Title	Diagnostic Imaging Data Set (DIDS) Guidance Document v6.0		
Document ID	SCCI1577 (Amd 10/2011 initial standard)		
Sponsor	Matt Fagg	**Status**	Final
Developer	Nicola Dawes	**Version**	6.0
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Diagnostic Imaging Data Set (DIDS) Guidance Document

Published October 2016

Information and technology
for better health and care

SCCI Standardisation Committee for Care Information

This information standard (SCCI1577) has been approved for publication by NHS England under section 250 of the Health and Social Care Act 2012.

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

This information standard comprises the following documents:

- Requirements Specification
- Implementation Guidance.

An Information Standards Notice (SCCI1577 Amd 10/2011) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

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

Date of publication: 5 October 2016

Document management

Revision History

Version	Date	Summary of Changes
0.1	13/12/2011	First draft for comment
0.2	20/12/2011	Updated following comments. Additional information added relating to iSOFT Radcentre
0.3	20/12/2011	Minor revisions
0.4	05/01/2012	Final Draft for comment in IC document format
0.5	14/01/2012	Following ISB QA comments
0.6	17/01/2012	Following feedback from trust plus website link
0.7	02/02/2012	Following update regarding .csv from NHS IC
0.8	29/02/2012	Following update from DH
0.9	01/03/2012	Change to contact details
1.0	01/03/2012	Formatting changes
1.1	24/04/2012	Update following system testing and user feedback
2.0	23/07/2012	Reformatting the guidance document
2.2	08/10/2012	Advice re duplicate Accession numbers See schema and FAQs
2.4	16/04/2013	New email address; advice re 3 month cut off validation rule and rebranding
3	08/07/2013	Branding update and links
3.1	20/09/2013	Amended links
3.2	06/12/2013	Amended content re .xml / .csv submissions and general updates, including comments from Sam Gross (DID service team analyst)
4.1	02/12/2014	Updating the Referrer Code validation information
4.2	16/12/2014	ND & SD review – addition of ‘opt out’ options in FAQ section and other minor changes
5.0		
5.1	05/05/2015	FL review – new sections on submission period, consent, and what can be submitted. Additional guidance around validating the submission.
5.2	05/05/2015	ND review – minor changes
5.3	10/07/2015	Update to guidance regarding complex procedures
5.4	01/02/2016	ND & AM review - update formatting guidance, ISB references replaced with SCCI
5.5	03/02/2016	SD review – minor changes plus clarification of what is in and out of scope
5.6	24/06/2016	AM update – minor changes to comply with SCCI uplift requirements

Approved by

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Nicola Dawes		Business Owner	16/12/2014	5.0
Shelia Dixon		NHS England Data Lead	24/06/2015	5.6
Nicola Dawes		Business Owner	24/06/2015	5.6

REVIEW DETAILS

Review Date:	
Reviewer	

GLOSSARY OF TERMS

Term or Abbreviation	What it stands for
DH	Department of Health
DID	Diagnostic Imaging Dataset
GMPC	General Medical Practice Code
HSCIC	Health and Social Care Information Centre
IHTSDO	The International Health Terminology Standards Development Organisation
NICIP	National Interim Clinical Imaging Procedure
PACS	Picture Archiving and Communication System
PCD	Patient Confidential data
RIS	Radiology Information System
SCCI	Standardisation Committee for Care Information
SNOMED CT®	Systematized Nomenclature of Medicine Clinical Terms
TRUD	Technology Reference data Update Distribution

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1 Background

1.1 Purpose of Document

This document has been created to help NHS Trusts in submitting the Diagnostic Imaging Dataset (DID) in compliance with SCCI1577 which can be found at www.content.digital.nhs.uk/isce/publication/scci1577

1.2 Background

The Diagnostic Imaging Dataset (DID) is a central collection of detailed information about diagnostic imaging tests carried out on NHS patients, which is extracted and submitted monthly. The dataset is collected at patient level and includes patient identifiers to enable linkage to other datasets, most notably cancer registration data. The Health and Social Care Information Centre (HSCIC) has a legal basis under the Health and Social Care Act 2012 to collect and process patient confidential data (PCD). Such data is held within the NHS Digital safe haven and access is tightly controlled by the NHS Digital DID Service team. PCD are not passed on to external parties except where explicit patient consent or appropriate S251 approvals are in place. Further information regarding S251 approvals can be found at: http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/

The submitted data covers four areas, providing information about:

- The patient (NHS number, date of birth, gender, ethnicity etc.)
- The referrer (referrer code, referring org code)
- The imaging provider (organisation site code)
- The imaging examination (imaging codes, key dates in the imaging process)

The DID system then derives additional information from reference data, such as geographic information (Lower and Middle Super Output Area); commissioning groups; organisation names (e.g. trust sites, GP practices); imaging related information (modality, body site, body system etc.); days between referral and test and days between test and report issue.

Combined, these data items give powerful information about usage of and NHS patients' access to diagnostic imaging tests across the country.

In order to submit data users will need to extract data from their Radiology Information System (RIS). The data required is summarised on page 7.

Data is required for:

- NHS-funded patients only
- Diagnostic imaging activity data captured in RIS only (not separate systems, such as for breast screening or cardiac ultrasound activity)

Further guidance on these data items is given in the NHS Data Model and Dictionary.

The DID fulfills a number of purposes:Improving Outcomes: A Strategy for Cancer (IOSC) set out the Coalition Government's ambition to close the gap in cancer survival rates between England and Europe. Achieving earlier diagnosis of cancer will be key to delivering this. The National Awareness and Earlier Diagnosis Initiative (NAEDI) has assembled a broad evidence base linking late diagnosis with poor survival and avoidable deaths. In order to achieve earlier diagnosis for English NHS patients, IOSC set out plans to improve access to selected diagnostic tests for GPs and to ensure that data is routinely collected on GP

usage of these tests so that GPs can benchmark their own usage of them and service provision can be monitored.

