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Emergency Care Data Set (ECDS) User Guide

Document Management (ECDS v4.0)

Revision History

Version	Date	Summary of Changes
3.2	28/09/2022	ECDS v4.0 first draft
3.3	14/11/2022	Updated draft for ECDS v4.0
3.4	25/01/2023	Draft for review by NHS England and ECDS Clinical Lead
4.0	30/01/2023	Publication version (version number to align with ECDS version number)
4.1	08/06/2023	Updated draft version following feedback received on version 4.0
4.2	04/07/2023	Publication version to support ECDS v4.0 implementation
4.3	11/10/2023	Updates post the ECDS v4.0 implementation date
4.4	14/11/2023	Updated draft to support ECDS Max and v4.0 implementation
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Reviewers

This document must be reviewed by the following people:

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John Winter	Programme Manager, NHS England	30/01/23 (v4.0), 04/07/23 (v4.2)	4.0, 4.2, 4.5, 4.7

Glossary of Terms

Term / Abbreviation	What it stands for
A&E	Accident and Emergency. This term is now superseded by the term 'Emergency Department' (see below)
CCG	Clinical Commissioning Group. CCGs are part of the government's reforms to the health and social care system. In April 2013, they replaced primary care trusts (PCT's) as the commissioners of most services funded by the NHS in England
CDS	Commissioning Data Set. These are the basic structures used for the submission of commissioning data to the Secondary Uses Service (SUS)
DAPB	The Data Alliance Partnership Board took over from the Data Coordination Board (DCB) (which replaced The Standardisation Committee for Care Information (SCCI)) as the body that provides assurance for all national data sets.
Data Item	A single component of a data set that holds one type of information and relates to a specific record
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data
Data Set	The full collection of data groups. See 'Technical Output Specification'
DHSC	Department of Health and Social Care
DM&D	NHS Data Model and Dictionary or simply, Data Dictionary. The NHS Data Model and Dictionary provides a reference point for approved Information Standards and Collections (including Extractions) (ISCEs) to support health care activities within the NHS in England. It has been developed for everyone who is actively involved in the collection of data and the management of information in the NHS
ED	Emergency Department: This is the term used within this document for a service providing emergency care.
EDIS	Emergency Department Information System. An electronic health record system used to manage data in support of Emergency Department patient care and operations
HES	Hospital Episode Statistics. 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
ICD 10	International Classification of Diseases (Revision 10)
ISN	Information Standards Notices are issued by the Data Alliance Partnership Board (DAPB) formerly known as the Data Coordination Board (DCB), and the Standardisation Committee for Care Information (SCCI), to give notice of changes to information requirements and information standards used by the NHS and Social Care Services
NHS National Tariff Payment System	A set of prices and rules to help providers of NHS care and commissioners provide best value to their patients. https://improvement.nhs.uk/resources/national-tariff/
NHS Digital	The Health and Social Care Information Centre (HSCIC) was a non-departmental body created by statute, also known as NHS Digital, with effect from 1 August 2016. On 1 February 2023 the statutory functions of NHS Digital transferred to NHS England under the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023 (Transfer Regulations) with effect from 1 February 2023 (Transfer Date).
Null	A data item with no value (i.e. blank) and therefore, has no meaning. This is different from a value of 0, since 0 is an actual value
ODS	Organisation Data Service. This service publishing codes that identify organisations and individuals across health and social care. An Organisation Data

Term / Abbreviation	What it stands for
	Service (ODS) code identifies an Organisation uniquely. https://digital.nhs.uk/organisation-data-service
Patient Proxy	A Patient Proxy is a representative of the Patient. This is most likely to be the case where the Patient is unable to communicate effectively, for example, for an infant or a PERSON who is mentally ill or who has learning disabilities
PbR	Payment by Results (now referred to as the NHS National Tariff Payment System – see above)
UKHSA	The UK Health Security Agency (UKHSA) is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats.
Urgent and Emergency Care Activity Type	The type of Urgent And Emergency Care Activity as defined in the NHS Data Model and Dictionary: Type 01 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Major Emergency Care Department' Type 02 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Mono-specialty Emergency Care Department' Type 03 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Urgent Treatment Centre' Type 05 - Same Day Emergency Care Attendance Type 06 - Urgent and Emergency Care Extended Care Episode Type 07 - Hot Clinic Attendance. Note this is only valid for piloting purposes.
RBAC	Role Based Access Control. 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. https://digital.nhs.uk/services/registration-authorities-and-smartcards
Refset	Reference Set. A SNOMED CT term used to refer to a defined sub-set of SNOMED CT codes, usually for a specific purpose.
Same Day Emergency Care (SDEC)	NHS England describes Same Day Emergency Care (SDEC) as a service which allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment.
SNOMED CT	Systemized Nomenclature of Medicine Clinical Terms. This is used by the NHS to support recording of clinical information
Spine	The NHS Spine allows information to be shared securely through national services such as the Electronic Prescription Service, Summary Care Record and the e-Referral Service. https://digital.nhs.uk/spine
SUS or SUS+	Secondary Uses Service. Source of data to enable a range of reporting and analysis for secondary uses. SUS supports the NHS and its partners in the areas of planning, commissioning, management, research, audit, public health and national initiatives, such as National Tariff.
TOS	Technical Output Specification
UEC	Urgent and Emergency Care is the umbrella term for all non-elective care and includes Emergency Department care, together with 999 Ambulance services and 111 Urgent Care services
UTC	Urgent Treatment Centre - the generic descriptor for Urgent Care facilities which offer treatments for minor injuries and illnesses for people of all ages and are open for a minimum of 12 hours / day 365 days per annum

Document Control:

Contents

1 About this Document

1.1 Purpose of the Document

The purpose of this document is to outline the manner by which the Emergency Care Data Set (ECDS) v4.0 should be used and interpreted by users, system suppliers and other stakeholders by providing information on each individual data group and its constituent data items.

This User Guide is applicable to all providers of Type 01, 02, 03, 05, 06 and 07 Urgent and Emergency Care Activity Types as defined in the Glossary[1] of this document.

1.2 Scope of the Document

This document is aimed at:

- ED, SDEC and UTC managers
- ED, SDEC and UTC clinicians
- ED, SDEC and UTC clerical staff
- Information management departments within data provider organisations
- IT system suppliers operating on behalf of Urgent and Emergency Care Services
- Those responsible for the collection and / or analysis of ECDS data.

The following areas are out of scope of this document:

- Detailed justification for the development of the Information Standard
- Data submission framework (i.e. how data is submitted by data providers to the Secondary Uses Service (SUS)). Further information about this will be available in the ECDS Technical Guidance.

This document should be read in conjunction with the following documents which can be found through the NHS England Information Standards website[2]:

- ECDS v4.0 Requirements Specification
- ECDS v4.0 Change Specification
- ECDS v4.0 Technical Output Specification
- ECDS v4.0 Implementation Guidance
- ECDS v4.0 NHS Data Model and Dictionary Change Request
- ECDS v4.0 Corrigendum (April 2023)

1.3 Schedule for updating this Document

Please note this guidance document is a live document. NHS England reserves the right to review and update it when necessary, for example in response to stakeholder feedback.

2 Background

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

The ECDS is closely aligned with the care and management of the patient, and the information collected is dual-purpose, meeting an existing range of secondary uses and, in some instances, for the direct care of the individual (primary uses).

ECDS is structured such that data collection for primary and secondary uses wherever possible are aligned to maximise data quality that benefits patients, staff, commissioners, researchers, and the wider NHS.

[1] URGENT_AND_EMERGENCY_CARE_ACTIVITY_TYPE (datadictionary.nhs.uk)

[2] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0092-2062-commissioning-data-sets-emergency-care-data-set

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

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 Emergency Care Departments; increased subspecialisation of hospital practice with a reduced number of 'generalist' hospital doctors.

The Emergency Care Data Set provides the following in response to that changing environment:

- accurate recording of the source of the patient's referral to the Emergency Care Department.
- the patient's chief complaint (the primary clinical reason for the attendance) captured consistently and submitted centrally.
- detailed information capturing what happens to patients during their emergency attendance, e.g. when patients are referred to inpatient services for assessment or admission.
- where patients go after their treatment in the Emergency Care Department is complete.
- the complexity and acuity of Emergency Care Department patients, and the value added by the Emergency Care Departments, are consistently described and able to be understood through the detailed data collected.
- better diagnostic data which gives an enhanced understanding of patient need, activity, and outcomes (and so value to attendance).
- consistent data on how patients use Emergency Care Departments, other urgent care services, and overall patient flow in the urgent care system. This allows understanding of patient access patterns, which allows appropriate planning.
- understanding of who is doing what and when within Emergency Care Departments. This helps ensure that patients receive safe and effective care when they need it.
- 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.
- understand Emergency Care Department attendances relating to injury and other modifiable factors to identify patterns that may be amenable to targeted interventions that will improve public health.
- facilitates targeted prevention strategies that could reduce the number of Emergency Care Department attendances.
- consistently monitor illness data arising from patients presenting to Emergency Care Departments, provides public health awareness of the current situation, as well as early warning of emerging population health threats. The UK Health Security Agency (UK HSA) has an Emergency Department Syndromic Surveillance System (EDSSS) which seeks to utilise national data.

2.1 Ownership and Management of ECDS

The structure and content of ECDS is owned by the National Clinical Director of Urgent and Emergency Care, NHS England. The clinical content of ECDS is managed by the ECDS Technical Committee, hosted by NHS England which has representation from relevant professional bodies, e.g. RCEM.

The administration and delivery of ECDS was performed by NHS Digital and is now performed by NHS England, which is also responsible for collecting data through the SUS (Secondary Uses Service) platform, which cleans and distributes data, and prepares the data for inclusion in the Hospital Episode Statistics; the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

2.2 Emergency Department Syndromic Surveillance System

Syndromic surveillance is the process of collecting, analysing and interpreting health-related data to provide an early warning of human or veterinary public health threats, which require public health action.

The Emergency Department Syndromic Surveillance System (EDSSS) monitors the daily visits in a network of emergency departments across England (and Northern Ireland to March 2018). A weekly report is published.

For queries regarding EDSSS please contact the UK Health Security Agency.

2.3 ED to GP Discharge Summary

The Professional Record Standards Body (PRSB) was commissioned by NHS Digital to develop information models to support the transfer of vital and accurate information to General Practice (GP) systems following an attendance at an ED.

The Emergency care discharge summary standard has been updated to version 2.1 (Dec 17 2019).

Further information can be found at: https://theprsb.org/standards/emergencycaredischarge

2.4 Other Useful Links

Hospital Accident and Emergency Activity:

Official Statistics for Hospital Accident and Emergency Activity are published.

The latest publication is for 2022-23. This publication looks at Accident and Emergency activity in England for the financial year 2022-23. It describes NHS accident and emergency activity and performance in hospitals in England. The data sources for this publication are the Emergency Care Data Set (ECDS) and Emergency Admissions Monthly Situation Reports (MSitAE) relating to A&E attendances in NHS hospitals, minor injury units and walk-in centres.

Processing cycle and ECDS data quality:

ECDS data comes from the routine submissions of data from providers to NHS England for the purposes of payment for and commissioning of healthcare in England.

Please see details of the processing cycle and ECDS data quality dashboards which are available.

National Cost Collection for the NHS:

Further details of the National Cost Collection for the NHS are available including details for Emergency Care:

3 The Emergency Care Data Set (ECDS)

3.1 Streaming from ED to other services

When the word 'streaming' is used in Emergency Care it implies a contractual arrangement whereby care of a patient who has had a limited assessment is transferred from one (organisation / site) to another (organisation / site) *without formal referral*. Increasingly these organisations are on the same site and share IT systems.

This is different from the usual case when a patient is only transferred to another organisation after full assessment and management of all problems, or all immediate problems, and there is:

- Formal transfer of care
- Formal referral / communication
- Mutual consent to the transfer of care.

When streaming occurs, there is a clear need to record key facts about the patient and the streaming assessment for reasons of:

- Clinical governance e.g. in case of an adverse outcome
- Operational management – it is essential to know which patients are in which facility
- Strategic planning / commissioning – to ensure that the right services are commissioned to support streaming
- Key information flow e.g. from GP record including patient safeguarding issues.

A basic streaming assessment should include:

- Patient Name
- Patient Identification – NHS Number / demographics
- Arrival Date / Time
- Arrival Mode – e.g. whether by ambulance
- Attendance Source – who advised to attend
- Attendance Category – has the patient been seen by another health practitioner in past 7 days?
- Chief Complaint and Acuity
- Discharge Status – the facility to which the patient has been streamed
- Departure Date / Time – the time at which the patient was streamed.

To improve patient flow and minimise clinical burden, not all the demographic information listed needs to be collected at the time streaming occurs and can be collated retrospectively e.g. when a patient books in at reception.

NHS England are undertaking a programme of work which should report in 2023; this may change the guidance provided.

3.2 SNOMED CT

SNOMED CT is an international clinical terminology that provides the vocabulary for systems to support the direct management of the health and care of an individual. The vocabulary consists of machine-readable codes for clinical concepts along with human-readable descriptions. It is provided via a set of data files that need to be incorporated in electronic applications.

ECDS uses specific SNOMED CT refsets (defined sub-sets of SNOMED CT codes set up for a specific purpose) in association with specified data items from the data set. SNOMED CT is managed and maintained internationally by SNOMED International[3] and in the UK by NHS England, as the UK National Release Centre (NRS) for SNOMED CT[4].

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:
https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-

[3] www.snomed.org

[4] https://isd.hscic.gov.uk/trud3/user/guest/group/2/home

including-extractions/publications-and-notifications/standards-and-collections/scci0034-snomed-ct

3.2.1 SNOMED CT and ECDS Design Principles

ECDS mandates the flow of key clinical data items using SNOMED CT.

Other data items use codes from the NHS Data Model and Dictionary.

ECDS SNOMED CT refsets have specifically been developed to ensure valid and reliable data.

A number of key design principles were used to guide what data items should / should not be included in these refsets, which are set out below:

1. The data items should be:
   - **Exhaustive**: the data items should cover all conditions and options commonly seen in EDs. Test: If a diagnosis condition had not been seen during the >50 physician years of experience of the Emergency Medicine physicians maintaining the list, it was not included.
   - **Exclusive**: for any given situation, there should be one and only one best answer. Test: The correct code to choose should be obvious to a F2 doctor on their first day.
2. There should be **no symptoms** (e.g. back pain) presented as a diagnosis code.
3. There should be **no vague terms** (e.g. 'unwell', 'unspecified', and 'other').
   - If these vague terms are available in a data set, they often become over-used in practice. Prior to ECDS, approximately 20% of all diagnosis codes and 95% of all 'reasons for presentation to ED' were vague, which rendered the data useless, and this is consistent with international findings[5]. Therefore, vague terms are avoided in ECDS. The exceptions to this rule occur when:
     - There are rare sub-specialty conditions e.g. neurology, endocrinology etc. for which a better group term does not exist
     - The list will not be able to keep up with real life e.g. a list of recreational drugs.
4. The data items should maximise usability by being presented to IT suppliers in a form that facilitates user interfaces that promote ease of use. This promotes reliable and valid coding e.g.
   - Use of pick lists of 10 items or less to avoid scrolling
   - Grouping of items in similar categories
   - Hierarchical lists with common items list first
   - Listing of synonyms and alternative search terms.
5. The items that form the data set should be 'normalised' as far as reasonably possible to avoid duplication and additional clinician burden.
6. The ECDS Max Diagnostic refset has been developed using the SNOMED hierarchical structure to develop a more detailed diagnosis refset e.g. for Same Day Emergency Care when specialist clinicians may require a more granular level of detail, but the data items still map up to the ECDS parent codes.

3.2.2 Implementation of SNOMED CT

Some system suppliers may design their systems so that the use of SNOMED CT is invisible to the user at the front end. Where this is the case, a user will be presented with a list of options and the selected option should be mapped behind the scenes to a SNOMED CT code before submission of ECDS.

The SNOMED CT system provides immensely detailed possibilities, specifically in relation to Chief Complaint and Diagnosis. 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 available in an unconstrained SNOMED CT data set can be confusing to clinicians who do not have the time or inclination to search through many hundreds of options, and this often results in data that is 'spuriously accurate'.

To address this issue, ECDS uses constrained SNOMED CT refsets as described above, specifically to capture Chief Complaint and Diagnosis (paired with a qualifier of either 'Confirmed Present' or 'Suspected' Diagnosis).

[5] Dinh, M.M., Russell, S.B., Bein, K.J., 2019. Diagnoses, damned diagnoses and statistics: Dealing with disparate diagnostic coding systems within the New South Wales Emergency Department Data Collection. Emergency Medicine Australasia 31, 830–836. https://doi.org/10.1111/1742-6723.13371

3.2.3 Maintenance of ECDS SNOMED CT refsets

From time to time, ECDS SNOMED CT refsets are updated to reflect the needs of the data set, clinical practice and for other reasons.

The overall structure and content of ECDS is owned by NHS England, with the National Clinical Director of Urgent and Emergency Care acting as Senior Responsible Officer for any changes necessary.

The ECDS Technical Committee is a clinically led dataset maintenance group, with clinical representation recruited through the Royal College of Emergency Medicine. The Technical Committee manages the **content** of the data items in ECDS. The **structure** of the data set is maintained through the NHS England Data Set Development Service.

- The ECDS data items can be found within the ECDS Technical Output Specification available from this link.
- The ECDS SNOMED CT refsets are included in the ECDS ETOS (Enhanced Technical Output Specification).
- ECDS SNOMED CT refsets are also downloadable with the SNOMED CT release files from TRUD https://isd.hscic.gov.uk/trud3/user/guest/group/0/pack/26.
- Subset metadata is hosted on the Data Dictionary for Care (DD4C) site[6]. There you can select subset metadata in the search options and enter the subset name, relevant terms or subset id. Each subset has a page with information such as the use, description, and an external links to browsers where you can view the SNOMED CT codes that make up the subset membership.
- If a clinician finds a clinical situation that requires a new SNOMED CT code, there is an ECDS feedback form[7] on the NHS England website and this is sent to the ECDS Technical Committee for review and discussion.
- Any new additions / updates or removals to the ECDS SNOMED CT refsets will be available via the existing SNOMED CT maintenance and release schedules and must be implemented in line with published schedules.

3.2.4 Changes to activity recorded in ECDS v4.0

The changes introduced into ECDS v4.0 to align to current clinical practice and new models of care mean that there are now four different types of activity in ECDS, which are:

- Emergency Care Attendance
- Same Day Emergency Care Attendance
- Urgent and Emergency Care Extended Care Episode
- Hot Clinic Attendance (only valid for piloting purposes)

These changes are reflected in the definitions used in the NHSE Data Model and Dictionary, which relate to the business definitions used in counting UEC activity.

- An Emergency Care Attendance is a CARE CONTACT.
- An Emergency Care Attendance is an individual visit by one PATIENT to an Emergency Care Department to receive treatment.
- An Emergency Care Attendance may be conducted face to face, or virtually by a CARE PROFESSIONAL from an Emergency Care Department who is qualified to deliver virtual care.

- A Same Day Emergency Care Attendance is a CARE CONTACT.
- A Same Day Emergency Care Attendance is the physical or virtual attendance of a PATIENT at an Urgent and Emergency Care Service for the provision of Same Day Emergency Care.
- A Same Day Emergency Care Attendance may be initiated following Emergency Care Streaming or Emergency Care Triage where the PATIENT has been assessed face to face or virtually by an appropriate CARE PROFESSIONAL.

- An Urgent and Emergency Care Extended Care Episode is an episode of clinical care for a PATIENT under the responsibility of a named CARE PROFESSIONAL in an Urgent and

[6] https://dd4c.digital.nhs.uk/dd4c/

[7] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds/feedback-form

Emergency Care Service, which occurs following initial assessment by a CARE PROFESSIONAL qualified for independent practice in Urgent and Emergency Care.

3.3 Same Day Emergency Care (SDEC)

NHS England describes Same Day Emergency Care (SDEC) as a service which allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment.

ECDS is able to capture Same Day Emergency Care (SDEC) activity. ECDS incorporates the time-based milestones necessary to understand time-sensitive care pathways, that are not present in alternatives.

ECDS v4.0 has been updated to record Same Day Emergency Care Activity. Further detail of these changes are set out in this document. To support implementation of these changes, example scenarios of the data to be submitted are included in Appendix D.

3.4 Urgent Treatment Centres

Urgent Treatment Centres (UTCs) were developed to standardise the disparate models of care that previously existed and operated as Type 3 and Type 4 services.

UTCs may be co-located with acute facilities, including Type 1 EDs and/or with primary care facilities (including GP Enhanced Access Hubs or Integrated Urgent Care Clinical Assessment Services) or may be standalone services. UTCs, wherever they are located, are expected to meet the UTC Principles and Standards (which a refreshed version will be published in 2023).

Only UTCs should report as Type 3. Alternative facilities, such as Out of hours GP appointments, GP streaming services, Minor Injury Services and Walk-in Centres are excluded from data collection through ECDS.

3.5 Injury Data Collection

There is a need to understand ED activity relating to injury and other modifiable factors to identify patterns that may be amenable to targeted interventions that will improve public health.

Prior to ECDS there was no consistent measurement of the number of people attending EDs as a result of injury. The result was a lack of targeted prevention strategies that could reduce the number of ED attendances and improve the lives of patients.

The ECDS structure and content of injury surveillance data items is derived from international best practice (World Health Organisation, European Union, Australia and Canada) and strikes a balance between usability and comprehensiveness, bearing in mind the number of patients for whom this data will be collected.

3.5.1 Injury classification

Within ECDS the term ‘Injury’ relates to harm or potential harm and is derived from the WHO definitions of injury.

Injuries include assaults, falls, accidents that result in damage to skin, subcutaneous tissues, muscles, tendons, nerves, vessels or organs or a combination of these.

Also included within ‘injuries’ are burns, bites, foreign bodies, impact from environmental factors such as UV or temperature, poisoning or overdoses and complications of care or legal interventions. This is based on the definition of ‘injury’ that is used that reflects an insult to the body from a source external to the body.

Each item that is ‘flagged’ as an injury (whether within Chief Complaint or Diagnosis) will require additional data entry:

- Geographical location of injury
- Injury intent (e.g. unintentional / self-inflicted / assault)
- Type of activity at time of injury (e.g. leisure / work)
- Physical activity being undertaken by individual at time of injury
- Mechanism of injury
- Whether drugs and alcohol were likely to have contributed to the injury.

3.5.2 Information Sharing to Tackle Violence (ISTV)

The Information Sharing to Tackle Violence (ISTV) Information Standard comprises a small de-identified data set collected by EDs and shared with local Community Safety Partnerships (CSP).

The data covers all ED attendances resulting from violent incidents, including:

- Time and date of the incident
- Time and date of arrival in ED
- Specific location of the incident
- Primary means of assault (i.e. weapon or body part used).

The ISTV standard is mandatory for Type 1 EDs in England and optional for all other ED types. The standard (ISB 1594 Amd 30/2012) was approved and published by the Information Standards Board (ISB) in September 2014[8]. ECDS previously introduced a number of new data items to ensure alignment with the ISTV data standard. ECDS v4.0 now takes over from the ISTV standard and all relevant data should be submitted via ECDS as part of implementing ECDS v4.0. The ISTV standard is scheduled to be retired in July 2024.

Providers should work with their system suppliers and local partners to ensure that ECDS injury information can be captured locally and that relevant information can be included as part of ECDS submission.

ECDS v4.0 includes a field (Assault Location Description) that allows the free text description of the location of an assault, following this being a pilot field in ECDS v3.0.

The intent is that this will allow all ISTV data to be collated automatically via ECDS, and this will ensure consistent implementation and oversight of violence prevention.

For specific user guidance relating to the injury data please see section 5.14 in this user guidance.

The Royal College of Emergency Medicine has published additional information on ISTV in March 2024. This includes three short films for clerical staff, clinical staff and healthcare workers and a new Standard Operating Procedure (SOP). These are available at:
https://rcem.ac.uk/information-sharing-to-tackle-violence/

Further reading:

Department of Health, NHS Digital / Information Standards Board (now known as Data Alliance Partnership Board); Implementation Guidance: Information Sharing to Tackle Violence (ISTV), Version 2.1, April 2019.

https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb1594-information-sharing-to-tackle-violence-minimum-dataset

Department of Health: Information Sharing to Tackle Violence: Guidance for Community Safety Partnerships on engaging with the NHS

https://www.gov.uk/government/publications/sharing-to-tackle-violence-guidance-for-community-safety-partnerships-on-engaging-with-the-nhs

[8] Information Standards Board for Health and Social Care. November 2014. Available at: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb1594-information-sharing-to-tackle-violence-minimum-dataset

Serious Violence Duty, Preventing and reducing serious violence, Statutory Guidance for responsible authorities, England and Wales, December 2022, Home Office.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1125001/Final_Serious_Violence_Duty_Statutory_Guidance_-_December_2022.pdf

Royal College of Emergency Medicine:

Information Sharing to Tackle Violence | RCEM

4 Improving System Usability

Poor system usability is one of the root causes that health IT often struggles to achieve its aims, and the challenges to delivering good informatics practice into the ED are significant.

There are many benefits (clinical, operational, and strategic) in having structured (coded) clinical information recorded and available at the point of care.

The barriers to this are rarely technical, and usually relate to process, workflow and the ergonomics of the human-computer interface e.g. “Are there enough computers?” or “Is it easy to log on / log off?”

The Emergency Medicine Journal contains information on the usability of electronic health record systems in UK Eds, following a survey which was completed to assess systems for usability[9].

4.1 Clinical Coding

In most inpatient specialties, data is entered by professional clinical coders who have been specifically trained to understand and use code sets. Their work is done away from front-line clinical areas, is quality-assured and directly used in tariff calculation. Therefore, the incentives are aligned to code accurately and this coding activity is recognised as a financially important role within the hospital.

Extensive experience has shown that the only way to ensure a consistently high standard of data quality and completion is to validate data entry at the point of entry; and ensure that patients cannot be discharged from the IT system without all relevant data completed. This has a direct clinical benefit in that the data is available to populate the patient / GP letter, which should be given to the patient at the point of discharge. This is not only good clinical practice but also minimises the risk of miscommunication and patient dissatisfaction.

ED staff are expected to enter data into the ED information system in real-time, which provides particular constraints to the way the IT should be used effectively.

