emergency Departments; increased subspecialisation of hospital practice with a reduced number of 'generalist' hospital doctors.

The current CDS Data Set Type 010 A&E has not evolved to keep pace with the changes described above, resulting in an 'information gap' in the data collected from Accident and Emergency Departments in England.

The Emergency Care Data Set project team has identified the following issues in the current data:

- A need for **accurate and relevant information regarding patients presenting to Accident and Emergency Departments** in England, and the quality of care delivered. The current CDS Data Set Type 010 A&E does not capture all the information relating to a patient's attendance at an Accident and Emergency Department, resulting in gaps in the record of the patient journey such as:
  - there is no accurate record of the source of the patient's referral to the Accident and Emergency Department.
  - the patient's chief complaint (the primary clinical reason for the attendance) is not captured consistently or submitted centrally.
  - there is no detailed information capturing what happens to patients during their Accident and Emergency attendance, e.g. when patients are referred to inpatient services for assessment or admission.
  - where patients go after their treatment in the Accident and Emergency Department is complete.
- The **complexity and acuity of Accident and Emergency department patients, and the value added by Accident and Emergency departments**, are not consistently described or understood through the data currently collected. The current Accident and Emergency Department data provides a simplistic view of the attendance focused on treatment and investigations, and what time patients arrive and leave. To understand each attendance in

greater detail additional information is required, particularly regarding the acuity and complexity of the patient.

- There is a need for **better diagnostic data to ensure an enhanced understanding of patient need, activity and outcomes**. Nationally, more than half of all Accident and Emergency Department attendances have no meaningful diagnosis, so there is no demonstrable value to the attendance.
- There is a need for **consistent data that facilitate an understanding of how patients use Accident and Emergency Departments**, other urgent care services, and overall patient flow in the urgent care system. Currently it is not possible to understand at what point in the patient journey contact has been made with different service types, which would help:
  - understand how patients access care
  - support effective service planning and organisation.
- Greater information is required to **understand who is doing what and when within** Accident and Emergency Departments. This will help ensure that patients receive safe and effective care when they need it.
- There is a need to **bring together disparate local and national initiatives aimed at improving urgent care services to encourage consistency**, and also to describe the work done across a range of providers in a common language.
- There is a need to **understand Accident and Emergency Department attendances relating to injury** and other modifiable factors to identify patterns that may be amenable to targeted interventions that will improve public health. Currently the data collected regarding injury related attendances are insufficient, which means we have no real understanding of the number of people attending Accident and Emergency Departments as a result of injury. The result is a lack of targeted prevention strategies that could reduce the number of Accident and Emergency Department attendances and improve the lives of patients.
- There is a need to **ensure that data on patient illnesses presenting to Accident and Emergency Departments is consistently monitored** to provide public health awareness of the current situation, as well as early warning of emerging population health threats. Public Health England (PHE) has an Emergency Department Syndromic Surveillance System (EDSSS). Currently this system only has access to data from 30 Accident and Emergency Departments in England, and thus does not represent the whole picture. The introduction of ECDS will support the capability to improve the information available to EDSSS.

## 2.5 ECDS Impact Assessment

NHS Digital were commissioned by the Emergency Care Data Set Project Board to undertake an impact assessment of ECDS which took place from December 2015 and a final report produced in September 2016. The impact assessment undertook a range of activities in order to help determine the recommended approach to implement ECDS into the health and care system.

The scope of the report included a review of; the data collection options, data submission frequency, impacts on system changes, increase in the number of data items, barriers to successful implementation, implementation timescales, rollout approach, costs, benefits and alignment with national policies.

The focus of the assessment was across the following areas;

- on local data collection and processing (Types 1 – 4),
- to central data processing (NHS Digital systems),
- for consumers of data from central systems,
- on consumers of local data flows.

The ECDS Impact Assessment outlined the following findings;

- existing national A&E data collections do not clearly demonstrate accurately all of the activity undertaken within Emergency Departments

- the majority of the benefits anticipated to be realised by local commissioners, who will use ECDS data to reconfigure services and direct resources to the most appropriate places for patients, however, quantifiable benefits are also anticipated
- collecting the CDS v6.2.1 Type 011 ECDS isn't anticipated to have a significant impact on those Accident and Emergency Departments already collecting the current CDS Data Set Type 010 A&E. This is largely because they may already collect some of the additional data items, many of which are very similar to those included in the proposed ECDS. However, the greatest impact will be the system changes which will need to be implemented to support collection of CDS v6.2.1 Type 011 - ECDS.

The ECDS Impact Assessment looked at the impact of changing the submission frequency of A&E data and found that a move to more frequent flows of data would be possible, but that this would need to be looked in more detail to understand how this could be implemented and the impact that this would have on providers. Further work concluded that whilst a daily feed was the most desirable submission frequency, in order to deliver ECDS benefits this would need to be phased in with providers initially increasing the frequency of data submission to weekly then progressing to daily by April 2018.

It is acknowledged that implementing ECDS in October 2017 will be challenging for providers. However, the need for a new emergency care data set is clear and NHS England have stated that there should not be any further delay in realising the considerable benefits of this work. The timetable for implementation has been accelerated to ensure that the ECDS is in place as the service moves into winter 2017/18.

Adoption of the ECDS will be incentivised and implementation is supported by a staged approach with NHS England and NHS Digital taking an active role in the management of the implementation process as 2017 proceeds.

### 3 Change Specification

Full details of all the data items will be available within the Technical Output Specification CDS v6.2.1 Type 011 - ECDS available from <http://content.digital.nhs.uk/isce/publication/SCCI0092-2062>.

This will include the following details:

- Data Group
- Data Item Name
- Data Item Status (Mandatory/ Required/ Optional)
- Data Item Definition / Description
- Data item format
- Justification for inclusion
- Code set format e.g. SNOMED CT/ DMD or ODS
- Whether the data item has a corresponding code set
- Link to Current CDS Type 010 data item (for information only)
- Validation Rules
- Confirmation of whether the data item; originates from CDS Type 010 A&E, i.e. the data item is also used within that CDS Type, or, whether the data item is a new data item not currently included within CDS Type 010 A&E.
- Relevant notes

### 3.1 Data Items

The following table outlines all the data items to be included within CDS v6.2.1 Type 011 - ECDS.

Some of these data items originate from CDS Type 010 A&E (including those which names may have changed, or have a new status but were previously collected within CDS Type 010) and some are new data items not currently found within CDS Type 010 A&E at all.