The, Public Health England Centre for Radiation, Chemical and Environmental Hazards (CRCE) annually reports on the frequency and collective dose for medical x-ray examinations, to support the provision of radioactive emission data for a European Commission directive (Article 45 of Council Directive 96/29/Euratom) measuring the background radiation emitted. The DID gives accurate details on both the specific tests performed and the demographics of the patients for an entire population, rather than just a small sample, allowing accurate reporting.

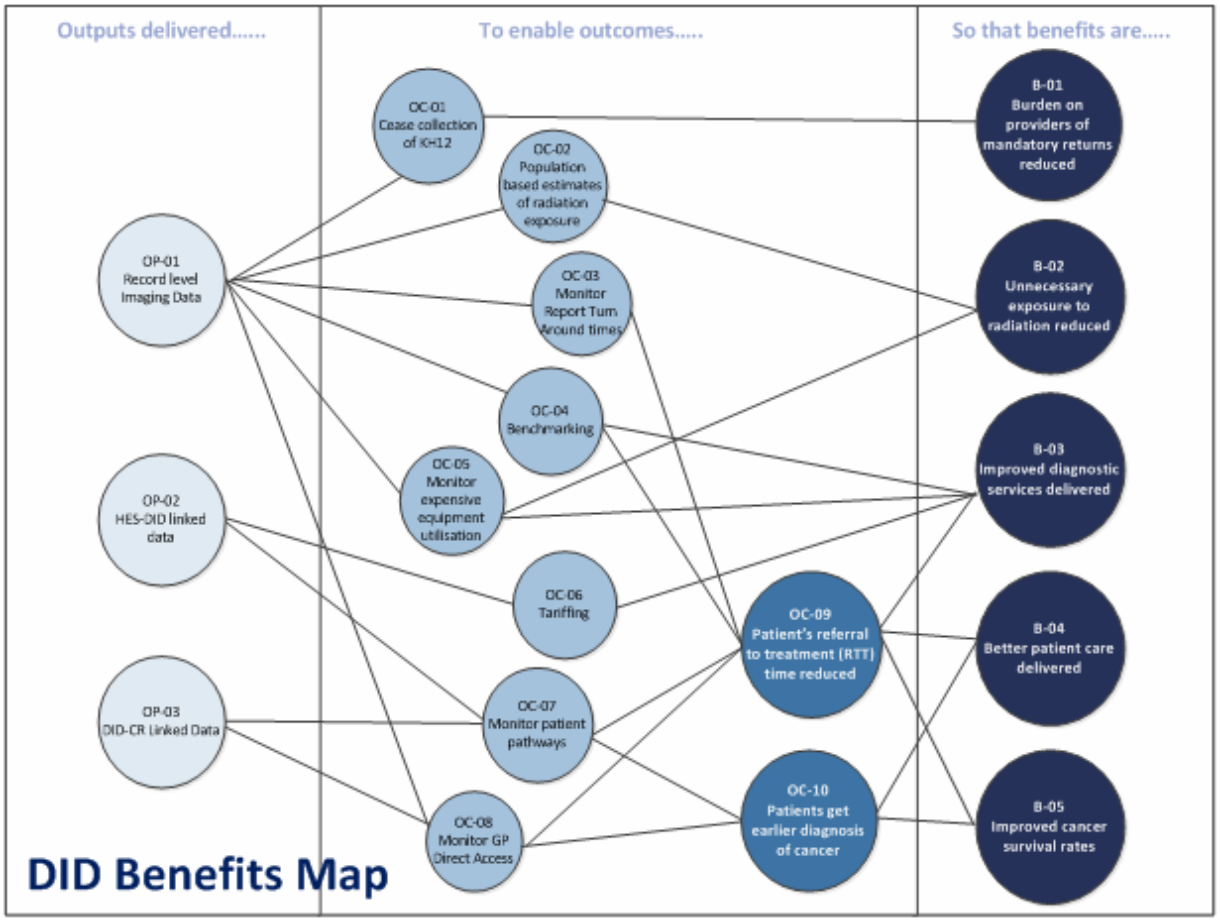
The dataset enables analysis of demographic and geographic variation in access to different test types and different providers.

The DID was designed to ensure that the data collected in the KH12 return, which covers all diagnostic imaging tests, can be replicated. Subject to assurances regarding suitability, DID would replace KH12, which would then be stopped to minimise the data burden on providers.

Information from the DID may inform the accreditation processes for imaging departments through the UK Imaging Services Accreditation Scheme and the assessment of imaging services by the Care Quality Commission.

This dataset provides information on the utilisation of high value imaging equipment such as MRI scanners.

Information about diagnostic testing is being linked to cancer patient's records held in Cancer Registries, expanding the understanding we have of their treatment pathway.



2 Data Submission

The process for submitting the Diagnostic Imaging Dataset via the NHS Digital secure web interface is described separately according to the published schedule. To access the submission portal you will need an account with NHS Digital. However, sign in is not necessary for the guidance or timetable.

Information on the timing of submissions is given on the DID website

Please note data should be submitted in the month after the test occurred, although it can be re-submitted/refreshed anywhere up to three months after the month of test. This longer period is in order to enable updates to a record after it has been initially submitted (for example the addition of a report issue date that occurred after the initial test). It is strongly advised that submitters do not leave data submission to the end of the three month window, as this may lead to missed submissions and the data may not be included in the monthly publications produced by NHS England. **The cut off point for inclusion in the monthly publication is the 26th of the month.**

An ideal submission timetable for a test recorded in February is below

15th February - Test date

Mid March – Record submitted, along with all other February tests for the trust

Mid April – Record resubmitted to correct a value, or to account for newly received data (such as a report issue date that occurred in March)

Mid May – Record resubmitted to correct a value, or to account for newly received data

26th May – Cut-off date for inclusion in NHS England Monthly reports. Any February data submitted beyond this point will not be included in reports.

31st May – Last possible date for submission of February data. Test dates occurring in February submitted after this date will be rejected by the system.