- Are time-pressured
- Receive no specific training regarding informatics and coding
- Have high staff turnover – trainee doctors 3-4 months
- Use many locums / agency workers.

and critically

- Do not use the data produced (i.e. have no direct stake in data quality or opportunity to feedback on it).

Several features are presented in this user guidance to help IT system designers make it as easy as possible for NHS ED staff to input information quickly and efficiently. The aim is to make it easy for staff to do the right thing.

Features include:

- Hierarchical coding for each code set where necessary so that sequential drop-down boxes can be used to gradually identify the correct data item
- Data items arranged so that the most frequently used is at the top of the list
- Data items arranged into groups (ECDS Group) of 10 items or less wherever possible to minimise scrolling
- Removal of data items that were confusing, duplicated or open to misinterpretation.

The ECDS ETOS (Enhanced Technical Output Specification) includes additional information in the code set to help system suppliers to maximise usability and will help minimise time spent searching for codes.

[9] https://emj.bmj.com/content/38/6/410

The ECDS ETOS is maintained by NHS England and is updated in line with the ECDS releases and at other times as required.

4.2 ECDS Sort Codes and Grouping

The ECDS (ETOS) includes specific measures to help guide IT developers on how ECDS refset codes should be presented to ensure ease of use.

The unique Identifiers and 'sort codes' are included in all of the ECDS refsets, which will help to minimise clinical time spent searching for codes by organising these such that the most commonly used entities appear at the top of lists. Every ECDS refset has 4 sort columns. This allows a consistent Unique ID to be created for all SNOMED codes in ECDS – the 'ECDS_UniqueID' in the ETOS.

Sort codes support logical sequential hierarchies for use in the larger refsets of codes. The aim is that this enables well-constructed sequential drop boxes which are easy to use – for example the aim is that two linked lists of ten items are much quicker and easier to navigate than one long list of 100 items that must be scrolled through.

In addition, consistent presentation of the data choices can make it much easier for staff to move from one hospital to another e.g. locums / trainees. It is recommended that the options should be presented by the ED Information System ordered by the sort order specified in the code set to aid the usability of ECDS for ED staff. Together with the ECDS Group code, the ECDS sort codes enable sequential sorting e.g. to support the use of linked dropdown boxes.

For some situations e.g. diagnosis, a real-time search box (e.g. suggestions are made as the user types in the box) would be an alternative.

4.3 ECDS Flags

The ECDS ETOS includes 'flags' in both the Diagnosis and Chief Complaint SNOMED CT refsets.

These flags are presented as guidance for suppliers and providers during implementation to help emphasise specific information relevant to ED attendances. It is entirely up to the provider and the system supplier as to whether they wish to implement the flags.

- Injury flag (Chief Complaint and Diagnosis) – Helps to identify whether an attendance is likely to be the result of an injury and could be used to trigger the injury data collection. The intention is that when implementing the Chief Complaint and Diagnosis lists where a Chief Complaint / Diagnosis is recorded in the system which has an injury flag the system should then ensure that the injury data items are completed for that record.
- SDEC – This indicates a diagnosis that may be amenable for Same Day Emergency Care, based on the 2018 Best Practice Tariffs for Same Day Emergency Care (these tariffs have now been deprecated as part of the move to a 'blended payment' system.) [A 'Same Day Emergency Care (SDEC) Index 125' is also planned to be published in future to describe priority conditions for Same Day Emergency Care.]
- Notifiable Disease – Indicates that this diagnosis is a 'Notifiable disease' and depending on the local public health protocols, there may be a statutory duty to report this to Public Health officials.
- Allergy – Identifies that the Chief Complaint and / or Diagnosis are allergy related and that this information should flow as an extra and specific part of the ED to GP Transfer of Care messaging. For more information refer to section 2.3 and 5.22 of this user guidance.
- Male – Indicates a chief complaint and/ or diagnosis more likely to appear in a patient of this gender, and is therefore helpful in checking data quality.
- Female – Indicates a chief complaint and/ or diagnosis more likely to appear in a patient of this gender, and is therefore helpful in checking data quality.

5 Data Item Guidance

This section provides guidance for the collection of all data items for inclusion within ECDS. Guidance for each data item is given within the data groups they occur in the NHS Data Dictionary. An overview of each data group showing the mandation, repeats, names and descriptions can be found in Appendix B.

The electronic copy of this document includes hyperlinks to the corresponding entries in the Data Dictionary where formal definition of the data item can be found and relationships with other data elements and attributes are defined.

5.1 Notation

The tables in sections 5.1.1 to 5.1.3 below present the notation and definitions which apply to the data groups and data items throughout this document:

5.1.1 Status

Status	Meaning	Description
M	Mandatory	These data groups and data items **MUST** be reported. Failure to submit these will result in the rejection of the interchange. They are necessary for ECDS to be correctly validated and accepted for processing by the Secondary Uses Service (SUS). In most instances, data items marked as 'Mandatory' will result in its parent data group also being marked as 'Mandatory', but this is not always the case, for example, although the Data Group: Urgent And Emergency Care Diagnoses (SNOMED CT) is marked as 'R' (Required), and therefore need not actually be populated, if it is used then all data items in the group Urgent And Emergency Care Diagnosis (SNOMED CT), Coded Clinical Entry Sequence Number and Urgent And Emergency Care Diagnosis Qualifier (SNOMED CT) are all marked as 'Mandatory' and so must be present.
R	Required	These data groups and data items **MUST** be reported where they apply. Failure to submit these items will not result in the rejection of the interchange but may affect the derivation of national indicators or national analysis. If at the time of submission to the SUS, the information remains incomplete the remaining data in the ECDS record should still be submitted. Once the organisation has updated its systems with the data, the data should be resubmitted. In some cases, for example a person leaves the ED before a diagnosis is made, then the data may never be resubmitted.
O	Optional	These data items **MAY** be populated on an optional basis at the submitter's discretion. Note that even if marked 'Optional', any data included in an ECDS submission to SUS must comply with its specification published in the NHS Data Model and Dictionary otherwise the data may be deemed invalid and rejected.
X	Pilot	This data element is for **piloting use only**. Note: items in the M/R/O/P column which are shown with notation X have **not** been approved by the Data Coordination Board and are included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the Emergency Care Data Set. These items have been included in the data set layout in order to provide advance notice to data providers and system suppliers of the intention to require these items at a later date. Unless Organisations are engaged in piloting activities relating to these items, they should **NOT** submit any data item marked X. Providers and Suppliers should make efforts to prepare for the eventual inclusion of these fields in future versions of the data set, so that future enablement is efficient and easy. .

Table 1: Data Group and Item Status

5.1.2 Format

Format	Meaning	Description
n	Numeric	The data item is made up of digits only, that is any numerals from 1 to 9. The 'n' is followed by the number of digits. For example, SNOMED CT data items all have the format 'min n6 max18', meaning up to 18 numerals are valid.
an	Alphanumeric	The data item is made up of both letters and numerals. This includes both upper- and lower-case letters, punctuation marks, and symbols (such as /, @, &). The 'an' is followed by the number of characters allowed. For example, 'max an10' means up to 10 characters is valid.
HH:MM:SS	Time format	Specific formats such as for a time have implied validation. For example, 'HH' must be in range 0-24, 'MM' 0-60 and 'SS' 0-60.
CCYY-MM-DD	Date Format	Similar to above, date formats must be a valid date, for example 2002-02-31 would be invalid.
max an25	Timestamp (ISO 8601 timestamp format)	ECDS v4.0 aligns to the ISO 8601 Timestamp format (Max an25) for all clinical fields that capture date and time or for fields which are expected to be 'system to system' automatic data transfer. For data which is recorded by administrative staff then the date field and time fields are still separate. The standard ISO 8601 timestamp format is used to capture key milestones on the patient journey, including UTC offset. A Timestamp is represented with the components of date, time and either the number of hours offset (plus or minus) from Greenwich Mean Time, or the letter Z to signify that it is the same as Greenwich Mean Time. For ECDS v4.0 offset time is restricted to: • +01:00 • +00:00 • -00:00 Examples of valid formats are: • 2020-08-21T10:15:20+01:00 British Summer Time (GMT + 1 Hour) • 2020-08-21T10:15:20+00:00 Greenwich Mean Time • 2020-08-21T10:15:20-00:00 Greenwich Mean Time • 2020-08-21T09:18:00Z Greenwich Mean Time.

Table 2: Data Item Format

5.1.3 Source

Format	Meaning	Description
SNOMED CT	Systemized Nomenclature of Medicine Clinical Terms	Codes are sourced from the SNOMED CT terminology which is a comprehensive set of clinical phrases or terms. In the UK this is managed by NHS England, as the UK National Release Centre (NRS) for SNOMED CT.
ISO	International Organisation for Standardisation	The code set complies with a published international standard. These standards are maintained by the International Organisation for Standardisation.
DM&D	Data Model and Dictionary	The code sets are defined and described in the NHS Data Dictionary
ODS	Organisation Data Service	These data items must be a code published by the Organisation Data Service (ODS). Data must be a valid ODS code.

Table 3 Data Item Source

5.2 Data Group: Patient Pathway

As part of ECDS v4.0 and as a result of the consultation process this data group has been retired. There is no requirement to submit this data in ECDS v4.0.

5.3 Data Group: Patient Identity

5.3.1 Definition and Group Status for Data Group

Definition: This data group carries the identity of the patient and is mandatory.

Group status: 'Mandated'

One occurrence of the group must be present for each patient. **ONLY ONE** of the following subgroups must be used:

- Unverified identity structure data group
- Verified identity structure data group
- Withheld identity structure data group.

5.3.2 Patient Identity Subgroup – Withheld Identity Structure

Definition: Used to carry minimal details where the CDS record has been anonymised (see Security Issues and Patient Confidentiality[10]).

Justification: Justification for collection is the CDS version 6-3 standard[11].

How to collect: The correct data group data items may be automatically generated where the IT system supports this, or human intervention may be required to remove identifying details during preparation of the Commissioning Data Set.

Data Items in the Withheld Identity Structure Subgroup are:

- NHS Number Status Indicator Code
- Organisation Identifier (Residence Responsibility)
- Withheld Identity Reason.

5.3.3 Patient Identity Subgroup – Verified Identity Structure

Definition: Used to carry patient identity details where the NHS Number status indicator code value in the patient record is 01 (Number present and verified).

Justification: Justification for collection is the CDS version 6-3 standard, see Withheld Identity Structure above.

How to collect: The correct data group data items (e.g. removal of name and address) may be automatically generated where the IT system supports this, or human intervention may be required to remove identifying details during preparation of the Commissioning Data Set.

Data Items in Verified Identity Structure Subgroup are:

- Local Patient Identifier (Extended)
- Organisation Identifier (Local Patient Identifier)
- NHS Number
- NHS Number Status Indicator Code
- Postcode of Usual Address
- Organisation Identifier (Residence Responsibility)
- Person Birth Date.

5.3.4 Patient Identity Subgroup – Unverified Identity Structure

Definition: Used to carry patient identity details where the NHS Number Status Indicator Code value in the patient record is any value **except 01** (Number present and verified).

[10] NHS Data Dictionary. 2017. Security Issues and Patient Confidentiality. Available at: www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/security_issues_and_patient_confidentiality.asp

[11] Information Standards Board for Health and Social Care ISB0092 AMD 16/2010 Commissioning Data Sets (CDS) Version 6.2 Available at: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb0092-commissioning-data-sets

Justification: Justification for collection is the CDS version 6-3 standard, see Withheld Identity Structure above.

How to collect: The correct data group data items should be automatically generated from the patient demographic record. However, note guidance on Security Issues and Patient Confidentiality relating to removal of identifying details in certain circumstances.

Data Items included in the Unverified Identity Structure Subgroup are:

- Local Patient Identifier (Extended)
- Organisation Identifier (Local Patient Identifier)
- NHS Number
- NHS Number Status Indicator Code
- Patient Full Name
- Patient Title
- Patient Given Name
- Patient Family Name
- Patient Name Suffix
- Patient Initials
- Patient Usual Address (Unstructured)
- Patient Usual Address (Structured)
- Postcode of Usual Address
- Organisation Identifier (Residence Responsibility)
- Person Birth Date.

5.3.5 Data Items in this Data Group

The table 5 overleaf shows all the data items used in the Patient Identity Data Group and which of the three subgroups they occur in. As shown, some of these data items are used in more than one subgroup and some are unique to a specific subgroup, for example Local Patient Identifier occurs in the Unverified and Verified subgroups whereas Withheld Identity Reason is only used in the Withheld Identity Structure Subgroup.

A shaded cell means it is NOT included in that subgroup.

Data Element Name	Format	Status within Subgroup	Source	Included in Unverified Subgroup	Included in Verified Subgroup	Included in Withheld Subgroup
Local Patient Identifier (Extended)	max an20	M	DM&D	Y	Y	N
Organisation Identifier (Local Patient Identifier)	min an3 max an5	M	ODS	Y	Y	N
NHS Number	n10	M in verified identity structure, R in unverified identity structure	DM&D	Y	Y	N
NHS Number Status Indicator Code	an2	M	DM&D	Y	Y	Y
Patient Full Name Or Patient Title Patient Given Name Patient Family Name Patient Name Suffix Patient Initials	max an70 max an35 max an35 max an35 max an35 max an35	M O M M O O	DM&D	Y	N	N
Patient Usual Address (Unstructured) Or Patient Usual Address (Structured)	an175 (5 lines each an35) max an35	M M	DM&D	Y	N	N
Postcode of Usual Address	min an2 max an8	M in verified identity structure, R in unverified identity structure	DM&D	Y	Y	N
Organisation Identifier (Residence Responsibility)	min an3 max an5	R	ODS	Y	Y	Y
Person Birth Date	an10 CCYY-MM-DD	R	DM&D	Y	Y	N
Withheld Identity Reason	an2	R	DM&D	N	N	Y

Table 4 Data items in the 'Patient Identity' Data Group

A full description of each data item is given below, the definition and justification are the same whichever subgroup it occurs in.

5.3.6 Local Patient Identifier (Extended)

Definition: A number used to identify a patient uniquely within a Health Care Provider. It may be different from the patient's case note number and may be assigned automatically by the computer system.

Data Dictionary:

LOCAL PATIENT IDENTIFIER (EXTENDED) (datadictionary.nhs.uk)

Justification: This is the local unique identifier given by the hospital facility to the patient that allows hospital records to be matched with emergency care records across local healthcare services. The local number is often used (as is the NHS number) to enable tracking patient pathways across different providers to have a complete understanding of an episode of care. This is essential to understand healthcare utilisation and to enable provision of services that match population need.

How to collect: The hospital that issued this patient identifier will be the one identified by the data item: Organisation identifier (local patient identifier) – see below.

This information will be auto populated once the patient has been booked in/registered in the ED or if there is no information system in place this number could be allocated by clerical staff.

5.3.7 Organisation Identifier (Local Patient Identifier)

Definition: The organisation identifier of the organisation that assigned the Local Patient Identifier (Extended).

Data Dictionary:

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER) (datadictionary.nhs.uk)

Justification: To make the Local Patient Identifier unique across provider organisations.

How to collect: This information will be auto populated once the patient has been booked in/registered in the ED or if there is no information system in place this number could be allocated by clerical staff.

5.3.8 NHS Number

Definition: The primary identifier of a person, it is a unique identifier for a patient within the NHS in England and Wales.

Data Dictionary: NHS NUMBER (datadictionary.nhs.uk)

Justification: The NHS Number enables aggregation of data across health and social care domains to understand patterns of healthcare usage to ensure that service provision matches need.

It is part of the Automatic Identification and Data Capture (AIDC) for Patient Identification Data Set Overview[12], supporting the accurate, timely and safe identification of NHS patients in England, by encoding the key patient identifiers into a GS1 Data Matrix 2D bar code (see AIDC standard for further information) and used on the identity band.

How to collect: It is mandatory to record the NHS Number for a patient. However, in emergency care, it is accepted that occasionally a patient will not have an NHS Number therefore this data item is 'Required' and not 'Mandatory', which ensures that data relating to the patient can still flow.

Although it is not a mandated field, data quality reports will be produced regarding completeness of this field. This information will be auto populated from NHS Spine / PAS where available, otherwise it will be entered by clerical staff.

The NHS Number is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm. When an NHS Number is provided it must pass the modulus 11 check as per NHS Number validation guidance[13].

If there is no NHS number, then this data item is omitted, and other unique identifiers will need to flow as per national process.

[12] https://datadictionary.nhs.uk/data_sets/clinical_content/aidc_for_patient_identification_data_set.html

[13] https://datadictionary.nhs.uk/attributes/nhs_number.html

This data item is linked with NHS Number Status Indicator Code (see below).

5.3.9 NHS Number Status Indicator Code

Definition: The trace status of the NHS number.

Data Dictionary: https://datadictionary.nhs.uk/attributes/nhs_number_status_indicator_code.html

Justification: The NHS Number is used nationally to link patients' records. This data item indicates how reliable the NHS Number will be for this purpose.

In most cases, this data item will be flowed with value '01 - Number present and verified'. This status indicates that the provider has validated the number against the central Patient Demographics Service (PDS)[14] and can be used to reliably link to other national data sets.

How to collect: This data item is mandatory for all the Patient Identity subgroups, irrespective of whether an NHS Number is present.

In cases where a patient's NHS Number is unavailable (which may be because the patient does not possess one) data providers should omit the NHS Number and supply the NHS Number Status Indicator Code of '07 – Number not present and trace not required'.

This information may be auto populated if the record has originated from the NHS Spine / PAS where available or it might otherwise be derived by the system upon entry of the NHS Number clerical staff.

5.3.10 Patient Name – Structured or Patient Name – Unstructured

Definition: This data item holds the name of the patient.

Patient name is the person name where the person name classification is 'Preferred Name' of the patient.

It can be either in a structured format; a two-element name, forename followed by surname, each element 35 alphanumeric characters or an unstructured format of 70 alphanumeric characters.

Data Dictionary:

Structured - https://datadictionary.nhs.uk/classes/person_name_structured.html

Unstructured - https://datadictionary.nhs.uk/classes/person_name_unstructured.html

Justification: To provide additional information to support tracing of the NHS Number nationally.

How to collect: This information will be auto populated from NHS SPINE / PAS where available or otherwise entered by clerical staff.

5.3.11 Patient Usual Address – Structured or Patient Usual Address – Unstructured

Definition: Patient Usual Address is the usual address nominated by the patient, where the address association type is 'Main Permanent Residence' or 'Other Permanent Residence'.

It can be submitted either as a structured address; a recognisable postal address comprised of up to five lines of 35 alphanumeric characters, or an unstructured address of 175 alphanumeric characters.

Note: the format relates to the physical layout, and not necessarily to the logical layout of the address.

Data Dictionary:

Structured - PATIENT USUAL ADDRESS (STRUCTURED) (datadictionary.nhs.uk)

Unstructured - PATIENT USUAL ADDRESS (UNSTRUCTURED) (datadictionary.nhs.uk)

Justification: To provide additional information to support tracing of the NHS Number nationally.

How to collect: This information will be auto populated from NHS Spine / PAS where available or otherwise entered by clerical staff.

[14] https://digital.nhs.uk/Demographics

5.3.12 Postcode of Usual Address

Definition: The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.

Data Dictionary:
www.datadictionary.nhs.uk/data_dictionary/data_field_notes/p/po/postcode_of_usual_address_de.asp

Justification: To provide additional information to support tracing of the NHS Number nationally and enables a range of derivations.,

How to collect: This information will be auto populated from NHS Spine / PAS where available or otherwise entered by clerical staff. This should be entered according to the standards within the NHS Postcode Directory: NHS Postcode Directory (datadictionary.nhs.uk)

5.3.13 Organisation Identifier (Residence Responsibility)

Definition: The Organisation Identifier (Residence Responsibility) is the Organisation Identifier derived from the Patient's Postcode of Usual Address.

This is where the Patient resides within the boundary of a:

- Sub Integrated Care Board Location
- Care Trust
- Local Health Board (Wales)
- Scottish Health Board
- Northern Ireland Local Commissioning Group
- Primary Healthcare Directorate (Isle of Man)
- Local Authority.

Data Dictionary:

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) (datadictionary.nhs.uk)

Justification: Where the record is anonymised, this data item enables access to the record by commissioners.

How to collect: Derived from postcode to sub-ICB look up files (via ODS) prior to submission to SUS.

5.3.14 Person Birth Date

Definition: The date on which a person was born or is officially deemed to have been born.

Data Dictionary: PERSON BIRTH DATE (datadictionary.nhs.uk)

Justification: Birth date is one component of the unique patient identifier for patients which is necessary if the NHS Number is not available.

Birth date used to calculate the age of the patient, which is important to know to understand patterns of healthcare use, and to enable commissioners to commission the correct services to meet need.

How to collect: This information will be auto populated from NHS SPINE / PAS where available or otherwise entered by clerical staff.

5.3.15 Withheld Identity Reason

Definition: This data item allows suppliers of 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.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/withheld_identity_reason.html

Justification: Allows providers who submit CDS records to indicate to recipients of the CDS record (for example, the commissioner of the activity) that the record has been purposely anonymised for a valid reason.

CDS is a patient level data set and contains patient identifiable information to support national analysis and commissioning. Providers are required, or may choose, to withhold patient identifiers for individual

patients for a variety of reasons including legal or statutory reasons (e.g. HIV / IVF), or upon request of the Caldicott Guardian or the patient. In other cases, patient identifiers may be omitted as a result of data quality issues.

As a result, there is a need to identify the reason that submitted records have been anonymised by the provider prior to submission. This will ensure that payment to providers is not withheld for records where patient details have been withheld legitimately.

Without this identifier, payment may be denied or allocated to an incorrect tariff by the commissioner due to the missing patient details.

How to collect: This will typically be flagged on a patient administration / care record system, sometimes as an alert on the patient's record, by administration staff upon request by the Caldicott Guardian or patient. This will usually occur at the point of either attendance for outpatient appointment or admission to the hospital.

Removal of patient identifiers as a result of legal / statutory requirements such as the Human Fertilisation and Embryology Act 1990[15] as amended by the Human Fertilisation and Embryology (Disclosure of Information) Act 1992[16] or relating to Sexually Transmitted Diseases including HIV and AIDS will normally be automated upon extraction based on the presence of certain diagnoses or procedures.

Full details of security and patient confidentiality are available on the NHS Data Dictionary website[17].

[15] www.legislation.gov.uk/ukpga/1990/37/section/37

[16] www.legislation.gov.uk/ukpga/1992/54/contents

[17] https://www.datadictionary.nhs.uk/supporting_information/security_issues_and_patient_confidentiality.html

5.4 Data Group: Patient Characteristics (Urgent And Emergency Care)

5.4.1 Definition and Justification for Data Group

Definition: To carry the characteristics of the Patient for Urgent and Emergency Care Activity.

Group status: 'Required'

5.4.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Person Stated Gender Code	an1	R	DM&D
Ethnic Category	max an2	R	DM&D
Ethnic Category 2021	max an3	X	DM&D
Accommodation Status (SNOMED CT)	min n6 max n18	R	SNOMED CT
Preferred Spoken Language (SNOMED CT)	min n6 max n18	R	SNOMED CT
Accessible Information Professional Required Code (SNOMED CT)	min n6 max n18	R	SNOMED CT
Interpreter Language (SNOMED CT)	min n6 max n18	R	SNOMED CT
Overseas Visitor Charging Category at CDS Activity Date	an1	R	DM&D

Table 5 Data items within 'Patient Characteristics (Urgent And Emergency Care)' Data Group

5.4.3 Person Stated Gender Code

Definition: The gender of a person. Person Stated Gender Code is self-declared or inferred by observation for those unable to declare their person stated gender.

Data Dictionary: PERSON STATED GENDER CODE (datadictionary.nhs.uk)

Justification: It is necessary to collect stated gender so that the anonymised ECDS data still contains important and relevant gender information. This helps to understand patterns of healthcare usage to ensure that service provision matches need e.g. emergency care provision for obstetric and gynaecological conditions. A person's gender may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment or transgender reassignment.

How to collect: This information will be auto populated from NHS Spine / PAS where available otherwise entered by clerical staff.

Gender should be inferred or accepted as reported by the respondent. It is usually unnecessary and may be inappropriate or even offensive to ask a person their gender.

The 'Indeterminate' code is available to cater for persons who do not identify with a particular gender.

5.4.4 Ethnic Category

Definition: The ethnicity of a person, as specified by the person.

Data Dictionary: ETHNIC CATEGORY (datadictionary.nhs.uk)

Justification: This information is necessary to ensure equity of access to medical care and the code set used is taken from the National Census by The Office for National Statistics

www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity#datasets

How to collect: This information will be auto populated from NHS Spine/ PAS where available, otherwise it will be entered by clerical staff. Ethnic category is the classification used for the 2001 census and is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2-character field.

The Office of National Statistics (ONS)[18] has developed a further breakdown of the national code groups which may be used locally. Use of the second character code is optional, however it must be able to be grouped consistently with the 16 main categories.

National code Z should be used where the person has been given the opportunity to state their ethnic category but chose not to.

Default code 99 should only be used when the person's ethnic category is not known, and the patient is unable to state their code e.g. unconscious. This should be a very rare event.

Ethnicity should be inferred or accepted as reported by the respondent. It is usually unnecessary and may be inappropriate or even offensive to ask a person their ethnicity.

A new data item – 'Ethnic Category 2021' has been introduced but is not to be submitted in ECDS v4.0. Any future changes to this will be communicated in updated user guidance.

5.4.5 Accommodation Status (SNOMED CT)

Definition: Accommodation Status (SNOMED CT) is the SNOMED CT concept ID which is used to identify the identify the details of the accommodation of the person.

Data Dictionary: ACCOMMODATION STATUS (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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 provides an opportunity to allow specific incentives to be incorporated into future tariff arrangements.

How to collect: This information may be captured directly within the PAS by administrative staff on patient registration at the ED.

Where this is not available, administrative staff should ask the question in a standard format such as:

"What type of accommodation are you currently living in?"