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	The unique booking reference number assigned by the Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the Choose and Book system. When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if subsequently the PATIENT does not attend or cancels the APPOINTMENT. UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) should only be	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		recorded where the type of booking system is the Choose and Book system.				
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	PATIENT PATHWAY IDENTIFIER	<p>An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY.</p> <p>This is a specific type of the attribute ACTIVITY IDENTIFIER.</p> <p>Where a pathway is initiated by a SERVICE REQUEST using the Choose and Book system, the PATIENT PATHWAY will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the ORGANISATION CODE of Choose and Book which is X09.</p> <p>Where the pathway is initiated by some other method, the PATIENT PATHWAY IDENTIFIER will be allocated by the Organisation receiving the SERVICE REQUEST which together with that Organisation's ORGANISATION CODE / ORGANISATION IDENTIFIER</p>	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		will uniquely identify the PATIENT PATHWAY.				
PATIENT PATHWAY - PATIENT PATHWAY IDENTITY	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	A unique identifier for an ORGANISATION.	M	ODS	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD STATUS	The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	WAITING TIME MEASUREMENT TYPE	The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY. The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health policy.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD START DATE	The start date of a REFERRAL TO TREATMENT PERIOD.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
PATIENT PATHWAY - REFERRAL TO TREATMENT PERIOD CHARACTERISTICS	REFERRAL TO TREATMENT PERIOD END DATE	The end date of a REFERRAL TO TREATMENT PERIOD.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The status of the NHS number.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	WITHHELD IDENTITY REASON	WITHHELD IDENTITY REASON is used in Data Group 'Withheld Identity Structure' in the Commissioning Data Sets (version 6-2 onwards). It allows suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system. Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - LOCAL PATIENT IDENTIFIER STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - VERIFIED IDENTITY	NHS NUMBER STATUS INDICATOR CODE	The status of the NHS number.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
STRUCTURE						
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	LOCAL PATIENT IDENTIFIER (EXTENDED)	A number used to identify a PATIENT uniquely within a Health Care Provider. It may be different from the PATIENT's casenote number and may be assigned automatically by the computer system. Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		sector or overseas PAS Number should be used.				
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER	The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	NHS NUMBER STATUS INDICATOR CODE	The status of the NHS number.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT NAME - PERSON NAME STRUCTURED OR PATIENT NAME - PERSON NAME UNSTRUCTURED	PATIENT NAME is the PERSON NAME where the PERSON NAME CLASSIFICATION is ' <i>Preferred Name</i> ' of the PATIENT.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PATIENT USUAL ADDRESS - ADDRESS STRUCTURED (Label format Postal Address) OR PATIENT USUAL ADDRESS - ADDRESS UNSTRUCTURED	PATIENT USUAL ADDRESS is the usual ADDRESS nominated by the PATIENT, where the ADDRESS ASSOCIATION TYPE is ' <i>Main Permanent Residence</i> ' or ' <i>Other</i> '	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
	(Character string)	<i>Permanent Residence</i> '.				
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	POSTCODE OF USUAL ADDRESS	The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	PERSON BIRTH DATE	The date on which a PERSON was born or is officially deemed to have been born.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PERSON STATED GENDER CODE	The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes.	R	DM&D	As per CDS 6.2 Type 010. Updated to align to most recent information standard to describe gender, changed from Person Gender Code.	Originates from A&E CDS Type 010
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ETHNIC CATEGORY	The ethnicity of a PERSON, as specified by the PERSON.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCOMMODATION STATUS (SNOMED CT)	An indication of the type of accommodation that a PATIENT currently has. This should be based on the PATIENT's main or permanent residence.	R	SNOMED CT	This item is necessary to identify rates of ED treatment, admission and discharge of specific populations of patients. This will substantially aid planning and delivery of care for specific population groups at both a local and central level e.g. by identifying patients such as nursing home residents whose care needs may be best met in the community. It will also allow specific incentives to be incorporated into any tariff arrangement.	NEW' A&E data item
PATIENT CHARACTERISTICS (EMERGENCY CARE)	PREFERRED SPOKEN LANGUAGE (SNOMED CT)	The language used by a PERSON.	R	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	NEW' A&E data item
PATIENT CHARACTERISTICS (EMERGENCY CARE)	ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT)	Whether a person requires an interpreter to communicate successfully.	R	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					ameliorated. This data is necessary to ensure that translation resources match patient need.	
PATIENT CHARACTERISTICS (EMERGENCY CARE)	INTERPRETER LANGUAGE (SNOMED CT)	The language of the interpreter needed to allow the person to communicate successfully.	R	SNOMED CT	Necessary to understand how best to provide for patient needs, identify language barriers that may prevent optimal healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.	NEW' A&E data item
PATIENT CHARACTERISTICS (EMERGENCY CARE)	OVERSEAS VISITOR CHARGING CATEGORY AT CDS ACTIVITY DATE	The charging category relating to an OVERSEAS VISITOR STATUS	R	DM&D	As per CDS 6.2 Type 010. Code set amended to align to new DH guidance on reclaiming overseas visitor's contributions to NHS care.	Originates from A&E CDS Type 010
MENTAL HEALTH ACT LEGAL STATUS	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START DATE records the start date of the Mental Health Act Legal Status Classification Assignment Period.	M	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
MENTAL HEALTH ACT LEGAL STATUS	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START TIME records the start time of the Mental Health Act Legal Status Classification Assignment Period.	M	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	NEW' A&E data item
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	NEW' A&E data item
MENTAL HEALTH ACT LEGAL STATUS	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.	R	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	NEW' A&E data item
MENTAL HEALTH ACT LEGAL STATUS	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is required for all PATIENTS who have a Hospital Provider Spell which includes the care of a CONSULTANT in the psychiatric specialties or have been discharged from such a Hospital Provider Spell and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.	M	DM&D	To support a better understanding of the use of the Mental Health Act in acute trusts, specifically Emergency Departments.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
GP REGISTRATION	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
GP REGISTRATION	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	R	ODS	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
EMERGENCY CARE ATTENDANCE LOCATION	ORGANISATION SITE IDENTIFIER (OF TREATMENT)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	M	Updated to new Organisation code guidelines	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
EMERGENCY CARE ATTENDANCE LOCATION	EMERGENCY CARE DEPARTMENT TYPE	An Emergency Care Department is a Department. An Emergency Care Department may be either: <ul style="list-style-type: none"> <li>• an Accident and Emergency Department or</li> <li>• an Ambulatory Emergency Care Service.</li> </ul>	M	As per CDS 6.2 Type 010. Updated to include new code for Ambulatory Emergency Care Unit in anticipation of this data set being used to	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
				support the collection of AEC data in the future.		
AMBULANCE DETAILS	AMBULANCE INCIDENT NUMBER	An identifier for each PATIENT TRANSPORT JOURNEY.	R	DM&D	As per CDS 6.2 Type 010 Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities that can benefit ambulance services, emergency departments and patients.	Originates from A&E CDS Type 010
AMBULANCE DETAILS	ORGANISATION CODE (CONVEYING AMBULANCE TRUST)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	R	ODS	Updated to new Organisation code guidelines. Amended from 'Optional' to 'Required' at request of DH. Making these data items required will allow linking of ambulance and emergency department data, thus providing information about a patient from the moment an ambulance is called until they leave hospital. This will provide learning opportunities	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					that can benefit ambulance services, emergency departments and patients.	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE IDENTIFIER	A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL MODE (SNOMED CT)	EMERGENCY CARE ARRIVAL MODE (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the transport mode by which the PATIENT arrived at the Emergency Care Department.	R	SNOMED CT	As per CDS 6.2 Type 010. Code set updated to include greater granularity in descriptors than used currently (brought in by emergency ambulance and other). Arrival mode helps commissioners to match the records of ambulance patients to Emergency Care and inpatient activity and is part of the information set that allows the patient journey to be across different providers in the healthcare system. Arrival mode is often used as a proxy for patient acuity in analysis and planning as patients brought to the Emergency Care facility by ambulance are more likely to be admitted than those who have arrived by private or	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					public transport. Amended to be collected in SNOMED CT.	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE CATEGORY	The category of Emergency Care Attendance.	R	DM&D	As per CDS 6.2 Type 010. Necessary to understand the reason and nature for the visit to the healthcare provider. This data item provides an indication of whether a PATIENT is making first or follow-up attendance at a particular Accident and Emergency Department. The increased clarity that the revised code set will bring will be important in commissioning services at local and national level. One of the most contentious areas in acute healthcare is whether patients who attend Emergency healthcare because other potentially more cost-effective alternatives have not been used or have failed. If patients attend Emergency healthcare despite having been seen recently in other healthcare settings, it may well be that the services currently commissioned are not effective. The recent evidence suggests	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					that the optimal horizon is approximately seven days, which is why this is chosen rather than 72 hours or 28 days.	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT)	The source of referral of each Accident and Emergency Episode. Source from which patient was referred/ advised to attend the ED. Not mode of transport.	R	SNOMED CT	Code set updated to include greater granularity in descriptors than currently used. This data item is necessary to understand why patients attend Emergency Care. This informs commissioning both locally and centrally and for long-term workforce planning so that the NHS can ensure that the correct blend of staff are recruited and trained.	Originates from A&E CDS Type 010
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.	R	ODS	This data necessary to link records for the (rare, but high acuity) patients who are transferred between institutions. As acute care networks and retrieval/ transfer arrangements become more common, recording this information will be increasingly important for commissioners of services to understand patient pathways, and where in the pathways value is added.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>This information is also important in payment mechanisms as incentives will need to be in place to ensure that the correct patients are transferred e.g. referring providers are not penalised because they transfer 'high value' patients.</p> <p>The regional organisation of healthcare into networks has increased the need for patients to be transferred to Emergency Centres with Specialist Services for optimum care of conditions that require highly specialised acute care delivered in regional centres e.g. Stroke, Cardiac, and Trauma.</p>	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL DATE	<p>An Emergency Care Arrival Date is an ACTIVITY DATE TIME.</p> <p>An Emergency Care Arrival Date may be either:</p> <ul style="list-style-type: none"> <li>• the Arrival Date At Accident and Emergency Department or</li> <li>• the Ambulatory Emergency Care Arrival Date.</li> </ul> <p>An Arrival Date At Accident and Emergency Department is the date the PATIENT self</p>	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.				
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE ARRIVAL TIME	An Arrival Time At Accident and Emergency Department is an ACTIVITY DATE TIME. Page 21 of 73 The Emergency Care Arrival Time may be either: • the Arrival Time At Accident and Emergency Department or • the Ambulatory Emergency Care Arrival Time. An Arrival Time At Accident and Emergency Department is the date the PATIENT self-presented at the Accident and Emergency Department or arrived in an Ambulance at the Accident and Emergency Department.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	AGE AT CDS ACTIVITY DATE	AGE AT CDS ACTIVITY DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the CDS ACTIVITY DATE.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
ATTENDANCE OCCURRENCE ACTIVITY	EMERGENCY CARE INITIAL ASSESSMENT DATE	An Emergency Care Initial Assessment Date is an ACTIVITY DATE TIME.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
CHARACTERISTICS		The Emergency Care Initial Assessment Date may be either: <ul style="list-style-type: none"> <li>• the Accident and Emergency Initial Assessment Date or</li> <li>• the Ambulatory Emergency Care Initial Assessment Date.</li> </ul> An Accident and Emergency Initial Assessment Date is the date that the PATIENT is first assessed in the Accident and Emergency Department.				
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE INITIAL ASSESSMENT TIME	An Emergency Care Initial Assessment Time is an ACTIVITY DATE TIME. The Emergency Care Initial Assessment Time may be either: <ul style="list-style-type: none"> <li>• the Accident and Emergency Initial Assessment Time or</li> <li>• the Ambulatory Emergency Care Initial Assessment Time.</li> </ul> An Accident and Emergency Initial Assessment Time is the time, recorded using the 24 hour clock, that the PATIENT is first assessed in the Accident and Emergency Department for first attendances and unplanned follow-up attendances.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
ATTENDANCE	EMERGENCY CARE	EMERGENCY CARE ACUITY	R	SNOMED	A single number that	NEW' A&E data

