ECDS

Emergency Care Data Set

Contents

1. Introduction

'We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do.'

Atul Gawande [1]

The need to understand Emergency Care

The budget for Emergency and Urgent Care in England is probably around £2bn. The exact amount is difficult to define, with a substantial historical overlap between this budget and those for acute hospital medical care and primary care.

The relative costs of delivering Emergency Care have changed over the last few years due to:

- External factors – These are well documented and include access to alternative sources of care, patient preferences, perceived value, consistency of service.

- Internal factors – these are less well documented/ understood and include the (appropriate) pressure to avoid admitting patients unnecessarily. This has resulted in the front-loading of testing and decision making, which is now performed in the Emergency Department (ED). Increased subspecialisation of hospital practice has reduced the number of 'generalist' hospital doctors, a trend previously noted in the USA.

What had historically been a fairly steady state has changed. As the patient flow, patient acuity and patient expectations have increased, the Emergency Care system has adapted internally to cope. Over recent years the system has started to decompensate on a regular basis, and the reasons for this have not been obvious to analysts and external observers.

At a national level it is difficult to understand the impact that these changes are having and why emergency care is failing as it would appear that:

- The numbers of patients have not changed much over the last ten years.

- There are more staff in Emergency Care now than ten years ago.

All analyses are based on the best information available from emergency care.

If however, what we are currently collecting is the wrong data – e.g. we are looking to understand traffic jams by measuring the number of horses on the roads – then this would account for the current apparently confusing situation.

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[1] Complications: a Surgeon's Notes on an Imperfect Science. London: Profile Books 2001

'If you don't take a temperature, you can't find a fever'

The current data set used for diagnostic coding in Urgent Care and Emergency Departments/ Centres, the 'Accident & Emergency Commissioning Data Set (CDS Type 010)', was developed in the late 1970s. At that time the work of an Accident and Emergency Department was largely minor injuries and occasional major trauma and CDS Type 010 was appropriate for measuring this work at that time.

In the last 40 years there has been a rapid and sustained increase in volume, scope and complexity of Urgent and Emergency Care. The main factors driving the change in provision and delivery of Urgent and Emergency Care include:

- The changing health needs of the population such as an ageing population and multiple comorbidities.

- Changes in access to alternative healthcare services.

- Changes in the way that the population choses to access services and their expectations of the care that they receive.

The current data set developed in the late 1970s only measures the items that were commonly performed (and therefore coded) in the 1970s – minor injuries and trauma. The numbers of these presentations have not changed much, but there are now large numbers of elderly patients with complex medical problems, and children (25% of Emergency Care workload), which the current system does not measure.

This helps to explain why in recent years the Emergency Care system has increasingly failed, and has done so with little apparent warning to those monitoring the system because it uses 1970s data.

The need for better information

The current Accident and Emergency Commissioning Data Set (CDS Type 010) has not evolved to keep pace with the changes referred to above and has resulted in an 'information gap' in the data collected from ED's. The information gap has reached such an extent that in 2013, the Commons Health Select Committee, when reviewing Urgent and Emergency Care, commented that the system was 'Flying Blind'[2].

The 'information gap' has led to the following issues:

- Current metrics of healthcare do not consistently measure inputs or outputs, making comparisons of 'value added' or different modes of healthcare delivery impossible.

- Urgent and Emergency Care system capacity and demand management are impossible to determine accurately.

- Multiple current coding systems with inconsistent implementation means data are not valid or reliable. This renders the information insufficient for either clinical use or policy-making.

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[2] Urgent and emergency services: Second Report of Session 2013–14 (2013) *House of Commons Health Committee*

- • Data quality – a Health and Social Care Information Centre (HSCIC) audit in 2013 showed that a valid, coded diagnosis exists for only half of all ED attendances. [3]

In 2014 the Secretary of State for Health reviewed these issues and agreed to support the development of a new data set that can properly capture and represent the full extent and granularity of Urgent and Emergency Care. The aim of this process is to agree a data set that will be approved by the HSCIC Standardisation Committee for Care Information (SCCI) as a nationally implemented Information Standard Notice (ISN).

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[3] HSCIC (2013) Focus on Accident and Emergency. Accessed 09/10/2915 via http://www.hscic.gov.uk/catalogue/PUB13040

1.1. Emergency Care Data Set (ECDS)

Development

The Emergency Care Data Set (ECDS) is derived from the Minimum Dataset for Emergency Care (MDEC). MDEC was developed over several years by what is now the Royal College of Emergency Medicine (RCEM) in response to the growth in volume and complexity of urgent and emergency care[4]. The components and structure of MDEC were informed by collaboration with national and international emergency medicine colleagues with previous experience of the development of similar datasets.

The ECDS is a *minimum* dataset and is not intended to restrict the data that is used in emergency care. It is designed to bring together many disparate local initiatives and practices to benefit all through being able to describe the work done across a range of providers in a common language.

The data set will be subject to public consultation throughout the SCCI process and version 1 was published online and made available for comment in May 2015. Version 2 of the ECDS is the result of this consultation and work with the HSCIC Data Dictionary and Messaging and Clinical Terminology teams to ensure that it aligns to national data standards.

The ECDS will supersede existing data collection arrangements and the Project Board is working with the HSCIC to understand the implications of replacing CDS Type 010 with the ECDS.

The ECDS will be subject to approval as an Information Standard by the Standardisation Committee for Care Information (SCCI) which is manged by the HSCIC. Further information regarding the SCCI process can be accessed at the HSCIC website[5].

Benefits of ECDS

The Emergency Care Data Set will deliver the following key benefits:

- Improved patient outcomes through better information and information exchange, including a reduction in risk by improving communication.

- Improved quality of data collected in ED's relating to patient presentation, diagnosis, discharge and follow-up, which will facilitate improved healthcare commissioning and the effective delivery of future healthcare policy and strategy.

- Improved communication between health professionals, which will enable accurate measurement, costing and remuneration of acute healthcare, specifically an improvement in the understanding of the cost and value of Emergency Care.

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[4] http://www.rcem.ac.uk/Shop-Floor/Informatics

[5] http://www.hscic.gov.uk/isce

The ECDS project has conducted a review of the benefits to be gained from the development and implementation of a new data set for emergency care. Further information relating to the benefits analysis work can be accessed via the SCCI portal (link to be updated when ISN approved).

Justification of ECDS

In order to ensure that the ECDS has a positive impact on the delivery of emergency care and supports the development of healthcare policy and strategy it is important to consider the following questions:

- Why does this information need to be collected and how will it be used?

- What benefits will accrue from collecting the information?

- What is the burden of collecting this information, both in terms of cost, time and workforce?

While it may seem self-evident that there is a need for many of the current data items to be updated, consideration of the above questions has allowed an opportunity to rationalise and simplify the information collected and justify the need to introduce new data items.

Many data items included in the ECDS are the same as are currently collected via CDS Type 010. However, during an initial review of CDS Type 010 it became apparent that whilst the principle for collection was sound the code sets used to populate this information did not capture the complexity and granularity necessary to accurately capture emergency care. As a result of this many code sets have been updated to allow more detailed recording and reporting.

All data items have been reviewed to maximise usability with the intention that the burden of collecting emergency care data should be reduced as a result of implementing the ECDS. This will be achieved by ensuring that:

- All data items are organised in logical structures e.g. hierarchical menus that software suppliers can implement easily.

- The most frequently used are at the top of lists so that staff do not waste time searching.

- All data items are easily 'usable' as coding will be done in real-time by clinicians and clerical staff. The options should clearly represent the real-life situations, must not be unnecessarily complex and that for all reasonably predictable clinical situations, there should be one obvious 'best' answer.

For each item, there is a 'justification' that explains the rationale and intended benefits from the proposed changes which supports need to collect the information.

Many of the data items in CDS version 010 and now ECDS are used by the Secondary Uses Service to derive the Healthcare Resource Group (HRG) version 4. HRG's offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Emergency Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within the NHS by matching resource with activity.

Although HRGs may be superseded as a method of payment, there will be an on-going need to measure complexity and acuity. The increased granularity and relevance of ECDS will ensure that commissioners and providers will have assurance that activity can be accurately measured and remunerated.

Acknowledgements

The ECDS Project Board is very grateful for the help we have received from many individuals and institutions in formulating this work, particularly

- Association of Ambulance Service Chief Executives
- British Emergency Eye Care Society
- British Medical Association
- Department of Health
- HSCIC
- Monitor
- NHS Elect
- NHS England
- NHS Providers
- Professional Records Standards Body (PRSB)
- Public Health England
- Royal College of Emergency Medicine
- Royal College of Paediatrics and Child Health
- Royal College of Psychiatrists, Faculty of Liaison Psychiatry
- Royal Pharmaceutical Society
- The Royal Society for the Prevention of Accidents

And all those who responded to the May 2015 ECDS consultation

1.2.   Understanding and Preventing Injury

A major change in ECDS from the current CDS Type 010 is the inclusion of an integrated injury surveillance data set.

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.

Injury kills over 14,000 people in the UK every year, in England alone, another 700,000 are seriously injured and approximately 6,500,000 attend hospital ED's[6]. Injury is the leading cause of preventable years of life to age 60, please see figure 1 below.