Coding Examples:

Description	Notes
Housed	**Includes:** house, farmhouse, apartment/ flat, permanent place of residence, rented or owned **Excludes:** Abandoned or derelict house, boarding house, hotel, caravan park, refuge, squat, homeless hostel, sofa surfing, institutional place of residence
Lives in warden-controlled accommodation	**Includes:** warden-controlled home with intermittent welfare checks **Excludes:** residential / nursing home with continuous dedicated staffing
Lives in a residential home	**Includes:** residential home, old people's home, monastery, children's home, long term residential home placements **Excludes:** hospital, nursing home, hospice, psychiatric hospital
Lives in a nursing home	**Includes:** nursing home, care home, hospice **Excludes:** hospital, residential home, psychiatric hospital
Lives in hospital	**Includes:** hospital, psychiatric hospital (long term) **Excludes:** hospice, nursing home
Sleeping out	**Includes:** people sleeping on the street, in parks, in cars, on buses, in bus /train stations or airports or in settings open 24 hours such as fast-food restaurants.

[18] Office of National Statistics, www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity

	Excludes: people who have any form of accommodation with a bed where they can sleep at night. People sleeping in boats, caravans or campervans. People in night shelters. Sofa surfing.
Lives in residential hostel	**Includes:** Anyone living in a single room in a shared hostel. Examples: Homeless hostel. Bail hostel. Women's refuge. Immigration hostel. **Excludes:** People who live in a night shelter (where they have no access to the accommodation during the day). Rough sleeping. Sofa surfing. Boarding house, Backpackers, hotel, caravan park, squat, temporary accommodation provided by local authority
Sleeping in night shelter	**Includes:** night shelter, homeless shelter, emergency housing **Excludes:** sleeping rough
Sofa surfer - person of no fixed abode	**Includes:** anyone sleeping temporarily in the accommodation of a family member, friend or acquaintance where they have no formal tenancy or right to live in that accommodation permanently. The person does not need to sleeping on a sofa – they could be sleeping anywhere in the accommodation. **Excludes:** people with any form of tenancy or current right to sleep in any form of accommodation. People who state they are on holiday. Rough sleeping. Homeless hostel.
Housing instability	**Includes:** boarding house, Backpackers, hotel, caravan park, squat, temporary accommodation provided by local authority, military camp, prison **Excludes:** house, farmhouse, non-institutional place of residence, apartment/ flat, permanent place of residence, homeless hostel
Homeless	**Includes:** anyone perceived to be homeless who does not fit into the above categories (please try to use the above categories first
Declines to provide accommodation details	**Includes:** any situation where the patient can physically answer questions but refuses to answer this question.
Unable to provide accommodation details	**Includes:** only in a situation when patient physically is unable to respond e.g. unconscious and not able to establish by other means

Foreign nationals or people on holiday should be coded according to their usual accommodation type e.g. A patient who usually lives in a residential home in France and is currently staying with family in the UK, should be coded as 'Lives in residential home'.

Table 6 Coding examples of application of 'Accommodation Status' codes

5.4.6 Preferred Spoken Language (SNOMED CT)

Definition: Preferred Spoken Language (SNOMED CT) is the SMOMED CT concept ID which is used to capture the preferred spoken Language of the person.

Data Dictionary: PREFERRED SPOKEN LANGUAGE (SNOMED CT) (datadictionary.nhs.uk)

Justification: Necessary to understand how best to provide for patient needs, identify language barriers that may prevent safe and effective healthcare and enable planning for how these may be ameliorated. This data is necessary to ensure that translation resources match patient need.

How to collect: This information may be captured directly within the PAS by administrative staff on patient registration at the ED.

Where this is not available, administrative staff should ask the question in a standard format such as:

"What is [your] [the person's] preferred language?"

Where a person is unable to consent for themselves (e.g. baby, child or who lacks capacity for any other reason) then the language of the person who is consenting will be recorded. For example, a parent / guardian or someone with lasting power of attorney.

The communication language is independent of the need for an interpreter (see below) e.g. a patient may communicate in English but need a sign language interpreter; or may mainly speak French but not need an interpreter.

N.B. This data item should always be asked before enquiring about whether an 'Accessible Information Professional' is required (see section 5.4.7 below).

The codes presented to support collection of this data item are from ISO 639.1 'Codes for the Representation of Names of Languages'[19].

5.4.7 Accessible Information Professional Required Code (SNOMED CT)

Definition: Accessible Information Professional Required code (SNOMED CT) is the SNOMED CT concept ID which is used to identify that the patient requires support from a communication professional.

Data Dictionary: ACCESSIBLE INFORMATION PROFESSIONAL REQUIRED CODE (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

ECDS supports the Accessible Information Standard (DCB 1605)[20] in meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

How to collect: This information may be captured directly within the PAS by administrative staff on patient registration at the ED.

Where this is not available, administrative staff should ask the question in a standard format such as: *"Do you / does [patient's name] require an interpreter?"*

This question is asked to determine the need for an interpreter / accessible information professional, not the capacity of the hospital to provide an interpreter.

- Use the code for 'Interpreter / accessible information professional needed' if the person indicates they need an interpreter, or your judgement is that clear communication would not be guaranteed without an interpreter / accessible information professional.
- Use the code for 'Interpreter not needed' if the person indicates that they do not need an interpreter and if preferred language is English.

In cases where the need is unclear, the need for an interpreter / accessible information professional can be answered by asking the question: *"If this person needed to consent for a life-threatening operation, or I were concerned about safeguarding issues, does this patient require assistance to be able to communicate in English for safe and valid consent / safeguarding decisions to be made?"*

In the common situation that a family member / accompanying person is present and necessary to interpret for the patient then the answer is always 'Yes'.

Local guidance should always be followed regarding the use of family members / accompanying persons as interpreters and when this is / is not permissible e.g. in resuscitation situations.

If the person's communication language is English, 'Interpreter required' can be assumed to be 'No', unless the person has individual communication needs e.g. sign language.

[19] Library of Congress. 2017. ISO 639.2. 'Codes for the Representation of Names of Languages' Available at: www.loc.gov/standards/iso639-2/php/code_list.php

[20] NHS Digital. 2017 Accessible Information. Available at:: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1605-accessible-information

This information must:

- Be checked for every ED attendance
- Be collected on, or as soon as possible after registration.

N.B. This data item should always be determined before enquiring about the interpreter language (see item 5.4.8 below).

5.4.8 Interpreter Language (SNOMED CT)

Definition: Interpreter Language (SNOMED CT) is the SNOMED CT concept ID which is used to record the Language of the interpreter required by the person.

This also covers where communication professionals are provided to support the needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss e.g. provision of British Sign Language (BSL) interpretation.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/interpreter_language__snomed_ct_.html

Justification: Identifies whether an interpreter is required to understand how best to provide for patient needs and ensure translation resources match patient need.

ECDS supports the Accessible Information Standard (DCB 1605)[21] in meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

How to collect: This information may be captured directly within the PAS by administrative staff on patient registration at the ED. Where this is not available, administrative staff should ask the question in a standard format such as: *"Do you require an interpreter?"*

This question is asked to determine the need for an interpreter not the capacity of the department to provide one. It answers the question: *"Does the patient require an interpreter to communicate?"*

Once recorded within the PAS this information could be auto populated when a person attends the department on a different occasion. No manual entry would be required unless the requirement has changed.

N.B. This data item should be captured after enquiring about the need for an accessible information professional (see item 5.4.7 above).

5.4.9 Overseas Visitor Charging Category at CDS Activity Date

Definition: The charging category relating to an overseas visitor status.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/overseas_visitor_charging_category_at_cds_activity_date.html

Justification: Code set aligns to DH guidance on reclaiming overseas visitors' contributions to NHS care.

How to collect: This information will typically be captured by the Overseas Visitor Officer / Manager for the provider and directly entered into the patient administration or clinical care record system.

5.5 Data Group: Patient Characteristics (Urgent And Emergency Care) - Social and Personal Circumstances SNOMED CT)

5.5.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of the SNOMED CT coded Social and Personal Circumstances for the patient.

[21] NHS Digital. 2017 Accessible Information. Available at: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1605-accessible-information

Group status: 'Required'

Justification: This information helps to understand the Social and Personal circumstances of the patient.

5.5.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Social and Personal Circumstance (SNOMED CT)	Min n6 max n18	M	SNOMED CT
Social and Personal Circumstance Recorded Timestamp	Max an25	M	DM&D

Table 8 Data items within 'Patient Characteristics (Urgent And Emergency Care) Social And Personal Circumstances (SNOMED CT)' Data Group

5.5.3 Social And Personal Circumstance (SNOMED CT)

Definition: Social and personal circumstance (SNOMED CT) is the SNOMED CT concept ID which is used to identify a social and personal circumstances for a person.

Data Dictionary: SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) (datadictionary.nhs.uk)

Justification: To help understand the Social and Personal circumstances of the patient. This may include e.g. occupational data to help identify individuals entitled to access specific care.

How to collect: Further information will be provided on how to collect this data. Until then no data should be submitted for this data item.

5.5.4 Social And Personal Circumstance Recorded Timestamp

Definition: Social and personal circumstance recorded timestamp is the date, time and time zone when the Social and Personal Circumstance (SNOMED CT) was recorded.

Data Dictionary: SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP (datadictionary.nhs.uk)

Justification: To help understand the Social and Personal circumstances of the patient.

How to collect: Further information will be provided on how to collect this data. Until then no data should be submitted for this data item.

5.6 Data Group: Mental Health Act Legal Status

5.6.1 Definition, Group Status and Justification for Data Group

Definition: To carry the patients Mental Health Act Legal Status.

Group status: 'Required'

Justification: Patients are often brought to EDs by Police under Section 136 of the Mental Health Act (MHA). This information helps identify the variation in potential need for mental health input in the ED.

5.6.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Mental Health Act Legal Status Classification Assignment Period Start Timestamp	max an25	R	DM&D
Mental Health Act Legal Status Classification Expiry Timestamp	max an25	R	DM&D

Data Element Name	Format	Status	Source
Mental Health Act Legal Status Classification Code	an2	M	DM&D

Table 3 Data items within 'Mental Health Act Legal Status' Data Group

5.6.3 Mental Health Act Legal Status Classification Assignment Period Start Timestamp

Definition: These data items record the start date / time of the Mental Health Act Legal Status Classification Assignment Period.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/mental_health_act_legal_status_classification_assignment_period_start_timestamp.html

Justification: To establish when the Mental Health Act Legal Status Classification for a person started.

How to collect: This data must be collected alongside the Mental Health Act Legal Status Classification Code (see below).

The most common use of the Mental Health Act in EDs is when a person is brought in under a section 136. In this case, the 'start clock' is when the patient is registered at the first place of safety and so will normally be when the person arrived at the ED. In this case the MHA Legal Status Classification Assignment Period Start Timestamp can be auto populated from the Urgent And Emergency Care Activity Start Date And Time with the option of being overridden by a user.

The user may need to override this if the person has been transferred from another place of safety in which case the start date / time of arrival at the original place of safety should be recorded or if the section is applied within the ED, although this is rare.

For other uses of the MHA, for example, if the person is detained for further assessment, then the Start Date / Time of the assignment period must be entered for example, by a nurse during a Mental Health Triage (depending on the model of care).

5.6.4 Mental Health Act Legal Status Classification Expiry Timestamp

Definition: The date / time when a Mental Health Act Legal Status Classification for a patient expires.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/mental_health_act_legal_status_classification_expiry_timestamp.html

Justification: To establish when the Mental Health Act Legal Status Classification for a person expires and a decision must be made about the person's on-going care.

How to collect: For most uses of the Mental Health Act in EDs the expiry date / time can be auto populated by the information system once a Mental Health Act Legal Status Classification Code and Start Date / Time has been collected (see table 10 below). There should be an option for the user to override the default expiry date if necessary.

5.6.5 Mental Health Act Legal Status Classification Code

Definition: A code which identifies the Mental Health Act Legal Status Classification. The National Code 'Informal' is used for those patients who are neither formally detained nor receiving supervised aftercare.

Data Dictionary: MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (datadictionary.nhs.uk)

Justification: This information 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.

Note that the National Code 'Informal' is used for those patients who are neither formally detained nor receiving supervised aftercare.

How to collect: This information should only be captured when a person attending the ED is formally detained under the Mental Health Act. For EDs this will most commonly be when the person has been detained under Section 136 by the police and brought into the ED as a place of safety and / or for medical treatment although other uses of the MHA may be applied in EDs.

If a person previously detained under the Mental Health Act is brought into the ED, then this should be entered on the Information System by administrative or nursing staff on receipt of the paperwork.

Depending on the model of care, people presenting in EDs with mental health needs may have a Mental Health Triage. During this process or at any stage during the patient's stay in the ED, if it is necessary to use the Mental Health Act, then the clinician should enter the details on the Information System.

It is envisaged that this data item will be entered by selecting from a list containing the appropriate options for the ED; a suggestion is given in the table 10 below. This is a subset of the codes defined in the DM&D but reducing the options, where appropriate, makes entry less cumbersome.

DM&D Code	Description	Start Date and Time	Expiry Date and Time	Extra Notes
02	Formally detained under MHA Section 2	Entered. The Date / Time Section 2 of the Mental Health Act is enacted.	Auto populated Start Date / Time **Plus 28 days** Can be overridden.	To be used when an application for admission for assessment is made.
03	Formally detained under MHA Section 3	Entered. The Date / Time Section 3 of the Mental Health Act is enacted.	Auto populated Start Date / Time Plus 6 calendar months Can be overridden.	To be used when an application for admission for treatment is made.
05	Formally detained under MHA Section 5 (2)	Entered. The Date / Time Section 5 (2) of the Mental Health Act is enacted.	Auto populated Start Date / Time **Plus 72 hours** Can be overridden.	To be used when the Mental Health Act is enacted when a patient is on a ward (e.g. If the ED has an observation ward) to detain the patient for further assessment.
20	Formally detained under MHA Section 136	Auto populated as the Emergency Care Arrival Date / Time Can be overridden.	Auto populated Start Date / Time **plus 24 hours** Can be overridden.	To be used either: When a person is brought to the ED under s136 of the Mental Health Act Or When a person is detained in the ED by an enactment of s136 of the Mental Health Act. Note: See footnote: The expiry date may need to be overridden if the s136 is extended to 36 hours.
Any other valid DM&D code		Entered.	Entered / Auto populated Note: Expiry Date / Time can be derived for time limited sections	Any other use of the Mental Health Act that is defined in the DM&D.

Table 4 Mental Health Act Legal Status Classification Codes

5.7 Data Group: GP Registration

5.7.1 Definition and Group Status for Data Group

Definition: To carry the patient's General Medical Practitioner and the General Practice details.

Group status: 'Required'

5.7.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
General Medical Practitioner (Specified)	an8	O	DM&D
General Medical Practice (Patient Registration)	min an6 max an8	R	ODS

Table 5 Data items in the 'GP Registration' Data Group

5.7.3 General Medical Practitioner (Specified)

Definition: The General Medical Practitioner PPD (Prescription Pricing Division) Code of the General Medical Practitioner specified by the patient.

Data Dictionary: GENERAL MEDICAL PRACTITIONER (SPECIFIED) (datadictionary.nhs.uk)

Justification: This data is necessary for communication of

- the patient's attendance(s) to the Emergency Care facility
- the patient's on-going care needs.

This information will support the onward flow of ED attendance information in the form of the GP letter and/or the GP Discharge Summary.

How to collect: This information should be entered by clerical staff by selecting the name of the General Medical Practitioner (and accompanying PPD code) from a locally sourced and managed drop-down list. The IT system would then enter the correct PPD code into the patient record.

5.7.4 General Medical Practice (Patient Registration)

Definition: An organisation site code is a code which identifies an Organisation Site uniquely.

In this instance this data item represents the organisation code (ODS code) of the General Medical Practice at which the person is registered.

Data Dictionary: GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) (datadictionary.nhs.uk)

Justification: This data is necessary for communication of

- the patient's attendance(s) to the Emergency Care facility
- the patient's on-going care needs.

This information will support the transfer of care from the Urgent and Emergency Care Activity to the patient's General Practitioner e.g. GP letter and/or the GP Discharge Summary.

How to collect: This information may be auto populated from NHS Spine / PAS where available or otherwise entered by clerical staff selecting the name of the General Medical Practice (and accompanying ODS code) from a locally sourced and managed drop-down list. The IT system would then enter the correct practice code into the patient record.

5.8 Data Group: Urgent and Emergency Care Activity Location

5.8.1 Definition and Group Status for Data Group

Definition: To carry the details of the Urgent and Emergency Care Activity Location.

Group status: 'Mandated'

5.8.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Organisation Site Identifier (of Treatment)	min an5 max an9	M	ODS
Urgent and Emergency Care Activity Type	an2	M	DM&D

Table 6 Data items in 'Urgent and Emergency Care Activity Location' Data Group

5.8.3 Organisation Site Identifier (of Treatment)

Definition: Organisation Site Identifier (of Treatment) is the Organisation Identifier of the Organisation Site where the Patient was treated, i.e. it should enable the treating Organisation to be identified.

Data Dictionary: ORGANISATION SITE IDENTIFIER (OF TREATMENT) (datadictionary.nhs.uk)

Justification: This data item is used to track patient pathways / episodes related to a specific site.

A single provider organisation may have multiple site codes with different facilities depending on geography and different modes/ types of services provided.

This data item is also helpful in understanding activity type and patient flows between organisations. This means that activity and demand can be better modelled/ predicted for commissioning, research and public health.

How to collect: This information should be auto populated by the local information system and should not be manually entered.

This identifies the site within the organisation where the patient was treated.

5.8.4 Urgent and Emergency Care Activity Type

Definition: The type of Urgent And Emergency Care Activity.

- Type 01 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Major Emergency Care Department'
- Type 02 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Mono-specialty Emergency Care Department'
- Type 03 - Emergency Care Attendance at an EMERGENCY CARE DEPARTMENT TYPE 'Urgent Treatment Centre'
- Type 05 - Same Day Emergency Care Attendance
- Type 06 - Urgent and Emergency Care Extended Care Episode
- Type 07 - Hot Clinic Attendance. Note this is only valid for piloting purposes.

Data Dictionary: URGENT AND EMERGENCY CARE ACTIVITY TYPE (datadictionary.nhs.uk)

Justification: Urgent and Emergency care is delivered in many different settings, and the value added by these different modes of healthcare in different environments is poorly understood.

Collecting this data allows commissioners to understand the case mix, acuity and value added of care, which in turn enables accurate provision of resources to match patient need. This field replaces Emergency Care Department Type in the previous version of ECDS to reflect the changes in activity recorded.

How to collect: This information will be auto populated from the information system.

Additional Information for Type 06 (Urgent and Emergency Care Extended Care Episode)

The definition of an Urgent and Emergency Care Extended Care Episode:

An Urgent and Emergency Care Extended Care Episode is an episode of clinical care for a PATIENT under the responsibility of a named CARE PROFESSIONAL in an Urgent and Emergency Care Service, which occurs following initial assessment by a CARE PROFESSIONAL qualified for independent practice in Urgent and Emergency Care.

[Typically, this decision will be taken during a Emergency Care Attendance or Same Day Emergency Care Attendance.]

The start of an Urgent and Emergency Care Extended Care Episode:

An Urgent and Emergency Care Extended Care Episode starts at the Urgent and Emergency Care Activity End Timestamp of the Emergency Care Attendance or Same Day Emergency Care Attendance within which the clinical decision was taken to discharge the patient to their normal place of residence, but with an ongoing duty of care to follow up under a Urgent and Emergency Care Extended Care Episode.

Attendances within an Urgent and Emergency Care Extended Care Episode:

An Urgent and Emergency Care Extended Care Episode spans a series of planned attendances (typically Same Day Emergency Care Attendances) for ongoing follow up care.

If during the same time period the PATIENT attends an Urgent and Emergency Care Service for unplanned attendances (for example their condition deteriorates and they attend the Emergency Care Department within the same Health Care Provider), then the unplanned attendance should also be recorded as being part of the Urgent and Emergency Care Extended Care Episode.

Linking Attendances to the Urgent and Emergency Care Extended Care Episode:

All Emergency Care Attendances and Same Day Emergency Care Attendances, either face to face or virtual, and either scheduled or unscheduled, that occurs during an Urgent and Emergency Care Extended Care Episode period, must be linked to the Urgent and Emergency Care Extended Care Episode.

The URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER which identifies the open Urgent and Emergency Care Extended Care Episode must be linked in the ELECTRONIC HEALTH RECORD system, and submitted in the Emergency Care Data Set Version 4 record relating to the Emergency Care Attendance or Same Day Emergency Care Attendance.

The end of an Urgent and Emergency Care Extended Care Episode:

A Urgent and Emergency Care Extended Care Episode should run for no longer than 4 weeks (28 days); and within this, the maximum interval between scheduled face to face or virtual attendances must be no longer than 7 days.

A Urgent and Emergency Care Extended Care Episode ends when either:

• The PATIENT is formally discharged from the Urgent and Emergency Care Extended Care Episode period of ongoing planned care, having received all necessary treatment (for example to their own GENERAL MEDICAL PRACTITIONER to manage care)

• A decision to admit to a WARD is taken by the responsible CARE PROFESSIONAL during a scheduled or unscheduled face to face or virtual attendance which is part of the Urgent and Emergency Care Extended Care Episode, for example if the condition of the PATIENT has deteriorated such that Admitted Patient Care is now clinically required

• The PATIENT is referred to another speciality or SERVICE within the same Health Care Provider, to continue treatment under a Care Professional Out-Patient Episode.

• When the ongoing clinical care of the PATIENT is transferred to a different Health Care Provider.

• The PATIENT dies

Additional information for the Urgent and Emergency Care Extended Care Episode:

Where the PATIENT is formally discharged from the Urgent and Emergency Care Extended Care Episode by the responsible CARE PROFESSIONAL and this decision is taken during a scheduled or unscheduled attendance, the Urgent and Emergency Care Activity End Timestamp for the Emergency Care Data Set Version 4 record relating to Urgent and Emergency Care Extended Care Episode is the same as the Urgent and Emergency Care Activity End Timestamp of the Emergency Care Attendance or Same Day Emergency Care Attendance where the clinical decision to discharge the PATIENT was taken.

In all cases, the PATIENT (and the receiving Health Care Provider if applicable) should receive a written summary of care delivered, and future suggested CARE PLANS.

If a decision to close the Urgent and Emergency Care Extended Care Episode is taken outside of a scheduled or unscheduled attendance (for example if the PATIENT is admitted to another Health Care Provider, dies, leaves the country, fails to attend scheduled attendances etc), the Urgent and Emergency Care Activity End Timestamp for the record relating to the Urgent and Emergency Care Extended Care Episode in the Emergency Care Data Set Version 4 submission would be the date, time and time zone that the clinical decision to close the Urgent and Emergency Care Extended Care Episode was taken. If appropriate/possible, the Health Care Provider to whom the PATIENT'S care is transferred, and the PATIENT themselves, should receive a written summary of care delivered and future suggested CARE PLANS.

Note: No data should be submitted for 'Type 07 – Hot Clinic Attendance' until formal pilots are set up. This guidance will be updated when this data can be submitted in ECDS.

5.9 Data Group: Ambulance Details

5.9.1 Definition, Group Status and Justification for Data Group

Definition: To carry ambulance details relating to the patient's arrival at Urgent and Emergency Care.

Group status: 'Required'

Justification: Ambulance Quality Indicators (AQIs)[22] require Ambulance Trusts to report on outcomes for patients that have been transported to hospital via an emergency ambulance for certain conditions, for example the indicator 'Outcomes from Cardiac Arrest: Survival to Discharge'.

Information to enable derivation of these outcomes is only available from hospital providers as they relate to what happens after responsibility for the patient has been handed over from the ambulance crew to the hospital healthcare professionals.

As a result, Providers are frequently required to use manual processes to identify patients to provide relevant outcomes information to ambulance trusts.

To support easier sharing of data locally the Ambulance Incident Number which is assigned to the incident upon receipt of an emergency call and transferred to the hospital by the ambulance crew and the Organisation Identifier are changed from 'Optional' data items to 'Required'.

This data group should be captured when the Urgent and Emergency Care Arrival Mode is one of the following:

ECDS Description	SNOMED Code	SNOMED Fully Specified Name
Emergency road ambulance	1048031000000100	Arrival by emergency road ambulance (finding)
Emergency road ambulance with medical escort	1048041000000109	Arrival by emergency road ambulance with medical escort (finding)
Non-emergency road ambulance	1048021000000102	Arrival by non-emergency road ambulance (finding)

[22] NHS England. 2017. Ambulance Quality Indicators. Available at: www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

ECDS Description	SNOMED Code	SNOMED Fully Specified Name
Helicopter	1048051000000107	Arrival by helicopter Air Ambulance (finding)
Fixed wing / medical repatriation by air	1048081000000101	Arrival by medical repatriation air ambulance (finding)

Table 7 Urgent and Emergency Care Arrival Mode codes indicated for collection of 'Ambulance Details' Data Group

This data group should only be included in ECDS v4.0 where the Consultation Mechanism (Urgent and Emergency Care) is '01' Face to Face.

5.9.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Ambulance Call Identifier	max an20	R	DM&D
Organisation Identifier (Conveying Ambulance Trust)	min an3 max an5	R	ODS
Care Contact Identifier (Ambulance Service)	max an20	R	DM&D

Table 8 Data items in 'Ambulance details' Data Group

5.9.3 Ambulance Call Identifier

Definition: A unique identifier for each Ambulance Call.

Data Dictionary: AMBULANCE CALL IDENTIFIER (datadictionary.nhs.uk)

Justification:

This data will enable 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.

How to collect: It is preferable that this data is automatically transferred to the ED information system from the Ambulance information system using transfer of care data flows, although the Ambulance Incident Number may be captured manually following the hand over from the ambulance staff to the ED. The patient's details should then be logged on the PAS / ED system by clerical staff with the ambulance incident number and the ODS identifier of the Ambulance Trust.

5.9.4 Organisation Identifier (Conveying Ambulance Trust)

Definition: Organisation Identifier (Conveying Ambulance Trust) is the Organisation Identifier of an Ambulance Service which conveys a Patient on a Patient Transport Journey.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/organisation_identifier__conveying_ambulance_trust_.html

Justification: This data element should be submitted where the patient arrived at hospital by Ambulance, and an ED Attendance or Hospital Provider Spell related to this patient transport journey was recorded.

As the format may differ between ambulance trusts and potentially result in duplication of ambulance incident numbers assigned there will also be the need to identify the organisation that issued the incident number to ensure that the combination of these is unique across the system.