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
OCCURRENCE ACTIVITY CHARACTERISTICS	ACUITY (SNOMED CT)	<p>(SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE ACUITY (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the acuity of the PATIENT's condition on the Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Time.</p> <p>The EMERGENCY CARE ACUITY (SNOMED CT) may be determined by a formal triage process, or by the physical allocation of the PATIENT to a specific clinical area such as Resuscitation.</p>		CT	<p>represents the acuity of the patient's illness, in accordance with internationally used definitions of acuity measurement.</p> <p>Presentation Acuity and Presentation Symptom should be recorded by the first clinician who sees the patient. 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: Presentation Acuity and Presentation Symptom.</p> <p>In the UK many EDs have historically used their own ways of labelling acuity. There is a need for Emergency Care to standardise their input measurement to record accurately the acuity of patients attending across a range of Emergency Care services, which will help inform optimum use of resources in the provision of Emergency Care. There is</p>	item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					benefit to capturing and communicating the level of acuity of the presenting patient as it enables all parties to understand the gravity of the patient's initial clinical state as assessed by those directly treating the patient.	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT)	EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) is the SNOMED CT® concept ID which is used to indicate the nature of the PATIENT's chief complaint as assessed by the CARE PROFESSIONAL first assessing the PATIENT.	R	SNOMED CT	There is a need for Emergency Care to standardise input measurement to record accurately the type of patients attending across a range of Emergency Care services, which will help inform commissioners – both central and local - as to the likely nature and complexity of patient loads. As the NHS moves to value-based commissioning, it is fundamentally important to be able to measure inputs and outputs. In the UK there has been no single measure of presenting symptoms, and many EDs have historically used their own set of measures or modified existing systems. A system-wide adoption of the Chief Complaint measure will	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					allow patient pathways to be standardised with decision support, and there is ample evidence that this improves quality of care and efficiency.	
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE DATE SEEN FOR TREATMENT	Accident and Emergency Date Seen For Treatment is the date, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
ATTENDANCE OCCURRENCE ACTIVITY CHARACTERISTICS	EMERGENCY CARE TIME SEEN FOR TREATMENT	An Accident and Emergency Time Seen For Treatment is the time, recorded using the 24 hour clock, that the PATIENT is seen by a clinical decision maker (someone who can define the management plan and discharge the PATIENT) to diagnose the problem and arrange or start definite treatment as necessary.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
INJURY CHARACTERISTICS	INJURY DATE	The date that the injury occurred.	M	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: <ul style="list-style-type: none"> <li>• in children, delay between injury time and presentation to a healthcare professional is well recognised as a 'red flag' indicating a high risk of child abuse.</li> <li>• evidence of a delay from injury to presentation will change clinical treatment e.g. avoid closing a wound when infection is likely to be present. If a subsequent complication occurs, such as wound infection, the evidence provided by this data - that there was a delay between injury and presentation would also reduce the risk of the healthcare provider being found liable.</li> </ul>	NEW' A&E data item
INJURY CHARACTERISTICS	INJURY TIME	The time that the injury occurred.	M	DM&D	This data item is necessary to identify delay between injury occurrence and presentation. Delay from injury is important to know in two situations: <ul style="list-style-type: none"> <li>• in children, delay between injury time and presentation to a healthcare professional is</li> </ul>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>well recognised as a 'red flag' indicating a high risk of child abuse.</p> <ul style="list-style-type: none"> <li>evidence of a delay from injury to presentation will change clinical treatment e.g. avoid closing a wound when infection is likely to be present. If a subsequent complication occurs, such as wound infection, the evidence provided by this data - that there was a delay between injury and presentation would also reduce the risk of the healthcare provider being found liable.</li> </ul>	
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (SNOMED CT)	The type of location at which the person was present when the injury occurred.	R	SNOMED CT	To be able to understand the patterns of injury, and more importantly how to prevent them, it is necessary to be able to collect basic information regarding the type of place where the injury occurred. This information allows the data to be aggregated in a meaningful way so that analysis can pick up patterns of injury that occur in certain contexts e.g. assaults outside a particular pub on a particular day of the week.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LATITUDE)	EMERGENCY CARE PLACE OF INJURY (LATITUDE) is the latitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	NEW' A&E data item
INJURY CHARACTERISTICS	EMERGENCY CARE PLACE OF INJURY (LONGITUDE)	EMERGENCY CARE PLACE OF INJURY (LONGITUDE) is the longitude of the EMERGENCY CARE PLACE OF INJURY (SNOMED CT), expressed in decimal degrees.	O	DM&D	Exact longitude and latitude is the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map.	NEW' A&E data item
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY INTENT (SNOMED CT)	The most likely <b>human</b> intent in the occurrence of the injury or poisoning as assessed by clinician.	R	SNOMED CT	Preventing preventable injury is of great benefit to individuals and society, and identifying the number and severity of assaults has been very difficult. Understanding injury intent underpins all injury prevention work, whether at a local or national level. An example of a targeted prevention strategy specifically focusing on one area of intent is the Information Sharing to Tackle Violence Information Standard (ISB 1594) which relies on assault related data (intent -	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					apparent assault).	
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT)	The status of activity being undertaken by the person at the moment the injury occurred.	R	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport. The ageing population has meant that the pattern and severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause.	NEW' A&E data item
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT)	The type of activity being undertaken by the person at the moment the injury occurred.	R	SNOMED CT	Injury surveillance has resulted in major reductions in injury from road traffic collisions and workplace incidents. However the biggest rise in injury in the last ten years are injuries occurring in the home and during leisure and sport. The ageing population has meant that the pattern and	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>severity of injuries occurring at home has become a significant health burden to the NHS. Better data will inform prevention of these injuries, and more granular activity data is essential for this process to understand the cause.</p> <p>Injury prevention could not and should not prevent all injury from recreational and sporting activity. However injury surveillance should identify activities that result in significant preventable injury.</p>	
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY MECHANISM (SNOMED CT)	How the injury was caused.	R	SNOMED CT	<p>To understand how people injure themselves it is necessary to collect a structured description of the mechanism of injury. This is particularly important for the increasing numbers of patients who are injured in the home, as it is suspected that relatively simple measures e.g. avoid polished floors or loose floor coverings may make a very large difference.</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
INJURY CHARACTERISTICS	EMERGENCY CARE INJURY ALCOHOL OR DRUG INVOLVEMENT (SNOMED CT)	A record of any drugs or alcohol used by the patient, which are thought likely to have contributed to the need to attend the ED.	R	SNOMED CT	Drugs and alcohol are frequently implicated in the cause of injury and the ECDS proposes a structured way to capture this data.	NEW' A&E data item
PATIENT CLINICAL HISTORY	COMORBIDITY (SNOMED CT)	A record of whether a person has any of the NHS list of medical co-morbidities.	R	SNOMED CT	Co-morbidities are a key determinant in patient care e.g. whether it is safe to treat a patient in the community or whether a patient should be admitted to hospital e.g. for pneumonia, cellulitis. An accurate list of co-morbidities and current medications are therefore essential pieces of knowledge in the effort to minimise inpatient admissions and risk to patients – ensuring the right treatment in the right place. Flowing this data nationally allows a better understanding of the factors that predict complexity of emergency care which in turn allows accurate commissioning of services to meet the needs of patients in the best and most effective way e.g. if there are many attendances for patients with diabetes-related complaints, would a community nurse be an effective intervention to	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					prevent these? Equally, if a patient presents with what appears to be a relatively minor condition e.g. a foot infection, the complexity and clinical relevance will not be appreciated if the patient's diabetes and heart failure are not known about. Ensuring this information is available at point of care minimises risk of inappropriate treatment and can facilitate implementation of guidelines and decision support.	
SERVICE AGREEMENT DETAILS	COMMISSIONING SERIAL NUMBER	A number used to uniquely identify a NHS SERVICE AGREEMENT by an Organisation acting as commissioner of patient care services.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
SERVICE AGREEMENT DETAILS	NHS SERVICE AGREEMENT LINE NUMBER	A number (alphanumeric) to provide a unique identifier for a line within a NHS SERVICE AGREEMENT.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
SERVICE AGREEMENT DETAILS	PROVIDER REFERENCE NUMBER	PROVIDER REFERENCE NUMBER is a number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
SERVICE AGREEMENT DETAILS	COMMISSIONER REFERENCE NUMBER	A number (alphanumeric) allocated by the commissioner to a REFERRAL REQUEST.	O	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF PROVIDER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
SERVICE AGREEMENT DETAILS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	An ORGANISATION CODE is a code which identifies an Organisation uniquely.	M	ODS	Updated to new Organisation code guidelines	Originates from A&E CDS Type 010
CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ISSUER CODE	A code which identifies the PROFESSIONAL REGISTRATION BODY.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
CARE PROFESSIONALS (EMERGENCY CARE)	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	The registration identifier allocated by an Organisation.	M	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL TIER (EMERGENCY CARE)	The tier of CARE PROFESSIONAL treating the PATIENT during an Emergency Care Attendance. The CARE PROFESSIONAL TIERS FOR EMERGENCY CARE are defined in the Royal College of Emergency Medicine Guidelines for Medical and Practitioner Staffing in Emergency Departments. See the Royal College of Emergency	M	DM&D	Recording the clinician(s) responsible for patient care is necessary for <ul style="list-style-type: none"> <li>Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load</li> <li>Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need</li> </ul>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		Medicine website at Medical and Practitioner Workforce Guidance.			<ul style="list-style-type: none"> <li>• Training metrics – ensuring that trainees are exposed to a suitable casemix of patients to achieve an appropriate level of expertise in their field.</li> <li>• Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This process data is necessary to understand and optimise the care process within emergency care. Ensuring that patients are assessed by a treating healthcare professional soon after arrival minimises the risk of undiagnosed severe disease, and is an important part of risk control in emergency care. Patient satisfaction is correlated with the time taken from arrival to the first treating clinical assessment.</li> </ul>	
CARE PROFESSIONALS (EMERGENCY CARE)	CARE PROFESSIONAL DISCHARGE RESPONSIBILITY INDICATOR (EMERGENCY CARE)	An indication of whether a CARE PROFESSIONAL is responsible for discharge of the PATIENT from an Emergency Care Attendance.	M	DM&D	<p>Recording the clinician(s) responsible for patient care is necessary for</p> <ul style="list-style-type: none"> <li>• Operational planning and clinical governance- ensuring that the right grade of clinician is responsible for the right acuity and complexity of</li> </ul>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>patient load</p> <ul style="list-style-type: none"> <li>• Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need</li> <li>• Training metrics – ensuring that trainees are exposed to a suitable casemix of patients to achieve an appropriate level of expertise in their field.</li> <li>• Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems. This process data is necessary to understand and optimise the care process within emergency care. Ensuring that patients are assessed by a treating healthcare professional soon after arrival minimises the risk of undiagnosed severe disease, and is an important part of risk control in emergency care. Patient satisfaction is correlated with the time taken from arrival to the first treating clinical assessment.</li> </ul>	