Please note that resubmission of records after their initial submission is only needed if the record has changed or been updated in some way. If there are no changes the initial submission is sufficient.

It is possible to request a three month bypass after this deadline, in order to amend incorrect data, or to allow a missed submission. Please be aware that data submitted in this way will not be included in the NHS England monthly publications. If you require a bypass please contact the Data Collections team at seft.team@nhs.net.

2.1 Data to Include

Submissions to the Diagnostic Imaging Dataset should include data as follows:

- Data pertaining to examinations conducted on NHS patients in England (including NHS Trusts, NHS Foundation Trusts and Independent Sector Providers who provide NHS funded diagnostic imaging tests)
- All data held in the RIS system, including procedures (with the exception of breast screening services, post mortem imaging, data relating to private patients, or any other diagnostic imaging tests not typically recorded on your central RIS)
- 1 record per examination. If multiple SNOMED CT or NICIP codes could be attributed to an examination the most complex should be used.

Submissions should not include:

- Data which is not held in the RIS
- Post mortem imaging

Please note: each record should **only be submitted by one organisation**. If you are an NHS organisation that uses another organisation (for example, an Independent Sector Provider or another NHS Trust) to perform a subset of your diagnostic imaging tests, you should ensure that either you or the other organisation submit this data, not both. Where possible, we would expect that data should be submitted by the organisation that carried out the test. This will avoid gaps or double counting in the data. **Please note: If data is submitted initially by one organisation, and the same record is later updated by a second organisation (for example if an organisation merges, or changes its name) the record will continue to be assigned to the original submitting organisation as this cannot be changed.**

2.2 Consent

Consult with your local Information Governance contacts regarding your local processes to follow in order to respect a patient's right to opt out of their information being included in DID.

To anonymise the data you should nullify all but one of the prescribed M* data fields listed in section 2.4 below.

Please note, the accession number does not need to be nullified or made into a default number. The accession number is not identifiable unless cross referenced with the records of the submitting organisation, and so can still be submitted to the data set. It is used by the system to archive old records when you submit updates to previously submitted records. The system will not allow the accession number to be blank, and the use of default numbers will cause archive errors and affect the activity counts for your trust that are published by NHS England.

Where a patient's records may have already been uploaded to DID by you or another provider you should direct the patient to the NHS Digital 'For The Public' website where there is information about what NHS Digital does with patient information and what choices they have regarding this.

2.3 Extract Format

The recommended format for submission is .xml as, once set up, this requires minimal data manipulation; however in the interim data may be submitted in .csv format. **(Please ensure the .xml and .csv extensions are in lower case as the data will not upload if these extensions are uppercase)**

If submitting data in .xml format please see the schema pack on the DID website, for details on how the data should be structured.

NHS Digital will continue to provide a translation service to convert files submitted in .csv format into the correct .xml format in the interim. The date when .csv format will no longer be accepted will be announced in due course. However, data submitters are urged to work with RIS suppliers to ensure that their RIS is enabled for .xml extracts.

2.4 CSV Specification

The **Schema Matching Name (Expected Element Name)** is the name of the field as expected when provided in .xml format. This has been included in the specification provided to demonstrate a mapping between the .csv structure and the .xml

The ***Column No/Order*** is the order in which they must appear

The **Format** column shows the format expected of the Field value

PLEASE DO NOT INCLUDE A HEADER ROW

PLEASE ENSURE THE FILE IS NOT OPEN WHEN UPLOADING AS THIS WILL NOT LOAD ONTO THE SYSTEM

The DID Governance Board views this collection as a mandatory collection and expects all fields to be submitted where the information is held within your systems.

M is mandatory; you must fill this field in. Your submission will rejected by the system if any mandatory fields are left blank. However, only one of the fields 'Imaging code (NICIP)' or 'Imaging code (SNOMED CT)' is necessary.

M* means that at least one of these fields must be filled in, although as many fields as possible should be provided if you have the information. A different field for different entries is acceptable, as long as at least one field is filled in for each entry.

The M* fields are:

- NHS number
- Date of birth
- Ethnicity
- Patient gender
- Patient home postcode
- Patient registered GP practice

R is required; you must fill this in if you have the information. Only if you do not have the information, e.g. your RIS does not capture it, you should leave it blank. NHS Digital and NHS England will be reviewing compliance with the required fields as part of a wider review on DID data quality.

Note that all M* fields are also ‘Required’ fields and will be subject to the same data quality review. Current validations check that at least one of the M* fields is populated. However, you should submit all of the M* fields that your system holds - even if this requires data manipulation.

Column No/ Order	M/ R	Schema Matching Name (Expected Element Name)	Format
1	**M***	**NHS NUMBER**	n10
2	**R**	**NHS NUMBER STATUS INDICATOR CODE**	an2
3	**M***	**PERSON BIRTH DATE**	an10 CCYY-MM-DD
4	**M***	**ETHNIC CATEGORY**	max an2
5	**M***	**PERSON GENDER CODE CURRENT**	an1
6	**M***	**POSTCODE OF USUAL ADDRESS**	max an8
7	**M***	**GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)**	an6
8	**M**	**PATIENT SOURCE SETTING TYPE (DIAGNOSTIC IMAGING)**	an2
9	**R**	**REFERRER CODE**	an8
10	**R**	**REFERRING ORGANISATION CODE**	max an6
11	**R**	**DIAGNOSTIC TEST REQUEST DATE**	an10 CCYY-MM-DD
12	**R**	**DIAGNOSTIC TEST REQUEST RECEIVED DATE**	an10 CCYY-MM-DD
13	**M**	**DIAGNOSTIC TEST DATE**	an10 CCYY-MM-DD
14	**M**	**IMAGING CODE (NICIP)**	max an6
15	**M**	**IMAGING CODE (SNOMED CT)**	min an6, max n18
16	**R**	**SERVICE REPORT ISSUE DATE**	an10 CCYY-MM-DD
17	**M**	**SITE CODE (OF IMAGING)**	min an5 max an9
18	**M**	**RADIOLOGICAL ACCESSION NUMBER**	max an20

n=Number

An=Alphanumeric

Numbers = length i.e. n10 states that a 10 digit number is required

Date formatting = CCYY-MM-DD i.e. Century/Century/Year/Year-Month/Month-Day/Day

For example the 31st of January 2012 would be 2012-01-31

Note that while ethnic category is normally expressed as a single letter, the default value, used for where ethnicity is unknown, is 99

max indicates a maximum length limit for the data item.