Figure 1. *% total preventable years of life lost in 2010 to people up to age 60 (graphic courtesy of the Royal Society for the Prevention of Accidents).*
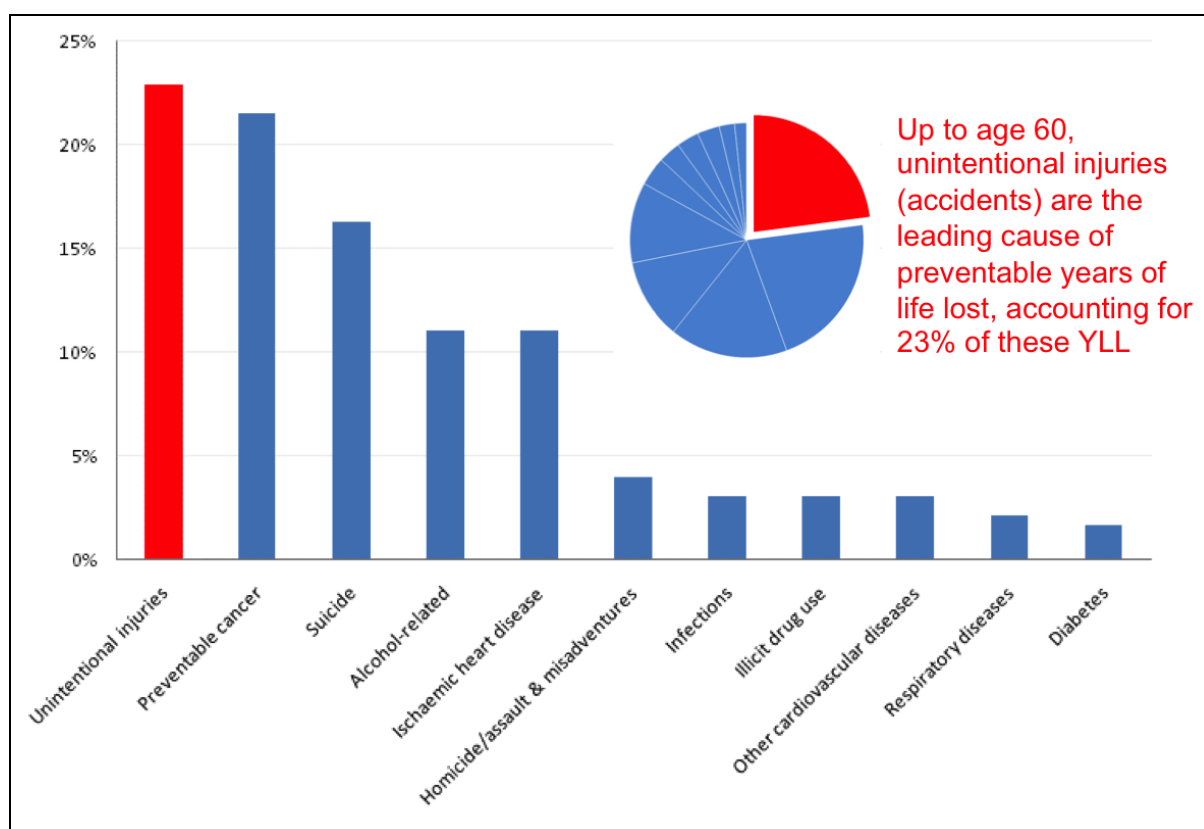
The ECDS represents an opportunity to re-think the way that injury-related data is collected. It is an opportunity to replace the many disparate data items currently collected with a consistent, integrated and more efficient method of recording data.

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[6] The Royal Society for the Prevention of Accidents, http://www.rospa.com/

Collecting injury data in an integrated fashion would provide the 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.

Injury is a major problem at all ages and only ceases to be the largest cause of preventable years of life lost at age 75. Unintentional injury is the leading cause of preventable years of life lost (YLL) until age 75 when it drops to 2nd behind cancer. At 85 years, it drops to 3rd behind cancer and cardiovascular disease, please see figure 2 below.

Figure 2. *% of total preventable years of life lost due to unintentional injury – by age (graphic courtesy of the Royal Society for the Prevention of Accidents).*
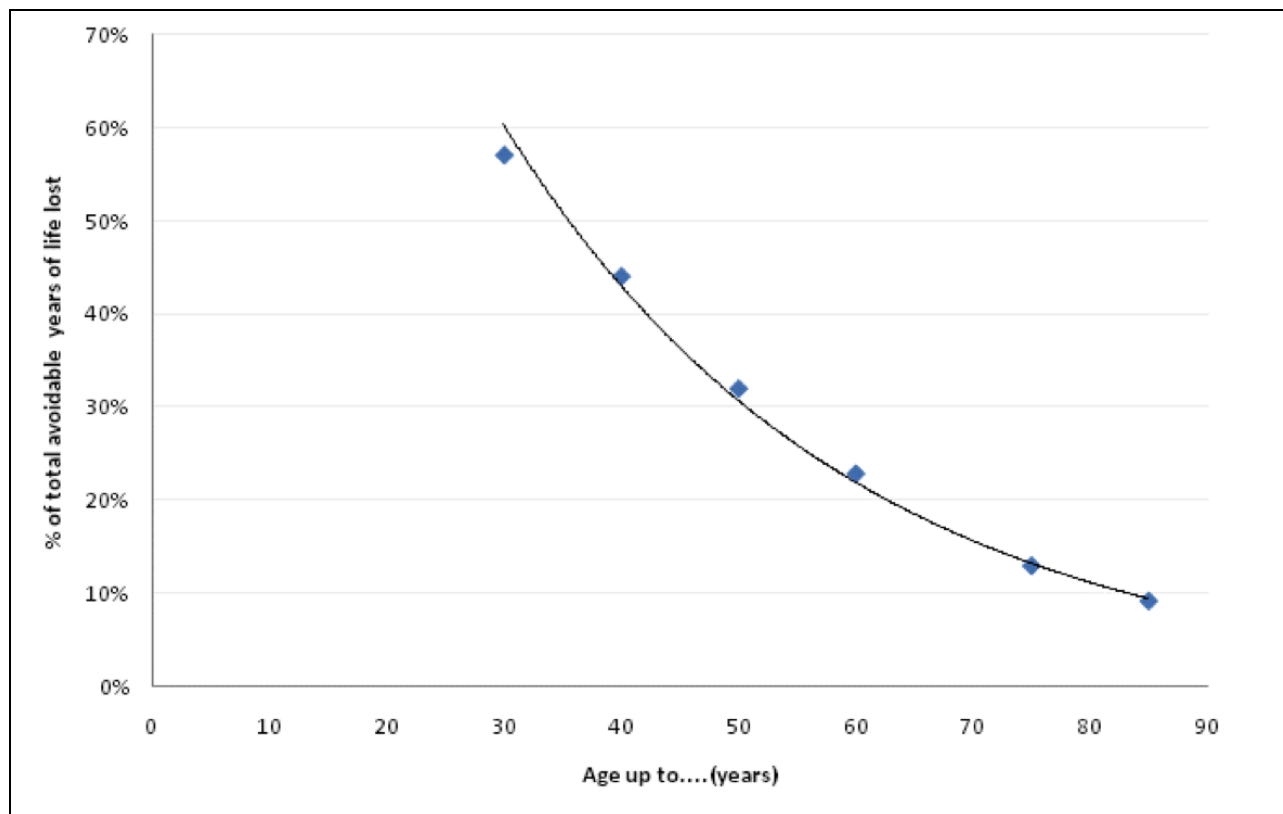
Information Sharing to Tackle Violence (ISTV)

Violence, particularly when resulting from alcohol use, has been shown to be preventable, however it is difficult to collect the information required for action. A recent initiative has been the 'Information Sharing to Tackle Violence' information standard (ISB 1594). Further information relating to the ISTC ISN can be accessed here:https://www.gov.uk/government/news/aes-and-police-to-share-information-to-help-tackle-violence .

The ECDS incorporates the key data items of the ISTV dataset and will enable better data capture and data sharing by ensuring that:

- Collection of injury data will be integrated into normal workflow.

- Injury data will be partnered by good quality diagnosis data.

- Anonymisation and information sharing protocols are integrated into the ECDS design.

Provenance of the injury data set

The injury data set described in ECDS is derived from three main sources:

- The injury dataset from the Victorian (Australia) Emergency Minimum Dataset (VEMD)[7] where it has been collected for more than 20 years, and has led to some key public health interventions.

- The European 'Joint Action for Minimisation of Injuries in Europe' (JAMIE)[8] project which states that all countries should collect ED injury data by 2015.

- World Health Organisation – Injury surveillance data set

In the UK and in Victoria (Australia), clinical staff are often tasked with collecting this data however there is no particular clinical expertise required to ask these questions or interpret the answers. Over the past five years a multidisciplinary group from the Royal College of Emergency Medicine, Public Health England and the Royal Society for the Prevention of Accidents have worked together to find alternative ways of collecting the data that would also minimise the burden on clinical staff.

Two methods were trialled – using clerical staff to enter the data, and using a kiosk to allow patients to enter the data. As a result of these work we propose that asking clerical staff to collect this data is the most effective and efficient method of providing injury surveillance in the NHS.

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[7] http://www.health.vic.gov.au/hdss/vemd/

[8] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3733502/

1.3. Information Governance

The implementation of the ECDS provides an opportunity to review all the data items collected and their information governance implications, particularly those that are transmitted centrally.

CDS Type 010 data flows to the Secondary Uses Service (SUS) data feed maintained by the HSCIC. SUS data is subject to a strict information governance framework and the ECDS project board will work with the HSCIC Information Governance team to ensure that the implementation of the ECDS aligns to this framework.

A Privacy Impact Assessment (PIA) will be carried out to identify and mitigate against any privacy or information governance risks associated with the implementation of the ECDS and resulting data collection, storage and reporting. Further information relating to the Information Governance processes associated with the ECDS can be accessed on the SCCI portal where project documents are available to the public (inset link when documents published).

To aid understanding, the rationale and any information governance issues arising from individual data items are handled within the justification field that exists for each item.

The central information governance issue in ECDS relates to how key Patient Identifiable Data (PID) is used and transmitted. This situation is currently managed by existing NHS business rules that stipulate how PID is used and how the situation when the usual unique person identifier (the NHS number) is not available is resolved – central transmission of unique identifiers.

Central transmission of Unique Identifiers of Patient Identifiable Data

The proposed transmission of unique identifiers of Patient Identifiable Data within ECDS is expected to follow the same practice as presently occurs within CDS Type 010[9].

The NHS number is necessary to be able to understand patterns of healthcare use and to ensure that the right services are commissioned in the right places. This can only be achieved through the use of a unique identifier, the NHS number was specifically devised for this purpose.

The options for transmitting the Patient Identifiable Data items are listed below.

1. **Option 1 (default)**

Under normal circumstances, the person's NHS number and identity are confirmed and their NHS number is used as the Unique Identifier, and the NHS Number Status Indicator is set to '01'.