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS (SNOMED CT)	Diagnoses of the patient, in order of their relevance to the emergency presentation.	M	SNOMED CT	<p>As per CDS 6.2 Type 010. A key element of the ECDS is a system to record diagnosis by pairing a diagnosis code from a SNOMED-CT subset (the ECDS Diagnostic Data Set) with a two way qualifier. The quality of diagnosis data currently collected in emergency care (CDS type 010 v6.2) is very poor. In developing the ECDS Diagnostic Data Set (DDS) a few key design principles were used:</p> <ul style="list-style-type: none"> <li>- Exhaustive : the DDS items should cover all conditions commonly seen, but not very rare conditions – i.e. if a candidate condition had not been seen during the &gt;50 physician years of experience of the senior EM physicians constructing the original list.</li> <li>- Exclusive: for any given clinical picture, there should be one and only one best answer.</li> <li>- There should be no vague terms ('unwell cause' 'unspecified')</li> <li>- There should be no symptoms (e.g. back pain)</li> </ul>	Originates from A&E CDS Type 010

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					presented as a diagnosis. - The diagnosis terms should maximise usability by being presented to IT suppliers in a form, and with instructions that facilitate ease of use and coding validity and reliability.	
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	CODED CLINICAL ENTRY SEQUENCE NUMBER	The sequence of the diagnosis in order of relevance to the emergency department attendance.	M	DM&D		NEW' A&E data item
EMERGENCY CARE DIAGNOSIS (SNOMED CT)	EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT)	The qualifier allows the clinician to express the (un) certainty of each of the diagnoses.	M	SNOMED CT	A qualifier enables users to express their certainty/ lack of certainty regarding a diagnosis.	NEW' A&E data item
EMERGENCY CARE INVESTIGATIONS	EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT)	The investigations performed while the person is under the care of the Emergency Care facility.	M	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new investigations codes. Amended to be collected in SNOMED CT.	Originates from A&E CDS Type 010
EMERGENCY CARE INVESTIGATIONS	PROCEDURE DATE (EMERGENCY CARE CLINICAL INVESTIGATION)	The date on which investigations were performed while the person was under the care of the Emergency Care facility.	R	DM&D		NEW' A&E data item
EMERGENCY CARE INVESTIGATIONS	PROCEDURE TIME (EMERGENCY CARE CLINICAL INVESTIGATION)	The time at which investigations were performed while the person was under the care of the Emergency Care facility.	R	DM&D		NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
EMERGENCY CARE TREATMENTS	EMERGENCY CARE PROCEDURE	The treatments performed while the person is under the care of the Emergency Care facility.	M	SNOMED CT	As per CDS 6.2 Type 010. Amended to include new treatment codes. Amended to be collected in SNOMED CT.	Originates from A&E CDS Type 010
EMERGENCY CARE TREATMENTS	PROCEDURE DATE	The date on which treatments were performed while the person was under the care of the Emergency Care facility.	R	DM&D		NEW' A&E data item
EMERGENCY CARE TREATMENTS	PROCEDURE TIME	The time at which treatments were performed while the person was under the care of the Emergency Care facility.	R	DM&D		NEW' A&E data item
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE (SNOMED CT)	An inpatient service to which the patient was referred for admission or opinion by the treating clinician.	R	SNOMED CT	This process data is necessary to understand and optimise the care process within emergency care. Current IT systems set up for CDS version 010 routinely collect the time and specialty of referral of a patient. This information is essential to plan bed capacity within the hospital and is also used by commissioners to understand patient flow. Therefore what is proposed will not provide an additional burden but is just standardising and flowing information that is generally already collected. The time and speciality of	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data will allow better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/ situations e.g. reverse queuing when exit block occurs. This data also helps inform commissioners as to what services and specialty support is necessary to commission to enable efficient emergency care.	
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST DATE (EMERGENCY CARE)	The DATE that a SERVICE REQUEST for an ACTIVITY was made.	M	DM&D	The date and time paired with the speciality of initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data will allow better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/ situations e.g. reverse queuing when exit block occurs. This data also helps inform commissioners as to what services and specialty support is necessary to commission to enable	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					efficient emergency care.	
REFERRALS TO OTHER SERVICES	ACTIVITY SERVICE REQUEST TIME (EMERGENCY CARE)	The TIME that a SERVICE REQUEST for an ACTIVITY was made.	M	DM&D	The date and time paired with the speciality of initial referral is valuable as it helps understand internal bottlenecks within the care process. Capturing this data will allow better benchmarking and standardisation of care processes and implementation of care protocols for specific conditions/ situations e.g. reverse queuing when exit block occurs. This data also helps inform commissioners as to what services and specialty support is necessary to commission to enable efficient emergency care.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT DATE	A Referred To Service Assessment Date is an ACTIVITY DATE TIME. A Referred To Service Assessment Date is the date that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	DM&D	ECDS has incorporated a timestamp for date of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	NEW' A&E data item
REFERRALS TO OTHER SERVICES	REFERRED TO SERVICE ASSESSMENT TIME	A Referred To Service Assessment Time is an ACTIVITY DATE TIME. A Referred To Service Assessment Date is the time that a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to, assesses the PATIENT.	R	DM&D	ECDS has incorporated a timestamp for time of referral to inpatient / specialist services. When we explored this further, there was feedback from existing data collection standards e.g. trauma (TARN) and the Mental Health Services Data set, that what matters in terms of patient outcome, patient flow and patient experience is the time interval from referral to time of physical assessment by the inpatient team.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT DATE	The date at which the decision is made to admit the person.	R	DM&D	<p>The 'Decision To Admit' decision is one of the key milestones in a patient's journey. This is a key metric for staff within the hospital, and the decision to admit is always captured, as this is essential in managing the inpatient bed capacity. Therefore while this data item is nominally 'new' it is data that is routinely collected in ED's IT systems and so in practical terms will not impose a burden on staff or IT systems.</p> <p>Collecting and flowing this additional data point as well as EmCare_Treatment_Complete also allows commissioners and providers to understand the point in the patient's journey that the need for admission became obvious, and therefore the point at which the hospital's resources should change from focussing on safe discharge to safe and quick admission.</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	DECIDED TO ADMIT TIME	The time at which the decision is made to admit the person.	R	DM&D	<p>The 'Decision To Admit' decision is one of the key milestones in a patient's journey. This is a key metric for staff within the hospital, and the decision to admit is always captured, as this is essential in managing the inpatient bed capacity. Therefore while this data item is nominally 'new' it is data that is routinely collected in ED's IT systems and so in practical terms will not impose a burden on staff or IT systems.</p> <p>Collecting and flowing this additional data point as well as EmCare_Treatment_Complete also allows commissioners and providers to understand the point in the patient's journey that the need for admission became obvious, and therefore the point at which the hospital's resources should change from focussing on safe discharge to safe and quick admission.</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT)	ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the same as attribute TREATMENT FUNCTION CODE. ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) is the TREATMENT FUNCTION CODE of the SERVICE to which a PATIENT is to be admitted.	R	DM&D	<p>The data is necessary to understand patient flow accurately and is used in real time at a local level to able to plan inpatient bed management.</p> <p>At a commissioning level this data allows commissioners to see trends in the type of patients being admitted to which specialty. This in turn enables services to be configured to spread the load and specific groups of patients to be targeted with interventions that avoid admission. This is particularly important in managing patients with long-term conditions such as COPD and diabetes, where avoidable acute admissions are common.</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE STATUS (SNOMED CT)	The status of the PATIENT on discharge from an Emergency Care Department. Captures whether treatment took place within the ED, if the patient was streamed to another service or if the patient left before treatment was complete.	R	SNOMED CT	<p>This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations.</p> <p>Analysis by Public Health England has shown that there is currently confusion about how the current CDS version 010 data regarding patient discharge and transfer of responsibility is implemented. The way that current data items are arranged has made it difficult for IT suppliers to implement consistently as 'destination on discharge/ disposition' is often conflated with follow up arrangements and transfer of care. The way this data is currently collected is inconsistent even in implementations by the same supplier.</p> <p>Therefore it is currently difficult to understand the outcomes of emergency care and this has frustrated the work of analysts and commissioners at a local</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>and national level. For ECDS these separate issues have been disaggregated and are presented as separate items:</p> <ul style="list-style-type: none"> <li>• Discharge status</li> <li>• Discharge Destination</li> <li>• Follow-up arrangements</li> </ul> <p>This will enable clear analysis of patient pathways through Emergency Care, and the increased clarity will ensure that commissioners can accurately match provision with need.</p>	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION DATE	<p>An Emergency Care Attendance Conclusion Date is an ACTIVITY DATE TIME. The Emergency Care Attendance Conclusion Date may be either:</p> <ul style="list-style-type: none"> <li>• the Accident and Emergency Attendance Conclusion Date or</li> <li>• the Ambulatory Emergency Care Attendance Conclusion Date.</li> </ul> <p>Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Date is the same as the PERSON DEATH DATE.</p>	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010 data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE ATTENDANCE CONCLUSION TIME	An Emergency Care Attendance Conclusion Time is an ACTIVITY DATE TIME. The Emergency Care Attendance Conclusion Time may be either: <ul style="list-style-type: none"> <li>• the Accident and Emergency Attendance Conclusion Time or</li> <li>• the Ambulatory Emergency Care Attendance Conclusion Time.</li> </ul> Where the PATIENT dies in the Emergency Care Department, the Emergency Care Attendance Conclusion Time is the same as the PERSON DEATH TIME.	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010 data item
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE DATE	An Accident and Emergency Departure Date is the date that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded. An Emergency Care Departure Date is an ACTIVITY DATE TIME. The Emergency Care Departure Date may be either: <ul style="list-style-type: none"> <li>• the Accident and Emergency Departure Date or</li> <li>• the Ambulatory Emergency</li> </ul>	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010 data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
		Care Departure Date.				
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DEPARTURE TIME	An Accident and Emergency Departure Time is the time recorded using a 24 hour clock that a PATIENT leaves an Accident and Emergency Department after an Accident and Emergency Attendance has concluded. An Emergency Care Departure Time is an ACTIVITY DATE TIME. The Emergency Care Departure Time may be either: <ul style="list-style-type: none"> <li>• the Accident and Emergency Departure Time or</li> <li>• the Ambulatory Emergency Care Departure Time.</li> </ul>	R	DM&D	As per CDS 6.2 Type 010	Originates from A&E CDS Type 010 data item
DISCHARGE FROM EMERGENCY CARE	SAFEGUARDING CONCERN (SNOMED CT)	SAFEGUARDING CONCERN (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE. SAFEGUARDING CONCERN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify an unresolved issue or concern regarding adult and child safeguarding that requires communication to another ORGANISATION or care agency.	R	SNOMED CT	Safeguarding information is routinely collected at a local level as part of normal safeguarding requirements but is collected inconsistently and there is no consistent central information regarding number and nature of referrals for safeguarding.	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT)	EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the intended destination of the PATIENT following discharge from the Emergency Care Department.	R	SNOMED CT	<p>This data item and its counterparts Emergency Care Discharge Status and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations.</p> <p>Analysis by Public Health England has shown that there is currently confusion about how the current CDS version 010 data regarding patient discharge and transfer of responsibility is implemented. The way that current data items are arranged has made it difficult for IT suppliers to implement consistently as 'destination on discharge/ disposition' is often conflated with follow up arrangements and transfer of care. The way this data is currently collected is inconsistent even in implementations by the same supplier.</p> <p>Therefore it is currently difficult to understand the outcomes of emergency care and this has frustrated the work of analysts and commissioners at a local</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>and national level. For ECDS these separate issues have been disaggregated and are presented as separate items:</p> <ul style="list-style-type: none"> <li>• Discharge status</li> <li>• Discharge Destination</li> <li>• Follow-up arrangements</li> </ul> <p>This will enable clear analysis of patient pathways through Emergency Care, and the increased clarity will ensure that commissioners can accurately match provision with need.</p>	
DISCHARGE FROM EMERGENCY CARE	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the ORGANISATION IDENTIFIER of the Organisation Site to which a PATIENT is discharged following an Emergency Care Attendance.	R	ODS	<p>This is designed to collect information regarding transfers of acute patients between healthcare facilities. As Emergency Care networks become embedded there will be patients whose needs cannot be met locally who need to travel to another facility e.g. cardiac, stroke, vascular, trauma etc. This detail is necessary to allow commissioners and researchers to be able to follow the patient journey and understand how resources are best used.</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS  (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT)	EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the SERVICE to which a PATIENT was referred for continuing care following an Emergency Care Attendance.	R	SNOMED CT	<p>This data item and its counterparts Emergency Care Discharge Destination and Emergency Care Discharge Follow-up are necessary to understand resource needs and transfer of responsibility between different organisations.</p> <p>Analysis by Public Health England has shown that there is currently confusion about how the current CDS version 010 data regarding patient discharge and transfer of responsibility is implemented. The way that current data items are arranged has made it difficult for IT suppliers to implement consistently as 'destination on discharge/ disposition' is often conflated with follow up arrangements and transfer of care. The way this data is currently collected is inconsistent even in implementations by the same supplier.</p> <p>Therefore it is currently difficult to understand the outcomes of emergency care and this has frustrated the work of analysts and commissioners at a local</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					and national level. For ECDS these separate issues have been disaggregated and are presented as separate items: <ul style="list-style-type: none"> <li>• Discharge status</li> <li>• Discharge Destination</li> <li>• Follow-up arrangements</li> </ul> This will enable clear analysis of patient pathways through Emergency Care, and the increased clarity will ensure that commissioners can accurately match provision with need.	
DISCHARGE FROM EMERGENCY CARE	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT)	EMERGENCY CARE DISCHARGE INFORMATION GIVEN (SNOMED CT) is the SNOMED CT® concept ID which is used to identify whether a copy of a letter to their GENERAL PRACTITIONER has been printed and given to the PATIENT on discharge from an Emergency Care Department.	R	SNOMED CT	There are many reasons to include this item: giving the patient a copy of the discharge letter <ul style="list-style-type: none"> <li>• Improves and ensures consistency of communication between Emergency Care clinician, patient and GP, and ensures that the patient understands what is communicated to the GP and expectations regarding follow up.</li> <li>• Ensures that the clinician does not write anything in the GP letter that they would not want the patient to read.</li> <li>• Allows the clinician to go</li> </ul>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					<p>through the letter with the patient to check understanding. This reduces the risk of complaints and is also provides the hospital with a good defence against complaints or legal action e.g. a patient who has a fit is told they cannot drive. If such a patient subsequently drives and injures other road users and there is evidence that the patient had a letter printed that contained the instruction not to drive, this ensures the NHS is not potentially liable.</p> <ul style="list-style-type: none"> <li>• It ensures the doctor has entered all the relevant clinical information before the patient leaves.</li> </ul> <p>NB this is not a substitute for an electronic copy of the letter, which will be sent anyway as part of the service specification. However it is well known that a relatively high proportion of Emergency Care patients do not have a General Practitioner or may be itinerant, so this document may be the only record they have to take to another healthcare provider.</p>	