Note that NHS Number Status Indicator and Patient Source Setting both require a leading zero. If you open a .csv file in Excel, Excel will identify these as numbers and drop the leading zeros; therefore you should reformat these columns as text before saving as .csv again.

2.5 National Exam and Local Codes

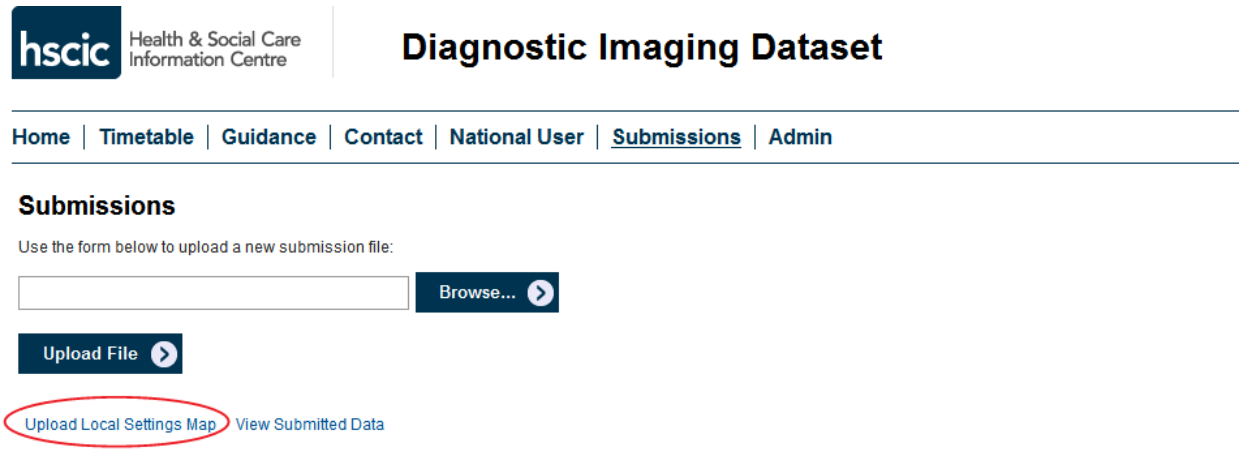
One of the key data items that the Diagnostic Imaging Dataset collects is information relating to the examination, i.e. the exam code. Trusts are required to use National Interim Clinical Imaging Procedure Codes (NICIP codes (ISB 0148)) or Systematized Nomenclature of Medicine Clinical Terms codes (SNOMED CT codes) but we acknowledge that some local codes remain for a variety of reasons. Whilst these codes are considered out of scope for NICIP it is important to report all imaging activity through the DID and where local codes are used they should map to the closest equivalent current NICIP code.

An interim "local codes mapping" service will be provided by NHS Digital which will map local codes into the relevant NICIP code by using a mapping file provided by you. The date from which NHS Digital intends to cease this mapping service will be announced in due course. After this time trusts will be required to map local codes to NICIP or SNOMED CT codes prior to submission.

In order to take up this mapping service a trust must:

- Submit a Look Up Table **before** you submit your data. This file should contain 2 columns of values only. The first value is the Local Code. The second is the NICIP code. Please do not include a header row
- Submit the data in a .csv format. This is because the validation of .xml data will fail unless the extract contains NICIP or Systematized Nomenclature of Medicine Clinical Terms codes (SNOMED CT codes).

The local codes mapping file should be submitted by clicking on the link shown circled in red below and not by the same method of submitting the data file.



You will also need to be aware that any local codes that are used for denoting importing of foreign images into PACS should not be double counted. This may occur if foreign films are imported using a code that could be counted as imaging activity at your site in DID. A system needs to be considered locally that takes account of this.

It is planned to fully replace NICIP codes with Systematized Nomenclature of Medicine Clinical Terms code (SNOMED CT). However the system is currently enabled for submissions of both NICIP and SNOMED CT codes. The system maps all submitted NICIP codes to their equivalent SNOMED CT code to enable derivation of examination categories such as modality, body site, body region etc. These are mapped directly from SNOMED CT codes.

New coding reference data packs (TRUD or Technology Reference data Update Distribution packs) for NICIP and SNOMED CT are released every April and October by the UK Terminology Centre (UKTC) as part of a formal management and review process NHS Digital aim to incorporate any new codes into the DID system as soon as possible after their release. Where imaging codes are retired or made inactive, the DID system gives data submitters six months grace before these codes are rejected by the system.

If you require help with NICIP codes, you can send an email to the UKTC helpdesk with NICIP in the subject.

Supporting implementation guidance, editorial principles, frequently asked questions and release covering letter can also be found on the NHS Digital UKTC website.

Complex Procedures

Submitting organisations may find that they are performing examinations which include multiple elements, each of which is covered by its own NICIP or SNOMED CT code. In these cases, the most complex code should be used. This should be determined in line with tariff guidance, in many cases the complex procedure codes are available for these situations.

If further advice is needed regarding the correct code to use please consult with the UK Terminology Centre. The organisation **should not** submit multiple records for a single examination, one for each code.

Organisations may be able to account for greater detail by recording procedure steps/protocols within their local RIS, but these should be separate from the examination codes submitted to DID.

Validation of your submission

Submitters have a number of opportunities to assure their data quality during the submission process.

Prior to submission

Before submitting your data, ensure you have read through the guidance in this document. Ensure your file is in the correct format, and check for any invalid codes or data that would prevent submission. If you have any queries or are uncertain of what is and is not valid please contact the DID team. In the future NHS Digital hopes to be able to provide a checking file, which will enable you to check the format of your file prior to submission.