The data items transmitted are:

- EmCare_Provider_Org_Code
- Person_Local_Number

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[9] http://tinyurl.com/nr2q2lc

- Person_Residence_Org_Code

- Person_NHS_Number

- Person_NHS_Number_Status_Indicator.

- Person_Birth_Date

- Person_Usual_Address_Postcode

2. Option 2

If a person's NHS number *cannot* be confirmed (the Person NHS Number Status Indicator ≠ '01'), the following information is transmitted:

- EmCare_Provider_Org_Code

- Person_Local_Number

- Person_Residence_Org_Code

- Person_NHS_Number

- Person_NHS_Number_Status_Indicator.

- Person_Birth_Date

- Person_Usual_Address_Postcode

- Person_First_Name

- Person_Family_Name

- Person_Usual_Address1

- Person_Usual_Address2

3. Option 3 – Withheld Identity

If there is a reason to withhold data transmission, the only information that is transmitted is:

- EmCare_Provider_Org_Code

- Person_NHS_Number_Status_Indicator_Code

- Person_Residence_Org_Code

- Person_Witheld_Identitiy reason

1.4. ECDS Data Dictionary Structure

Data, Codes, Language and Terminology

An ED visit ('Episode of Care') can be viewed as a series of steps from presentation through to discharge. These steps are captured as data items, which need to be recordable as a code.

The ideal code set is both:

- **Exhaustive** – the codes available cover all reasonably predictable 'real-life' scenarios.
- **Exclusive** – any 'real-life' event should only map to one code.

In addition the data types should be 'normalised' – there should be no duplication of data collected.

The range of data collected needs to balance desire to collect data with the cost of data collection and maintain user engagement.

Data field	Definition	Options/Example
Field name	The name of the data item	Person_Given_Name
Field Definition	The definition of the data item.	Person_Given_Name_ - The legally recognised first/ given name for the person.
Format	How the data in the field should be represented. This must include the format used to represent a data item and the specified or maximum number of characters that may be collected.	**Format** **ALPHANUMERIC** - a field on which calculations are not performed **NUMBER** - a field on which calculations may be performed Time and date are specified using the NHS / ISO 8601 standard. The time zone is not used. **DATE** – a date field in the format YYYY-MM-DD (10 characters) **DATETIME** – YYYY-MM-DDThh:mm:ss (19 characters) 'YYYY' is year 'MM' is month range 01 to 12 'DD' is date range 01 to 31 'T' separates the date and time 'hh' is hours range 00 to 23 'mm' is minutes range 00 to 59 'ss' is seconds range 00 to 59 In Emergency Care, it is common for care episodes to cross midnight and errors can occur when date and time entities are handled separately, so wherever possible combined 'DATETIME' fields are used. **Field Size** Expressed as a whole number in brackets after the format. Field size is either expressed as a number only, which

Data field	Definition	Options/Example
Format continued…		will be if the field is a pre-determined length e.g. DATETIME or as a maximum number of characters that may be accommodated in that field. **XML** eXtensible Mark-up Language (XML) is used to provide a structure for data that is both human and machine readable. The structure specified in data items describes the way the data is stored in the data set, not how the data will be presented to staff for entry.
Source	Indicates the source of the coding used for the data item.	**NHS DM&D**[10] - [NHS Data Model & Dictionary, maintained by HSCIC] **SNOMED CT**[11] - [Systematized NOmenclature of MEDicine--Clinical Terms, maintained by HSCIC] **ODS** [12] - [Organisational Data Services – Maintained by HSCIC]
Entry	How the data field should be populated, e.g. by which staff group/IT system	**CLINICAL** **CLERICAL** **AUTOPOPULATED**
Requirement	The requirement for collection: for which patients is the data required, and to where the data is sent.	**NATIONAL**– Mandatory, required for national reporting Or **LOCAL** – Optional, not required for central reporting but ensures consistent data structures for research, audit and benchmarking etc. Required for **ALL** patients Or **OPTIONAL**
Provenance	Origin of the data field.	**CDS** - When the data item is unchanged from the current CDS version 010 data set **CDS (replaces 'Doctor Name')** - When the current CDS version 010 collects the same data but ECDS will change the name/ format/ code set. **NEW -** When the data item proposed is not currently collected in any format in CDS version 010.
Justification	Why it is necessary to collect this data item, and how this data will be used to benefit patients and the NHS.	Person_Residence_Type Will support the identification of rates of ED treatment, admission and discharge of populations of patients. Will also aid planning and delivery of care for these

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[10] http://systems.hscic.gov.uk/data/nhsdmds

[11] http://systems.hscic.gov.uk/data/uktc

[12] http://systems.hscic.gov.uk/data/ods/

Data field	Definition	Options/Example
		population groups at both a local and national level.
Notes	Should include information regarding use e.g. How a question should be asked, detail about how data should be coded, how many data items may be entered in each field and detail about how to deal with overlap conditions that could potentially be coded in multiple ways	EmCare_Diagnosis Up to 5 diagnosis codes will be accepted. The order of diagnosis should reflect the relevance each diagnosis to the current presentation – if a patient with heart failure has a syncopal episode from a probable arrhythmia, and falls fracturing their neck of femur, this is coded: #NoF (confirmed)/ Arrhythima (working diagnosis)/ CCF (confirmed)
Code Set	The codeset to be used, if any. If not known, then detail regarding when this work will be completed, and by which organisation.	SNOMED CT '63481000000130	Emergency care diagnoses '

1.5. Quick reference

Each data item is accompanied by quick reference tabs which relate to the data dictionary structure and help to highlight key characteristics of the data item.

Data Entry Role

One of the ECDS project objectives is to minimise the burden of data collection on all staff, particularly clinical staff. Therefore wherever possible we have proposed which staff group should collect the data item. Where possible the ECDS encourages the auto population of information so reduce the duplication of data collection, however it is recognised that the ability to do this will depend on the information system in use.

AUTO   This item would normally be entered by the computer system without any direct human intervention. e.g. when a referral to an inpatient unit is made, this will be time and date stamped by the system without any further input from the clinician.

CLERICAL   This item would normally be entered by clerical staff

CLINICAL   This item would normally be entered by clinical staff

Provenance

The provenance of the data items is important to be able to understand whether items are already collected as part of CDS Type 010 or are new.

CDS   This item is a current part of CDS Type 010. This means that this data item is already collected, although some of these data items may be updated in range and/or format.

NEW   This item is a new item.

Local/ National data flow

Some items need to be submitted nationally for many reasons including commissioning, research and remuneration, whereas some items are only ever collected for local use. All data flow is governed by national Information Governance arrangements.

LOCAL

This data will **not** be transmitted nationally. Collection of local data in a standardised format ensures that if further patient details are needed e.g. commissioning, contact tracing, audit/ research etc. then they are in a consistent format.

NATIONAL

All data marked 'National 'will flow nationally.

2. Data Dictionary for the Emergency Care Data Set

2.1. Person Demographics

Field name	Format	Source	Entry	Requirement	Provenance
Person_Given_Name	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL	ALL - LOCAL ALL - NATIONAL	CDS
Person_Family_Name	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL	ALL - LOCAL ALL - NATIONAL	CDS
Person_Stated_Gender	ALPHANUMERIC (1)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
Person_Birth_Date	DATE (10)	NHS DM&D	AUTO	ALL - LOCAL ALL - NATIONAL	CDS
Person_Age_At_Attendance	NUMBER (6)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
Person_NHS_Number	NUMBER (10)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
Person_NHS_Number_Status_Indicator	ALPHANUMERIC (2)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
Person_Identity_Withheld_Reason	ALPHANUMERIC (2)	NHS DM&D	CLERICAL	OPTIONAL NATIONAL	CDS
Person_Local_Number	ALPHANUMERIC (20)	NHS DM&D	CLERICAL AUTO	OPTIONAL - LOCAL ALL - NATIONAL	CDS
Person_Usual_Address1	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
Person_Usual_Address2	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
Person_Usual_Address_Postcode	ALPHANUMERIC (max 10)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
Person_Residence_Org_Code	ALPHANUMERIC (max 10)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
Person_Residence_Type	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
Person_Residence_LSOA	ALPHANUMERIC (max 10)	ONS	AUTO	ALL - NATIONAL	NEW
Person_Preferred_Contact	ALPHANUMERIC (max 255)	NHS DM&D/XML	CLERICAL	OPTIONAL - LOCAL	NEW
Person_GP_Practice_Code	ALPHANUMERIC (max 6)	ODS	CLERICAL	ALL - NATIONAL	CDS
Person_Comm_Lang	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
Person_Interpreter_Rqd	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
Person_Interpreter_Lang	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
Person_Ethnic_Category	ALPHANUMERIC (max 2)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS

Field name	Format	Source	Entry	Requirement	Provenance
Person_School	ALPHANUMERIC (max 10)	ODS	CLERICAL	ALL - LOCAL	NEW
Person_Companion	ALPHANUMERIC (max 255)	NHS DM&D	CLERICAL	OPTIONAL - LOCAL	NEW
Person_Special_Patient_Note_Local	ALPHANUMERIC (max 4096)	NHS DM&D	CLINICAL AUTO	OPTIONAL - LOCAL	NEW
Person_Additional_Information	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO	OPTIONAL - LOCAL	NEW
Person_Adverse_Reaction	ALPHANUMERIC (max 4096)	tbc	AUTO	OPTIONAL - LOCAL	NEW
Person_Cormorbidities	ALPHANUMERIC (max 255)	tbc	AUTO	ALL - NATIONAL	NEW
Person_Current_Meds	ALPHANUMERIC (max 4096)	SNOMED/ XML / DM&D	AUTO	OPTIONAL NATIONAL	NEW

2.1.1.   Person_Given_Name

CLERICAL

LOCAL

CDS

Definition

The legally recognised first/given name for the person.

Format

ALPHANUMERIC (max 35)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is:

ALL - NATIONAL

Provenance

CDS replaces

- PATIENT NAME (change to name)

Justification

Patient identifier mainly used in local system.

Notes

Not flowed nationally necessary unless NHS number is absent (see Information Governance section).