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
RESEARCH AND OUTBREAK NOTIFICATION	CLINICAL TRIAL IDENTIFIER	A unique identifier assigned to a CLINICAL TRIAL.	O	DM&D	<p>Nearly all research in Emergency Care in the UK is government funded, and therefore data collection and aggregation is an important direct cost for any research. At present, the customisation of any software to aggregate the results of patient recruitment is a significant barrier and cost to such research. Inability to do research harms the NHS' ability to better understand emergency care and commission the right care that meets patient needs. Promoting research, audit and benchmarking across the NHS requires embedded IT support as a key enabler. The ability to capture and flow relevant data cost-effectively enables multi-centre trials that will save the NHS many thousands of pounds in building custom IT solutions to track patient recruitment. Facilitating multi-centre trials is particularly important because they increase the reliability of the research – the results are much more likely to</p>	NEW' A&E data item

DATA GROUP	DATA ITEM NAME	DATA ITEM DEFINITION	DATA ITEM STATUS (M/R/O)	SNOMED CT / DM&D / ODS	JUSTIFICATION	DATA ITEM PROVENANCE
					be robust and applicable across a wide range of hospitals, and therefore the research itself is much more cost-effective.	
RESEARCH AND OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION	DISEASE OUTBREAK NOTIFICATION is used in the CDS v6.2.1 Type 011 - Emergency Care Commissioning Data Set to support collection of nationally-notifiable data relating to outbreaks of disease which are identified in Emergency Care Departments. Where a SNOMED CT CODE is available, the DISEASE OUTBREAK NOTIFICATION field should contain this. If a SNOMED CT CODE is NOT available, then it is permissible to submit free-text detail of the disease.	O	DM&D	By including this field, the data set will address key National Institute of Health Research (NIHR) priorities for efficient research design, and will enable research into and rapid response to major infectious disease health threats.	NEW' A&E data item

### Data Element Status

**M = Mandatory:** this data element is mandatory and the technical process (e.g. submission of the data set) cannot be completed without this data element being present

**R = Required:** NHS business processes cannot be delivered without this data element

**O = Optional:** the inclusion of this data element is optional as required for local purposes. Systems must however enable the capture and reporting or derivation of such items.

The term 'mandation' relates to items that are required for national submission to support national policy requirements and include both M(andatory) and R(equired) items.

## 3.2 Summary of Changes

The table below summarises the number of each type of change specifically as a result from introducing CDS v6.2.1 Type 011 - ECDS within CDS v6.2.

Type	Sub-Total
New A&E data item	47
Originates from A&E CDS Type 010	61
<b>Total</b>	<b>108</b>

## 3.3 Detailed Data Set Changes

Full details of the differences between the current CDS Type 010 A&E and CDS v6.2.1 Type 011 - ECDS are outlined within the ECDS Technical Output Specification available from: <http://content.digital.nhs.uk/isce/publication/SCCI0092-2062>

## 3.4 Use of SNOMED CT

As the NHS moves to being paperless at the point of care, exchanging data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every system uses its own vocabulary then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

Providers of health and care are required to be paperless at the point of care before 2020: such systems must incorporate SNOMED CT as the clinical terminology to provide the content for structured data within scope of the terminology. The SNOMED CT standard was approved by the Information Standards Board in 2011; providers implementing electronic health and care related systems must ensure those systems are SNOMED CT enabled at the point of implementation.