How to collect: If this information is not automatically populated from transfer of care data flows, it should be auto populated by selecting the name of Ambulance service (and/or the Ambulance service ODS identifier) from a locally sourced and managed drop-down list. The IT system would then enter the correct ODS identifier into the patient record.

5.9.5 Care Contact Identifier (Ambulance Service)

Definition:

Care Contact Identifier (Ambulance Service) is the activity identifier for a care contact made within an ambulance setting. It is allocated by the ambulance service and is specific to a single patient contact. For ambulance 'incidents' that involve only one patient, it may be synonymous with the incident identifier.

For incidents involving more than one patient there will be a unique Care Contact Identifier (Ambulance Service) for each patient within that incident. The patient will have more than one Care Contact Identifier (Ambulance Service) if the same patient is treated more than once in separate ambulance incidents.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/care_contact_identifier__ambulance_service_.html

Justification: This data item allows the linkage of ECDS to the Ambulance Data Set at the care contact level. Previous data linkage was limited to the Ambulance 'incident' identifier because this was the only unique identifier collected consistently via Ambulance Trusts in England. This data item aligns with the development of the Ambulance Data Set that includes a more specific Care Contact identifier.

How to collect: This information should be automatically populated using transfer of care data flows from the Ambulance information system to the ED information system. It should not be manually entered due to the likelihood of mis-keying errors.

5.10 Data Group: Expected Date and Time of Treatment

5.10.1 Definition and Group status for Data Group

Definition: To carry the expected date and time of treatment that is given to the patient.

Group status: 'Required'

5.10.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Emergency Care Expected Date and Timestamp Of Treatment	max an25	R	DM&D
Emergency Care Treatment Allocation Timestamp	max an25	R	DM&D

Table 16 Data items within 'Expected Date and Time of Treatment' Data Group

5.10.3 Emergency Care Expected Date and Timestamp of Treatment

Definition: An Emergency Care Expected Date and Timestamp of Treatment is the date, time and time zone a patient should expect to receive treatment at the Emergency Care Department.

An Emergency Care Expected Date and Timestamp of Treatment is either given to the patient in advance of arrival at an Emergency Care Department (e.g. by NHS 111), or upon arrival at an Emergency Care Department.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/emergency_care_expected_date_and_timestamp_of_treatment.html

Justification: The date and timestamp of Expected Time of Treatment will allow the creation of Key Performance Indicators that track whether this service standard is being achieved. Additionally, being able to identify patients with Expected Times of Treatment will allow more accurate tracking of whether key UTC service standards are being achieved for walk in patients.

How to collect: This item is captured when a patient attends an Emergency Department having been directed there by NHS 111, if the patient has been given a specific timeslot to attend for treatment.

Therefore, it should only be present if the 'Attendance Source' = NHS 111 telephone / internet advice.

This should be the first date/ time of the appointment at the ED, reported by the patient (e.g. if the patient is re-booked for another time this is not recorded.

Initially, this data group only applies to UTCs. However, this model of practice is being extended to all forms of Emergency Department therefore all sites should ensure they are able to collect and submit it.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2.

5.10.4 Emergency Care Treatment Allocation Timestamp

Definition: Emergency Care Treatment Allocation Timestamp is the date, time and time zone that an Emergency Care Expected Date and Timestamp of Treatment slot, was allocated to the Patient by NHS 111.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/emergency_care_treatment_allocation_timestamp.html

Justification: Incorporating the date and timestamp of Expected Time of Treatment will allow the creation of Key Performance Indicators that track whether this service standard is being achieved. Additionally, being able to identify patients with Expected Times of Treatment will allow more accurate tracking of whether key UTC service standards are being achieved for walk in patients.

How to collect: **This item is captured when the NHS 111 operator creates the slot** for the patient to attend ED (it is the action of creating the slot. It is not the patient's expected ED treatment time slot, which is different, and that is the expected date/ timestamp of expected treatment at an Emergency Department).

Therefore, it should only be present if the Attendance Source = NHS 111 telephone / internet advice

This data group only applies to UTCs. However, this model of practice is being extended to all forms of Emergency Department therefore all sites should ensure they are able to collect and submit it.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.11 Data Group: Urgent and Emergency Care Activity Characteristics

5.11.1 Definition and Group Status for Data Group

Definition: To carry the characteristics of the Urgent and Emergency Care Activity.

Group status: 'Mandated'

5.11.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Urgent and Emergency Care Activity Identifier	min an 1 max an20	M	DM&D
Consultation Mechanism (Urgent and Emergency Care)	an2	R	DM&D
Urgent and Emergency Care Arrival Mode (SNOMED CT)	min n6 max n18	R	DM&D
Urgent and Emergency Care Attendance Category	an1	R	DM&D
Urgent and Emergency Care Attendance Source (SNOMED CT)	min n6 max n18	R	SNOMED CT
Organisation Site Identifier (Urgent and Emergency Care Attendance Source)	min an5 max an9	R	DM&D
Urgent and Emergency Care Activity Start Date and Time	an19 YYYY-MM-DDThh:mm:ss	M	DM&D
Age at CDS Activity Date	max an3	M	DM&D
Urgent and Emergency Care Initial Assessment Timestamp	max an25	R	DM&D
Urgent and Emergency Care Acuity (SNOMED CT)	min n6 max n18	R	SNOMED CT

Data Element Name	Format	Status	Source
Urgent and Emergency Care Chief Complaint (SNOMED CT)	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Timestamp Seen For Treatment	max an25	R	DM&D
Urgent and Emergency Care Extended Care Episode Identifier	min an1 max an20	R	DM&D

Table 9 Data items in 'Urgent and Emergency Care Attendance Activity Characteristics' Data Group

5.11.3 Urgent And Emergency Care Activity Identifier

Definition: The Urgent And Emergency Care Activity Identifier is an identifier allocated by an Urgent and Emergency Care Service to provide a unique identifier for each Urgent And Emergency Care Activity Type.

Data Dictionary: URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER (datadictionary.nhs.uk)

Justification: This identifier is allocated by an ED to provide a unique identifier for each ED activity.

This item is necessary to track each individual activity; and is particularly important in data that has been anonymised as it still allows individual episodes of care to be identified.

An example of this use might be where a commissioner sees many patients' episodes with a particular condition and uses this information to alter service provision.

For an Emergency Care Attendance, Urgent And Emergency Care Activity Identifier is the same as the Emergency Care Attendance Identifier in previous Emergency Care Data Sets (CDS V6-2-2 Type 011 – Emergency Care CDS and CDS V6-2-3 Type 011 – Emergency Care CDS), but the format/length is extended to max an20 characters for Emergency Care Data Set v4.0.

For a Same Day Emergency Care Attendance, the Urgent And Emergency Care Activity Identifier should carry a system-generated unique identifier for each Same Day Emergency Care Attendance undertaken by the Health Care Provider.

For an Urgent and Emergency Care Extended Care Episode, the URGENT AND EMERGENCY CARE ACTIVITY IDENTIFIER should carry the URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER (which is a system generated unique identifier for each Urgent and Emergency Care Extended Care Episode).

All Emergency Care Attendances and Same Day Emergency Care Attendances, either face to face or virtual, and either scheduled or unscheduled, that occurs during an Urgent and Emergency Care Extended Care Episode period, must be linked to the Urgent and Emergency Care Extended Care Episode.

How to collect: A consistent format for the local identifier is necessary to identify each individual activity. This identifier should be auto populated in the ED information system at the time of the patient contact in the ED, whether this is at clinical assessment or at reception.

There should be no overlap or duplication of identifiers between Urgent And Emergency Care Activity Identifier generated by the Urgent and Emergency Care Service's Electronic Health Record system used to record each of these types of activity. For example, it is not permissible to generate the same Urgent And Emergency Care Activity Identifier to be used for both an Emergency Care Attendance and a Same Day Emergency Care Attendance.

Each Activity Identifier must be unique within the Health Care Provider and Organisation Site Identifier (Of Treatment).

In the case of duplicate Activity Identifiers being recorded, both should be deleted and new replacement records with unique Attendance Identifiers should be resubmitted.

5.11.4 Consultation Mechanism (Urgent and Emergency Care)

Definition: Consultation Mechanism (Urgent and Emergency Care) is the main mechanism used to undertake Urgent and Emergency Care Activity.

Data Dictionary: CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) (datadictionary.nhs.uk)

Justification: Virtual consultations are now commonly carried out across urgent and emergency care. This change enables ECDS to capture the range and complexity of virtual consultations and accurately reflect the activity undertaken. Currently, this is not possible within ECDS v3.0 and commissioners cannot accurately understand the demand and supply.

How to collect: It is expected that this data is recorded in systems or that providers are working to record and map this data.

5.11.5 Urgent And Emergency Care Arrival Mode (SNOMED CT)

Definition: Urgent And 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 Urgent And Emergency Care Service.

Data Dictionary: URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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 analysed 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 public transport.

How to collect: Clerical staff should capture this information when the patient is registering in the ED.

"How did you get here today?"

For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

5.11.6 Urgent And Emergency Care Attendance Category

Definition: The category of Emergency Care Attendance or Same Day Emergency Care Attendance.

A First Attendance is the first or only attendance for the same incident, which may be an injury or occurrence of a condition; a follow-up attendance is a visit to the same department for the same incident as the first visit within the episode. If a Patient has a recurring condition, such as epilepsy, or a tendency for joints to dislocate, there would be a new First Attendance each time that the Patient presents with the condition.

A subsequent attendance may not always be a follow-up attendance. It could qualify as an attendance at a consultant out-patient clinic and if so, it needs to be recorded appropriately.

National Code Definitions

- 1 – Unplanned first Emergency Care Attendance or Same Day Emergency Care Attendance for a new clinical condition (or deterioration of a chronic condition)
- 2 – Unplanned follow-up Emergency Care Attendance or Same Day Emergency Care Attendance for the same or a related clinical condition and within 7 days of the first Emergency Care or Same Day Emergency Care Attendance at THIS Urgent and Emergency Care Service
- 3 – Unplanned follow-up Emergency Care Attendance or Same Day Emergency Care Attendance for the same or a related clinical condition and within 7 days of the first Emergency Care or Same Day Emergency Care Attendance at ANOTHER Urgent and Emergency Care Service
- 4 – Planned follow-up Emergency Care Attendance or Same Day Emergency Care Attendance within 7 days of the first Emergency Care Attendance or Same Day Emergency Care Attendance at THIS Urgent and Emergency Care Service
- X – Not Applicable (PATIENT dead on arrival to Urgent and Emergency Care Service)

Data Dictionary: URGENT AND EMERGENCY CARE ATTENDANCE CATEGORY (datadictionary.nhs.uk)

Justification: 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 Emergency Care 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.

Evidence suggests that the optimal horizon is approximately seven days, which is why this is chosen rather than 72 hours or 28 days.[23].

How to collect: This information should be captured by clerical staff as soon as possible after arrival at the ED.

As part of the registration process, clerical staff should ask the patient:

"Have you already seen your GP or anyone else about this problem?"

If the Emergency Care Attendance Category is "X – Not Applicable/Dead on Arrival" then no other data is required apart from Emergency Care Discharge Status, which should be recorded as "63238001 – Dead on Arrival".

If Emergency Care Discharge Destination is recorded for patients who are Dead on Arrival, then the code which should be recorded is "305398007 – Mortuary".

5.11.7 Urgent and Emergency Care Attendance Source (SNOMED CT)

Definition: The source of referral of each Emergency Care Attendance Episode. It is the source from which the patient was referred or advised to attend the ED. It is not the mode of transport.

Data Dictionary: URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

How to collect: This data item captures any mechanism / reason by which a patient decided to attend the Emergency Care facility. This includes formal referrals e.g. from GP or consultant with / without a letter, and informal / advice that a patient may receive. This information should be captured by clerical staff as soon as possible after arrival at the Emergency Department.

To ensure accurate information is collected, this should be asked as an open and non-judgemental question e.g. *"Did anyone specifically advise you to attend the Emergency Department?"*

If more than one option could be selected, then the last person / service who saw the patient before they arrived at the ED should be used.

NB: The terms used in the code set which refer to health professionals e.g. Doctor, Nurse etc. refer only to these people acting in their professional capacity i.e. 'on duty'. When off duty they are classified as 'Self / family / friends / education / work colleague'.

The term 'Nurse':

Includes:

- District Nurse, Community Midwife, and Health Visitor, nurses employed within Residential Homes, Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes:

- Healthcare Assistants (HCA)
- Community Psychiatric Nurse (code as mental health assessment team)
- Nurses within the treating hospital or other acute care facility.

[23] Patient Returns to the Emergency Department: The Time-to-return Curve; KL. Rising ACADEMIC EMERGENCY MEDICINE (2014); 21:864–871

The ‘Ambulance service’ option should only be used when an ambulance crew are transporting a patient who deteriorates during the transfer to the extent that they need to be diverted to the Emergency Care facility.

A referral from radiology should be coded as from ‘GP’ or ‘OPD’ depending on the source of the request for radiology.

Coding examples:

Scenario	Guidance
“I was referred by the GP”	Referred by GP / member of Primary Health Team
“I was advised to attend by my GP’s practice nurse”	Referred by GP / member of Primary Health Team
“I was advised to attend by NHS 111”	Referred by NHS telephone / internet advice
“I was referred by my friend who is a practice nurse”	Self / family / friends / education / work colleague
“I consulted an online GP who advised me to attend”	Referred by non-NHS telephone / internet advice
“I was knocked unconscious playing football and my friends called an ambulance”	Self / family / friends / education / work colleague
Elderly patient transferred from a rehabilitation ward, located in separate hospital within Trust with shortness of breath	Inpatient ward
An 18-year-old male arrives in the ED in an ambulance after being repatriated from Thailand. He had been an inpatient in a Thai hospital for two weeks following a road traffic collision.	Inpatient ward
“I fell over in the street and a passing doctor advised me to come in to be checked out”	Self / family / friends / education / work colleague
A patient was found lying unconscious in his Police cell and an emergency ambulance was called to transfer him to the ED.	Referred by police
“I fell over in the street and a passing doctor advised me to come in to be checked out”	Self / family / friends / education / work colleague

Table 10 Coding examples for application of ‘Urgent and Emergency Care Attendance Source (SNOMED CT)’ codes

5.11.8 Organisation Site Identifier (Urgent And Emergency Care Attendance Source)

Definition: The organisation identifier of the Organisation Site from which a patient arrived at an Emergency Care Department.

Data Dictionary: ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE) (datadictionary.nhs.uk)

Justification: This data is 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.

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.

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.

How to collect: This information should only be captured when the patient is booked into the ED following a transfer from another institution belonging to same organisation or a different organisation for continuing care. If the patient is transferred from an overseas hospital, then the code used should align to the ODS standard.

This information should be entered by clerical staff selecting the name of the organisation (and accompanying ODS identifier) from a locally sourced and managed drop-down list. The IT system would then enter the correct ODS code into the patient record.

This data item should be submitted for all presentations where the data item Urgent And Emergency Care Attendance Source is recorded as one of the following:

ECDS_Description	SNOMED_Code	SNOMED_Fully_Specified_Name
Emergency department	1066431000000102	Referred by hospital emergency department (finding)
Urgent care service	1066441000000106	Referred by urgent care service (finding)
Outpatient service inc. Same Day Emergency care	835091000000109	Referred by hospital outpatient department (finding)
Inpatient	835101000000101	Referred by hospital ward (finding)

Table 11 Urgent And Emergency Care Attendance Source codes for Organisation Site Identifier

5.11.9 Urgent And Emergency Care Activity Start Date and Time

Definition:

An Urgent and Emergency Care Activity Start Date and Time is the start date and time which is applicable to a specific type of Urgent and Emergency Care activity type.

For a face to face Same Day Emergency Care Attendance (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that the PATIENT arrived in person or in an Emergency Ambulance at the Urgent and Emergency Care Service for the provision of Same Day Emergency Care.

For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Codes 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity Start Date and Time is the date and time that contact was made with the PATIENT by a CARE PROFESSIONAL from a Same Day Emergency Care Service who is qualified to deliver virtual clinical care.

Data Dictionary: Urgent and Emergency Care Activity Start Date and Time (datadictionary.nhs.uk)

Justification: This date / time is the starting point for all process metrics in Emergency Care which then flow into SUS+ e.g. time-based metrics such as the 12-hour standard, time to see clinician, time to decision to admit etc.

How to collect: This information should be auto populated by the information system at the defined start point of the relevant Urgent and Emergency Care Activity (for example, the first point that a patient contacts the ED).

Clerical staff are not trained to clinically assess patients, so for risk and clinical governance reasons, clinical assessment or streaming should precede patient registration.

For the Emergency Care Clinical Quality Indicators, for patients arriving by Emergency Ambulance, the Urgent and Emergency Care Activity Start Date and Time is when handover occurs, or 15 minutes after the Emergency Ambulance arrives at the ED, whichever is the sooner.

The arrival time is the time that the patient presents at the ED (either self-presented or via another means) and is the 'clock start' time for the purposes of any time-based metrics.

5.11.10 Age at CDS Activity Date

Definition: 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.

Data Dictionary: AGE AT CDS ACTIVITY DATE (datadictionary.nhs.uk)

How to collect: This is a derived field, so this information should be derived at provider level and should flow in ECDS.

Where date of birth is not known, and age cannot be estimated, use default code 999.

In cases where it is not possible to collect a patient's details e.g. when the patient is unconscious and there are no relatives present, an estimated age could be collected in the system which could be used to populate this field.

5.11.11 Urgent And Emergency Care Initial Assessment Timestamp

Definition: An Urgent and Emergency Care Initial Assessment Timestamp is the date and time that the patient is first assessed during an Emergency Care Attendance or a Same Day Emergency Care Attendance.

An initial assessment would include:

- the taking of a brief patient medical history
- pain assessment
- early warning scores (including vital signs).

The assessment should be conducted by a Care Professional who has received appropriate training.

Data Dictionary: Urgent and Emergency Care Initial Assessment Timestamp (datadictionary.nhs.uk)

Justification: The initial assessment date and time are necessary to understand and optimise the care process within emergency care.

The elapsed time from arrival to assessment is used as a key quality metric, as ensuring that patients are assessed by an appropriately qualified healthcare professional soon after arrival minimises the risk of undiagnosed severe disease. It is therefore part of an Emergency Care system's early warning system for matching service provision and demand and is an important part of risk control in emergency care.

Patient satisfaction is correlated with the time taken from arrival to first assessment.

How to collect: Please see above under Urgent and Emergency Care Activity Start Date and Time. Arrival Date / Time, as when assessment on arrival / streaming occurs, the initial assessment timestamp will be the arrival time.

Assessment may include:

- The taking of a brief patient history
- Pain assessment and treatment
- Assessing vital signs / early warning score
- Assessing patient acuity and chief compliant
- Allocating a treatment area.

This data should be automatically entered by the IT system when the care clinician inputs the health assessment data or input manually if automation is not available.

'Care clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the Nursing and Midwifery Council who has appropriate training and support for this role and who is **authorised to care for patients independently** – in practice this is usually a nurse.

In this context 'Clinician' does not include trainees or Health Care Assistants but does include Physician Associates working under the direct supervision of a registered medical practitioner.

In this context 'Clinician' does not include trainees or Health Care Assistants but does include Physician Associates working under the direct supervision of a registered medical practitioner.

5.11.12 Urgent And Emergency Care Acuity (SNOMED CT)

Definition: Urgent And 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 Urgent and Emergency Care Initial Assessment Date and Emergency Care Initial Assessment Timestamp.

The Urgent And 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.

Data Dictionary: URGENT AND EMERGENCY CARE ACUITY (SNOMED CT) (datadictionary.nhs.uk)

Justification: Urgent And Emergency Care Acuity is a measure of the urgency and severity of the condition with which the patient has presented to the emergency care facility as defined by the first clinician who assesses the patient.

The measure of acuity submitted must be the initial assessment of acuity. If this subsequently changes e.g. the patient deteriorates, this may be recorded locally but only the first value should be submitted as Urgent And Emergency Care Acuity.

Emergency care facilities must use one consistent measure of acuity across all modes of care within their organisation.

The National Early Warning Score version 2 is included in ECDS 4.0.

For adult patients who do not require a NEWS2 score to be calculated, then a brief visual assessment by a qualified clinician (usually a nurse) is the most common way of assessing acuity. Any assessment scale should incorporate measures of mental health in a common framework e.g. ECDS combined triage / chief complaint sheet.

Streaming, where this occurs, aims to identify low acuity patients whose needs may be met by services/ clinicians other than the mainstream Emergency Department.

How to collect: Urgent And Emergency Care Acuity is a measure of the urgency and severity of the condition with which the patient has presented to the emergency care facility, as defined by the first clinician who assesses the patient.

'Clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the Nursing and Midwifery Council who has appropriate training and support for this role and who is **authorised to treat patients independently** – in practice this is usually a nurse.

This role is specifically outside the scope of practice of a Nursing Associate.

In this context 'Clinician' does not include trainees or Health Care Assistants but does include Physician Associates working under the direct supervision of a registered medical practitioner.

Acuity is represented by an integer (number) between '1' and '5', '1' being the most serious / time sensitive and '5' the least.

For the Emergency Care Acuity codes please see the table below.

ECDS_Description	SNOMED_Code	SNOMED_Fully_Specificied_Name	Notes
1 - Immediate care level emergency care	1064891000000107	Immediate resuscitation level emergency care (regime / therapy)	Maps to 'Resus'
2 - Very urgent level emergency care	1064911000000105	Very urgent level emergency care (regime / therapy)	
3 - Urgent level emergency care	1064901000000108	Urgent level emergency care (regime / therapy)	Maps to 'Majors'
4 - Standard level emergency care	1077241000000103	Standard level emergency care (regime / therapy)	Maps to 'Minors'
5 - Low acuity level emergency care	1077251000000100	Non-urgent level emergency care (regime / therapy)	

Table 20 Urgent and Emergency Care Acuity codes

Acuity scores should be allocated using the following framework:

1. Any patients needing immediate resuscitation = acuity level 1.

2. Any adult patient not needing immediate resuscitation but who has arrived by ambulance OR is deemed likely to need full clinical assessment within the first half hour of attendance: Perform NEWS2 assessment and enter acuity on the basis of this.
3. Any child or any adult patient not covered by the two conditions above should be allocated an acuity score based on either:
    - an explicit method of calculating acuity e.g. a triage score / Early Warning Score
    - a guideline-based tool e.g. the ECDS Acuity Guide sheet
    - an implicit judgement of acuity e.g. majors = 3, minors = 4.

NB. If the acuity is implied through the treatment area, this is defined by the patient's needs, not the resources available e.g. if a patient is a category '3' patient but due to resource issues is treated in a category '1' or category '4' clinical area, the patient remains a category '3' patient.

A project to standardise the measurement of acuity is currently running and is likely that this guidance will change in 2024.

A sample Acuity scoring tool is available on the ECDS website[24].

Acuity should be recorded by the first clinician who sees the patient and must be the **initial** assessment of acuity. If this subsequently changes e.g. the patient deteriorates, this may be recorded locally but only the first value should be submitted as Emergency Care Acuity.

5.11.13 Urgent And Emergency Care Chief Complaint (SNOMED CT)

Definition: Urgent And 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.

Data Dictionary: URGENT AND EMERGENCY CARE CHIEF COMPLAINT (SNOMED CT) (datadictionary.nhs.uk)

Justification: There is a need for Urgent and Emergency Care to standardise input measurement to record accurately the type of patients attending across a range of Urgent and 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 allow patient pathways to be standardised with decision support, and there is ample evidence that this improves quality of care and efficiency.

How to collect: This data item captures the nature of the patient's chief complaint as defined by the clinician first assessing the patient, mapped to one of the items in the list of Chief Complaints.

'Clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the Nursing and Midwifery Council who has appropriate training and support for this role and who is **authorised to treat patients independently** – in practice this is usually a nurse.

In this context 'Clinician' does not include trainees or Health Care Assistants but does include Physician Associates working under the direct supervision of a registered medical practitioner.

The Chief Complaint must be the **initial** Chief Complaint. If the Chief Complaint subsequently changes e.g. on questioning by the main treating clinician, this may be recorded locally but only the first value should be submitted as Emergency Care Chief Complaint.

Coding examples:

Scenario	Guidance
Patient attends saying they are at risk of being evicted and requires help	Social problem
Patient presents redness of arm after a bee sting saying he/she is allergic to bees and is having 'an allergic reaction'	Disorder of skin

[24] https://digital.nhs.uk/binaries/content/assets/website-assets/ecds/ecds_chief_complaint_and_acuity_september_2017.pdf

Scenario	Guidance
Patient has had a blood test showing high potassium and advised to attend the ED but has no symptoms	Asymptomatic

Table 12 Coding examples for Urgent And Emergency Care Chief Complaint

5.11.14 Urgent And Emergency Care Timestamp Seen for Treatment

Definition: The Urgent and Emergency Care Timestamp Seen For Treatment is the date, time and time zone when the Patient is seen by a clinical decision maker (a Care Professional who can define the management plan and discharge the Patient) to diagnose the problem and arrange or start definitive treatment as necessary.

Data Dictionary: Urgent and Emergency Care Timestamp Seen For Treatment (datadictionary.nhs.uk)

Justification: This is the date, time and timezone at which the treating clinician first assesses the patient.

'Treating clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the General Medical Council, who has appropriate training and support for this role and who is **authorised to assess, diagnose, treat and discharge patients independently** – in practice this is most commonly a doctor.

In this context 'treating clinician' **does** include trainees (e.g. F1 doctors and trainee Nurse Practitioners) assessing and treating patients under the direct supervision of an appropriately qualified clinician. The supervising clinician must always review the patient prior to discharge and their review must be registered by the IT system and must be transmitted as part of the ECDS record.

Clinician in this context **does not** include Medical Student, Nursing Student, Health Care Assistant Nursing Associate or any staff member not specifically trained and certified by a professional registration body to operate as a fully independent practitioner.

How to collect: This data should be auto populated by the information system when the clinician first takes responsibility for the patient, by assigning their name to the patient immediately before physically going to see the patient.

This data should be automatically entered by the IT system when the clinician inputs the health assessment data or input manually if automation is not available.