Further given names are not recorded.

Code Set

None

2.1.2.   Person_Family_Name

CLERICAL

LOCAL

CDS

Definition

The legally recognised family name (surname) of the person.

Format

ALPHANUMERIC (max 35)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is:

ALL - NATIONAL

Provenance

CDS replaces

- PATIENT NAME (change to name.)

Justification

Patient identifier mainly used in local system.

Notes

Not flowed nationally necessary unless NHS number is absent (see Information Governance section).

Code Set

None

2.1.3. Person_Stated_Gender

CLERICAL

NATIONAL

CDS

Definition

The state of being male or female (typically used with reference to social and cultural differences rather than biological ones).

Format

ALPHANUMERIC (1)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- PERSON GENDER CODE CURRENT (change to name)

Justification

Necessary to collect and transmit 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.

Notes

This item could be derived from the NHS Number if this is available.

World Health Organisation definitions[13]:

- "Sex" refers to the biological and physiological characteristics that define men and women.

- "Gender" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

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[13] http://www.who.int/gender/whatisgender/en/   [accessed 29/4/2015]

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. Gender may be inferred from other cues such as observation, relationship to respondent, or first name.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment or transgender reassignment. However, throughout the process, which may be over a considerable period of time, a person will usually identify with a specific gender allowing gender to clearly be recorded as either Male or Female.

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

Code Set

Code	Descriptor
1	Male
2	Female
9	Indeterminate
X	Unknown (not recorded)

2.1.4. Person_Birth_Date

AUTO

LOCAL

CDS

Definition

The person's date of birth.

Format

DATE (10)

Source

NHS DM&D

Entry

AUTO-POPULATED from NHS spine if available.

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is: ALL - NATIONAL

Provenance

CDS replaces

- PERSON BIRTH DATE (change in name)

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 population need.

Notes

This item will be auto-populated from the NHS spine using NHS Number if this is available.

This data item will only flow nationally if the NHS Number is not known.

If a person's birth date is unknown, the Person_Age_At_Attendance field can still be completed with an estimated age. If a date of birth is subsequently entered, the Person_Age_At_Attendance field should be over-written with the correct age.

Code Set

None

2.1.5. Person_Age_At_Attendance

AUTO

NATIONAL

CDS

Definition

The person's age at the date of first contact in the emergency care facility.

Format

NUMBER (6)

Structure: Age in completed years + '.' + number of completed months (01-11) with a leading zero for single digits e.g.

1.07	24.05	39.11

Source

NHS DM&D

Entry

AUTO-POPULATED from Person_Birth_Date if available

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- AGE AT CDS ACTIVITY DATE (change to name and format to capture age in months)

Justification

Person_Age_At_Attendance is necessary to allow the dataset to be anonymised while still preserving a non-attributable marker of a person's age. This is common practice in NHS data sets and this item therefore does not duplicate Person_Birthdate.

Age of the patient which is important to understand patterns of healthcare use, and to enable commissioners to commission the correct services to meet population need.

Notes

Normally calculated at the date of first contact in the emergency care facility.

If the date of birth is **not** known e.g. for an unconscious patient, an estimated age may be entered instead. If Person_Birth_Date is subsequently entered, the Person_Age_At_Attendance field should be over-written with the correct age.

Code Set

None

2.1.6. Person_NHS_Number

CLERICAL

NATIONAL

CDS

Definition

The person's unique NHS identifier.

Format

NUMBER (10)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- NHS NUMBER - PATIENT IDENTITY (change in name)

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.

Part of the Automatic Identification and Data Capture (AIDC) for Patient Identification Data Set Overview, which supports the accurate, timely and, therefore, safer identification of NHS patients in England, by encoding the key patient identifiers into a GS1 DataMatrix 2D bar code which is printed on the identity band.

It is a technology enabling standard: implementation of this standard will enable subsequent processes involving the patient and care provided to the patient (where these processes are also bar coded) to be automatically identified using Automatic Identification and Data Capture (AIDC) techniques, e.g. bed management, phlebotomy, theatres management, medications administration and assets management.

Notes

The person's unique NHS identifier that is matched with the patient through a local database and / or the NHS Spine. This data item is linked with Person_NHS_Number_Status_Indicator.

Standardised format as per NHS data dictionary (9 digit + checksum).

If there is no NHS number then this data item reported as null and other unique identifiers will need to flow as per national process outlined in section 1.3 of this paper.

Code Set

None

2.1.7. Person_NHS_Number_Status_Indicator

Definition

The status of the NHS number.

Format

ALPHANUMERIC (2)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- NHS NUMBER STATUS INDICATOR CODE (change in name)

Justification

This is the companion item to the NHS Number and is always reported with the NHS Number.

Notes

The code set should be presented by order of the codes to ensure usability.

Code Set

Code	Descriptor
01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS Number or PATIENT detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old)

2.1.8. Person_Identity_Withheld_Reason

CLERICAL

NATIONAL

CDS

Definition

The reason why a person's record has been purposely anonymised.

Format

ALPHANUMERIC (2)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL – NATIONAL

(Mandatory for all patients who withhold identity – standard NHS business rules)

Provenance

CDS replaces

- WITHHELD IDENTITY REASON (change in name)

Justification

Used in Data Group 'Withheld Identity Structure' in Commissioning Data Sets (version 6-2 onwards). It allows suppliers of Commissioning Data Set records to indicate to recipients of the record (for example, the Commissioner of the activity) that the record has been purposely anonymised for a valid reason.

Notes

If used, the Person_NHS_Number_Status_Indicator and Person_ Residence_Org_Code must still be transmitted, but NHS Number, Name, Address, Postcode and Birthdate are not sent.

Code Set

Code	Descriptor
01	Record anonymised for legal/ statutory reasons
02	Record anonymised at request of Caldicott Guardian
03	Record anonymised at request of patient
97	Record anonymised for other reason
99	Identity withheld but reason not known

2.1.9. Person_Local_Number

CLERICAL

LOCAL

CDS

Definition

The person's unique identifier given by the hospital in which the person is first treated.

Format

ALPHANUMERIC (20)

Source

NHS DM&D

Entry

CLERICAL / AUTO-POPULATED from local IT systems

Requirement

OPTIONAL - LOCAL

Unless patient admitted when is: ALL – NATIONAL

Provenance

CDS replaces

- LOCAL PATIENT IDENTIFIER - PATIENT IDENTITY (change in name)

Justification

This is the local unique (**not** episode) identifier ['LocPatID'] given by the hospital facility to the patient that allows hospital records to be matched with emergency care records. The local number enables Public Health researchers and Commissioners to be able to track patient pathways across different providers to have a full picture of an episode of care. This is essential to understand healthcare utilisation and to enable provision of services that match population need.

Notes

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

Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.

This data item must be collected for all relevant patients that attend Type 1/ Type 2 EDs and are admitted.

No spaces should be included – underscore [_] should replace all spaces.

The hospital that issued this unique patient identifier will be the one identified by EmCare_Provider_Org_Code.

Code Set

None

2.1.10.   Person_Usual_Address1

AUTO

LOCAL

CDS

Definition

The first line of the person's address.

Format

ALPHANUMERIC (max 35)

Source

NHS DM&D

Entry

AUTO-POPULATED from NHS Number if available/ CLERICAL if not available

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is: ALL - NATIONAL

Provenance

CDS replaces

- PATIENT USUAL ADDRESS (change in name)

Justification

Person identifier mainly used in local system.

Necessary as part of contact information when follow-up necessary e.g. if result missed/ mis-interpreted.

Notes

In most circumstances, the first line of the address should include the house number and road. These details should be those recorded by the Land Registry e.g. do not use the house name unless that is what is recorded on the Land Registry.

If the patient is from abroad, this should be the country of origin only.

Not flowed nationally necessary unless NHS number is absent (standard NHS practice as detailed in the Information Governance section).

Code Set

None

2.1.11. Person_Usual_Address2

AUTO

LOCAL

CDS

Definition

The second line of the person's address.

Format

ALPHANUMERIC (max 35)

Source

NHS DM&D

Entry

AUTO-POPULATED from NHS Number if available/ CLERICAL if not available

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is: ALL - NATIONAL

Provenance

CDS replaces

- PATIENT USUAL ADDRESS (change in name)

Justification

Person identifier mainly used in local system. Necessary as part of contact information when follow-up necessary e.g. if result missed/ mis-interpreted.

Notes

In most circumstances, the second line of the address should include the village/ suburb and postal town. These details should be those recorded by the Land Registry.

If the patient is from abroad, this should be all the address except for the country of origin.

Not flowed nationally necessary unless NHS number is absent (standard NHS practice as detailed in the Information Governance section).

Code set

None

2.1.12.   Person_Usual_Address_Postcode

AUTO

LOCAL

CDS

Definition

The postcode of the place at which the person normally resides.

Format

ALPHANUMERIC (max 10)

Source

NHS DM&D

Entry

AUTO-POPULATED from NHS Number if available/ CLERICAL if not available

Requirement

ALL - LOCAL

Unless the NHS Number is not provided, in which case it is: ALL - NATIONAL

Provenance

CDS replaces

- POSTCODE OF USUAL ADDRESS (change in name)

Justification

Person identifier mainly used in local system. Necessary as part of contact information when follow-up necessary e.g. if result missed/ mis-interpreted.

Notes

For hotels, prison, sheltered housing or homeless in hostel, use postcode of building.

Not flowed nationally necessary unless NHS number is absent (standard NHS practice as detailed in the Information Governance section).

Code Set

Standard NHS Data Dictionary code set, which includes formatting instructions and specific codes for special/ country postcodes for situations not otherwise described e.g. person's normal country of residence (for visitors), homeless persons not in hostel etc.

2.1.13.   Person_Residence_Org_Code

AUTO

NATIONAL

CDS

Definition

The code allocated to the organisation (i.e. commissioning organisation) responsible for this person's care.

Format

ALPHANUMERIC (max 10)

Source

NHS DM&D

Entry

AUTO-POPULATED – calculated from Person_Usual_Address_Postcode using local lookup table.