On Submission

Upon submitting your data, the system will carry out a number of validations. In some cases the file will be rejected if validation rules are breached. Other validations will generate warnings to alert you to potential issues.

All errors will generate text to explain the validation issue, which should help submitters in rectifying the problem, and the following section should help in identifying issues that will cause validation warnings or rejections.

Post Submission

Once your data has been submitted it will be accessible through the iView submitter cube within 24 hours. This provides you with the opportunity to check that your data is as expected.

All registered users of the DID system are automatically granted access to view data for their organisation in iView. You will have access to two iView cubes, 'Submitter' and 'Community'. Submitter cube will present you with the data you have submitted up until the day before and you can only view your own organisation's data. Community cube will present you with data for all organisations and aligns with the most recent publication from NHS England. Data on the Community cube is rounded to the nearest 5 and small numbers are supressed to prevent potential identification of individuals. iView can be accessed here using the same username and password you use to access the DID system.

If you have any concerns about the quality of your data, it can be resubmitted as many times as required within the submission period, to rectify any issues. Only records affected by data quality issues need to be resubmitted, you do not need to resubmit your entire file in order to rectify a single record.

In addition, NHS England publish provisional monthly figures each month which can also be used by submitting organisation to assure their data. If you feel that published figures for your organisation are incorrect due to a data quality issue you can request a bypass to allow you to resubmit your data after the three month cut off (up to 6 months after the test date). This will not change the published monthly figures but can be taken into account for the annual refresh publication. The NHS England publications can be accessed here: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/

3 Diagnostic Imaging Dataset formatting guide

Guidance for formatting of DID data items for .csv upload, Please refer back to page 9 for an explanation of M, M* and R.

NOTE: PLEASE DO NOT INCLUDE A HEADER ROW IN THE DATA

Table 1 – DID data items (for .csv format)

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
NHS Number	**NHS NUMBER**	M*	The patient's unique NHS code, it is 10 numeric digits in length and an unbroken sequence **iSOFT RIS** users note the following field should be used: Patient NHS Number	Must pass the Modulus 11 Algorithm check digit test NOT ALLOWED 123 456 7890 *n*0000000000*n*

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
NHS Number Status	**NHS NUMBER STATUS INDICATOR CODE**	R	Permitted National Codes: 01 Number present and verified 02 Number present but not traced 03 Trace required 4 Trace attempted - No match or multiple match found 5 Trace needs to be resolved - (NHS Number or patient detail conflict) 6 Trace in progress 7 Number not present and trace not required 08 Trace postponed (baby under six weeks old) Note that when this is not present the DID will not reject the submission. **Agfa RIS** users note : Referred as NHS number in RIS but in Cognos is mapped through to SIS code found in patient folder.	permitted national codes Must include Leading Zero Note to users creating .csv format in Excel, this column should be formatted as text to retain the leading zero
Date of Birth	**PERSON BIRTH DATE**	M*	This is the patient's date of birth Format: CCYY-MM-DD **Agfa RIS** users note : Birthday in the patient record in RIS. In Cognos it is the same as Birthdate and can be found within patient folder. **iSOFT RIS** users note the following field should be used: Demog DoB The format of date is compliant with the NHS Data Model and Dictionary and means that it is machine readable. If you open a .csv with dates in this format in Excel, Excel will convert the dates back to the Excel default format for dates DD/MM/CCYY. These will need converting back to the correct format for submission.	Cannot be after date of examination: **<= "Date of test"** Cannot be after date of submission: **<= Today** Cannot be after date of report issue **<= "Date test report issued"** NOT ALLOWED any other date format

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Ethnicity	**ETHNIC CATEGORY**	M*	Ethnic Category is the classification used for the 2001 census. http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/end/ethnic_category_code_de.asp?shownav=1 It is a 1 letter code (A,B,C,D,E,F,G,H,J,K,L,M,N,P,R,S,Z) **Agfa RIS** users note This is held in PAS but can be mapped through. In the patient record in RIS it is held in the tab EXTRA called ethnic group. In Cognos this is found under patient, supplementary information, value. **iSOFT RIS** users note the following field should be used: Demog Ethnic Origin Code.	Must be from defined values 99 = Not Known ONLY 1 LETTER ALLOWED NOT ALLOWED leading and trailing blanks
Patient Gender	**PERSON GENDER CODE CURRENT**	M*	Permitted National Codes: 0 = Not known 1 = Male 2 = Female 9 = Not specified Note that "0 Not Known" means that the sex of the patient has not been recorded. "9 Not Specified" means indeterminate, i.e. unable to be classified as either male or female. **iSOFT RIS** users note the following field should be used: Demog Sex	Must be one of the defined national codes NOT ALLOWED M or F
Patient Home Postcode	**POSTCODE OF USUAL ADDRESS**	M*	**Agfa RIS** users note : In the RIS this is detailed as town in the patient demographic area. In Cognos this is found under Patient, Zip Code **iSOFT RIS** users note the following field should be used: Address Postcode	Must only have 1 space between 2 parts of post code. Postcode must be in a valid format NOT ALLOWED partial postcodes

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Patient Registered GP Practice	**GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)**	M*	Default Codes V81997 Not Registered V81998 Not Applicable V81999 Not Known **Agfa RIS** users note : Found in the RIS under GP in the patient demographic area. The GP details are then found in **Cognos** under the patient folder, Physician and Physician Code. **iSOFT RIS** users note the following field should be used: Attendance reg. Practice code or in some cases the RIS may be configured so that this information is held in Demog Reg. Practice Code. Care should be taken to ascertain which field to extract.	Must be one of the defined national codes For a GP practice we would expect a 6 digit code e.g. A12345, B78945 Not a branch surgery e.g. A12345001. The system will reject branch surgery codes