Further details in relation to the SNOMED CT Standard is available from:

<http://content.digital.nhs.uk/media/22807/0034352016req-spec/pdf/0034352016req-spec.pdf>

In support of the use of SNOMED CT as outlined above, ECDS will mandate the use of SNOMED CT, which in addition to supporting earlier adoption of SNOMED CT, will properly capture and represent the full extent and granularity of Emergency Department activity, and therefore:

- enable an accurate understanding of the cost and value of emergency care
- facilitate improved healthcare commissioning
- improve the quality of patient care in England's Emergency Departments
- provide more effective delivery of healthcare strategy and policy

ECDS mandates the flow of some of its key data items using SNOMED CT (other data items remain in the NHS Data Modelling and Dictionary formats). SNOMED CT should be implemented in the Emergency Department Information System and flow as part of the CDS v6.2.1 Type 011– ECDS.

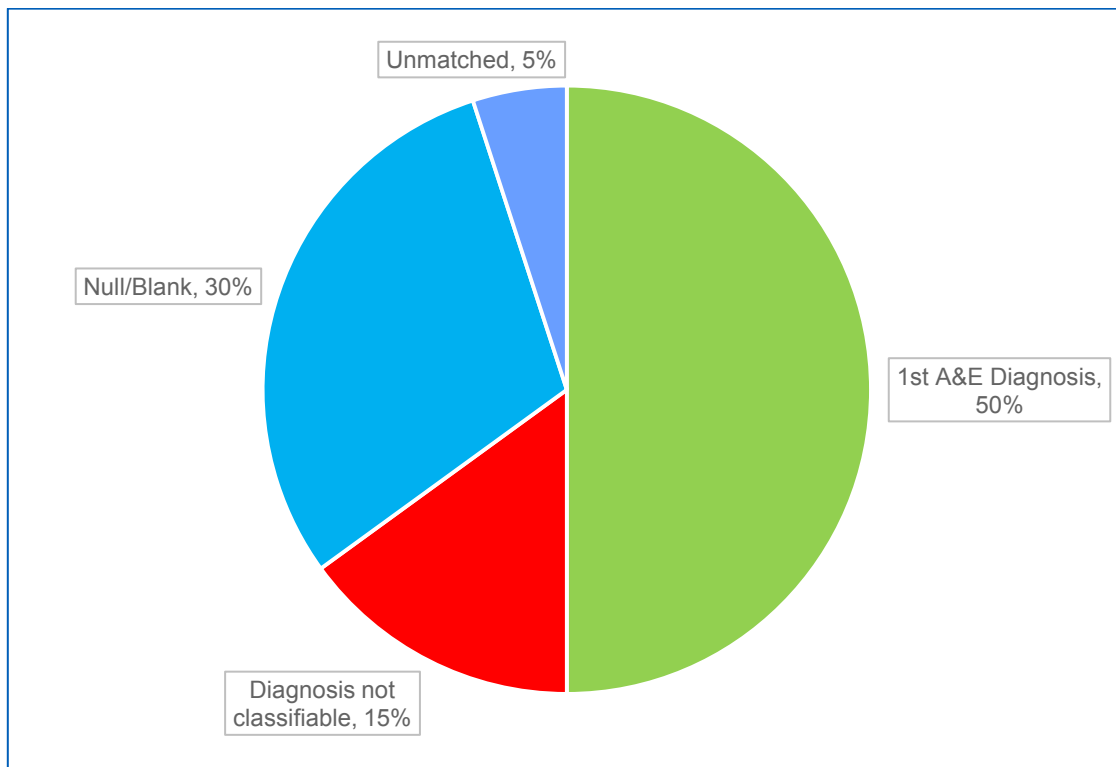
SNOMED CT subsets have specifically been developed to ensure valid and reliable data. Further details of how SNOMED CT will be used to support ECDS are available from within the ECDS User Guidance, available from: <http://content.digital.nhs.uk/ECDS>

The ECDS introduces SNOMED CT subsets to collect clinical information, specifically Chief Complaint and Diagnosis.

Currently submitters of CDS Type 010 can submit information from different diagnostic coding systems which greatly impairs valid comparisons of the data and is likely to be a contributing factor towards the current poor quality of the diagnostic information available from Emergency Departments. The three most commonly used diagnosis recording systems are the 'A&E CDS National Values Table for Discharge Diagnosis', SNOMED-CT and ICD-10.

Information available in NHS Digital’s annual A&E Reports presents clearly the current poor quality of A&E diagnostics information. Figure 1 shows 50% of cases having a 1<sup>st</sup> diagnosis recorded, with the remaining 50% have either a null value, an unclassifiable diagnosis or a diagnosis submitted which was not matched when it was received by NHS Digital.

**Figure 1. A&E First Diagnosis<sup>2</sup>**



The comprehensive SNOMED-CT (Systemic Nomenclature Of MEDical –Clinical Terms) system provides immensely detailed diagnostic possibilities and in principle the granularity and wealth of detail available in a fully unconstrained SNOMED CT data set is appealing. However, in practice the overwhelming choice of using a fully unconstrained SNOMED CT data set can be confusing and often results in data that is spuriously accurate.

To understand the quality of the diagnosis found in the 50% of 1<sup>st</sup> A&E diagnosis in Figure 1, analysis of diagnostic data collected by a trust using already using SNOMED CT to capture diagnosis was completed.

Analysis of diagnostic information collected from the trust during 2013-2015 showed that 7 of the top 10 diagnoses (by volume) were either symptoms or non-specific and were not ‘true’ diagnoses (see grey diagnoses in Table 1 below).

The ECDS proposes the use of a constrained SNOMED CT subset of approximately 750 diagnoses, paired with a qualifier (further information relating how to capture diagnosis and a qualifier can be found in the ECDS User Guidance, available from: <http://content.digital.nhs.uk/ECDS>).

Following the introduction of the ECDS diagnostic subset in the trust as part of the ECDS pilot the top 10 diagnoses collected during the pilot period represented a ‘true’ diagnosis.

<sup>2</sup> NHS Digital. 2017. Hospital Accident and Emergency Activity, 2015-16. Accessed 01/02/2017. Available at <http://www.content.digital.nhs.uk/catalogue/PUB23070>

**Table 1: Top 10 diagnoses recording before and after the ECDS Type pilot**

Diagnoses recorded pre ECDS pilot (2013-2015)		Diagnoses recorded post ECDS pilot (Aug/Sept 2016)	
Description of diagnosis	Volume	Description of diagnosis	Volume
Disease (disorder)	41,343	Concussion with no LOC (disorder)	3,891
Chest pain (finding)	22,224	Worried well (finding)	3,374
Minor head injury (disorder)	21,977	Lower respiratory tract infection (disorder)	3,344
Abdominal pain (finding)	14,110	Urinary tract infectious disease (disorder)	2,313
Soft tissue injury (disorder)	9,968	Soft tissue injury (disorder) 9,968	2,285
Urinary tract infectious disease (disorder)	9,480	Sprain of ankle (disorder)	1,881
Abdominal pain- cause unknown (finding)	7,851	Infectious gastroenteritis (disorder)	1,721
Sprain of ankle (disorder)	7,816	Acute coronary syndrome (disorder)	1,482
Headache (finding)	7,285	Cellulitis	1,339
Falls (finding)	6,661	Sprain of knee (disorder)	1,175
<b>Total</b>	<b>148,715</b>	<b>Total</b>	<b>23,174</b>

The codes used prior to implementation of the ECDS Diagnosis subset did not accurately communicate the nature of the patient's illness to the patient or another clinician. The introduction of a constrained SNOMED CT subset as part of the ECDS greatly improves the number of 'true' diagnoses recorded in A&E.

## 3.5 Changes to CDS Technical Architecture/ Submission

There are no changes expected to the existing mechanism for submitting or extracting CDS v6.2 data to Secondary Uses Service (SUS) or access to SUS such as Role Based Access Controls (RBAC), with the exception of CDS v6.2.1 Type 011 - ECDS. As a result of implementing CDS v6.2.1 Type 011 - ECDS, providers will be required to submit data via the Messaging Exchange for Social Care and Health (MESH) service and also flow the data initially on a weekly basis (if locally required) but ultimately on a daily basis.