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ORGANISATION CODE, RESIDENCE RESPONSIBILITY (change in name)

Justification

Necessary to enable the provider organisation to identify the commissioning organisation, and therefore essential to ensure remuneration to the provider to be matched with the patient episode.

Notes

Always transmitted nationally, even if identity withheld.

Code Set

Standard NHS Data Dictionary code set that includes specific codes for special/ country postcodes for situations not otherwise described e.g. overseas visitor.

2.1.14. Person_Usual_Residence_Type

CLERICAL

NATIONAL

NEW

Definition

The type of residence where the patient *usually* resides.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

NEW

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 will also allow specific incentives to be incorporated into any tariff arrangement.

Notes

For foreign nationals or persons on holiday code according to their usual accommodation type.

The code set should be presented by order of the codes to ensure usability.

This is a NEW item however the code set used is a subset of SNOMED codes currently collected in respect of Mental Health attendances.

Code Set

SNOMED	Descriptor	Includes	Excludes
242711000000100	Home	House, farm house, non-institutional place of residence, apartment/ flat, boarding house, hotel, caravan park, refuge	Institutional long-term place of residence Abandoned or derelict house
394923006	Residential institution **without** routine nursing care	Children's home, residential home, old people's home, military camp, prison, monastery	Hospital, nursing home, hospice, psychiatric hospital
160734000	Residential institution **with** routine nursing care	Nursing home, hospice	Hospital, residential home, psychiatric hospital
224225002	Medical service area	Hospital, clinic, Psychiatric hospital (long term)	Hospice, nursing home
224231004	Homeless in temporary accommodation	Night shelter, homeless shelter	
32911000	Homeless without accommodation	Homeless, abandoned or derelict housing	Night shelter, homeless shelter

2.1.15. Person_Residence_LSOA

AUTO

NATIONAL

NEW

Definition

Lower Super Output Area of a person's current place of residence

Format

ALPHANUMERIC (max 10)

Source

Office of National Statistics (ONS)

Entry

AUTO-POPULATED from Person_Usual_Address_Postcode using ONS lookup tables.

Requirement

ALL - NATIONAL

Provenance

NEW

Justification

The Lower Layer Super Output Area is the geographical coding system used by the Office of National Statistics to aggregate data for health and social care analysis.

This item is necessary to identify rates of ED treatment, admission and discharge of specific populations of patients.

In government and social care deprivation indices are mapped using LSOA, and as deprivation is known to be a factor in Emergency Care use, the collection of data in this format will substantially aid planning and delivery of care for specific population groups at both a local and central level.

Notes

The LSOA is used in anonymised datasets to minimise the risk of patient identifiable data e.g. used in the NHS Sexual Health/Genitourinary Medicine data set for this reason.

Code Set

Derived from Person_Usual_Address_Postcode using a lookup table from Office of National Statistics.

http://www.ons.gov.uk/ons/guide-method/geography/products/postcode-directories/

2.1.16.   Person_Preferred_Contact

CLERICAL

LOCAL

NEW

Definition

The person's preferred method of contact.

Format

ALPHANUMERIC (max 255)

XML to include modes of contact in tags e.g.

> <email>president@whitehouse.gov</email>
>
> <mobile>0777987654321</mobile>
>
> <home phone>0201234567890</home phone>

Source

NHS DM&D / XML

Entry

CLERICAL

Requirement

OPTIONAL - LOCAL

Provenance

NEW as part of data set, but currently routinely collected locally.

Justification

At least one of home phone, mobile phone and email should be completed to allow immediate contact for follow-up in the event of unexpected results.

Common reasons for this would be that a diagnosis changes or a result from a test that may take several days becomes available - e.g. if missed fracture, bacterial growth from blood cultures.

Notes

The XML tag structure enables current common modes of contacting patients to be used but also allows these to be extended in the future without re-writing the data structure.

Optional, but at least one of home phone, mobile phone and email should be completed to allow immediate contact for follow-up e.g. if missed fracture.

A clear statement should be made regarding the use of this information:-

> *"Your contact details will only be used in relation to aspects of your direct care and will not be shared with any other organisation".*

No zeros, spaces or brackets should be in the data, as the number may be re-formatted for display using these conventions.

Non-UK phone numbers, should be prefixed with +, country code and then phone number, with leading zero removed, if necessary.

Email addresses should be checked for validity using standardised e.g. regular expression algorithms.

Code Set

None

2.1.17. Person_GP_Practice_Code

Definition

The NHS Organisational Data Services code of the practice at which the person is registered.

Format

ALPHANUMERIC (max 6)

Source

ODS

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- GENERAL MEDICAL PRACTICE CODE (change in name)

Justification

Necessary for communication of a person's on-going care needs.

Notes

Should be implemented in a way that allows common choices to be coded easily.

Code Set

ODS codes, including specific codes for certain situations (foreign national, no GP etc.)

2.1.18.   Person_Comm_Lang

CLERICAL

NATIONAL

NEW

Definition

The person's preferred communication language.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

NEW

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. As translation resources are procured nationally, this data is necessary to ensure that provision matches need.

Notes

The options must be presented by the ED Information System ordered by the sort order specified in the Code Set to aid the usability of ECDS for clerical staff.

The standard question to ask is:

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

Where a person is not able 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.

Code Set

Please see Appendix C

The code set presented is adapted from a national standard data set, ordered to ensure maximum usability.

2.1.19. Person_Interpreter_Rqd

CLERICAL

NATIONAL

NEW

Definition

Whether a person requires an interpreter to communicate successfully.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

NEW

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. As translation resources are procured nationally, this data is necessary to ensure that provision matches need.

Notes

Answers the question: "Does the patient require an interpreter to communicate?"

The question 'Do you require an interpreter?' is asked to determine need for an interpreter, not the capacity of the hospital to provide an interpreter.

'Communication Language' should always be asked before 'Interpreter Required'.

If the person's communication language is English, Interpreter Required can be assumed to be 'No'.

This information must:

- Be checked for every admitted patient episode

- Be collected on, or as soon as possible after, registration.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

Use 'Yes' if the person indicates they need an interpreter, or your interpretation is that clear communication would not be guaranteed without an interpreter.

Use 'No' if the person indicates that they do not need an interpreter/ if preferred language is English.

Where a person is not able 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.

Code Set

SNOMED Code	Term
315595002	No/ not known
315594003	Yes

2.1.20.   Person_Interpreter_Lang

CLERICAL

NATIONAL

NEW

Definition

The language of the interpreter needed to allow the person to communicate successfully.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL – NATIONAL **if** Person_Interpreter_Rqd = Yes

Provenance

NEW

Justification

Necessary to provide for patient needs and prevent harm that may occur through inadequate understanding. Necessary at a national level to understand the need for provision and therefore how services should be organised to meet these needs. As translation resources are procured nationally, this data is necessary to ensure that provision matches need.

Notes

The options must be presented by the ED Information System ordered by the sort order specified in the Code Set to aid the usability of ECDS for clerical staff.

The standard question to ask is:

"What language interpreter should we ask for? "

Where a person is not able to consent for themselves (e.g. baby, child or confused) then an interpreter of the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.

Code Set

Please see Appendix D

2.1.21.   Person_Ethnic_Category

CLERICAL

NATIONAL

CDS

Definition

The person's description of their ethnic origin.

Format

ALPHANUMERIC (max 2)

Source

NHS DM&D (Patient Demographics Service)

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ETHNIC CATEGORY - PATIENT CHARACTERISTICS, A AND E (change in name and code set)

Justification

Necessary to ensure equity of access to medical care.

Notes

Systems should not be set up to enter a default code.

The code set should be presented by order of the codes to ensure usability.

Patients should be presented with the Code Set and asked "Which one of these groups most closely matches your ethnic origin?"

Update in code set is required as CDS 010 list does not reflect the current mix of UK population.

The proposed code set below is a standard from the NHS Patient Demographics Service.

Code Set

Please see Appendix E

2.1.22.   Person_School

CLERICAL

LOCAL

NEW

Definition

The name of the person's normal place of education or childcare.

Format

ALPHANUMERIC (max 10)

Source

ODS

Entry

CLERICAL

Requirement

ALL – LOCAL for all children/young adults 4-16 years

Provenance

NEW

Justification

This data is an integral part of safeguarding process, to enable protection of vulnerable children. It may help to detect and monitor abnormal patterns of behaviour that may signify issues within the school e.g. injuries, bullying.

This data is also helpful to detect abnormal patterns of disease that may be clustered within schools e.g. meningococcal meningitis, measles.

Notes

The name of the patient's normal place of education or childcare.

Should be implemented in a way that allows common choices to be coded easily.

If child is between schools and new school known, use that school, otherwise code as old school.

This data is already routinely collected in EDs but not necessarily in the Data Dictionary approved format.

Code Set

[NHS ODS code set for educational establishments including those codes for special circumstances e.g. child from abroad, child home-schooled etc.]

2.1.23.   Person_Companion

CLERICAL

LOCAL

NEW

Definition

The person attending with the patient.

Format

ALPHANUMERIC (max 255)

Source

NHS DM&D

Entry

CLERICAL

Requirement

OPTIONAL - LOCAL

Provenance

NEW

Justification

This is particularly important in child safeguarding work when many people who may not be related to the child may bring the child to hospital, and it is a common mistake to assume a close family relationship between a child and adult who attend together.

Notes

The person attending with the patient, when that person is not a first-degree relative e.g. parent or child.

Presentations where person attending may have reduced capacity for autonomous decision-making e.g. child, elderly and confused, and who is accompanied by a person who is not their first-degree relative.

If it is possible that domestic violence is involved, caution is advised regarding recording this detail.

The role of the companion should also be described wherever possible, preferably in brackets.

Examples include a grandparent, carer, guardian, school teacher or nurse, police, custodial staff e.g.

Mr John Brown [carer], Mrs J Smith [schoolteacher]

This data is already routinely collected in ED's but not necessarily in the Data Dictionary approved format.

Code Set

None

2.1.24. Person_Special_Patient_Note_Local

Definition

A record of confidential details that may be relevant to people who attend the ED.