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Patient Type	**PATIENT SOURCE SETTING TYPE (DIAGNOSTIC IMAGING)**	M	Setting that the patient has come from **National Codes:** 01 = Admitted Patient Care - Inpatient (this Health Care Provider) * 02= Admitted Patient Care - Day case (this Health Care Provider) * 03 = Out-patient (this Health Care Provider) 04 = GP Direct Access 05 = Accident and Emergency Department (this Health Care Provider) 06 = Other Health Care Provider 07 = Other Note: these values are based on intended management at the time of the diagnostic test request. **Agfa RIS** users note: Found in the RIS under Patient Status but this needs to be mapped through from PAS in this field. In the Cognos this is found under Request and is Patient Status (1) **iSOFT RIS** users note the following field should be used: Attendance Patient Group. The Attendance site code = local individual ward/area code within site. Care should be taken to ensure that this data should relate to the National codes as described above and not a local reference to individual areas.	Must be one of the defined national codes NOT ALLOWED to drop the leading zero Note to users creating .csv format in Excel, this column should be formatted as text to retain the leading zero

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Referrer	**REFERRER CODE**	R	This field is the code of the person making the referral. This will normally be a health care professional - a general medical practitioner or a consultant (so will be a number preceded by either a G or C respectively) or a Physiotherapist / Emergency Nurse practitioner in which case this would be the HPC registration number. Default codes: C9999998 = Consultant code not known CD999998 = Dental Consultant: General Medical Council (GMC) number/ General Dental Council (GDC) number not known D9999998 = Dentist code not known G9999998 = General Medical Practitioner (GMP) code not known H9999998 = Other health care professional (from 1 April 2006) M9999998 = Midwife (from 1 April 2006) N9999998 = Nurse (from 1 April 2006) R9999981 = Referrer other than General Medical Practitioner (GMP), General Dental Practitioner (GDP) or Consultant Other GP Codes A9999998 = Ministry of Defence Doctor P9999981 = Prison doctor X9999998 = Not Applicable, not known **Agfa RIS** users note: In the RIS this is Requesting Physician, in Cognos this is found under Request and requesting physician, physician code. **iSOFT RIS** users note the following field should be used: Attendance Ref. Doctor Code **Cerner RIS** users note**:** Due to the fact that this is a module of an EPR rather than a dedicated RIS, it would be possible to select the clinician who originally referred a patient to a hospital. This field should include the details of the clinician who is requesting the diagnostic procedure.	It is important for referrer code to be accurate when linking DID data to cancer registration data. Must be in one of the following formats. **C** followed by up to **7 digits** (consultant) **CH** followed by up to **6 digits** (chiropodist) **D** followed by up to **7 digits** (dentist) **DT** followed by up to **6 digits** (dietician) **CD** followed by up to **6 digits** (dental consultant) **G** followed by up to **7 digits** (GP England and Wales) **PH** followed by up to **6 digits** (Physiotherapist) **S** followed by up to **7 digits** (GP Scotland) **SL** followed by up to **6 digits** (speech language therapist) [**Z** as 1st character], [E,N,S or W as 2nd character], followed by up to **6 digits** (GP N.Ireland) 2 digits, followed by one letter, followed by 4 digits, followed by one letter [NNLNNNNL] (Nurse) **NOTE:** Referrer Code for a GP must be their GMP (General Medical Practitioner) code and not their GMC (General Medical Council) code. A GP may have more than one GMP code if they operate from multiple practices. **Please note:** invalid codes are currently accepted by the system and are changed to "99" to represent an invalid code. In the near future additional validation will be introduced to prevent the submission of invalid values.

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Referring Organisation	**REFERRING ORGANISATION CODE**	R	Referring organisation code is the organisation code of the organisation from which the referral is made, such as a GP practice or NHS Trust. This should be the nationally recognised ODS code. It is important that local codes are not used. Format: min an3 max an6. Note: Only organisation codes which have been notified to and issued by the Organisation Data Service (ODS) may be used. Look for the ets.zip file under **NHS Trusts and Sites** – second section on the page Please remember that PCTs were never classed as referring organisations and were accepted erroneously by the system. PCTs were no longer accepted by the system as valid Referring Org Codes from April 2013 Trusts should be aware that in many cases the referring organisation will be the actual trust itself (for example in the case of ward and clinic requests). When this is a request from a GP then the referring organisation will be the site code of the GP practice, which is different to the referrer. (The actual referrer is an individual, identified by their own number, as explained in REFERRERCODE, and is personal rather than describing an organisation). ODS Default Codes: X99998 - Referring organisation code not applicable X99999 - Referring organisation code not known **Agfa RIS** users note: This is Requesting hospital in the RIS **iSOFT RIS** users note the following field should be used: REFPRACTICE-> PCGKEY	Must be from defined values A 3 digit code for the organisation that is referring the patient (e.g. RXD, RDV) not a site code (e.g. RXD45, RDV01) For a GP practice we would expect a 6 digit code e.g. A12345, B78945 Not a branch surgery e.g. A12345001. The system will reject branch surgery codes

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Date of Test Request	**DIAGNOSTIC TEST REQUEST DATE**	R	Date the referrer made the referral request Format: CCYY-MM-DD **Agfa RIS** users note: This is a user definable property and is set up by the site **iSOFT RIS** users note: Date of Test Request = Attendance Request Date **Cerner RIS** users note**:** It may not be possible to capture this field The format of date is compliant with the NHS Data Model and Dictionary and means that it is machine readable. If you open a .csv with dates in this format in Excel, Excel will convert the dates back to the Excel default format for dates DD/MM/CCYY. These will need converting back to the correct format for submission.	Cannot be before the date the request was received: **<="Date test request received"** Alert if more than one year before "Date of test": **>" Date of Test" + 1 year** NOT ALLOWED any other date format
Date Test Request Received	**DIAGNOSTIC TEST REQUEST RECEIVED DATE**	R	Date that the diagnostic provider received the referral request Format: CCYY-MM-DD **Agfa RIS** users note: This is a user definable property and is set up by the site. **iSOFT RIS** users note: this field may be the same as the Attendance Request Date The format of date is compliant with the NHS Data Model and Dictionary and means that it is machine readable. If you open a .csv with dates in this format in Excel, Excel will convert the dates back to the Excel default format for dates DD/MM/CCYY. These will need converting back to the correct format for submission.	Cannot be before the date that the test request was received: **>= "Date of test request"** Alert if more than one year before "Date of test" **>"Date of Test" + 1 year** NOT ALLOWED any other date format