5.11.15 Urgent And Emergency Care Extended Care Episode Identifier

Definition: An Urgent and Emergency Care Extended Care Episode Identifier is a system-generated Activity Identifier which uniquely identifies an Urgent and Emergency Care Extended Care Episode within a Health Care provider and Organisation Site Identifier (Of Treatment).

Data Dictionary: URGENT AND EMERGENCY CARE EXTENDED CARE EPISODE IDENTIFIER (datadictionary.nhs.uk)

Justification: This is a new data item in ECDS v4.0 to support the capture of the intention to treat a patient and both ongoing duty of care and subsequent handover of care for a single acute condition. For clinical governance reasons it must be clear who is responsible for the patient at all times.

Background:

An Urgent and Emergency Care Extended Care Episode is an episode of clinical care for a patient under the responsibility of a named care Professional in an Urgent and Emergency Care Service, which occurs following initial assessment by a care professional qualified for independent practice in Urgent and Emergency Care.

Typically, this decision will be taken during a Emergency Care Attendance or Same Day Emergency Care Attendance.

The start of an Urgent and Emergency Care Extended Care Episode:

An Urgent and Emergency Care Extended Care Episode starts at the Urgent and Emergency Care Activity End Timestamp of the Emergency Care Attendance or Same Day Emergency Care Attendance within which the clinical decision was taken to discharge the patient to their normal place of residence, but with an ongoing duty of care to follow up under a Urgent and Emergency Care Extended Care Episode.

Attendances within an Urgent and Emergency Care Extended Care Episode:

An Urgent and Emergency Care Extended Care Episode spans a series of planned attendances (typically Same Day Emergency Care Attendances) for ongoing follow up care. If during the same time period the patient attends an Urgent and Emergency Care Service for unplanned attendances (for example their condition deteriorates and they attend the Emergency Care Department within the same Health Care Provider), then the unplanned attendance should also be recorded as being part of the Urgent and Emergency Care Extended Care Episode.

Linking Attendances to the Urgent and Emergency Care Extended Care Episode:

All Emergency Care Attendances and Same Day Emergency Care Attendances, either face to face or virtual, and either scheduled or unscheduled, that occur during an Urgent and Emergency Care Extended Care Episode period, must be linked to the Urgent and Emergency Care Extended Care Episode.

The Urgent And Emergency Care Activity Identifier which identifies the open Urgent and Emergency Care Extended Care Episode must be linked in the Electronic Health Record system, and submitted in the Emergency Care Data Set v4.0 record relating to the Emergency Care Attendance or Same Day Emergency Care Attendance.

Therefore, the Urgent and Emergency Care Extended Care Episode Identifier must carry the unique identifier for the open Urgent and Emergency Care Extended Care Episode, whenever a scheduled or unscheduled Emergency Care Attendance or Same Day Emergency Care Attendance occurs within the open period.

How to collect: This is a system generated Activity Identifier.

5.12 Data Group: Assessment Tool Group (SNOMED CT)

5.12.1 Introduction

This data group, plus Coded Clinical Observations and Coded Clinical Findings, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice.

For NEWS2, Pain Score, Delirium Score (4AT) and the Clinical Frailty Scale, only the results from the first assessment need to be submitted.

A full worked example for a patient involving both the NEWS2 and Clinical Frailty Scale assessments is included in Appendix C.

5.12.2 Definition and Group status for Data Group

Definition: To carry the details of the SNOMED CT coded Asssessment Tools for the patient

Group status: 'Required'

How to collect: This data group is used to record the aggregate **score** and individual section **scores** (not observations or findings) of a clinical assessment and when these are calculated and validated to form a complete score, this will be recorded as a coded scored assessment.

When submitting the scores from a clinical assessment, the whole data group is repeated once for each section, in addition to once for the overall total clinical assessment score.

5.12.3 Data Items in this Data Group

Data Element Name	Format	Status	Source
Coded Assessment Tool Type (SNOMED CT)	min n6 max n18	M	SNOMED CT
Person Score	max an5	M	DM&D
Assessment Tool Validation Timestamp	max an25	M	DM&D

Table 22 Data items within 'Assessment Tool Group (SNOMED CT)' Data Group

The Assessment Tool Group (SNOMED CT) is Required and the data items within it are Mandatory, which means that the data items must be completed if the data group is relevant.

5.12.4 Coded Assessment Tool Type (SNOMED CT)

Definition: The SNOMED CT concept ID which is used to identify an Assessment in SNOMED CT.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/coded_assessment_tool_type__snomed_ct_.html

Justification: To monitor outcomes and activities depending on Coded Assessments.

How to collect: The local user interface should present the user with a way of completing the different code assessment sections in an efficient and logical manner. Invisible to the user, a SNOMED CT code will be attached to correctly identify each section of the assessment, as well as the overall assessment score.

The ECDS Assessment Tools tab in the ECDS ETOS shows the permissible SNOMED CT values for the NEWS2 assessment.

5.12.5 Person Score

Definition: The score taken from an Assessment Tool. This could be for an individual element of, or question within, an Assessment Tool, a subtotal or total score. The purpose of the Person Score is to measure changes in health and wellbeing.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/person_score.html

Justification: To monitor outcomes and activities and quantify

How to collect: For each section of the clinical assessment there should be a place to enter the score for that section as a numeric value. The overall score should be calculated according to the rules of the assessment in question.

5.12.6 Assessment Tool Validation Timestamp

Definition: The Assessment Tool Validation Timestamp is the date, time and time zone that the Coded Assessment Tool Type (SNOMED CT) was validated by the Care Professional.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/assessment_tool_validation_timestamp.html

Justification: To capture the date and time the assessment was validated by the care professional, so that the time difference between the scored assessment and the senior clinical review can be calculated.

How to collect: When the individual section scores are validated by an appropriate care professional a timestamp should be recorded automatically to capture the time this happened. The section scores may be validated one by one, each with its own timestamp, or collectively as a group.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.12.7 Simple NEWS2 examples for Coded Scored Assessment

Example A

A patient receives a NEWS2 assessment. The patient's respiration rate is in the normal range, so their NEWS2 score for this section is zero. The ECDS submission for this section of the NEWS assessment would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Assessment Tool Type (SNOMED CT)	1104301000000104	Royal College of Physicians National Early Warning Score 2 - respiration rate score (observable entity)
Person Score	0	Not applicable
Assessment Tool Validation Timestamp	2020-08-21T10:15:20+01:00	Not applicable

Example B

A patient receives a NEWS2 assessment. The patient's total NEWS2 score is 12. The ECDS submission for the total NEWS assessment score would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Assessment Tool Type (SNOMED CT)	1104051000000101	Royal College of Physicians National Early Warning Score 2 total score (observable entity)
Person Score	12	Not applicable
Assessment Tool Validation Timestamp	2020-08-21T10:15:20+01:00	Not applicable

5.13 Data Group: Observation Group (SNOMED CT)

5.13.1 Introduction

This data group, plus Coded Scored Assessment and Coded Clinical Findings, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice.

For NEWS2, Pain Score, Delirium Score (4AT) and the Clinical Frailty Scale, only the results from the first assessment need to be submitted.

A full worked example for a patient involving both the NEWS2 and Clinical Frailty Scale assessments is included in Appendix C.

5.13.2 Definition and Group status for Data Group

Definition: To carry the details of the SNOMED CT coded Clinical Observations for the Patient

Group status: 'Required'

How to collect: When conducting the assessment, a series of clinical observations are made. When submitting the Coded Clinical Observations from an assessment, the whole data group is repeated once for each observation.

5.13.3 Data Items in this Data Group

Data Element Name	Format	Status	Source
Coded Observation (SNOMED CT)	min n6 max n18	M	SNOMED CT
Observation Value	max an10	M	DM&D
Unit of Measurement (UCUM)	max an20	R	DM&D
Coded Observation Timestamp	max an25	M	DM&D

Table 23 Data items within 'Observation Group (SNOMED CT)'

5.13.4 Coded Observation (SNOMED CT)

Definition: Coded Observation (SNOMED CT) is the SNOMED CT concept ID which is used to identify an Observable Entity.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/coded_observation__snomed_ct_.html

Justification: Required for analysis of the outcomes and activity between different activities or results.

How to collect: The IT system should present a logical and clear way of entering the series of observations, alongside the associated values and units of measurement (see below).

Tab 14.1 (CODED OBSERVATION) in the ECDS ETOS shows acceptable SNOMED CT values for different types of clinical observation.

5.13.5 Observation Value

Definition: The value of a Clinical Investigation Result Item.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/observation_value.html

Justification: Used to compare outcomes between different comparable measurements.

How to collect: These should be recorded into the IT system either by manually entering the readings where necessary, or by taking the readings from connected certified medical devices.

Note regarding medical devices: Using connected certified medical devices is allowed, however the results MUST be validated by a suitably qualified person before committing the data to the ED system.

Note regarding NEWS2 and the ACVPU assessment: For all NEWS2 observations other than the result of the ACVPU assessment, the observation value MUST be entered as a numerical value only and an associated UCUM Unit of Measurement must be recorded and submitted.

For ACVPU the IT system should allow the user to choose from the appropriate options, and in ECDS return either the letter 'A' (Alert), 'C' (Confused), 'V' (Responds to Voice), 'P' (Responds to Painful stimulus) or 'U' (Unconscious). Do NOT to put a value in the UCUM Unit of Measurement field for ACVPU observations.

5.13.6 Unit of Measurement (UCUM)

Definition: The Unit of Measurement using the Unified Code for Units of Measure (UCUM) code system.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/ucum_unit_of_measurement.html

Justification: Used to compare outcomes between different comparable measurements

How to collect: The UCUM unit of measurement is mandatory for all numerical values. For more information on UCUM please follow this link.

The table below shows the example values to put in the UCUM field for different observations:

Observation	UCUM Unit of Measurement	Meaning
Respiratory rate	/min	Per minute
Oxygen saturation	%	Percent
Systolic blood pressure	mmHg	Millimetres of mercury
Heart rate	/min	Per minute
Body temperature	Cel	Celsius

Table 24 UCUM Unit of Measurement indicators for a selection of Observation types

5.13.7 Coded Observation Timestamp

Definition: Coded Observation Timestamp is the date, time and time zone that the Coded Observation (SNOMED CT) was recorded by a Care Professional.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/coded_observation_timestamp.html

Justification: To capture the date and time the observation was completed

How to collect: This is the timestamp when the observation was made or, for connected medical devices, the timestamp when the observation was verified by a qualified individual.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.13.8 Simple NEWS2 examples for Coded Clinical Observation

Example A

A patient receives a NEWS2 assessment. Their respiration rate is 26 respirations per minute, indicating that their respiration rate is well outside the normal healthy range. The ECDS submission for this observation would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Observation (SNOMED CT)	86290005	Respiratory rate (observable entity)
Observation Value	26	Not applicable
Unit of Measurement (UCUM)	/min	Not applicable
Coded Observation Timestamp	2020-08-21T10:15:20+01:00	Not applicable

Example B

A patient receives a NEWS2 assessment. Their ACVPU assessment indicates that they are confused. The ECDS submission for this observation would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Observation (SNOMED CT)	1104441000000107	Alert Confusion Voice Pain Unresponsive scale score (observable entity)
Observation Value	C	Not applicable
Unit of Measurement (UCUM)	NULL	Not applicable
Coded Observation Timestamp	2020-08-21T10:15:20+01:00	Not applicable

5.14 Data Group: Finding Group (SNOMED CT)

5.14.1 Introduction

This data group, plus Coded Scored Assessment and Coded Clinical Observations, is used to capture and flow patient clinical data. It is described here in generic form, together with a simple use case to illustrate how to use it in practice.

For NEWS2, Pain Score, Delirium Score (4AT) and the Clinical Frailty Scale, only the results from the first assessment need to be submitted.

A full worked example for a patient involving both the NEWS2 and Clinical Frailty Scale assessments is included in Appendix C.

5.14.2 Definition and Group status for Data Group

Definition: To carry the Finding details of the Patient Emergency Care Attendance

Group status: 'Required'

How to collect: This data group is repeated once for each Clinical Finding associated with the ECDS record.

NEWS2: For NEWS2, the finding relating to the 'Air of Oxygen' part of the NEWS2 assessment should go in this group.

Clinical Frailty Scale: The result of the Clinical Frailty (Rockwood) Scale should go in this group.

The Clinical Frailty Scale is the scale, as defined by a clinician, based on the patient's usual activity status two weeks prior to the attendance resulting in the current medical assessment. The score must be validated by the ED staff, and must be conducted for any patient over 65. Where applicable, the score as determined by the conveying ambulance service can be entered as the default, but a member of clinical ED staff must validate it.

5.14.3 Data Items in this Data Group

Data Element Name	Format	Status	Source
Coded Finding (SNOMED CT)	min n6 max n18	M	SNOMED CT
Coded Finding Timestamp	max an25	M	DM&D

Table 25 Data items within Finding Group (SNOMED CT)

5.14.4 Coded Finding (SNOMED CT)

Definition: Coded Finding (SNOMED CT) is the SNOMED CT concept ID which is used to identify a Finding.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/coded_finding__snomed_ct_.html

Justification: Required for analysis of the outcomes and activity between different activities or results.

How to collect: The system should allow the user to enter the information in a clear and logical manner.

NEWS2: For NEWS2 the 'Air or Oxygen' section of the assessment should allow the user to choose from two options indicating whether the patient is breathing room air or using supplemental oxygen. These values should be submitted in ECDS using an appropriate SNOMED code.

The ECDS ETOS tab ECDS Assessment Tools presents acceptable applicable SNOMED codes. **Pain Score:** The ECDS ETOS tab ECDS Assessment Tools presents the acceptable options for the Pain Score.

One and only one of these options MUST be used for the Pain Score.

Delirium Score (4AT): The ECDS ETOS tab ECDS Assessment Tools presents the acceptable options for the Delirium Score (4AT).

One and only one of these options MUST be used for the Delirium Score (4AT).

Clinical Frailty Scale: The ECDS ETOS tab ECDS Assessment Tools presents the acceptable options for the Clinical Frailty Scale.

One and only one of these options MUST be used for the Clinical Frailty Scale.

5.14.5 Coded Finding Timestamp

Definition: Coded Finding Timestamp is the date, time and time zone that the Coded Finding (SNOMED CT) was recorded by a Care Professional.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/coded_finding_timestamp.html

Justification: To capture the date and time the finding was completed.

How to collect: This is the timestamp when the finding was made and verified by a qualified individual.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.14.6 Simple examples for Coded Clinical Observation

Example A (NEWS2)

A patient receives a NEWS2 assessment. They are breathing room air. The ECDS submission for this Finding would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Finding (SNOMED CT)	722742002	Breathing room air (finding)
Coded Finding Timestamp	2020-08-21T10:15:20+01:00	Not applicable

Example B (Clinical Frailty Scale)

A patient receives a Clinical Frailty Scale assessment. They are found to have a Clinical Frailty Scale of '3 – managing well'. The ECDS submission for this Finding would be as follows:

Data Element Name	Value Submitted	SNOMED Description
Coded Finding (SNOMED CT)	1129351000000108	Canadian Study of Health and Aging Clinical Frailty Scale level 3 - managing well (finding)
Coded Finding Timestamp	2020-08-21T10:15:20+01:00	Not applicable

5.15 Data Group: Injury Characteristics

5.15.1 Definition, Group status and Justification for Data Group

Definition: To carry the details of injuries

Group status: 'Required'

Justification:

To date, injury data has been collected in a piecemeal way in the UK. This has been driven by a focus on a particular injury cause such as road trauma, major trauma, assault, or firework injuries, rather than to develop a better overall understanding of the causes of injury. The ECDS data fields are derived from the WHO injury surveillance recommendations together with insights from international best practice. Clinical expertise is not necessary to collect injury data and most sites that are collecting this successful are using clerical (reception) staff to collect this data.

Collecting injury data in an integrated fashion will provide evidence to help develop a better understanding of the external causes of injury and support the development of specific injury prevention programmes which will lead to a reduction in the number of accidents and hospital-treated unintentional injuries.

The data collected in the injury surveillance section is the only part of ECDS where injury intent is recorded e.g. assaults and self-harm.

Therefore, injury information is an essential part of the clinical record and must be completed in all cases where the Chief Complaint or Diagnosis codes are injury related (see below). In addition, this information must be transmitted to the GP and other health professionals by inclusion in the patient letter / electronic message.

The injury data group is only required to be collected once e.g. only when the Urgent And Emergency Care Attendance Category is '1 - Unplanned first Emergency Care Attendance for Same Day Emergency Care Attendance a new clinical condition (or deterioration of a chronic condition)'.

Addition of the Assault Location Description field

The national violence prevention strategy is heavily reliant on knowing the exact geographical location at which a violence-related injury occurred. Therefore, following consultation with:

- NHS England
- NHS Digital
- The National Clinical Director for Prevention of Violent Injury
- The ISTV team
- Public Health England

The free text description of the location of the assault is included in ECDS as a data item following being introduced as a pilot data item in ECDS v3.0 (see below – Assault Location Description).

The Royal College of Emergency Medicine has published additional information on ISTV in March 2024. This includes three short films for clerical staff, clinical staff and healthcare workers and a new Standard Operating Procedure (SOP). These are available at:
https://rcem.ac.uk/information-sharing-to-tackle-violence/

How to collect: The injury data items should be collected for all presentations which may be related to injury.

If the provider has implemented the ECDS Emergency Care Chief Complaint and Emergency Care Diagnosis code set 'flags' these will highlight the presentations where the injury information is required. Please see below:

- Chief Complaint injury flag equals '1'

AND / OR

- Diagnosis injury flag equals '1'

If clerical staff record the patient's details before a Chief Complaint is recorded the injury data items should be collected to the best of their ability based on the information the patient provides. Clinical knowledge is not necessary to capture these data items.

Clinical staff should then be able to review that information to correct / update, if necessary, during the patient's stay in the ED.

5.15.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Injury Date and Time	an19 YYYY-MM-DDThh:mm:ss	M	DM&D
Emergency Care Place of Injury (SNOMED CT)	min n6 max n18	R	SNOMED CT
Emergency Care Place of Injury (Latitude)	max n2.n6	O	DM&D
Emergency Care Place of Injury (longitude)	max n3.n6	O	DM&D
Emergency Care Injury Intent (SNOMED CT)	min n6 max n18	R	SNOMED CT
Emergency Care Injury Activity Status (SNOMED CT)	min n6 max n18	R	SNOMED CT
Emergency Care Injury Activity Type (SNOMED CT)	min n6 max n18	R	SNOMED CT
Emergency Care Injury Mechanism (SNOMED CT)	min n6 max n18	R	SNOMED CT
Emergency Care Injury Alcohol or Drug Involvement (SNOMED CT)	min n6 max n18	R	SNOMED CT
Assault Location Description	max an255	R	DM&D

Table 26 Data items within 'Injury Characteristics' Data Group

5.15.3 Injury Date and Injury Time

Definition: The date / time that the injury occurred.

Data Dictionary:

Injury Date and Time – https://datadictionary.nhs.uk/data_elements/injury_date.html

Justification: This data item is necessary to identify delay between injury occurrence and presentation.

Delay from injury is important to know in two situations:

• 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.

• 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.

The date / time of injuries is helpful in understanding patterns of healthcare usage; if many patients are attending an ED for non-acute injuries, it may be that alternative healthcare provision is necessary.

All injuries will have a date and time so these are set to mandatory.

How to collect: This should represent the approximate date and time that the injury occurred.

If the date or time is not known, it should be estimated.

5.15.4 Emergency Care Place of Injury (SNOMED CT)

Definition: The type of location at which the person was present when the injury occurred.

Data Dictionary:

https://datadictionary.nhs.uk/data_elements/emergency_care_place_of_injury__snomed_ct_.html

Justification: 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.

How to collect: This information should be collected by clerical staff at the point of booking in at reception. If this information is disclosed during assessment / treatment it should also be possible to update / enter this information into the record.

Coding examples: The code reported should be the one which best characterises the location where the patient was situated at the time the injury occurred, based on the information available at the time it is recorded.

For example, on how to capture injury place type please see below:

Scenario	Guidance
Man has foot trod on by cow within a milking shed on a farm	Farm
Child breaks arm whilst playing football in an outdoor sports field on school premises	Educational establishment The coding should reflect the organisational area of responsibility e.g. Sports area in a school grounds, code as 'school' Garden at a historic National Trust estate, code as 'recreational area'
Child falls whilst playing in by a river, on a farm	If two or more categories are equally appropriate, select the code sequenced first in the code list – in this example it would be *'Place of occurrence of injury is farm'*
Elderly lady falls and hurts hip whilst walking in a historic National Trust garden	Recreational area

Table 27 Coding examples for 'Place of Injury'

5.15.5 Emergency Care Place of Injury (Latitude) and Emergency Care Place of Injury (Longitude)

Definition: The latitude and the longitude of the place of injury, expressed in decimal degrees.

Data Dictionary:

Latitude – EMERGENCY CARE PLACE OF INJURY (LATITUDE) (datadictionary.nhs.uk)

Longitude – EMERGENCY CARE PLACE OF INJURY (LONGITUDE) (datadictionary.nhs.uk)

Justification: The ISTV standard identifies patterns of injury specifically related to assault and then provide an intervention to prevent further injury. There is good evidence that if a large number of alcohol related assaults are occurring outside a particular venue, licensing requirements can be strengthened, which reduces the further risk of injury.

The ISTV standard uses free text fields to capture detailed location information which is then shared with local partners.

How to collect: The latitudinal and longitudinal coordinates of the location of the injury could be collected by extraction from another electronic system e.g. ambulance electronic patient record system, from a member of clerical staff capturing the coordinates by using mapping software e.g. Google maps geocoding API[25], by accessing an electronic mapping system or a kiosk system with an inbuilt electronic map.

Emergency Care Place of Injury (Latitude) Emergency Care Place of Injury (Longitude) are shown as separate (optional) data elements within the ECDS.

However, within the ECDS XML Schema, the items are modelled with an (optional) XML attribute 'EmergencyCarePlaceOfInjury_LatitudeAndLongitude', under which both elements 'Latitude' and 'Longitude' MUST be present if the data is submitted.

[25] Google. 2017. Google Maps API. Available at: https://developers.google.com/maps/documentation/geocoding/start?csw=1

5.15.6 Emergency Care Injury Intent (SNOMED CT)

Definition: The most likely **human** intent in the occurrence of the injury or poisoning as assessed by a clinician.

Data Dictionary: EMERGENCY CARE INJURY INTENT (SNOMED CT) (datadictionary.nhs.uk)

Justification: Preventing preventable injury is of great benefit to individuals and society; and identifying the number and severity of assaults has been very difficult.

Members of the public frequently use the term 'accident' but this term is unhelpful in seeking to understand which injuries are likely to be:

- intentional
- the result of sub-optimal judgement
- completely unforeseeable e.g. 'hit by meteorite'.

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)[26] which relies on assault related data (intent – apparent assault).

How to collect: The user should capture the most likely **human** intent in the occurrence of the injury or poisoning as assessed by clinician.

When a member of the public uses the term 'accident' this usually implies that it is an unintentional injury, but this needs to be clarified:

- 'unintentional overdose' occurs when a patient mistakenly / inadvertently takes too many tablets e.g. a confused patient or a child eats tablets thinking they are sweets.
- 'intentional overdose' occurs when a patient intentionally takes too many tablets, whether or not they intended to seek treatment for this.

The standard question should be: *"Was this intentional?"*.

ISTV – Assaults will be identified for inclusion in the ISTV data flow by use of the data item 'EMERGENCY CARE INJURY INTENT' and departments need to ensure that all patients attending as victims of assault are recorded under one of the following two codes:

SNOMED_Code	SNOMED_UK_Preferred_Term
1082491000000103	Alleged victim of physical assault by lone assailant
1082501000000109	Alleged victim of physical assault by multiple assailants

Where either of the above two codes are recorded, then the data item 'ASSAULT LOCATION DESCRIPTION' should be completed in ECDS (note this may only be completed when the assault location is not a Home or Private Address).

.

Coding examples:

The concept ECDS aims to capture is the **human intent to produce the injury**, **not** the intent to undertake an activity that may have happened to result in injury.

If more than one category is judged to be equally appropriate, select the one listed first.

Scenario	Guidance
Child ingests a parent's prescription medication	Accidental injury
Patient attempts suicide by ingesting 30 paracetamol tablets	Self inflected injury
Patient stabbed during an attempted mugging by one person	Alleged victim of physical assault by lone assailant
Juggling chainsaws (unsuccessfully)	Accidental injury

[26] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb1594-information-sharing-to-tackle-violence-minimum-dataset

Scenario	Guidance
Stray dog bites postal worker	Injury caused by animal
A dog used intentionally as a weapon	Alleged victim of physical assault (Should be coded according to the human intent i.e. assault, with the involvement of the dog captured as the injury mechanism = animal bite.)

Table 28 Coding examples for 'Injury intent'

5.15.7 Emergency Care Injury Activity Status (SNOMED CT)

Definition: The status of activity being undertaken by the person at the moment the injury occurred e.g. being educated, working.

Data Dictionary: EMERGENCY CARE INJURY ACTIVITY STATUS (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

Many of the activities listed in the following category 'Injury Activity Type' can be undertaken in a variety of roles e.g. Tennis may be played as:

- sport (leisure)
- coach (paid work)
- coach (unpaid work)
- school activity (being educated).

This category allows these activities to be distinguished to understand which groups of people are vulnerable to injury and how injury prevention can best be targeted at those most at risk.

How to collect: To answer both this question and the following question (Injury Activity Type), the patient should be asked: *"What were you doing at the time you were injured?"*

The patient's role should be clarified if necessary: *"Were you working as a chainsaw juggler, or is this just your hobby?"*

Coding examples:

Scenario	Guidance
Self-inflicted injury	Unless this occurs during the course of another activity e.g. during paid work, record as 'Leisure' time
An elderly lady presents having fainted as she walked up the stairs	Activity of daily living
A young male presents with a painful, swollen ankle after being tackled whilst playing football in school	Injury whilst engaged in education activity

Table 29 Coding examples for 'Emergency Care Injury Activity Status'

5.15.8 Emergency Care Injury Activity Type (SNOMED CT)

Definition: The type of activity being undertaken by the person at the moment the injury occurred.