Format

ALPHANUMERIC (max 4096)

Source

NHS DM&D

Entry

AUTO-POPULATED from previous encounters

CLINICAL for new information

Requirement

OPTIONAL - LOCAL

Provenance

NEW

Justification

This information is routinely collected in ED's and provides the organisational memory for the ED's. Historically it has been stored in a variety of insecure formats e.g. lever arch files, Excel spreadsheets, local insecure databases.

It is necessary to provide an organisational memory regarding the optimum treatment plan for certain patients.

By ensuring this information is collated, stored securely and available to the clinician at time of treatment, good patient care is facilitated.

Notes

Confidential details that may be relevant about patients who attend the ED e.g. risk of violence to staff or others, management plans for patients who attend regularly with specific conditions such as self-harm.

This information would be discoverable under the Freedom of Information Act/ Data Protection Act and therefore must be factual, avoid opinions and be up to date. This section should not include details (e.g. ex-partner's contact details) to which the patient should not have access.

These should *not* include general medical details but may be appropriate to include specific medical details that are relevant to treatment in the ED for which specific guidance would otherwise be lacking. These might be viewed as a more up to date and private version of the 'sticker on the front of the notes'.

Possible items that might be included in this area are:

- Haemophiliac, normal treatment is…

- Hereditory angioedema, treatment is …

- History of violence

- Transplant patient

- Visually impaired

- Hearing impaired

- Communication difficulties

- Chronic pain

- Special needs

- Care plan available

- Advance directives details

- Contact details of relevant other health professionals

Entries into this data field must only be performed by a senior clinician and must be timed and dated, and a system to ensure review must be included.

Code Set

None

2.1.25.   Person_Additional_Information

AUTO

LOCAL

NEW

Definition

A record of a person's specific medical details that are relevant to treatment in the ED.

Format

ALPHANUMERIC (max 4096)

Source

NHS DM&D

Entry

AUTO-POPULATED from Summary Care Record 'Additional Information'/local information sharing

Requirement

OPTIONAL - LOCAL

Provenance

NEW

Justification

This information may be routinely collected and used in ED's and may be stored in a variety of insecure formats e.g. lever arch files, Excel spreadsheets, local insecure databases. It is necessary to provide an organisational memory regarding the optimum treatment plan for certain patients, and this is particularly the case for those patients who move from hospital to hospital either because they are visiting another area, or sometimes because they have an itinerant or chaotic lifestyle.

By ensuring this information is collated, stored securely and available to the clinician at time of treatment, good patient care is facilitated.

Communication of care needs is particularly important in End of Life care and this field allows that data to flow from the organisation co-ordinating care (the General Practitioners) to the Emergency Care providers via the Summary Care Record.

Notes

This field, which exists as a recognised NHS Data Dictionary entity within the Summary Care Record, is the correct way to record and share this information.

This item may include general items from the Summary Care Record 'Additional Information'[14] field that are available, and is an optional field. The information contained in this will be held locally and will not be flowed nationally.

This information is solely that from the Summary Care Record or local information sharing agreement.

The information should include specific medical details that are relevant to treatment in the ED. These might be viewed as a more modern and private version of the 'sticker on the front of the notes'.

Possible items that might be included in this area are:

- Haemophiliac, normal treatment is…

- Hereditary angioedema, treatment is …

- History of violence

- Transplant patient

- Visually impaired

- Hearing impaired

- Communication difficulties

- Chronic pain

- Special needs

- End Of Life Care plan (ISB 1580 standard)

- Contact details of relevant other health professionals

Code Set

None

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[14] Summary Care Record Quick Guide EMIS Web SCR v2.1 HSCIC Aug 2015

2.1.26.   Person_Allergies_Adverse_Reaction

AUTO

LOCAL

NEW

Definition

A record of any specific allergies and adverse reactions the person has.

Format

ALPHANUMERIC (max 4096)

Source

To be confirmed

Entry

AUTO POPULATED

Detail from previous patient episodes will be entered automatically from the Summary Care Record or the local IT system.

Requirement

OPTIONAL - LOCAL

Provenance

NEW

Justification

Allergy and adverse reactions are a major source of preventable patient harm in hospital, and recording and delivering this information systematically is a key benefit of an ED Information System.

Notes

This information should be recorded early in the patient attendance, and should be visible next to any drug prescription charting produced by an EDIS.

A fully implemented electronic patient record system will include this functionality.

This item is from the Academy of Royal Medical Colleges' report 'Standards for the clinical structure and content of patient records'[15].

As per AoRMC report, this data item should include as much relevant detail as possible regarding:

- causative agent
- description of the reaction
- probably of recurrence

---

[15] Standards for the clinical structure and content of patient records (2013) Academy of Royal Medical Colleges

- date first experience

If No Known Drug Allergies, 'NKDA' should be reported.

Code Set

[An internationally agreed allergy classification structure will be finalised in SNOMED/ XML in autumn 2015 and will be used to define this data item.]

2.1.27.   Person_Comorbidities

AUTO

NATIONAL

NEW

Definition

A record of whether a person has any of the NHS list of medical co-morbidities.

Format

ALPHANUMERIC (max 255)

Source

To be confirmed

Entry

AUTO-POPULATED

This data will be entered automatically from the patient's local electronic health record or in from a local or national care record system. Data entry will **not** be performed by ED staff.

Requirement

ALL – NATIONAL

(**OPTIONAL** to collect depending on IT system capability, but if collected, should flow nationally)

Provenance

NEW

Justification

Co-morbidities are a key determinant in patient care e.g. whether it is safe to treat a patient in the community or whether a patient should be admitted to hospital e.g. for pneumonia, cellulitis.

An accurate list of co-morbidities and current medications are therefore essential pieces of knowledge in the effort to minimise inpatient admissions and risk to patients – ensuring the right treatment in the right place.

Flowing this data nationally allows a better understanding of the factors that predict complexity of emergency care which in turn allows accurate commissioning of services to meet the needs of patients in the best and most effective way e.g. if there are many attendances for patients with diabetes-related complaints, would a community nurse be an effective intervention to 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.

Notes

If the patient's GP has identified that the patient has any of the NHS list of medical co-morbidities, these should be listed here.

A fully implemented electronic patient record system will include this functionality.

This item should **not** allow ED clinicians to enter data – this is just a holder for information drawn from either the SCR or a local equivalent. The ED Information System must draw this information down from the database automatically *without any clinician input*.

Code Set

Please see Appendix F.

2.1.28.   Person_Current_Meds

AUTO

NATIONAL

NEW

Definition

A record of a person's current medications.

Format

ALPHANUMERIC (max 4096)

Source

SNOMED / XML / NHS DM&D

Entry

AUTO-POPULATED

This data will be entered automatically from the patient's Summary Care Record, available through the NHS Spine. Data entry will **not** be performed by ED staff.

Requirement

ALL – NATIONAL

(**OPTIONAL** to collect depending on IT system capability, but if collected, should flow nationally)

Provenance

NEW

Justification

Knowledge of a person's current medications is a crucial first step to minimise the risk of drug interactions, which are a major preventable cause of patient harm. Patients attending the ED rarely bring a list of their current medication.

The Summary Care Record contains an accurate list of the current medications, which is kept up to date from the GP's IT systems. An accurate, up to date list of patient medications is a key piece of knowledge to minimise risk to patients by preventing drug interactions. Ensuring this information is available at point of care minimises risk of inappropriate treatment and can facilitate implementation of guidelines and decision support e.g. testing and management of anticoagulant or anti-epileptic medication.

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 medication-related complaints, would a community nurse be an effective intervention to prevent these?

Notes

This data will be entered automatically from the patient's Summary Care Record, available through the NHS Spine. Data entry will **not** be performed by ED clinicians.

Code Set

[as per Summary Care Record medication data]

2.2. Episode Demographics

Field name	Format	Source	Entry	Requirement	Provenance
EmCare_Provider_Org_Code	ALPHANUMERIC (max 9)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Provider_Site_Code	ALPHANUMERIC (max 9)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Provider_Site_Type	ALPHANUMERIC (max 1)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Unique_ID	NUMBER (12 characters zero-filled)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Arrive_Transport_Mode	NUMBER (2 characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
EmCare_Amb_Unique_ID	ALPHANUMERIC (max 20)	NHS DM&D	CLERICAL	ALL - NATIONAL	NEW
EmCare_Arrive_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Attendance_Type	NUMBER (2 Characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
EmCare_Referral_Source	NUMBER (2 characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
EmCare_Arrive_Transfer_Source	ALPHANUMERIC (max 9)	NHS DM&D ODS	CLERICAL	ALL - NATIONAL	NEW
EmCare_Assess_DateTime	DATETIME	NHS DM&D	AUTO	ALL - NATIONAL	CDS
Em_Care_Clinicians	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Referred_Service	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO CLINICAL	ALL - NATIONAL	NEW
EmCare_DTA_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	NEW
EmCare_Complete_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Depart_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
EmCare_Admit_Specialty	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW

2.2.1. EmCare_Provider_Org_Code

AUTO

NATIONAL

CDS

Definition

The organisation code of the organisation that issued the person's unique Local Patient Identifier (LocPatID).

Format

ALPHANUMERIC (max 9)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL – NATIONAL

Provenance

CDS replaces

- ORGANISATION CODE (change in name.)

Justification

This data item helps to identify the patient's unique inpatient record.

This item is essential so that through the SUS mechanism, patient treatment activity can generate appropriate remuneration.

There are additional benefits in understanding activity and demand and being able to model these for commissioning, research and Public Health.

Notes

Used in combination with Person_Local_Number.

Code Set

None

2.2.2. EmCare_Provider_Site_Code

AUTO

NATIONAL

CDS

Definition

The organisation site code using the standard NHS Data Dictionary ODS terms.

Format

ALPHANUMERIC (max 9)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- SITE CODE (TREATMENT) (change in name)

Justification

Used to track patient pathway/episode. A single provider organisation may have multiple site codes depending on geography and different modes/types of services provided.

This item is essential so that through the SUS mechanism, patient treatment activity can generate appropriate remuneration.