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Date of Test	**DIAGNOSTIC TEST DATE**	M	Date the test took place Format: CCYY-MM-DD **Agfa RIS** users note: In RIS this is called Date but from the browser field is the request date **iSOFT RIS** users note the following field should be used: DATACONFIRM ->CONFDATE. If CONFDATE is not available then SORTDATE will be picked from DATAEXAM The format of date is compliant with the NHS Data Model and Dictionary and means that it is machine readable. If you open a .csv with dates in this format in Excel, Excel will convert the dates back to the Excel default format for dates DD/MM/CCYY. These will need converting back to the correct format for submission.	Cannot be before the date that the test was requested **>=”Date of test request”** Cannot be before the date that the test request was received: **>=”Date test request received”** Cannot be after the date of the report issue **<=”Date test report issued”** Cannot be more than 3 months from beginning of submission month **< 3 months from beginning of submission month** (i.e. if you are submitting a file to the DID system in December 2014, Date of Test cannot be before 1st September 2014) NOT ALLOWED any other date format
Imaging Code (NICIP)	**IMAGING CODE (NICIP)**	M	NICIP: National Interim Clinical Imaging Procedure code, which enables identification of both the test modality and body site of test. Further Details can be found at: http://systems.digital.nhs.uk/data/uktc/imaging	Must be from defined values

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Imaging Code (SNOMED CT)	***Or*** **IMAGING CODE (SNOMED CT)**	M	SNOMED CT: Systematized Nomenclature of Medicine Clinical Terms code, which enables identification of both the test modality and body site of test. SNOMED CT is due to take over from NICIP codes in April 2015 Further details can be found at: http://systems.digital.nhs.uk/data/uktc/snomed Note: This may be called the "Exam Code" within HSS CRIS and within Agfa RIS **iSOFT RIS users note** the following field should be used: Exam Examination Code. iSOFT are in the process of adding new fields to differentiate between NICIP and SNOMED CT fields	Must be from defined values If SNOMED CT codes are not being provided, please leave this field blank.
Date Test Report Issued	**SERVICE REPORT ISSUE DATE**	R	Date the diagnostic provider issued the test report Format: CCYY-MM-DD **Agfa RIS** users note: In the RIS this is called the creation date and can be found under report, again this is configurable to each individual site. **iSOFT RIS** users note the following field should be used: Section Authorised Date. However it should be noted that this functionality is limited within the current release. For example, in the attendance if there are two exams Ex1 and Ex2. For the Ex1, there are 2 report sections created then the latest report section authorised date will be taken. The format of date is compliant with the NHS Data Model and Dictionary and means that it is machine readable. If you open a .csv with dates in this format in Excel, Excel will convert the dates back to the Excel default format for dates DD/MM/CCYY. These will need converting back to the correct format for submission	Alert if more than month after "Date of test" **> "date of test" + 1 month** NOT ALLOWED any other date format

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
Provider Site Code	**SITE CODE (OF IMAGING)**	M	Site code (of imaging) is the organisation site code of the organisation at which the imaging took place, for example: Example NHS Trust Site = RH802 ODS Default Codes: 89999 - Non-NHS UK Provider where no organisation site code has been issued 89997 - Non-UK Provider where no organisation site code has been issued Note: Only organisation codes which have been notified to and issued by the Organisation Data Service (ODS) may be used. Look for the ets.zip file under **NHS Trusts and Sites** – second section on the page. **iSOFT RIS** users note the following field should be used : DATAATTEND-> SITEKEY It is worth noting that in trusts where there are more than one site of imaging, it is important that the RIS is able to capture which of these sites has actually performed the procedure, so a 3 digit site code would be rejected by DID	Must be from defined values

Name	NHS Data Model and Dictionary Reference	M/R	Comments	Validation
RIS Accession Number	**RADIOLOGICAL ACCESSION NUMBER**	M	Unique RIS record number for the exam. **iSOFT RIS** users note the following field should be used: Accession Number. Note: Care should be taken to ensure that the study number within RIS (attendance number) is not extracted here. **Cerner RIS** users note: This number should be unique to the specific examination. This is required so that a differentiation can be made between multiple body parts examined at the same attendance.	Each accession number must be unique within the site code. They should refer to the exam, not to the patient. From September 2013 duplicate accession numbers will not pass validation. Care should be taken not to reuse accession numbers that have been provided in previous years, even where the same patient is undergoing the same test at a different point in time. This would cause your previous submitted record to be moved from LIVE data into the DID ARCHIVE, which is not accessible through iView and not included in any DID Publications or other data uses.

4 Frequently asked questions

Q: If a submission is to be based on April data, and is to be submitted in May, what does April refer to?

A: April data is to be based on imaging tests carried out in April, that is, those with date of test in April.

Q: What is the difference between the date of test request and date of test request received?

A: The date of test request is when the imaging request was made. For paper based work flows this is when the clinician writes the request. For electronic ordering, this is when the electronic form is completed. It may not be possible in all cases to differentiate between the two. For sites using electronic requesting this is usually the same date.

Q: **My submitted file does not seem to be validating?**

A: Ensure that the submitted file is closed before you submit your data.

Q: **I don't know our Provider site code. What is this and how do I find further information?**

A: This is the code of the site providing the care. Trusts that perform imaging at multiple locations need to be able to supply information as to which site performed the test, which is reflected in the provider site code.

Note: Only organisation site codes which have been notified to and issued by the Organisation Data Service may be used.

Q: The RIS we use does not display the NHS number status indicator code.

A: If the RIS does not capture or display this information then it is acceptable to submit to DID with this data item left blank. In cases where this is available, it should be submitted.