SUS+ development is underway to support implementation of the CDS v6.2.1 Type 011 - ECDS from October 2017.

## 3.6 Changes for Local Providers

There are likely to be changes to the following in relation to local implementation of changes to introduce the new CDS v6.2.1 Type 011 - ECDS.

### Local Systems (e.g. Patient Administration, Care Record Systems & Clinical Systems)

One or more of the following local systems may need changing to include:

- Addition of new data elements to systems to support local electronic data collection
- Changes to system configuration to allow information to be updated once and then correctly assigned onto individual CDS records
- Changes to extract routines to ensure new data elements can be extracted in a way conducive to inclusion with a CDS submission, including those already captured within the system
- Changes to enable an automated feed of CDS v6.2.1 Type 011 - ECDS on a weekly then a daily basis
- To support the new code sets, local systems will need to support SNOMED CT output to NHS Digital. SNOMED CT front-end collection is not mandatory although code sets should be accurately represented and translated to SNOMED CT before transmission to NHS Digital
- There may be a need to perform local mapping of values to support local grouping.

### Local Data Warehouses

Increasingly providers use a data warehouse as the basis for generating CDS submissions to allow the linkage of required information from disparate systems.

There is little if no change expected to the structure of local data warehouses and extraction routines, which will continue to require output data in CDS v6.2 format for translation in XML. It will need to be determined locally what if any changes will be required. Again one of the main changes will be to support the daily flow of CDS v6.2.1 Type 011 - ECDS.

### Business Processes

In some cases changes introduced as a result of the CDS v6.2.1 Type 011 - ECDS may require new, or changes to existing business processes.

This may include new, or changes to existing, local guidance and data recording forms, and may require some degree of training for users.

### Change for CDS Users

Users of CDS data such as commissioners, public health observatories and commercial organisations will need to make appropriate changes to systems to support the new data outlined within CDS v6.2.1 Type 011 - ECDS.

## 4 Impact Assessment

### 4.1 Impact of not including CDS v6.2.1 Type 011 - ECDS

If the changes to CDS v6.2, specifically the inclusion of CDS v6.2.1 Type 011 - ECDS, is not approved:

Stakeholder	Description	Impact
Trusts	Will not be able to fully and accurately reflect actual activity that they undertake centrally.	Medium
Trusts	Will be likely to be required to implement new, ad-hoc flows of information and data requests to NHS organisations.	Medium
Trusts	Will not be able to influence the development of and attract tariff that accurately reflects the activity that has been undertaken by the Trust.	Medium
Trusts	Continuation of being unable to provide consistent data to facilitate how patients use EDs and other urgent care services, and therefore lose the understanding of patient flow within the urgent care system across England. E.g. being able to easily identify how patient's access care will allow for more effective service planning within commissioning organisations and support the spread of best practice.	Medium
Trusts	Miss the opportunity to provide accurate information about the causes of rising demand across England, and therefore impacts on the ability to allow for more effective service development and commissioning.	Medium
Trusts	Continued collection of unusable data currently collected due to the lack of current data granularity.	Low
Trusts	Will be unable support workforce planning in the specialties required to deliver urgent and emergency care.	Low
Commissioners	National Tariff will not fully and accurately reflect activity undertaken for their responsible populations.	Medium
Department of Health	Continued limitations of being able to effectively monitor the more detailed and varied policy commitments aimed at improving the quality of patient experience and specifically outcomes.	High
Public Health	Continued inability to consistently monitor patient illnesses presenting to EDs or emerging health threats.	Medium
Patients	Lack of accurate and relevant information being passed on to Primary care and used to populate health care records.	High
Patients	Current lack of information such as chief complaint, discharge information and poor diagnostic data will not demonstrate whether the patient has received efficient and safe care when they needed it.	High
Patients	Current lack of injury data will mean that emergency attendances as a result of injury will continue without a coordinated strategy for injury prevention.	Medium

## 4.2 Impact if Changes are Included

If changes to CDS v6.2 are approved there will be an impact upon the following:

Stakeholder	Description	Impact
Trusts	Will be required to align business processes to capture new data items that are not already captured. As a result of providing the capability to record more useful data, this will improve the understanding of how patients access emergency care and ensure that they receive safe and efficient care when they need it. Redundant data items will no longer be required to be collected.	Medium
Trusts	May have costs associated with local implementation of changes e.g. system changes, training of staff etc.	Low
Commissioners	Will be required to align business processes and update systems/tools to receive and analyse of the newly included ECDS.	Low
System suppliers	Will be required to update systems to support the capture and extraction and/or derivation of new or changed Emergency Department data items.	Medium
System suppliers	Will be required to support a move to an automated weekly/daily flow of ECDS.	Medium
XML/Middleware Suppliers	Will be required to support the following XML schemas; <ul style="list-style-type: none"> <li>- The existing CDS v6.2 including CDS Type 010 A&amp;E</li> <li>- The new CDS 6.2.1 including CDS v6.2.1 Type 011 - ECDS</li> </ul>	Medium
XML/Middleware Suppliers	Will be required to support a move to an automated weekly/daily flow of ECDS.	Medium
SUS	Will be required to support CDS v6.2 including CDS Type 010 A&E and in parallel, support CDS 6.2.1 including CDS v6.2.1 Type 011 - ECDS. Confirmation from the SUS Programme has been provided to confirm appropriate development within the required timeframe	High
HES	Will be required to support existing HES plus new ECDS. A&E publications will have to include both. Mapping will be required to continue time series. New data items will have to be published to demonstrate benefits. Short timescales mean limited time for development of publications and related processes. Optional August date shortens timescale and introduces uncertainty. Publications cannot “miss out” Accident and Emergency Departments which flow ECDS.	High

## 5 Implementation Plan

The table below outlines when Emergency Departments must and may start to flow the CDS v6.2.1 Type 011 - ECDS to NHS Digital.

Emergency Department Type	Start	Completion
Type 1 : General Emergency Department (24 hour)	1 <sup>st</sup> Aug 2017	1 <sup>st</sup> Oct 2017
Type 2 : Specialist Emergency Department	1 <sup>st</sup> Aug 2017	1 <sup>st</sup> Oct 2017
Type 3 : Minor Injury Unit (including Urgent Care Centres)	1 <sup>st</sup> Aug 2017	1 <sup>st</sup> Oct 2018
Type 4 : Walk in Centre	1 <sup>st</sup> Aug 2017	1 <sup>st</sup> Oct 2018
Retiring of CDS Type 010 A&E	n/a	31 <sup>st</sup> Mar 2019

Implementation of CDS v6.2.1 Type 011 - ECDS within CDS v6.2 will continue to utilise existing capabilities via SUS.

When SUS+ is available it is expected that CDS v6.2.1 Type 011 - ECDS will align to the deployment roll out as per CDS v6.2.

Following implementation providers will continue to be able to submit CDS Type 010 A&E if so chosen to SUS using CDS v6.2.

## 6 Further Information and Support

Further information is available from the following organisations:

### NHS Digital

- Standardisation Committee for Care Information (SCCI):**  
 For information relating to the introduction of the new CDS v6.2.1 Type 011 - ECDS, including change specification, requirements specification and standard:  
<http://content.digital.nhs.uk/isce>
- NHS Data Model and Dictionary Service:**  
 For information relating to the NHS Data Dictionary including CDS 6.2 data elements, attributes, business definitions, supporting information and CDS 6.2 XML schemas:  
<http://www.datadictionary.nhs.uk/>
- NHS Digital:**  
 For enquiries relating to the CDS v6.2.1 Type 011 - ECDS standard.  
[enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk)
- Hospital Episode Statistics:**  
 HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.  
<http://content.digital.nhs.uk/hes>

### NHS England

- Further information relating to ECDS and NHS England.  
<https://www.england.nhs.uk/ourwork/tsd/ec-data-set/>