There are additional benefits in understanding activity and demand and being able to model these for commissioning, research and Public Health.

Notes

This uses a standard maintained list of organisational codes, and is the same for all patients in a particular site, although co-located primary care facilities would generally have their own code.

Code set

None

2.2.3. EmCare_Provider_Site_Type

AUTO

NATIONAL

CDS

Definition

The emergency care site type.

Format

ALPHANUMERIC (max 1)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY DEPARTMENT TYPE (change in name)

Justification

Emergency care is delivered in many different settings, and the value-added by these different modes of healthcare in different environments is very poorly understood. This data describes the type of site providing the care so that commissioners can understand the casemix, acuity and value-added, which in turn enables accurate provision of resources to match patient need.

The coding system is primarily designed for ED and Ambulatory Emergency Care use. The additional codes for other modes of urgent care delivery allow commissioners to use a common system for these if wanted.

Notes

The emergency care site type, based on the standard NHS Data Dictionary terms for the different types of ED.

While ECDS has been developed to ensure the needs of ED's, Urgent Care Centres and Ambulatory Emergency Care will be met, we are aware of other clinical settings that may want to use ECDS, and therefore have included these in the code set for compatibility.

Code Set

Code	Descriptor
1	Type 1 – General Emergency Department (24 hour)
2	Type 2 – Specialist Emergency Department (e.g. paediatric, ophthalmology)
3	Type 3 – Minor Injury Unit
4	Type 4 – Walk in Centre
X	Emergency Centre *with* Specialist Services e.g. Trauma/ Stroke/ Vascular/ Cardiac
Z	Emergency Centre *without* specialist services (24 hour)
U	Urgent Care Centre (including non-24 hour Emergency Department)
F	Specialist Receiving Facility
A	Ambulatory Emergency Care
E	Elderly Care Assessment Unit
M	Medical Assessment Unit
S	Surgical Assessment Unit
C	Community based assessment (not General Practitioner)
G	Community based assessment (General Practitioner)
9	Ambulance Service

2.2.4. EmCare_Unique_ID

AUTO

NATIONAL

CDS

Definition

Local unique identifier of patient episode.

Format

NUMBER (12 characters zero-filled)

Source

NHS DM&D

Entry

AUTOPOPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- A and E ATTENDANCE NUMBER (change in number structure to avoid mismatching of patient records)

Justification

A consistent format for the local identifier is necessary to identify each attendance.

This item is necessary to track an individual attendance, and is particularly important in data that has been anonymised as it still allows individual episodes of care to be identified, although these are not traceable back to the patient outside the provider organisation that is able to match the Unique ID to the patient.

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

Notes

Must be a 12 digit zero-filled incremental attendance counter e.g. 000000042355

Having a consistent unique record identifier will enable a consistent interface for data tracking e.g. commissioning, contact tracing, research, audit.

Some ED information systems reset the counter every year. These systems should be implemented as year + 8 digit zero-filled number e.g. 201600042355.

Implementation

- The EmCare_Unique_ID must be generated at the time of first contact within the ED, whether clinical assessment or reception desk.

- An EmCare_Unique_ID *must not be changed*: if there is a problem with an EmCare_Unique_ID, the visit should be deleted and re-started with a new EmCare_Unique_ID.

- An EmCare_Unique_ID *must never be re-used*: it must not be re-assigned to another presentation for the same patient or to another patient.

- In the case of duplicate EmCare_Unique_IDs being recorded, one or (preferably) both must be deleted.

Code Set

None

2.2.5. EmCare_Arrive_Transport_Mode

CLERICAL

NATIONAL

CDS

Definition

The transport mode by which the patient arrived at the ED.

Format

NUMBER (2 characters)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY ARRIVAL MODE (change in name and code set)

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 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.

Notes

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

The code set should be presented by order of the codes to ensure usability.

e.g. patients transported by helicopter require road transportation to and/or from the transferring hospital. Assuming the air transport involves the greater distance, select code 31.

Code set

Code	Descriptor
11	Patient's own transport
12	Public transport
21	Emergency road ambulance NHS
22	Emergency road ambulance non-NHS
23	Emergency road ambulance with medical escort
31	Air Ambulance - helicopter
33	Fixed Wing/ Medical repatriation by air
51	Non-emergency road ambulance NHS
52	Non-emergency road ambulance non-NHS
81	Police/ Prison
97	Other specified
99	Unspecified

2.2.6. EmCare_Amb_Unique_ID

CLERICAL

NATIONAL

NEW

Definition

The unique identifier allocated to the emergency care episode when the patient arrives by ambulance.

Format

ALPHANUMERIC (max 20)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

All patients whose EmCare_Transport_Mode code is 21 - 50 (i.e. Ambulance/Helicopter/Aircraft)

Provenance

NEW

[Replaces current term AMBULANCE INCIDENT NUMBER (CDS version 010) – see Notes below]

Justification

Necessary to track patients through care systems, enabling commissioners to have a clear view of the relative value of different providers in the healthcare system.

In the current CDS version 010 the incident number is collected, however this is now no longer used within the ambulance service as the episode unique identifier. This is because although an incident number is still used, more than one ambulance may be called to a single incident and therefore the incident number is no longer unique to a single patient.

Ensuring a unique identifier is particularly helpful in the context of the current NHS push to ensure that as much care is delivered close to home - the 'Vanguard' models of care. It is necessary to be able to understand that by delivering more care by one mode e.g. Ambulance or Minor Injury Unit, it is reducing care delivered by another mode e.g. ED's.

Notes

This field should be auto-populated if there is a system to automatically upload the ambulance electronic notes into the hospital electronic patient record.

If the patient did not arrive by ambulance, this field should be null.

Code Set

None

2.2.7. EmCare_Arrive_DateTime

AUTO

NATIONAL

CDS

Definition

The time and date that the patient was first clinically assessed or registered in the ED / ambulatory care / assessment facility, whichever comes first.

Format

DATETIME (19 characters)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ARRIVAL DATE AT ACCIDENT AND EMERGENCY DEPARTMENT (change in format)
- ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (change in format)

Justification

Necessary starting point for all process metrics in Emergency Care that then flow into SUS e.g. four hour standard, time to see clinician, time to decision to admit etc.

Notes

Auto-populated when the clerical staff create a new patient attendance record.

The time and date that the patient was first clinically assessed or registered in the ED / ambulatory care / assessment facility, whichever comes first.

If EmCare_Assess_DateTime is earlier than EmCare_Arrive_DateTime (i.e. if a patient is clinically assessed before clerical details are taken), then EmCare_Arrive_Time should be set as the EmCare_Assess_DateTime.

Code Set

None

2.2.8. EmCare_Attendance_Type

CLERICAL

NATIONAL

CDS

Definition

The reason and nature for the person's visit to the healthcare provider.

Format

NUMBER (2 Characters)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- A AND E ATTENDANCE CATEGORY (change in name and code set)

Justification

Necessary to understand the reason and nature for the visit to the healthcare provider.

The increased clarity that the revised code set will bring will be important in commissioning services at local and national level. One of the most contentious areas in acute healthcare is whether patients who attend Emergency healthcare because other potentially more cost-effective alternatives have not been used or have failed. If patients attend Emergency healthcare despite having been seen recently in other healthcare settings, it may well be that the services currently commissioned are not effective.

The most recent evidence[16][17] suggest that the optimal horizon is approximately seven days, which is why this is chosen rather than 72 hours or 28 days.

Notes

Should be completed as soon as possible after arrival in 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?"

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[16] Patient Returns to the Emergency Department: The Time-to-return Curve (2014) Acad Em Med ; Rising KL et al

[17] Unscheduled return visits in adults to the Emergency Department (2015) EMJ ; Trivedy CR and Cooke MW

The code set should be presented by order of the codes to ensure usability.

Code Set

Code	Descriptor
11	Emergency presentation: Presentation due to a **new** clinical condition OR **deterioration** of a chronic condition
21	**Planned or anticipated** return visit **within seven days** following attendance at **this** health provider**. Includes ambulatory care.**
31	**Unplanned** attendance with **same/ related problem** as has attended **this** health provider in **within seven days**. Includes failed discharge
32	**Unplanned** attendance with **same/ related problem** as has attended **another** health provider in **within seven days**. Includes failed discharge.
61	Arranged admission
62	Patient in transit to another institution
63	Transfer from another medical institution for increased care
81	Dead on arrival – no intent/ attempt to resuscitate in Emergency Care facility
97	Other specified
99	Unspecified

2.2.9. EmCare_Referral_Source

CLERICAL

NATIONAL

CDS

Definition

The source from which patient was referred/advised to attend the ED.

Format

NUMBER (2 characters)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- SOURCE OF REFERRAL FOR A and E (change in name and code set)

This code set adapted from the Victorian Emergency Minimum Dataset (Australia).

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.

Notes

Source from which patient was referred/advised to attend the ED. **Not** mode of transport.

Nurse includes:

- District Nurse, Community Midwife, Health Visitor, nurses employed within Aged Care Residential Home, 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 this hospital or other acute care facility.

Code referral from radiology as GP or OPD depending on the source of the request for radiology.

The code set should be presented by order of the codes to ensure usability.

If more than one code *could* be selected, the *first* code should be selected.

Code set

Code	Descriptor
11	Self, family, friends,
12	Planned review/ Ambulatory Emergency Care patient
15	Carer (external, not family or friend)
21	GP/ practice nurse
22	Out of hours GP service
31	NHS Telephone/ internet advice e.g. NHS 111
32	Urgent care centre/ Minor injuries unit/ Walk-in centre
41	Nurse (*not practice nurse*) e.g. school nurse, community midwife, health visitor
42	Advanced Care Practitioner (community based)
43	Mental health assessment team
44	Social services
51	Inpatient - this hospital/ organisation
52	Outpatient – this hospital/ organisation
55	Inpatient – another hospital/ organisation
56	Outpatient – another hospital/ organisation
71	Pharmacist (including community pharmacist)
72	Dentist (including community dentist)
73	Optician/ optometrist
76	Private specialist
81	Police service/ Forensic medical officer/ Prison medical/ nursing team
82	Fire service
83	Search and rescue / Coastguard/ Mountain rescue
91	Non-NHS telephone / internet advice
97	Other specified
99	Unspecified

2.2.10.   EmCare_Arrive_Transfer_Source

Definition

The ODS code of the healthcare facility from which the patient has been transferred to this ED.