Q: It is not clear to me who the referrer is. Could this be more than one person?

A: The referrer will only ever be one person. It is the actual person who is in charge of the request. In the case of a GP request this will be the GP. Please use the GP's GMP code. When the patient is referred from somewhere in the trust, this will usually be the consultant in charge of their care.

Q: Why do we need to submit the date in this format? I am sure this is different to the SUS returns

A: This is the NHS Data Model and Dictionary specification. All data items containing dates must be submitted in this format to be accepted when uploaded to the NHS Digital secure website.

Q: Why does the system not generate all errors at once?

A: A variety of options to validate and display errors were considered and the one chosen was deemed to be the most effective. We accept that it is frustrating not to get all errors at once, but they are generated in this way since submissions are checked in stages. If the first stage of errors has not been resolved, the system is unable to proceed to validate the file further until these have been corrected. An example is where a DID user misses out a data field - under this scenario if the validation engine continued to validate, it would imply that all the data in subsequent fields is in error. A further point relates to capacity of the website to display errors, so whilst all errors at the given stage are summarised, not all can be displayed on the website.

Q: What file format can I upload my data in?

A: The file should be submitted in either .csv or in .xml if the correct .xml schema is being used. Please do not upload your data in any other format, including Excel or Zip files, as it will not be successful.

Q: I am using practice codes, organisation codes and sites that should work but they are failing validation, why is this?

A: The codes for these fields must be from the defined codes on the Organisation Data Service, available on the NHS Digital website.

This website can be used to search by code, organisation name, address or postcode. On occasion, the system's reference data may require updating to reflect newly released codes. We aim to do this as soon as practicably possible. In such circumstances it may be possible to submit records with default codes in and amend these in a later submission once the system reference data is back up to date.

Q: Why do the NHS Number Status and the Patient Type need to have leading zeros?

A: The format of this collection has been defined according to the NHS Data Model and Dictionary. If you open a .csv containing the leading zeros in Excel, Excel will recognise the column as number and drop the leading zero by default. These will have to be reformatted as text values prior to resaving a .csv.

Q: If a field is not known and is a non-mandatory field, what do I enter in that field?

A: Any non-mandatory fields that are not known will need to be left blank.

Please do not enter 'NULL', '-', double commas or speech marks.

Where possible please use the default codes as provided in Table 1.

Q: Planned tests display as a warning but I don't want to manipulate the data to remove the warning as this would be inaccurate?

A: Planned tests need to be submitted in the same way as non-planned tests. As long as records which have these warnings are genuine it is ok to submit data with warnings. Warnings will not stop a file from passing validation.

Q: I am struggling with mapping some of my local codes with NICIP codes. Who can I contact for help with this?

A: NHS Digital can offer support in this area. Please email the UKTC helpdesk with NICIP in the subject.

Supporting implementation guidance, editorial principles, frequently asked questions and release covering letter can also be found on the NHS Digital UK Terminology Centre website.

Q: Why is the Radiology department responsible for this collection when we are struggling with data formatting and have very little resource to spend on non-clinical activity?

A: We would strongly encourage you to work in collaboration with your Information Services team so that you provide them with the extract and they manipulate the data to the required format. Some Information Services teams have provided practical support with the responsibility for submitting data remaining in the Radiology department and others have taken this responsibility from the Radiology department.

Q: I am getting a validation error saying I have duplicate records. What should I do?

A: The system uses a combination of site code and accession number to define uniqueness. The accession number should be a unique reference assigned to each individual examination. If the accession number used is not unique the system will detect duplicates within your return.

The main reasons for this error are:

- An alternative number such as an attendance number has been used in lieu of the accession number. For attendance numbers the reference is unique to each set of exams that an individual receives on a particular date. In this case please append the exam code to the attendance number, which should create a unique reference. If another number has been used in place of an accession number please contact NHS Digital for assistance. **In these cases please consider reviewing the RIS extract query to ensure that the number used in the accession field is unique to a specific examination**
- There are blank lines in the data return which are not apparent in Excel. To resolve this open the .csv file via notepad, this will show the data with the comma delimitation. Scroll down to the end of the valid data; you need to delete any commas below the valid data that contains only blanks
- Blank rows within the submission. Check the submission for any blank rows, if there are any these need to be deleted
- Genuine duplicated lines. If the return has what appears to be genuine duplicate lines please identify each of the duplicated lines and delete. **In this case please review the RIS extract query to ensure that it is not creating the duplicates**
- Examinations where the test results have been re issued at a later date. The original examination remains a valid entry however the re issued result does not count as a valid examination and needs to be deleted.

The NHS Digital Data Collection team are happy to assist in resolving these should you need further advice.

Q: What happens if I don't successfully submit this data?

A: This is a mandatory collection. Details of any organisations who fail to submit will be passed to NHS England and the DID Governance Group to start their escalation process. NHS Digital are here to support the successful collation and submission of data. As this is a monthly submission it is important that the errors in the data are rectified on a more long term basis (involving system changes) for future submissions. The NHS Digital Data Collection team are on hand to support this process.

Q: I am getting an error message: Row Number: 0 | Accession Number: | Provider Site Code: : Duplicate accession number and provider site code detected; each distinct spell of scanning activity must be represented by a unique accession number and provider site code combination

A: Duplicate Accession Numbers within the same site code will not pass validation. Please ensure you have extracted the right Accession Number, not the Patient/Attendance Number. If you need further assistance please contact the NHS Digital Data Collection team where we can help you to identify the duplicates.

Q: I am getting the error message: Row Number: | Accession Number: | Provider Site Code: DiagnosticTestDate: Date of test cannot be more than three complete months previous to today.

A: Data containing test dates over 3 months old, (from the beginning of the month of submission), will not be automatically uploaded onto the DID system, please contact the NHS Digital Data Collection team.

5 xml schema pack

The schema pack is available to download from the DID website.

6 Further Information

Support and advice is available, contact details are available on the DID website

or please email seft.@nhs.net