Data Dictionary: EMERGENCY CARE INJURY ACTIVITY TYPE (SNOMED CT) (datadictionary.nhs.uk)

Justification: Insights from injury surveillance have resulted in major reductions in injury from road traffic collisions and workplace incidents. However, the biggest rise in injury in the last ten years is from 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.

How to collect: Please see 'Injury Activity Status' above.

The injury activity list has been revised many times to achieve a balance between the need for granular information and the need for usable lists of information.

When an exact activity or sport is not listed, please choose the nearest appropriate one, and if there is a clear need for a new category / activity, please report this to NHS England as per section 3.2.3 of this user guidance.

Coding examples:

Scenario	Guidance
An elderly lady presents having fainted as she walked up the stairs	Ascending stairs
Patient presents with intentional overdose of paracetamol whilst at home in their bedroom	Leisure at home
A young male presents with a painful, swollen ankle after being tackled whilst playing football	Sports: team: football (soccer)

Table 30 Coding examples for 'Emergency Care Injury Activity Type'

5.15.9 Emergency Care Injury Mechanism (SNOMED CT)

Definition: How the injury was caused.

Data Dictionary: EMERGENCY CARE INJURY MECHANISM (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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. avoiding polished floors or loose floor coverings may make a very large difference.

How to collect: This item captures how the injury was caused; and must be disaggregated from injury intent.

Patients frequently volunteer the mechanism of injury but if in doubt / to clarify it may be helpful to check the mechanism by 'reading back' the ECDS mechanism that it appears to meet: *"So you were juggling chainsaws and you slipped – this sounds like 'Stabbed / cut with other sharp object'?"*

Coding examples:

Scenario	Guidance
Patient falls and hits shoulder causing dislocation of left shoulder	Blunt injury
Driver in a road traffic collision	Depending on details this might be: • Blunt injury (hit by steering wheel • Injury due to projectile (hit by airbag debris) • Burn due to fire • Penetrating injury caused by glass
Patient presents with intentional overdose of paracetamol	Poisoning (disorder)

Table 31 Coding examples for 'Emergency Care Injury Mechanism'

5.15.10 Emergency Care Injury Alcohol or Drug Involvement (SNOMED CT)

Definition: 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.

Data Dictionary:
www.datadictionary.nhs.uk/data_dictionary/data_field_notes/e/eme/emergency_care_injury_alcohol_or_drug_involvement_(snomed_ct)_de.asp

Justification: Drugs and alcohol are frequently blamed in the causation of injury and the rise in patient demand for emergency care. This information will help establish the extent to which drugs (whether legal or illegal) and alcohol are major social and public health issues.

The information gathered by this component of ECDS will enable targeted measures such as public health and policing to minimise harm.

How to collect: This data item collects whether, in the judgement of the person collecting the information, the injury is likely to have occurred as a result of alcohol or drug involvement.

NB: This does not necessarily imply consumption of alcohol by the person who is injured; and is a simple 'balance of probability' i.e. more than 50% chance / more likely than not. It does not require proof that alcohol or drugs were involved.

Coding examples:

Notes:

- This data item is NOT looking to establish causation or association for non-injury diagnoses.
- If injury has not occurred, then the injury surveillance questions should not be completed.
- A patient who has consumed alcohol but not injured themselves, or others, should not be coded under injury surveillance.

Scenario	Guidance
Liver failure as a result of long-term alcohol consumption	NO coding in this case. There is no acute injury or poisoning
Fractured skull due to alcohol intoxication	Injury following alcohol use (Fractured skull coded as diagnosis)
Attended having with chest pain, also consumed alcohol, but not had an injury	NO coding required in this case

Table 32 Coding examples for 'Emergency Care Injury Alcohol Or Drug Involvement'

5.15.11 Assault Location Description

Definition: Provides further comment and/or details of the Location where an assault took place.

Assault Location Description may only be completed when the assault Location is NOT a Home or Private Address, as this could identify the Patient.

Data Dictionary: ASSAULT LOCATION DESCRIPTION (datadictionary.nhs.uk)

Justification: The ISTV Information Standard (ISB1594) describes the rationale for collecting and sharing ED data regarding injuries caused by violence.

How to collect: Under the terms of the ISTV information standard this data MUST be collected as part of routine patient care in Emergency Departments.

ECDS Version 3.0 included this data item for the first time.

Pilot testing of this data item was subsequently undertaken and a mandate to submit this data is now in place in this ISN.

5.16 Data Group: Patient Clinical History

5.16.1 Definition and Group Status for Data Group

Definition: To carry the patient clinical history details

Group status: 'Required'

5.16.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Comorbidity (SNOMED CT)	min n6 max n18	R	DM&D

Table 33 Data items in 'Patient Clinical History' group

5.16.3 Comorbidity (SNOMED CT)

Definition: Comorbidity (SNOMED CT) is the SNOMED CT concept ID which is used to identify comorbid conditions.

Data Dictionary: COMORBIDITY (SNOMED CT) (datadictionary.nhs.uk)

Justification: Co-morbid conditions are a key determinant of patient complexity, risk and outcomes 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-morbid conditions is therefore an essential piece of knowledge to ensure that the right care is delivered in the right place, and to minimise avoidable harm e.g. by admitting patients unnecessarily.

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 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.

The Comorbidity field may in future be titled the 'Long Term Conditions' field.

How to collect: This data item is repeated once for each comorbidity.

If the patient's GP has identified that the patient has any of the NHS list of medical co-morbid conditions, then these may be included within the primary care record which should be able to be viewed as part of a fully functional electronic patient record system.

It is up to the local IT provider to determine how best to record co-morbid condition information in the patient record once they have been disclosed by the patient, viewed in the Summary Care Record (SCR) or Local Health Care Record Exemplar (LHCRE), populated from the local electronic patient record or other local source of patient information.

5.17 Data Group: Service Agreement Details

5.17.1 Definition, Group status and Justification for Data Group

Definition: To carry the details of the Provider, Commissioners and Service Agreements.

Group status: 'Mandated'

Justification: Is the same as for the CDS version 6-3 standard[27].

Where commissioning information in stored within the clinical system, this could be derived. However, it may be necessary to obtain the data from finance and contracting systems to populate these fields prior to submission of the Commissioning Data Set record.

ECDS v4.0 allows multiple commissioners to be recorded where relevant. This is designed to support specific scenarios where more than one commissioner may be responsible for the patient's care.

5.17.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Organisation Identifier (Code Of Provider)	min an3 max an5	M	ODS
Organisation Identifier (Code Of Commissioner)	min an3 max an5	M	ODS
Start Date (Commissioner Assignment Period)	an10 CCYY-MM-DD	R	DM&D
End Date (Commissioner Assignment Period)	an10 CCYY-MM-DD	R	DM&D
NHS Service Agreement Identifier	max an20	R	DM&D
NHS Service Agreement Line Identifier	max an20	O	DM&D
Provider Reference Identifier	max an20	O	DM&D
Commissioner Reference Identifier	max an20	R	DM&D
Service Code	max an12	R	DM&D

Table 34 Data items in 'Service Agreement Details' Data Group

Please see the ECDS v4.0 Technical Output Specification for full details of Data Item and Data Group repeat status.

5.17.3 Commissioning Serial Number

Definition: A number used to uniquely identify an NHS Service Agreement by an organisation acting as commissioner of patient care services.

Data Dictionary: COMMISSIONING SERIAL NUMBER (datadictionary.nhs.uk)

How to collect: See 5.17.1 above.

5.17.4 NHS Service Agreement Line Number

Definition: A number (alphanumeric) to provide a unique identifier for a line within an NHS Service Agreement.

Data Dictionary: NHS SERVICE AGREEMENT LINE NUMBER (datadictionary.nhs.uk)

How to collect: See 5.17.1 above.

5.17.5 Provider Reference Number

Definition: Provider Reference Number is a number convention agreed locally between a provider and Commissioner for use within a Commissioning Data Set message.

Data Dictionary: PROVIDER REFERENCE NUMBER (datadictionary.nhs.uk)

[27] Information Standards Board for Health and Social Care ISB0092 AMD 16/2010 Commissioning Data Sets (CDS) Version 6.2 Available at: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb0092-commissioning-data-sets

How to collect: See 5.17.1 above.

5.17.6 Commissioner Reference Number

Definition: A number (alphanumeric) allocated by the commissioner to a Referral Request.

Data Dictionary: COMMISSIONER REFERENCE NUMBER (datadictionary.nhs.uk)

How to collect: See 5.17.1 above.

5.17.7 Organisation Identifier (Code of Provider)

Definition: The Organisation Identifier of the Organisation acting as a Health Care Provider.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/organisation_identifier__code_of_provider_.html

How to collect: See 5.17.1 above.

5.17.8 Organisation Identifier (Code of Commissioner)

Definition: The Organisation Identifier of the Organisation commissioning health care.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/organisation_identifier__code_of_commissioner_.html

How to collect: See 5.17.1 above.

5.18 Data Group: Care Professionals (Urgent and Emergency Care)

5.18.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of the Care Professionals active during the Emergency Care Attendance. Care Professionals means Treating Clinician(s) and Care Clinician(s) according to the definitions below.

Group status: 'Required'

Justification: Recording the Treating Clinician(s) and Care Clinician(s) responsible for patient care is necessary for:

- Operational planning and clinical governance – ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load
- Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need
- Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field
- Performance data. Time to see clinician is used as a performance / quality metric in many healthcare systems
- Patient satisfaction is correlated with the time taken from arrival to the first treating clinical assessment.

This data group 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.

This group is a repeating group, which means multiple treating clinicians can be recorded against the specific episode of care.

Treating clinician

'Treating clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the General Medical Council, who has appropriate training and support for this role and who is **authorised to assess, diagnose, treat and discharge patients independently** – in practice this is most commonly a doctor.

In this context 'treating clinician' **does** include trainees (e.g. F1 doctors and trainee Nurse Practitioners) assessing and treating patients under the direct supervision of an appropriately qualified clinician. The supervising clinician must always review the patient prior to discharge and their review must be registered by the IT system and must be transmitted as part of the ECDS record.

A physician assistant (PA) is a 'treating clinician' but all patients treated by a PA must also have an allocated Medical Practitioner recorded on the ECDS record who holds full General Medical Council registration and who is responsible for all the care provided by the PA – this is the clinician responsible for discharge.

Care clinician

'Care clinician' in this context MUST be a member of staff registered by a professional registration body e.g. the Nursing and Midwifery Council who has appropriate training and support for this role and who is **authorised to care for patients independently** – in practice this is usually a nurse.

'Care clinician' in this context **does not** include Medical Student, Nursing Student, Health Care Assistant or any staff member not specifically trained and certified by a professional registration body to operate as a fully independent practitioner.

In this context 'clinician' **does not** include trainees or Health Care Assistants but **does** include physician associates (PAs) working under the direct supervision of a registered medical practitioner.

5.18.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Professional Registration Issuer Code	an2	M	DM&D

Data Element Name	Format	Status	Source
Professional Registration Entry Identifier	max an32	M	DM&D
Care Professional Tier (Urgent and Emergency Care)	an2	M	DM&D
Care Professional Discharge Responsibility Indicator (Urgent and Emergency Care)	an1	M	DM&D
Care Professional Clinical Responsibility Timestamp	max an25	R	DM&D

Table 35 Data items in 'Care Professionals (Urgent and Emergency Care)' Data Group

5.18.3 Professional Registration Issuer Code

Definition: A code which identifies the Professional Registration Professional Registration Body.

Data Dictionary: https://datadictionary.nhs.uk/data_elements/professional_registration_issuer_code.html

Justification: This is the professional registration / regulatory body for the relevant healthcare provider and identifies the type of healthcare professional providing the service.

GMC (General Medical Council) guidance 'Good Clinical Practice (2019)'[28] specifically states:

> *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.14*
>
> *Clinical records should include:*
>
> *a) relevant clinical findings*
> *b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c) the information given to patients*
> *d) any drugs prescribed or other investigation or treatment*
> *e) who is making the record and when.*

Updated standards were published by the GMC in August 2023 which are in effect from 30 January 2024. Please see:

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance#record-your-work-clearly-accurately-and-legibly

How to collect: This data should be automatically populated by the ED IT system from the list of practitioners working in the Emergency Care facility.

5.18.4 Professional Registration Entry Identifier

Definition: The registration identifier allocated by an Organisation.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/professional_registration_entry_identifier.html

Justification: All clinicians should know their unique identifier and its incorporation in medical records is recommended in guidance issued by the Academy of Medical Royal Colleges standard for the clinical structure and content of patient records.

The patient record is a legal document and can be seen by the patient / their lawyer or coroner. The GMC 'Duties of a Doctor' defines the responsibilities of the medical practitioner regarding the recording of accurate clinical information.

How to collect: This data should be automatically populated by the ED IT system from the list of practitioners working in the Emergency Care facility.

[28] General Medical Council. 2013. Good Medical Practice. Available at: www.gmc-uk.org/guidance/good_medical_practice.asp

5.18.5 Care Professional Tier (Urgent and Emergency Care)

Definition: The tier of care professional treating the patient during an Emergency Care Attendance.

The Care Professional Tier for Emergency Care is defined in the Royal College of Emergency Medicine Guidelines for Medical and Practitioner Staffing in EDs[29].

Data Dictionary: CARE PROFESSIONAL TIER (URGENT AND EMERGENCY CARE) (datadictionary.nhs.uk)

Justification: Recording the clinician(s) responsible for patient care is necessary for:

- Operational planning and clinical governance – ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load.
- Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need.
- Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field.
- Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems.

Key to providing appropriate levels of staffing and ensuring the best possible skill mix across the workforce is an understanding of the 'capability' required to run departments which should be based on the model of care within the ED.

In this context 'capability' is the provision of the right number of staff with the right skills with a focus on the capability of the individual clinician rather than the job title they use, as there are many job titles with overlapping and indistinct roles.

Emergency care is an intrinsically high-risk environment and there is a clinical governance need to record and manage the risk of patients seen by trainee and more junior staff. Therefore, ECDS incorporates the ability to record when a patient is reviewed by a senior staff member as part of their care.

A simple tier system has been developed by the Royal College of Emergency Medicine that integrates the medical and non-medical practitioners in a single hierarchy. Please see table 32 below:

Code	Scope of Practice	Example
1	Require complete supervision. All patient care must be signed off by a senior before admission or discharge.	F1 doctors, trainee practitioners
2	Require access to advice or direct supervision, or practice independently but with limited scope of practice.	ENPs, ANPs / ACPs, most physician assistants, ESPs, F2 doctors, CT1-2 doctors, some primary care clinicians
3	More senior / experienced clinician, requiring less direct supervision. Fewer limitations in scope of practice.	CT3 in EM, junior Speciality Doctors, senior ANPs / ACPs, some physician assistants, most primary care clinicians
4	Senior clinician able to supervise an ED alone with remote support. Possess some extended skills. Full scope of practice.	CT4 and above, senior Speciality Doctors
5	Senior clinician with accredited advanced qualifications in EM. Full set of extended skills. Full scope of practice.	Consultants in EM

Table 36 ECDS Care Professional Tier codes

In a Type 1 ED, there is always a designated senior decision-maker in the ED – sometimes defined as the 'Admitting Officer' who is available to review patients, and this should be a treating clinician from tier 3, 4 or 5.

[29] Royal College of Emergency Medicine. 2017. Medical and Practitioner Staffing in Emergency Departments. Available at: www.rcem.ac.uk/docs/Workforce/RCEM%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf

How to collect: This data should be automatically populated by the ED IT system from the list of practitioners working in the Emergency Care Facility.

The IT system must ensure that it is easy to capture / document the **review** of a patient / patient plan by a *senior* decision-maker i.e. tier 3 and above.

Coding examples:

Scenarios	Guidance
A medical student is allocated to take a patient's history and perform an examination. Should the medical student be listed as care professional?	No, a medical student is not a registered practitioner legally allowed to practice independently, and so must always be supervised by a clinician who is certified to practice independently by an appropriate body e.g. GMC / NMC/ HCPC.
Patient seen by physician associate	As above
Patient seen by a F1 (intern) doctor	An F1 doctor is Tier 1
Patient seen by F2 doctor and discussed with ED consultant, before being seen in department by surgical registrar. Which of these interactions should be coded and at what grade?	Within the ED, both the trainee doctor (Tier 2) treating the patient and the senior reviewing ED consultant (Tier 5) would be recorded. The surgical referral would be captured in the referrals section and is not recorded in this section.
Patient seen by General Practitioner working in the ED	A GP working in the ED will normally be working at Tier 3 unless they have extended ED experience and scope of practice
Patient with back pain seen and discharged by physiotherapist working in ED facility as independent practitioner seeing only minor injuries.	The physiotherapist is working as an independent practitioner treating and discharging patients without supervision from other healthcare professionals and so should be recorded as the treating care professional. As the scope of practice is limited, this would be Tier 2
Child with fractured arm seen by senior nurse practitioner and who performs reduction of the fracture with sedation performed by a senior ED trainee.	The tier of the treating nurse practitioner would be 3, and the tier of the senior ED trainee is likely to be 4.

Table 37 Coding examples for Care Professionals

5.18.6 Care Professional Discharge Responsibility Indicator (Urgent and Emergency Care)

Definition: An indication of whether a care professional is responsible for discharge of the patient from an Emergency Care Attendance.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/care_professional_discharge_responsibility_indicator__emergency_care_.html

Justification: Recording the clinician(s) responsible for patient care is necessary for:

- Operational planning and clinical governance – ensuring that the right grade of clinician is responsible for the right acuity and complexity of patient load
- Workforce planning – ensuring that the right number of clinical staff are trained to satisfy the service need
- Training metrics – ensuring that trainees are exposed to a suitable case mix of patients to achieve an appropriate level of expertise in their field.
- Performance data. Time to see clinician is used as a performance/ quality metric in many healthcare systems.

This is a flag that identifies the clinician responsible for the patient's discharge. It will be this / these names that will appear on the patient discharge letter.

The discharging clinician is responsible for making sure that all treatment is complete, even if they did not initiate and conduct all treatment, and for completing coding and discharge documentation, see the coding examples below for more guidance.

How to collect: Only one clinician must be responsible for the patient's discharge. This data should be automatically populated by the ED IT system using the current responsible clinician, whichever is the earliest of:

EITHER

- the time the patient is discharged from the Emergency Care facility

OR

- when the GP discharge documentation is completed.

Coding examples:

Scenario	Guidance
An ED patient being managed by a nurse practitioner is reviewed by a registrar from an inpatient team, who advises that they will follow up the patient in outpatients and the patient is discharged.	Although advice has been given, the patient remains an ED patient and so the ED nurse practitioner is the discharging clinician.
An ED patient is discharged by an ED F2 doctor after having discussed with an ED consultant.	The junior doctor is the clinician completing the discharge documentation. The senior review is captured separately.
An ED physician associate (or ED F1 intern doctor) assesses a patient in the ED and the patient is reviewed by an ED registrar and a discharge plan is made.	The ED registrar is the discharging clinician as neither F1 doctors nor physician associates are legally allowed to discharge patients from care.

Table 38 Coding examples for Care Professional Discharge Coordinator

5.18.7 Care Professional Clinical Responsibility Timestamp

Definition: A Care Professional Clinical Responsibility Timestamp is the date, time and time zone when the Care Professional first became clinically responsible for the patient.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/care_professional_clinical_responsibility_timestamp.html

Justification: This timestamp shows the sequence and seniority of clinical decision-making during the patient's journey.

How to collect: Normally, this field should be populated automatically by the ED IT system whenever a new clinician first becomes involved in the patient's care episode. This may be when a clinician formally becomes responsible for the care of the patient, or when a clinician becomes involved in the care through other means such as conducting clinical observations.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.19 Data Group: Urgent and Emergency Care Diagnoses (SNOMED CT)

5.19.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of SNOMED CT coded Clinical Diagnoses.

Group status: 'Required'

This data group is a repeating group and the permitted occurrence of the data group, and all its individual elements are from a minimum of 0 to an unlimited maximum.

Justification: The diagnosis process is the central focus of the patient journey in the emergency department, and often the main reason a patient attends for care.

Recording and communicating an accurate diagnosis has been greatly facilitated by using a curated list limited of diagnoses introduced in 2017.

Consistent use of a diagnosis list has benefited clinical communication, commissioning, research and audit, and the data quality of diagnosis is one of the key data items measured by NHS England.

This data group provides the basis for reporting all emergency care diagnoses in order of relevance and with a level of (un)certainty. This is urgently needed to articulate trends in the level and nature of demand for urgent and emergency care.

5.19.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Urgent and Emergency Care Diagnosis (SNOMED CT)	min n6 max n18	M	SNOMED CT
Coded Clinical Entry Sequence Number	min n1 max n5	M	DM&D
Urgent and Emergency Care Diagnosis Qualifier (SNOMED CT)	min n6 max n18	M	SNOMED CT

Table 39 Data items in 'Urgent and Emergency Care Diagnoses (SNOMED CT)' Data Group

5.19.3 Urgent and Emergency Care Diagnosis (SNOMED CT)

Definition: Emergency Care Diagnosis (SNOMED CT) is the SNOMED CT concept ID which is used to identify the Patient Diagnosis.

Data Dictionary: URGENT AND EMERGENCY CARE DIAGNOSIS (SNOMED CT) (datadictionary.nhs.uk)

Justification: The diagnosis list used in ECDS has revolutionised the understanding of emergency care in England. Prior to implementing ECDS, the data quality for ED diagnosis was approximately 35% real diagnosis, the remainder being either absent, symptoms or vague diagnoses e.g. 'disease'.

ECDS v3.0 used a curated list of approximately 1000 SNOMED terms (ECDS Core Diagnoses) that had been refined over many years and millions of patients to ensure the terms are:

- **Exhaustive**: the data items are designed to cover all conditions commonly seen in EDs. Test: If a diagnosis condition had not been seen during the more than 50 clinician years, it was not included.
- **Exclusive**: for any given clinical situation, there should be one and only one best answer. Test: The correct code to choose should be obvious to a F2 doctor on their first day.
- There are **no symptoms** (e.g. back pain) presented as a diagnosis code.
- There are **no vague terms** ('unwell' / 'unspecified' / 'other').

The ECDS Enhanced Technical Output Specification, published on the NHS England website includes a full list of the ECDS Diagnoses Core codes, together with hierarchical and search terms that are designed to make it easy to find and aggregate individual diagnostic data items.

As at the ECDS v4.0 implementation date of 1st July 2023, there are approximately 1200 SNOMED codes in ECDS Diagnosis Core.

ECDS v4.0 introduces ECDS Diagnosis Max, a list of an additional c. 58,000 SNOMED codes, allowing more granularity and greater accuracy in recording diagnosis. A full list of these codes will be published on the ECDS guidance web pages and also the SUS website, together with the ECDS Core codes.

How to collect: Each diagnosis will be recorded by the treating clinician. It is recognised that no diagnosis list could capture every condition that might present to the ED, as in two coding examples:

- very rare conditions could occur e.g. pseudopseudohypoparathyroidism
- new diagnostic entities may evolve e.g. Zika virus, Covid-19

The diagnosis should be submitted according to the following protocol:

1. The clinician should search for the most appropriate diagnosis as represented in the approved ECDS diagnosis code set (whether from the ECDS Diagnosis Core or ECDS Diagnosis Max).
2. In 99.9% of patients, a diagnosis from the ECDS diagnosis code set will be the only diagnosis that a clinician will need to record.
3. The diagnosis that is submitted to SUS+ via ECDS must always be one from the ECDS diagnosis code set (whether from ECDS Diagnosis Core or ECDS Diagnosis Max).
4. If a more detailed diagnosis is required and is not in the approved ECDS diagnosis code set, the clinician should select a diagnosis that is the closest match (e.g. Endocrine condition (disorder) in the case of pseudopseudohypoparathyroidism) to that required and record the more detailed diagnosis in the patient local health record.
5. If a clinician makes a more detailed diagnosis that is not contained in the approved ECDS diagnosis code set, then this diagnosis must be communicated in the transfer of care documentation e.g. in the GP discharge letter.
6. If for any reason a diagnosis has been selected outside of the ECDS approved diagnosis code set and submitted as part of ECDS v4.0, the diagnosis will not be visible in the SUS+ platform except to the submitter and will not be made available to secondary users of the data (such as commissioners or researchers).
   Any data quality (DQ) reports provided by NHS England will report this as a DQ error and the provider will be notified that the data item is not in ECDS range.
   In this case, the clinician must inform NHS England that the diagnosis is missing from the ECDS diagnosis code set by enquiries@nhsdigital.nhs.uk. This will help in maintaining the code set to keep it in line with current practice.
7. In the event of new diagnosis categories that are needed before the SNOMED subset can be updated e.g. in a pandemic, then guidance may be issued to use one of the 'research' field (See Disease Outbreak Notification) to record relevant information.

Coding examples

Scenario	Guidance
Child attends ED with suspected ingestion of grandmother's prescribed medication.	Poisoning (suspected)
no injury or illness detected	No abnormality detected
Overdose of multiple drugs – beta blockers, sedatives (benzodiazepines) and alcohol, due to mental health issues	The diagnosis should be listed in order of clinical significance to the patient's care in the ED.
Learning difficulty	Long-term issues that are not materially involved in the acute patient episode but may still be relevant are captured in the Comorbidity section, not the diagnosis section.
Patient with complex housing issue that is felt to be exacerbating mental and physical health.	Social problem
Headache	'Headache' is a symptom not a diagnosis. Codes commonly used in this situation may be: tension headache, migraine or cluster headache.
Patients with chest pain, abdominal pain	'Chest pain' and 'abdominal pain are symptoms not diagnoses. When a 'confirmed' diagnosis is not possible, then a 'suspected' diagnosis should be used.

Scenario	Guidance
	The use of 'no abnormality detected' as a diagnosis has increased substantially with the introduction of ECDS. A presentation with chest pain, investigations of a d-dimer and CTPA and a final diagnosis of 'no abnormality detected' tells an accurate patient story that captures the value of the patient care in a way that a chief complaint and a diagnosis of chest pain does not.
Child with minor head injury – knocked out for 10 seconds playing football.	Minor head injury is now classified according to the length of time of loss of consciousness so we can better understand the effect of traumatic brain injury.

Table 40 Coding examples for 'Urgent and Emergency Care Diagnosis (SNOMED CT)'

Additional guidance for ECDS Diagnosis Max

A list of the diagnosis codes which can be submitted in ECDS to SUS+ is available in the 'ECDS Refset MAX Specification' on the NHSE ECDS guidance web page.

The valid diagnosis codes will also be updated to include the additional diagnosis codes published on the SUS+ web pages.

Choice of ECDS Diagnosis Core or ECDS Diagnosis Max

Both ECDS Diagnosis Core and ECDS Diagnosis Max are acceptable for population of the ECDS Diagnosis data item for any ECDS submission. The decision of which to implement within a UEC Activity Type should be made locally and is a clinical decision.

When to use ECDS Core:

ECDS Core was designed to help clinicians code consistently and quickly in areas of the Urgent Care system where there is rapid turnover of patients and has been adopted by the IT system suppliers to support this. It is therefore most appropriate to use in Type 1/2/3 Urgent and Emergency Care Activity Types.

When to use ECDS Max:

With the wider variety of patient conditions and more detailed investigations, depending on local configuration it is likely that clinical staff working in SDEC (UEC Activity Type 5) will prefer the ECDS Max, and the same is likely to be true for Hot Clinics (UEC Activity Type 7).

For UEC Activity Type 6, the same diagnosis code(s) (whether ECDS Diagnosis Core or ECDS Diagnosis Max) submitted in the triggering attendance and the final attendance should be submitted.

To support providers to implement either ECDS Diagnosis Core or ECDS Diagnosis Max, core codes are included in ECDS Diagnosis Max. Core codes can be easily identified in ECDS Diagnosis Max via the value of '1000' for the 'Sort4' column or value of '1000' for the last 4 digits of the 'ECDS_UniqueID'.

In addition, Core codes can also be identified by comparing the code values in the columns 'SNOMED_Code' and 'ECDS_MAX_Child_SNOMED_Code' in this file for the same row of data, where the code values are the same in both columns. (Please note that Core Codes which have been Deprecated cannot be identified in ECDS Diagnosis Max by the above two methods).

Additional definitions relevant for ECDS Diagnosis Max are available in the Document Guidance worksheet of the 'ECDS Refset MAX Specification'.

To support a 'mixed economy' of ECDS Diagnosis Max Child codes and ECDS Diagnosis Core Codes being able to be submitted, a mapping will be implemented in SUS+ to map child code diagnosis data to

parent code level diagnosis data to support analysis and use of ECDS data at a consistent level where needed.

If an ECDS Diagnosis Max child code has been submitted, then the parent code(s) do not need to be submitted in ECDS in addition to the child code unless the parent code diagnosis has also been made separately.

The data items 'Coded Clinical Entry Sequence Number' and 'Urgent and Emergency Care Diagnosis Qualifier (SNOMED CT) must also be completed in ECDS when submitting a diagnosis from ECDS Diagnosis Max.

To support a phased transition to ECDS v4.0, providers submitting CDS v6.2.3 Type 011 (ECDS v3.0) may submit ECDS Diagnosis Max codes for the data item EMERGENCY CARE DIAGNOSIS (SNOMED CT) if they are able to do so. If providers do this, they should have regard for and follow the rest of the user guidance which applies for ECDS Diagnosis Max.

5.19.4 Coded Clinical Entry Sequence Number

Definition: The sequence number of a Coded Clinical Entry, recorded to enable correct sequential processing of data.

Data Dictionary:
https://datadictionary.nhs.uk/data_elements/coded_clinical_entry_sequence_number.html

Justification: This enables the user to order the diagnoses in terms of significance, with the first diagnosis being the most important / significant.

How to collect: The Coded Clinical Entry Sequence Number should be assigned to each recorded diagnosis by the information system, and the diagnosis sequence must be clear for patients, staff and commissioners, as **usually only the primary diagnosis will be used for most commissioning / tariff / training / workforce purposes.**

5.19.5 Urgent and Emergency Care Diagnosis Qualifier (SNOMED CT)

Definition: Urgent and Emergency Care Diagnosis Qualifier (SNOMED CT) is the SNOMED CT concept ID which is used to express the level of certainty of a Patient Diagnosis recorded during an Urgent and Emergency Care Activity.

Data Dictionary: URGENT AND EMERGENCY CARE DIAGNOSIS QUALIFIER (SNOMED CT) (datadictionary.nhs.uk)

Justification: A qualifier enables users to express their certainty / lack of certainty regarding a diagnosis.

How to collect: Each diagnosis qualifier will be recorded by the treating clinician. The options are:

- **'Suspected'** diagnosis – should be used to capture situations where the threshold for proving a diagnosis is not met, and investigation and treatment are on-going.
- **'Confirmed'** diagnosis – should be used when the diagnosis is established beyond reasonable doubt.

A default value for the qualifier should **not** be used.

If a formal diagnosis is not made in the ED, e.g. for some Mental Health diagnoses, then the most relevant / likely diagnosis should be listed with the 'Suspected' qualifier.

5.20 Data Group: Urgent and Emergency Care Investigations (SNOMED CT)

5.20.1 Definition and Group Status for Data Group

Definition: To carry the details of SNOMED CT coded Clinical Investigations.

Group status: 'Required'

This data group is a repeating group and the permitted occurrence of the data group and all its individual elements are from a minimum of 0 to an unlimited maximum.

5.20.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Urgent and Emergency Care Clinical Investigation (SNOMED CT)	min n6 max n18	M	SNOMED CT
Coded Procedure Timestamp (Urgent and Emergency Care Clinical Investigation)	max an25	R	DM&D

Table 41 Data items in 'Urgent and Emergency Care Investigations (SNOMED CT)' Data Group

5.20.3 Urgent and Emergency Care Clinical Investigation (SNOMED CT)

Definition: Urgent and Emergency Care Clinical Investigation (SNOMED CT) is the SNOMED CT concept ID which is used to identify a Clinical Investigation performed while a Patient is under the care of an Urgent and Emergency Care Service.

Data Dictionary: URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION (SNOMED CT) (datadictionary.nhs.uk)

How to collect: This data item should capture the investigations performed while the patient is under the care of the Emergency Care facility.

Investigations should be captured accurately in sufficient detail for the patient record and mapped to an appropriate ECDS code for submission. In addition to this, the ECDS Technical User Guide explains how ECDS investigations are further mapped for tariff purposes.

5.20.4 Coded Procedure Timestamp (Urgent and Emergency Care Clinical Investigation)

Definition: Coded Procedure Timestamp (Urgent and Emergency Care Clinical Investigation) is the date, time and time zone a Clinical Investigation was performed during an Urgent and Emergency Care Activity.

Data Dictionary: CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE CLINICAL INVESTIGATION) (datadictionary.nhs.uk)

Justification: Date / Time stamps are routinely collected by current IT systems in order to track patient progress through the Emergency Care system.

They are used to help clinicians and managers optimise patient flow through the Emergency Care system e.g. by ensuring that patient blood samples, if needed, are taken soon after the patient arrives. These data items do not require any clinician input as they are collected when the blood tests are ordered, and therefore there is no clinical burden in collecting this information.

Collating this information and flowing it centrally will allow better benchmarking of emergency systems, ensuring optimum use of resources.

How to collect: The date and time should be populated by the information system when the investigation is undertaken by the clinician.

5.21 Data Group: Urgent and Emergency Care Treatments (SNOMED CT)

5.21.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of SNOMED CT coded Procedures.

Group status: 'Required'

This data group is a repeating group and the permitted occurrence of the data group and all its individual elements are from a minimum of 0 to an unlimited maximum.

5.21.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Urgent and Emergency Care Procedure (SNOMED CT)	min n6 max n18	M	SNOMED CT
Coded Procedure Timestamp (Urgent and Emergency Care Procedure)	an10 CCYY-MM-DD	R	DM&D

Table 42 Data items in 'Urgent and Emergency Care Treatments (SNOMED CT)' Data Group

5.21.3 Urgent and Emergency Care Procedure (SNOMED CT)

Definition: The treatments performed while the Patient is under the care of the Emergency Care facility.

Data Dictionary: EMERGENCY CARE PROCEDURE (SNOMED CT) (datadictionary.nhs.uk)

Justification: This data item is currently used to capture the procedures / treatments that are used to determine remuneration in the national Tariff system.

This data item is also communicated to the GPs in the discharge summary as it is important for the GP to understand what investigations and treatments have been performed.

How to collect: This data item should capture the procedures / treatments performed while the patient is under the care of the Emergency Care facility.

Treatments should be captured accurately in sufficient detail for the patient record and mapped to an appropriate ECDS code for submission. In addition to this, the ECDS Technical User Guide explains how ECDS treatments are further mapped for tariff purposes.

5.21.4 Coded Procedure Timestamp (Urgent and Emergency Care Procedure)

Definition: Coded Procedure Timestamp (Urgent and Emergency Care Procedure) is the date, time and time zone a patient procedure was performed during an Urgent and Emergency Care Activity.

Data Dictionary: CODED PROCEDURE TIMESTAMP (URGENT AND EMERGENCY CARE PROCEDURE) (datadictionary.nhs.uk)

Justification: Date / Time stamps are routinely collected by current IT systems in order to track patient progress through the Emergency Care system. They are used to help clinicians and managers optimise patient flow through the Emergency Care system e.g. by ensuring that patient blood samples, if needed, are taken soon after the patient arrives.

Collating this information and flowing it centrally will allow better benchmarking of emergency systems, ensuring optimum use of resources.

How to collect: The treatment date and time should be populated by the Information System when the treatment is undertaken by the clinician.

5.22 Data Group: Referrals to Other Services

5.22.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of referrals to other services.

Group status: 'Required'

This data group is a repeating group and the permitted occurrence of the data group and all its individual elements are from a minimum of 0 to an unlimited maximum.

Justification: This data group is necessary to understand and optimise the care process within emergency care. It captures information relating to inpatient services to which the patient was referred for admission or opinion by the treating clinician and the date / time of the referral(s).

This information is essential to plan bed capacity within the hospital and is also used by commissioners to understand patient flow.

Information regarding referral for an opinion is routinely collected by ED IT systems but does not flow centrally.

5.22.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Referred to Service (SNOMED CT)	min n6 max n18	R	SNOMED CT
Activity Service Request Timestamp (Urgent and Emergency Care)	max an25	M	DM&D
Referred to Service Assessment Timestamp	max an25	R	DM&D

Table 43 Data items in 'Referrals to Other Services' Data Group

5.22.3 Referred to Service (SNOMED CT)

Definition: Referred To Service (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the Service to which a Patient was referred for admission or opinion by the treating Care Professional.

Data Dictionary: REFERRED TO SERVICE (SNOMED CT) (datadictionary.nhs.uk)

Justification: This process data is necessary to understand and optimise the care process within emergency care.

IT systems 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 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.

How to collect: This data item should be captured alongside the date and time that the patient was first referred to the inpatient service for admission or opinion, this is irrespective of acceptance or otherwise by the relevant specialty.

This information will be auto populated by the IT system based on the clinical action to refer the patient to an inpatient or specialist unit.

An inpatient or specialist service to which the patient was referred by the treating clinician includes specialties that may be supra-regional e.g. burns, neurosurgery, spinal, trauma, vascular, stroke and cardiac / cardiothoracic and therefore may not be based in the same hospital.

If a patient is referred to Same Day Emergency Care, then this data item should be submitted as 898791000000105 Referral for ambulatory care (procedure).

If some of the services included in the ECDS Referred to Service code subset are not available, then the provider may want to remove such items from the code set used locally.

Coding examples

Scenario	Guidance
Patient referred to surgical team with suspected appendicitis.	Referral to general surgery
Patient with abdominal pain referred to surgical team who review and decide that it is a possible gynaecological diagnosis and refer to the gynaecology team.	First referral: general surgery Second referral: gynaecology
Patient referred to respiratory specialist nurse for review /advice Should this be coded as a referral?	The specialist nurse is a member of the respiratory medicine team, so the referral should be recorded as to 'respiratory medicine'

Table 44 Coding examples for 'Referred To Service (SNOMED CT)'

5.22.4 Activity Service Request Timestamp (Urgent and Emergency Care)

Definition: Activity Service Request Timestamp (Urgent and Emergency Care) is the date, time and time zone that a patient was referred to another service during an Urgent And Emergency Care Activity.

Data Dictionary: ACTIVITY SERVICE REQUEST TIMESTAMP (URGENT AND EMERGENCY CARE) (datadictionary.nhs.uk)

Justification: The date, time and time zone paired with the speciality of 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 urgent and emergency care.

How to collect: This is a DateTimeStamp. The date, time and time zone recorded is the time that the patient was referred to an inpatient or other service. The date, time and time zone of referral is taken irrespective of acceptance or otherwise by the relevant inpatient specialty or other service to which the referral has been made. This data item is captured automatically on an EPR system when a referral is made and in most systems this data is expected to be automatically captured in the background.

5.22.5 Referred to Service Assessment Timestamp

Definition: Referred to Service Assessment Timestamp is the Clinical Intervention Date, , Clinical Intervention Time and time zone a Patient was assessed by a Care Professional from a service to which the patient had been referred.

Data Dictionary: REFERRED TO SERVICE ASSESSMENT TIMESTAMP (datadictionary.nhs.uk)

Justification: ECDS has incorporated a timestamp for date of referral to inpatient / specialist services. When this was explored 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.

How to collect: The Referred to Service Assessment Timestamp is the date, time and time zone the clinician from the service to which the patient has been referred independently assesses the patient. The Referred to Service Assessment Timestamp is not the date, time and time zone at which the clinician from the relevant service starts reviewing the patient notes, radiology or pathology results. The Referred to Service Assessment Timestamp is expected to be captured automatically in most systems in the background and to ensure accuracy should not be able to be back-timed / back-dated.

If the patient is not independently assessed by the inpatient team/specialist service, this data item should not be completed.

5.23 Data Group: EMED3 Fit Note

Definition, Group Status and Justification for Data Group

Definition: To carry the details of the eMED3 Fit Note issued.

Group status: 'Required'

Justification: This group is designed to allow information about fit notes issued in secondary care to be submitted to ECDS, in support of the Information Standard 'DAPB4011: eMED3 (fit notes) in Secondary Care'.

Data Items in this Data Group

Data Element Name	Format	Status	Source
EMED3 Fit Note Assessment Date	R	an10 CCYY-MM-DD	DM&D
EMED3 Fit Note Condition (SNOMED CT)	R	min n6 max n18	SNOMED CT
EMED3 Fit Note Diagnosis (ICD)	R	min an4 max an6	DM&D
EMED3 Fit Note Start Date	R	an10 CCYY-MM-DD	DM&D
EMED3 Fit Note End Date	R	an10 CCYY-MM-DD	DM&D
EMED3 Fit Note Duration	R	max an3	DM&D
EMED3 Fit Note Recorded Date	R	an10 CCYY-MM-DD	DM&D
EMED3 Fit Note Follow Up Assessment Required Indicator	R	an1	DM&D
EMED3 Fit Note Issuer	R	an2	DM&D

Table 45 Data items in 'EMED3 Fit Note' Data Group

5.23.1 EMED3 Fit Note Assessment Date

Definition: An eMED3 Fit Note Assessment Date is the date on which a PATIENT was assessed as requiring an eMED3 Fit Note.

Data Dictionary: EMED3 FIT NOTE ASSESSMENT DATE

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: The care professional will note this at the time.

5.23.2 EMED3 Fit Note Condition (SNOMED CT)

Definition: EMED3 FIT NOTE CONDITION (SNOMED CT) is a SNOMED CT® concept identifier which is used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.

Data Dictionary: EMED3 FIT NOTE CONDITION (SNOMED CT)

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: TBC

5.23.3 EMED3 Fit Note Diagnosis (ICD)

Definition: EMED3 FIT NOTE DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to describe the reason that a CARE PROFESSIONAL issued an eMED3 Fit Note for a PATIENT.

Data Dictionary: EMED3 FIT NOTE DIAGNOSIS (ICD)

Justification: N/A see below.

How to collect: This data item was included for consistency with other NHS England data sets. ECDS does not use ICD codes in any other data group and values for this data item should not be submitted. Data for the item 'EMED3 Fit Note Condition (SNOMED CT)' should instead be submitted as above.

5.23.4 EMED3 Fit Note Start Date

Definition: EMED3 FIT NOTE START DATE is the date that the eMED3 Fit Note Applicable Period commenced.

Data Dictionary: EMED3 FIT NOTE START DATE

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: The care professional will note this at the time.

5.23.5 EMED3 Fit Note End Date

Definition: EMED3 FIT NOTE END DATE is the date that the eMED3 Fit Note Applicable Period ended.

Data Dictionary: EMED3 FIT NOTE END DATE

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: The care professional will note this at the time.

5.23.6 EMED3 Fit Note Duration

Definition: EMED3 FIT NOTE DURATION is the number of days duration of an eMED3 Fit Note Applicable Period.

Data Dictionary: EMED3 FIT NOTE DURATION

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: The care professional will note this at the time.

5.23.7 EMED3 Fit Note Recorded Date

Definition: An eMED3 Fit Note Recorded Date is the date on which a record of an eMED3 Fit Note issued to a PATIENT was recorded on the Health Care Provider's ELECTRONIC HEALTH RECORD.

Data Dictionary: EMED3 FIT NOTE RECORDED DATE

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: This is expected to be a system generated date.

5.23.8 EMED3 Fit Note Follow Up Assessment Required Indicator

Definition: An indication of whether a follow up CARE CONTACT is required at the end of the eMED3 Fit Note Applicable Period.

Data Dictionary: EMED3 FIT NOTE FOLLOW UP ASSESSMENT REQUIRED INDICATOR

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: The care professional will note this at the time.

5.23.9 EMED3 Fit Note Issuer

Definition: The type of care professional who issued the fit note.

Note: This item was not implemented at the ECDS v4.0 implementation date of 01 July 2023. It had been introduced to provide advance notice to data providers and system suppliers of the intention to report this item at a later date. The status of this data item has subsequently changed from 'X' (Pilot) to 'R' (Required). This change will be implemented from 1 April 2024 and this data item can be submitted from this date.

Data Dictionary: EMED3 FIT NOTE ISSUER

Justification: To align to the requirements of the Information Standard DAPB4011.

How to collect: This is expected to be captured by the system from the details for the care professional who issued the fit note.

The 5 valid code values which will be able to flow for this data item from 1 April 2024 are:

- '01' - Doctor
- '02' - Nurse
- '03' - Occupational therapist
- '04' - Pharmacist
- '05' - Physiotherapist

5.24 Data Group: Discharge from Urgent and Emergency Care

5.24.1 Definition, Group Status and Justification for Data Group

Definition: To carry the details of discharge from Urgent and Emergency Care.

Group status: 'Required'

Justification: This data group is necessary to understand resource needs and transfer of responsibility between different organisations.

This enables clear analysis of patient pathways through Emergency Care.

5.24.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Decided to Admit Date and Time	an19 YYYY-MM-DDThh:mm:ss	R	DM&D
Activity Treatment Function Code (Decision To Admit)	an3	R	DM&D
Urgent and Emergency Care Clinically Ready To Proceed Timestamp	max an25	R	DM&D
Urgent and Emergency Care Discharge Status (SNOMED CT)	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Activity End Timestamp	max an25	R	DM&D
Safeguarding Concern (SNOMED CT)	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Discharge Destination (SNOMED CT)	min n6 max n18	R	SNOMED CT
Organisation Site Identifier (Discharge From Urgent and Emergency Care)	min an5 max an9	R	ODS
Urgent and Emergency Care Discharge Follow Up (SNOMED CT)	min n6 max n18	R	SNOMED CT
Urgent and Emergency Care Discharge Information Given Indicator	an1	M	DM&D

Table 46 Data items in 'Discharge from Urgent and Emergency Care' Data Group

5.24.3 Decided to Admit Date and Decided to Admit Time

Definition: The Decided to Admit Date and Time is the decision to admit was made.

Data Dictionary:

DTA Date – DECIDED TO ADMIT DATE (datadictionary.nhs.uk)

DTA Time – DECIDED TO ADMIT TIME (datadictionary.nhs.uk)

Justification: Decision to admit is a key internal operational metric for staff **within** providers of emergency care.

Use of DTA in time calculations resulted in a perverse incentives to delay the time at which a 'decision to admit' was made, and this extended stay on a trolley resulted in harm to patients. Therefore 12 hour reporting is now from time of arrival in the ED, and this is consistent with reported metrics in Scotland / Wales and Northern Ireland.

ECDS v3.0 introduced the 'Clinically Ready To Proceed timestamp', which much more precisely defines when a patient has completed all the key care requirements in the emergency department and is therefore 'clinically ready to proceed' to either admission or discharge.

The 'Decision to Admit' data item is retained for ECDS v4.0 but is planned to be deprecated in April 2024 with the removal of the ED components of SitReps, and this will enable CRTP to become the single metric used to signify when ED treatment of a patient is complete.

How to collect: This is the date / time at which the ED staff treating the patient decided that the patient was not going to be able to be discharged back to the community from the ED and would need to be admitted.

The Decision to Admit:

- is a clinical decision by ED clinical staff based on assessment of patient needs
- occurs (and is recorded) irrespective of acceptance or otherwise by an inpatient specialty
- occurs (and is recorded) irrespective of the availability of a physical ward bed.

These data items should be auto populated by the IT system based on clinical action to admit the patient.

If a patient is admitted under the care of the ED in an observation ward, then it will be the date / time at which the decision is made to admit the patient to the observation unit.

NB. When the decision to admit is activated, the responsibility for the patient's care transfers to the inpatient unit consultant, as it is not possible for a patient to have more than one unit / consultant responsible for their care.

5.24.4 Activity Treatment Function Code (Decision to Admit)

Definition: Activity Treatment Function Code (Decision to Admit) is the Treatment Function Code of the service to which a patient is to be admitted.

Data Dictionary: ACTIVITY TREATMENT FUNCTION CODE (DECISION TO ADMIT) (datadictionary.nhs.uk)

Justification: This data item captures the inpatient service to which the patient will be admitted.

The data is necessary to understand patient flow accurately and is used in real time at a local level to be able to plan inpatient bed management.

At a commissioning level this data allows commissioners to link patient records and 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.

How to collect: The codes used are the Treatment Function Codes used in other CDS Types.

This information will be captured in the background by the IT system and will be triggered by clinical staff upon deciding to admit the patient.

5.24.5 Urgent And Emergency Care Clinically Ready to Proceed Timestamp

Definition: An Urgent and Emergency Care Clinically Ready to Proceed Timestamp is the **first** date and time that the Care Professional, authorised to discharge the Patient from the Emergency Care Attendance or Same Day Emergency Care Attendance, makes a **clinical** decision that the Patient no longer requires ongoing care in the Emergency Care Department or Same Day Emergency Care premises.

The Patient will have one of the following outcomes:

- admitted to a Ward
- transferred to a designated Department / clinical service area outside the Emergency Care Department but within the same Health Care Provider
- transferred to another Health Care Provider for continuation of care
- discharged from the Emergency Care Department.

Data Dictionary: Urgent and Emergency Care Clinically Ready To Proceed Timestamp (datadictionary.nhs.uk)

Justification: Capturing this data helps ensure that patients who require admitting are moved to an appropriate inpatient bed as quickly as possible to support good flow through the UEC system or discharged as appropriate.

This is an important milestone in the patient journey because it defines when the Emergency Medicine care is complete. Any delay after this point is potentially avoidable.

Historically this milestone was measured by the 'Decision to Admit', however this no longer reflects clinical practice, as the 'decision to admit' does not reflect a patient's physiological stability, pain control etc as some patients (e.g. a patient with a fractured neck of femur can have a decision to admit based on clinical assessment but they still require analgesia and an X-ray)

How to collect: Clinically Ready to Proceed is a single timestamp recorded at the first instance that the treating clinician decides that the patient is clinically stable and therefore ready to go to one of the options described above.

A patient may have investigations and / or treatments that have been requested by Emergency Department clinicians e.g. CT scan. This does not mean that the patient is not 'Clinically Ready to Proceed'.

Clinically Ready to Proceed is collected for all patients, admitted and discharged.

For patients who are discharged without Clinically Ready to Proceed being completed (i.e. physically leave the ED within 10 minutes of being discharged by the Clinician), then the CRTP time/date should be auto-entered as the discharge time/ date.

If there is any disagreement as to whether a patient is Clinically Ready to Proceed, the only arbiter is the most senior Emergency Clinician by Tier in the Emergency Department at that time, sometimes defined as the 'Admitting Officer'.

Notes: For details on how to populate a Timestamp, please see Table 2 in Section 5.1.2

5.24.6 Urgent and Emergency Care Discharge Status (SNOMED CT)

Definition: Urgent and Emergency Care Discharge Status (SNOMED CT) is the SNOMED CT concept ID which is used to indicate the status of the patient on discharge from an Urgent and Emergency Care Activity.

Data Dictionary: URGENT AND EMERGENCY CARE DISCHARGE STATUS (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

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.

This data item and its counterparts Urgent and Emergency Care Discharge Destination (SNOMED CT) and Urgent and Emergency Care Discharge Follow-up (SNOMED CT) are necessary to understand resource needs and transfer of responsibility between different organisations.

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.

How to collect: This information will be captured by clinical staff upon discharging the patient.

Where the Urgent and Emergency Care Discharge Status (SNOMED CT) equals '1066301000000103 – Left before initial assessment / Left care setting before initial assessment' then the Emergency Care Diagnosis must be equal to '185330002 – left before clinical assessment'.

Where the Urgent and Emergency Care Discharge Status (SNOMED CT) equals '63238001 - Dead on arrival / Dead on arrival at hospital' then the Urgent and Emergency Care Diagnosis (SNOMED CT) must be equal to '812481000000104 - Dead on arrival'.

ECDS_Description	SNOMED_Code	SNOMED_Description
Left before initial assessment	1066301000000103	Left care setting before initial assessment
Left after assessment with intent to attend other healthcare provider	1066311000000101	Left care setting after initial assessment

ECDS_Description	SNOMED_Code	SNOMED_Description
Left after assessment but before treatment complete (destination unknown)	1066321000000107	Left care setting before treatment completed
Dead on arrival	63238001	Dead on arrival at hospital

Table 47 Coding examples for 'Urgent and Emergency Care Discharge Status (SNOMED CT)'

5.24.7 Urgent and Emergency Care Activity End Timestamp End Timestamp

Definition: An Urgent and Emergency Care Activity End Timestamp is the date and that a patient leaves an Emergency Care Department after an Urgent And Emergency Care Activity has concluded.

Data Dictionary:

Urgent and Emergency Care Activity End Timestamp (datadictionary.nhs.uk) **Justification:** This defines the end of the patient care in the Emergency Care facility and therefore is essential to calculate the elapsed time spent in the facility from patient arrival.

The elapsed time is the single most cited key performance indicator for Emergency Care that is calculated – the four-hour standard of care, which is defined as from patient arrival to departure.

How to collect:

An Urgent and Emergency Care Activity End Timestamp is the date and time that a PATIENT leaves the Emergency Care Department after an Urgent and Emergency Care Activity has concluded.

- For an Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity End Timestamp is the same as the Emergency Care Departure Date and the Emergency Care Departure Time.
- For an Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity End Timestamp is the date and time that contact with the PATIENT is completed and the virtual Emergency Care Attendance concludes.
- For a Same Day Emergency Care Attendance where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Face to face', the Urgent and Emergency Care Activity End Timestamp is the date and time that the PATIENT left the Same Day Emergency Care Service.
- For a Same Day Emergency Care Attendance undertaken virtually (where the CONSULTATION MECHANISM (URGENT AND EMERGENCY CARE) is National Code 'Telephone', 'Video Consultation' or 'Chat Room (Synchronous)'), the Urgent and Emergency Care Activity End Timestamp is the date and time that contact with the PATIENT is completed and the virtual Same Day Emergency Care Attendance concludes.
- For an Urgent and Emergency Care Extended Care Episode the Urgent and Emergency Care Activity End Timestamp is the date and time that the Urgent and Emergency Care Extended Care Episode closes.

Notes:

- For PATIENTS who die during an Emergency Care Attendance or Same Day Emergency Care Attendance (or dead on arrival), the Urgent and Emergency Care Activity End Timestamp is the date the body was removed from the Urgent and Emergency Care Service premises
- The PATIENT may leave the Urgent and Emergency Care Service temporarily during an Urgent and Emergency Care Activity, for example for an X-ray, but they remain under the care of a CONSULTANT in the Urgent and Emergency Care Service.

5.24.8 Safeguarding Concern (SNOMED CT)

Definition: 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.

Data Dictionary: SAFEGUARDING CONCERN (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

The Safeguarding Concern SNOMED subset was developed in conjunction with the NHS England Safeguarding team and specialty colleges e.g. Royal College of Paediatrics and Child Health and Royal College of Emergency Medicine to allow clinicians to record their concerns about patient welfare in a structured manner.

How to collect: Within the ED IT system, the list should be headed 'Safeguarding issues / follow-up required'. This data item does not imply that there is necessarily a problem. Rather, it allows clinicians to identify patients where:

- there are concerns regarding the patient's welfare or that of other vulnerable persons
- there are identified risks to the patient's welfare or other vulnerable persons
- there is evidence of harm to the patient or other vulnerable persons.

Recording a safeguarding concern does not imply that there is necessarily a significant safeguarding issue rather that the clinician has identified the need for more information and that follow-up is necessary to ensure the welfare of the patient or other potentially vulnerable individuals.

The question should be phrased as:

'Follow-up is requested regarding concerns of ED staff regarding specific safeguarding concern from ECDS SNOMED CT subset.'

The safeguarding data item of ECDS **must** be completed before a patient leaves the department, unless the patient leaves the care facility before care is completed.

In the case that a patient leaves the care facility before care is completed, the Safeguarding item must still be completed, as these individuals are more likely than the general ED population to have safeguarding issues.

5.24.9 Urgent and Emergency Care Discharge Destination (SNOMED CT)

Definition: Urgent and 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 an Urgent and Emergency Care Activity.

Data Dictionary: URGENT AND EMERGENCY CARE DISCHARGE DESTINATION (SNOMED CT) (datadictionary.nhs.uk)

Justification: The physical destination of the patient is used to understand the patient's journey and, at the most basic level, whether they are admitted to hospital or discharged.

In addition, it also collects information about the care level of the ward in which the patient is admitted e.g. Intensive Care Unit / High Dependency Unit. This is very useful to understand patterns of acuity, especially at a high level or if services are under severe pressure e.g. pandemic / disaster.

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.

How to collect: This information will be captured by clinical staff upon discharging the patient and will generally be coded in the background e.g. discharge to 'Oak Ward' will be coded as 'Admitted – ward bed outside ED'.

Coding examples

Scenario	Guidance
13-year-old male attends with suspected torsion of testis. Paediatric Surgery is not provided at the hospital of attendance, so the patient is transferred as an emergency to another hospital.	Patient transfer to another health care facility
Patient brought to ED unconscious but wakes up and becomes increasingly aggressive and assaults a member of staff. After excluding conditions requiring acute medical or psychiatric intervention, the patient is removed by police.	Discharge to police custody
Patient did not wait to be seen in ED. How should we code his discharge?	The ED system should be set up so that if a patient leaves before being seen, it is not necessary to input a Discharge Destination. If the EC Discharge Status = left before seen / left before treatment complete, the record will be valid with a null value in ED Discharge Destination.
A patient who normally resides in a nursing home attends ED and is treated and discharged back to the nursing home.	Residential care facility with 24 hour nursing care (e.g. nursing home)

Table 48 Coding examples for 'Urgent and Emergency Care Discharge Destination (SNOMED CT)'

5.24.10 Organisation Site Identifier (Discharge from Urgent and Emergency Care)

Definition: Organisation Site Identifier (Discharge from Urgent and Emergency Care) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE to which a PATIENT is discharged following Urgent and Emergency Care Activity.

Data Dictionary: ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE) (datadictionary.nhs.uk)

Justification: 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.

How to collect: This information should only be recorded where Emergency Care Discharge Destination is code '19712007 – Transfer to another hospital / Patient transfer to another health facility', irrespective of whether or not the patient is admitted at the sending hospital e.g. to Short Stay / CDU / Observation ward.

This information should be entered by clerical staff in order to complete the patient record.

Clerical staff will enter the name of the transfer organisation which will auto-populate the organisations ODS code e.g. Cambridge University Hospitals NHS Foundation Trust = 'RGT'

5.24.11 Urgent And Emergency Care Discharge Follow Up (SNOMED CT)

Definition: Urgent and 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 Urgent and Emergency Care Activity.

Data Dictionary: URGENT AND EMERGENCY CARE DISCHARGE FOLLOW UP (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

The follow up options specified in this coded / structured section would normally be complemented by free text in the clinical narrative that would be sent to the GP. This is particularly important when the follow up requires more detail or specific / unusual consideration.

How to collect: This information will be captured by clinical staff upon discharging the patient. This will usually be via a list of local options for follow up e.g. fracture clinic / DVT clinic which will then be coded to the relevant options in the ECDS list.

Coding examples:

Scenario	Guidance
Patient admitted to inpatient bed	No coding required for this data item
Patients who die in the department	No coding required for this data item
Patient is having follow-up in outpatients and their GP; what do we code?	Referral to outpatient department

Table 49 Coding examples for 'Urgent and Emergency Care Discharge Follow-up (SNOMED CT)'

5.24.12 Urgent and Emergency Care Discharge Information Given Indicator

Definition: Urgent and Emergency Care Discharge Information Given Indicator is used to identify whether a copy of a letter to their GENERAL PRACTITIONER has been given to the PATIENT on discharge from an Urgent And Emergency Care Service**.**

Data Dictionary:

URGENT AND EMERGENCY CARE DISCHARGE INFORMATION GIVEN INDICATOR (datadictionary.nhs.uk)

Justification: This is designed to ensure that the patient is provided with a physical, printed copy of the letter to the GP. This minimises the risk of miscommunication and ensures that the patient always has a written follow-up plan. There are many reasons to include this item:

- giving the patient a copy of the discharge letter
- 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.
- Ensures that the clinician does not write anything in the GP letter that they would not want the patient to read.
- Allows the clinician to go 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.
- It ensures the doctor has entered all the relevant clinical information before the patient leaves.

Note: 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.

While an electronic copy may also be provided e.g. through a patient portal, a paper copy allows all patients to access this information, and if necessary, to share it with other parties e.g. to help the patient understand items within it, and this is particularly important if there are barriers to communication.

How to collect: Answers the question:

"Has the GP a letter been printed and given to the patient?"

The field should be auto populated e.g. auto ticked when the GP letter is generated by the system.

It should be possible to override (e.g. un-tick) this if the letter is not given to the patient.

5.25 Data Group: Research and Disease Outbreak Notification

5.25.1 Definition and Group Status for Data Group

Definition: To carry details of any Research and / or Disease Outbreak Notifications.

Group status: 'Optional'

5.25.2 Data Items in this Data Group

Data Element Name	Format	Status	Source
Clinical Trial Identifier	max an20	O	DM&D
Disease Outbreak Notification Description	max an20	R	DM&D
Disease Outbreak Notification (SNOMED CT)	min n6 max n18	R	SNOMED CT

Table 50 Data items in 'Research and Disease Outbreak Notification' Data Group

5.25.3 Clinical Trial Identifier

Definition: A unique identifier assigned to a clinical trial.

Data Dictionary: CLINICAL TRIAL IDENTIFIER (datadictionary.nhs.uk)

Justification: Nearly all research in Emergency Care in the UK is government funded, and therefore data collection and aggregation are an important direct cost for any research.

At present, the customisation of any software to aggregate the results of patient recruitment into clinical trials is a significant barrier and cost to such research. Inability to do research harms the NHS' ability to better understand emergency care and commission care that meets patient needs.

Promoting research 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.

Multi-centre trials are particularly important because they increase the reliability of the research – the results are much more likely to be robust and applicable across a wide range of hospitals, and therefore the research itself is much more cost-effective.

By including this field, the data set will address key National Institute of Health Research (NIHR) priorities for efficient research design[30].

Researchers will be able to collect patient data from one or more organisations and / or sites.

How to collect: The IT system should provide the ability to enter a trial identifier which is recognised and registered with an organisation which is a Primary Registry in the WHO[31] International Clinical Trials Registry Platform[32].

The Clinical Trial Identifier is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised organisations or individuals.

5.25.4 Disease Outbreak Notification Description

Definition: Disease Outbreak Notification Description is used in CDS V6-2-3 Type 011 – Emergency Care Commissioning Data Set to support the collection of nationally notifiable data relating to outbreaks of disease, which are identified in Emergency Care Departments, where a SNOMED CT CODE is NOT available.

[30] www.nihr.ac.uk/about-us/our-contribution-to-research/how-we-are-improving-research/adding-value-in-research.htm

[31] World Health Organisation www.who.int/en/ or World Health Organisation (datadictionary.nhs.uk)

[32] Primary Registries in the WHO International Clinical Trials Registry Platform https://www.who.int/clinical-trials-registry-platform/network/primary-registries

Disease Outbreak Notification Description is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised Organisations or individuals.

Data Dictionary: DISEASE OUTBREAK NOTIFICATION DESCRIPTION (datadictionary.nhs.uk)

Justification: This data item supports collection of nationally notifiable data relating to outbreaks of disease which are identified in Emergency Care Departments.

Ability to capture and flow data regarding major public health threats will enable research into and rapid response with automatic data aggregation, which will save significant time at a local and national level. This will enable scarce resources to be concentrated on patient care rather than on collecting / transmitting / aggregating and reporting data.

How to collect: Where a SNOMED CT code is available, the Disease Outbreak Notification (SNOMED CT) field should contain this. If a SNOMED CT code is NOT available, then it will be permissible to submit locally agreed codes as specified by Public Health officials in this field.

5.25.5 Disease Outbreak Notification (SNOMED CT)

Definition: Disease Outbreak Notification (SNOMED CT) is the SNOMED CT concept ID describing nationally notifiable outbreaks of disease.

Disease Outbreak Notification (SNOMED CT) is collected for a specified purpose at national level only and will not be available from the Secondary Uses Service for use by unauthorised Organisations or individuals.

Data Dictionary: DISEASE OUTBREAK NOTIFICATION (SNOMED CT) (datadictionary.nhs.uk)

Justification: 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.

How to collect: Where a SNOMED CT code is available, the Disease Outbreak Notification (SNOMED CT) field should contain this.

Appendix A – Data Item Overview

This was previously removed the User Guidance to ensure accuracy and reduce maintenance costs. For a complete overview of the Data Set, please view the Data Set Summary tab within the Technical Output Specification.

Appendix B – Data Group Overview

The below table gives an overview of all the data groups in ECDS v4.0:

Structure / Group ID	Structure / Group Name	Tab Name	Structure / Group Description	Structure / Group Mandation	Structure / Group Repeats
011001-011003	PATIENT IDENTITY	5. PATIENT IDENTITY	To carry the Identity of the Patient.	M	1..1
11001	PATIENT IDENTITY - WITHHELD IDENTITY STRUCTURE	5. PATIENT IDENTITY	To carry the Identity of the Patient.	M	1..1
11002	PATIENT IDENTITY - VERIFIED IDENTITY STRUCTURE	5. PATIENT IDENTITY	To carry the Identity of the Patient.	M	1..1
11003	PATIENT IDENTITY - UNVERIFIED IDENTITY STRUCTURE	5. PATIENT IDENTITY	To carry the Identity of the Patient.	M	1..1
11004	PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE)	6. PATIENT CHARACTERISTICS	To carry the characteristics of the Patient for Urgent and Emergency Care Activity.	R	0..1
11005	PATIENT CHARACTERISTICS (URGENT AND EMERGENCY CARE) - SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)	7. SOCIAL AND PERSONAL CIRCUMST	To carry the details of the SNOMED CT coded Social and Personal Circumstances for the Patient.	R	0..*
11006	MENTAL HEALTH ACT LEGAL STATUS	8. MENTAL HEALTH ACT	To carry the patients Mental Health Act Legal Status.	R	0..*
11007	GP REGISTRATION	9. GP REGISTRATION	To carry the Patient's General Medical Practitioner and the General Practice details.	R	0..1
11008	URGENT AND EMERGENCY CARE ACTIVITY LOCATION	10. ATTENDANCE LOCATION	To carry the details of the Urgent and Emergency Care Activity location.	M	1..1
11009	AMBULANCE DETAILS	11. AMBULANCE DETAILS	To carry ambulance details relating to the patients arrival at Emergency Care.	R	0..1
11010	EXPECTED DATE AND TIME OF TREATMENT	12. EXPECTED DATE & TIME OF TRE	To carry the expected date and time of treatment given to the patient.	R	0..1
11011	URGENT AND EMERGENCY CARE ACTIVITY CHARACTERISTICS	13. ATTENDANCE ACTIVITY	To carry the characteristics of the Urgent and Emergency Care Activity.	M	1..1
11012	ASSESSMENT TOOL GROUP (SNOMED CT)	14. ASSESSMENT TOOL	To carry the details of the SNOMED CT coded Assessment Tools for the Patient.	R	0..*
11013	OBSERVATION GROUP (SNOMED CT)	15. CODED CLINICAL OBSERVATIONS	To carry the details of the SNOMED CT coded Clinical Observations for the Patient.	R	0..*
11014	FINDING GROUP (SNOMED CT)	16. CODED CLINICAL FINDINGS	To carry the details of the SNOMED CT coded	R	0..*

Structure / Group ID	Structure / Group Name	Tab Name	Structure / Group Description	Structure / Group Mandation	Structure / Group Repeats
			Clinical Findings for the Patient.		
11015	INJURY CHARACTERISTICS	17. INJURY CHARACTERISTICS	To carry the details of injuries.	R	0..1
11016	PATIENT CLINICAL HISTORY	18. PATIENT CLINICAL HISTORY	To carry patient clinical history details.	R	0..1
11017	SERVICE AGREEMENT DETAILS	19. SERVICE AGREEMENT DETAILS	To carry the details of the Provider, Commissioners and Service Agreements.	M	1..1
11018	CARE PROFESSIONALS (URGENT AND EMERGENCY CARE)	20. CARE PROFESSIONALS	To carry the details of the Care Professionals active during the Urgent and Emergency Care Activity.	R	0..*
11019	URGENT AND EMERGENCY CARE DIAGNOSES (SNOMED CT)	21. DIAGNOSIS	To carry the details of SNOMED CT coded Clinical Diagnoses.	R	0..*
11020	URGENT AND EMERGENCY CARE INVESTIGATIONS (SNOMED CT)	22. INVESTIGATIONS	To carry the details of SNOMED CT coded Clinical Investigations.	R	0..*
11021	URGENT AND EMERGENCY CARE TREATMENTS (SNOMED CT)	23. TREATMENTS	To carry the details of SNOMED CT coded Procedures.	R	0..*
11022	REFERRALS TO OTHER SERVICES	24. REFERRALS TO OTHER SERVICES	To carry the details of referrals to other services.	R	0..*
11023	EMED3 FIT NOTE	25. EMED3 FIT NOTE	To carry the details of EMED3 Fit Note issued.	R	0..1
11024	DISCHARGE FROM URGENT AND EMERGENCY CARE	26. DISCHARGE	To carry the details of discharge from Urgent and Emergency Care.	R	0..1
11025	RESEARCH AND DISEASE OUTBREAK NOTIFICATION	27. RESEARCH & DISEASE OUTBREAK	To carry details of any Research and/or Disease Outbreak Notifications.	R	0..1
1001	ECDS V4 Type 001 - CDS Interchange Header	29. CDS Interchange Header	To define the mandatory identity and addressing information for a Commissioning Data Set submission.	M	1..1
2001	ECDS V4 Type 002 - CDS Interchange Trailer	30. CDS Interchange Trailer	To define the mandatory identity and addressing information for a Commissioning Data Set submission.	M	1..1
3001	ECDS V4 Type 003 - CDS Message Header	31. CDS Message Header	To define the mandatory identity and addressing information for a Commissioning Data Set submission.	M	1..1
4001	ECDS V4 Type 004 - CDS Message Trailer	32. CDS Message Trailer	To define the mandatory identity and addressing information for a Commissioning Data Set submission.	M	1..1
005B001	ECDS V4 Type 005B - CDS Transaction	33. CDS Trans Header BULK	To carry Commissioning Data Set identification and addressing data and other	M	1..1

Structure / Group ID	Structure / Group Name	Tab Name	Structure / Group Description	Structure / Group Mandation	Structure / Group Repeats
	Header Group - Bulk Update Protocol		data indicating the specific use of the Bulk Replacement Update Mechanism of the Commissioning Data Set Submission Protocol.		
005N001	ECDS V4 Type 005N - CDS Transaction Header Group - Net Change Protocol	34. CDS Trans Header NET	To carry Commissioning Data Set identification and addressing data and other data indicating the specific use of the Net Change Update Mechanism of the Commissioning Data Set Submission Protocol.	M	1..1

Appendix C – NEWS2, UEC Pain Scale, 4AT score and CFS worked example

Scenario: 78y/o female attends with chest pain on breathing. She undergoes an initial assessment at 15:23 on 01/08/2023, which includes measuring vital signs, calculating a NEWS-2 score, calculating a 4AT score, measuring her pain, and assessing her Clinical Frailty Score. She is not known to have a history of type 2 respiratory failure.

Observations

- Respiratory rate: 30/min – NEWS-2 score of 3
- Peripheral oxygen Saturation: 93% – NEWS-2 score of 2
- Systolic blood pressure: 130 mmHg – NEWS-2 score of 0
- Heart rate: 115 beats per minute – NEWS-2 score of 2
- Consciousness level: Alert – NEWS-2 score of 0
- Temperature: 38.2°C – NEWS-2 score of 1
- She is breathing air – NEWS-2 score of 0
- Total NEWS-2 score 8
- Pain score is 1/3

Delirium using the 4AT Score

1. She was alert (0/4 in 4AT)
2. She made one mistake when asked to name her age, date of birth and place (name of the hospital), and current year (1/4 in 4AT)
3. She started but was unable to complete seven months when asked to say the months of the year backwards (1/4 in 4AT)
4. There was no evidence of significant change or fluctuation in alertness, cognition or other mental functions in the preceding 2 weeks (0/4 in 4AT)

Clinical Frailty Score

Two weeks prior to assessment, she was not dependent on others for daily help, but symptoms associated with chronic problems such as osteoarthritis meant that her activities were often limited. She walked with a stick and had done for some time. Her Rockwood Clinical Frailty Scale was assessed as 4.

Assessment Tool Group

Her six clinical observations and the fact she is breathing room air each generate a NEWS-2 component score, the total NEWS-2 score, her pain score, 4AT score and CFS should be submitted as 33 values in 3 data items which use 11 CODED ASSESSMENT TOOL TYPES.

CODED ASSESSMENT TOOL TYPE (SNOMED CT)		PERSON SCORE	ASSESSMENT TOOL VALIDATION TIMESTAMP
SNOMED_Fully_Specified_Name	**SNOMED_Code**		
Royal College of Physicians National Early Warning Score 2 - respiration rate score (observable entity)	**1104301000000104**	**3**	**2023:08:01T15:23:00+01:00**
Royal College of Physicians National Early Warning Score 2 - oxygen saturation scale 1 score (observable entity)	**1104311000000102**	**2**	**2023:08:01T15:23:00+01:00**

Royal College of Physicians National Early Warning Score 2 - air or oxygen score (observable entity)	1104331000000105	0	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - systolic blood pressure score (observable entity)	1104341000000101	0	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - pulse score (observable entity)	1104351000000103	2	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - consciousness score (observable entity)	1104361000000100	0	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 - temperature score (observable entity)	1104371000000107	1	2023:08:01T15:23:00+01:00
Royal College of Physicians National Early Warning Score 2 total score (observable entity)	1104051000000101	8	2023:08:01T15:23:00+01:00
Verbal Rating Scale pain intensity score (observable entity)	1144798005	2	2023:08:01T15:23:00+01:00
4 A's Test for delirium and cognitive impairment score (observable entity)	1239211000000103	2	2023:08:01T15:23:00+01:00
Canadian Study of Health and Aging Clinical Frailty Scale score (observable entity)	763264000	4	2023:08:01T15:23:00+01:00

Coded Clinical Observations Group

Her six CODED CLINICAL OBSERVATIONS should be submitted as 24 values in 4 data items using 6 CODED OBSERVATION.

CODED OBSERVATION (SNOMED CT)		OBSERVATION VALUE	UNIT OF MEASUREMENT (UCUM)	CODED OBSERVATION TIMESTAMP
SNOMED_Fully_Specified_Name	SNOMED_CT code			
Respiratory rate (observable entity)	86290005	30	/min	2023:08:01T15:23:00+01:00
Hemoglobin saturation with oxygen (observable entity)	103228002	93%	%	2023:08:01T15:23:00+01:00
Systolic arterial pressure (observable entity)	72313002	130	mmHg	2023:08:01T15:23:00+01:00
Heart rate measured at systemic artery (observable entity)	78564009	115	/min	2023:08:01T15:23:00+01:00
Alert Confusion Voice Pain Unresponsive scale score (observable entity)	1104441000000100	Alert	A	2023:08:01T15:23:00+01:00
Core body temperature (observable entity)	276885007	38.2	°C	2023:08:01T15:23:00+01:00

Coded Clinical Finding Group

The fact that she is breathing air should be submitted in the DATA GROUP 'FINDING GROUP (SNOMED CT)' as below, in addition to the data submitted in the 'ASSESSMENT TOOL GROUP (SNOMED CT)'.

CODED FINDING (SNOMED CT)		CODED FINDING TIMESTAMP
SNOMED_Fully_Specified_Name	SNOMED_Code	
Breathing room air (finding)	722742002	2023:08:01T15:23:00+01:00

IMPORTANT NOTICE re Rockwood Clinical Frailty Score data

Note that in ECDS v4, there are two ways to submit the CFS: as a CODED ASSESSMENT TOOL TYPE (SNOMED CT), or as a CODED FINDING (SNOMED CT). **It is preferable to submit as a CODED ASSESSMENT TOOL TYPE (SNOMED CT) because in future iterations of ECDS it will not be possible to submit CFS as CODED FINDING (SNOMED CT),** however currently either can be used. Sites should never submit using both methods. In this example, her Rockwood Clinical Frailty Score is 4. 2 values should be submitted in 2 data items using 1 CODED FINDING.

CODED FINDING (SNOMED CT)		CODED FINDING TIMESTAMP
SNOMED_Fully_Specified_Name	SNOMED_Code	
Canadian Study of Health and Aging Clinical Frailty Scale level 4 - vulnerable (finding)	1129361000000106	2023:08:01T15:23:00+01:00

Appendix D – Example scenarios to show data to be submitted.

Published as a separate document to aid ease of reading.

Appendix E – Further guidance for Same Day Emergency Care.

Guidance on completion of data items in patients attending SDEC:
URGENT AND EMERGENCY CARE ARRIVAL MODE (SNOMED CT) – “Arrival Mode” and,
URGENT AND EMERGENCY CARE ATTENDANCE SOURCE (SNOMED CT) – “Attendance Source”

The value in Arrival Mode and Attendance Source must reflect the mode of transport that the patient arrived in SDEC and the referral to SDEC, rather than any immediately preceding UEC Activity Type. This means if a patient is transferred from ED to SDEC (whether streamed or seen definitively in ED), regardless of the mode of arrival or referral source to ED, the Arrival Mode to SDEC should be “Arrival by own transport (finding)” and the Attendance Source should be “Referred by hospital emergency department (finding)”. Although technically the patient may not always have walked from ED to SDEC (they may have been pushed in a wheelchair etc), “Arrival by own transport (finding)” is the most appropriate for use in this use case.

Examples:

1. Patient arrives in SDEC from ambulance service; a single ECDS record, Type 5, Arrival Mode = Arrival by emergency road ambulance (finding), Attendance Source = Referred by ambulance service (finding)

2. Patient attends ED after calling an ambulance and is streamed to SDEC; two ECDS records:
    a. ‘Streaming’ Type 1, Arrival Mode = Arrival by emergency road ambulance (finding), Attendance Source = Referred by self (finding)
    b. Full Type 5, Arrival Mode = Arrival by own transport (finding), Attendance Source = Referred by hospital emergency department (finding)

3. Patient attends ED by ambulance which was called by a GP after a GP consultation, is seen in ED, then transferred directly to SDEC; two ECDS records:
    a. Full Type 1, Arrival Mode = Arrival by emergency road ambulance (finding), Attendance Source = Referred by member of Primary Health Care Team (finding)
    b. Full Type 5, Arrival Mode = Arrival by own transport (finding), Attendance Source = Referred by hospital emergency department (finding)