Format

ALPHANUMERIC (max 9)

Source

NHS DM&D, ODS

Entry

CLERICAL

Requirement

ALL - NATIONAL

All presentations where EmCare_Referral_Source = 55 or 56 (another hospital)

Provenance

NEW

Justification

This data necessary to link records for the (rare, but high acuity) patients who are transferred between institutions. As acute care networks and retrieval/ transfer arrangements become more common, recording this information will be increasingly important for commissioners of services to understand patient pathways, and where in the pathways value is added.

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.

Notes

The ODS code of the healthcare facility from which the patient has been transferred to this ED.

If transfer from overseas hospital code as per ODS standard.

This data is already collected for some inter-hospital transfers e.g. neonates and this allows patient tracking between organisations.

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, Trauma.

Code set

None

2.2.11.   EmCare_Assess_DateTime

AUTO

NATIONAL

CDS

Definition

The date and time the patient was first *clinically* assessed in the Emergency Care facility.

Format

DATETIME (19 characters)

Source

NHS DM&D

Entry

AUTO-POPUALTED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY INITIAL ASSESSMENT DATE (change in name and format)
- A and E INITIAL ASSESSMENT TIME (change in name and format)

Justification

This process data is necessary to understand and optimise the care process within emergency care. The elapsed time from arrival to assessment is used as the key quality metric as ensuring that patients are assessed by a 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.

Notes

The date and time the patient was first *clinically* assessed in the Emergency Care facility.

This is auto-populated when the clinician first takes responsibility for the patient, by assigning their name to the patient immediately before physically going to see the patient.

Clinician in this field is any member of staff registered by the General Medical Council, Nursing and Midwifery Council or Health and Care Professions Council and authorised to treat patients independently.

This may include:

- The taking of a brief patient history

- Pain assessment and treatment

- Vital signs / early warning score

Depending on the model of care used, this may be either the same as the EmCare_Arrive_DateTime or EmCare_Clinician_DateTime, or it may be different from either of these.

Code Set

None

2.2.12.   EmCare_Clinicians

AUTO

NATIONAL

CDS

Definition

A record of the clinical encounters between a patient and their treating clinician(s).

Format

ALPHANUMERIC (max 4096) - XML structure

XML format, incorporating the type, unique identifier and seniority of the clinician(s) who have been directly involved in the patient's care the Emergency Care episode, together with the time the patient was first seen by that clinician:

<CLIN>

>   <TYPE>[the code for the treating healthcare professional type e.g. GMC]</TYPE>

>   <UID>[the 12 character (max) alphanumeric unique identifier of the treating healthcare professional]</UID>

>   <TIER>[the tier of capability of healthcare professional]</TIER>

>   <DISCHARGE>[binary – the clinician(s) responsible for discharging the patient from emergency care episode]</DISCHARGE>

>   <TIMESTAMP>[the 19 character timedate stamp when the clinician first assessed the patient]</TIMESTAMP>

</CLIN>

e.g. for a patient seen by a consultant

>   <CLIN><TYPE>1</TYPE><NUM>3488937</NUM><TIER>5</TIER><DISCH>1</DISCH><TIMESTAMP>2016-02-16T08:00:00</TIMESTAMP></CLIN>

up to 20 clinicians will be accepted

Source

NHS DM&D

Entry

AUTOPOPULATED

Requirement

ALL - NATIONAL

All presentations, unless EmCare_Discharge_Status = 71 to 79 - 'Left before treatment complete' or 'Dead on arrival'.

Provenance

CDS - Replaces

ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT (change in name / structure)

- A and E TIME SEEN FOR TREATMENT (change in name / structure)

- CARE PROFESSIONAL TYPE CODE (change in name / structure)

- A and E STAFF MEMBER CODE (change in name / structure)

- PROFESSIONAL REGISTRATION ISSUER CODE (MAIN OPERATING CARE PROFESSIONAL) (change in name / structure)

- PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (MAIN OPERATING CARE PROFESSIONAL) (change in name / structure)

- PROFESSIONAL REGISTRATION ISSUER CODE (RESPONSIBLE ANAESTHETIST) (change in name / structure)

- PROFESSIONAL REGISTRATION ENTRY IDENTIFIER (RESPONSIBLE ANAESTHETIST) (change in name / structure)

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 casemix 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 process data is necessary to understand and optimise the care process within emergency care. Ensuring that patients are assessed by a treating healthcare professional soon after arrival minimises the risk of undiagnosed severe disease, and is an important part of risk control in emergency care.

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

Notes

A clinical encounter has **not** occurred when patient was referred for a specialty opinion, nor when a telephone opinion was sought or given.

A clinical encounter has occurred if a telecare system has been used e.g. a clinician interacts with a patient over a computer/video link.

This data would not be entered directly by the clinician but would be entered automatically by the ED IT system.

Clinician details to be recorded.

Clinician

Clinician in this context is defined as any health professional who **physically reviews** the patient who has the professional authority to perform **all** of the following functions:

- examine the patient,

- make a diagnosis,

- prescribe treatment and

- discharge the patient

Clinician is therefore either a doctor, Emergency Nurse Practitioner (which may also include other higher grades in the Nursing hierarchy e.g. Sister/ Matron/ Nurse Manager/ Nurse Consultant), Advanced Care Practitioner or Extended Scope Physiotherapist.

Clinician in this context does not include Medical Student, Nursing Student, Health Care Assistant or nursing staff not in the specified groups above.

1. Type (1 character)

The regulatory body responsible for issuing the unique identifier of the treating clinician

Code set

Code	Descriptor
1	General Medical Council
2	General Dental Council
3	Nursing and Midwifery Council
4	Health and Care Professions Council

2. Unique Identifier (max 12 characters)

The Unique Identifier issued by the regulatory body to the treating clinician.

All clinicians should know their unique identifier and its incorporation in medical records is recommended in the standards of the Association of Royal Medical Colleges [REF].

3. Tier

Tier of professional practice in Emergency Care.

Code set

Tier	What it means	Example
1	Require complete supervision. All patients 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	ENPs, ANPs / ACPs, PAs, ESPs, F2 doctors, CT1-2 doctors, some primary care clinicians
3	More senior / experienced clinicians, requiring less direct supervision. Generally fewer limitations in scope of practice	CT3 in EM, junior Speciality Doctors, some ANPs /ACPs and PAs, some primary care clinicians
4	Senior clinicians **able to supervise an Emergency Department alone** with remote support. Possess some extended skills. Full scope of practice.	CT4 and above, senior Speciality Doctors
5	Senior clinicians with accredited advanced qualifications in EM Full set of extended skills. Full scope of practice.	Consultants in EM

4. TimeDate stamp

This is the standard timedatestamp format used throughout ECDS that captures the time at which the clinician first **interacts** with the **patient**.

5. Discharging clinician

This is a flag that identifies the clinicians 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.

The data structure should allow more than one discharging clinician to allow Tier 1 clinical staff to have the discharge decision validated by the reviewing higher tier clinician.

At least one clinician must be responsible for the patient's discharge.

Code set

Code	Descriptor
1	Responsible for discharging patient
0	Not responsible for discharging patient

2.2.13.   EmCare_Referred_Service

AUTO

CLINICAL

NATIONAL

NEW

Definition

An inpatient service to which the patient was referred for **admission or opinion** by the treating clinician.

Format

ALPHANUMERIC (max 4096) – XML / SNOMED / DATETIME

XML format, incorporating the specialty to which the patient has been referred and the time at which the referral occurred.

<REF>

    <SPEC>[The SNOMED code for the specialty to which the patient has been referred (max 18 Char)] </SPEC>

    <TIMESTAMP>[The DATETIME that the referral was made (19 Char)]</TIMESTAMP>

</REF>

e.g. for a patient referred to cardiology and orthopaedics

<REF><SPEC>183519002</SPEC><TIMESTAMP>2016-02-16T08:00:00</TIMESTAMP></REF>

<REF><SPEC>183545006</SPEC><TIMESTAMP>2016-02-16T08:10:00</TIMESTAMP></REF>

Up to 20 referrals will be accepted (more than 10 specialties may be involved in a complex trauma).

Source

NHS DM&D

Entry

AUTOPOPULATED / CLINICAL

Requirement

ALL - NATIONAL

Provenance

NEW

Justification

This process data is necessary to understand and optimise the care process within emergency care.

Current IT systems set up for CDS version 010 routinely collect the time and specialty of referral of a patient. This information is essential to plan bed capacity within the hospital and is also used by

commissioners to understand patient flow. Therefore what is proposed will not provide an additional burden but is just standardising and flowing information that is generally already collected.

The time and speciality of 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.

Notes

An inpatient service to which the patient was referred for **admission or opinion** by the treating clinician. This includes specialties that are supra-regional e.g. burns, neurosurgery, trauma, vascular etc.

Referral to an inpatient service occurs when the ED clinician requires specialist advice regarding management.

The time recorded is the time that the patient was **first referred** to an inpatient service. The time of first referral is taken irrespective of acceptance or otherwise by the relevant inpatient specialty.

Information regarding referral for an opinion is now routinely collected by the IT systems, and therefore what is proposed will not provide an additional burden but is just standardising information already collected.

This data item is captured automatically on an EPR system when a referral is made and therefore although nominally a clinician entered value, *in most systems this data is already automatically captured*.

Code Set

Please see Appendix G.

The options should be presented as a tree or two linked dropdown boxes with options arranged using the sort codes to ensure maximum usability (presenting the common choices at the top of lists).

If some of these services are not available locally they may be removed from the local code set.

TimeDate stamp

This is the standard timedatestamp format used throughout ECDS that captures the time at which the clinician first **interacts** with the **patient**.

2.2.14.   EmCare_DTA_DateTime

AUTO

NATIONAL

NEW

Definition

The date and time at which the decision is made to admit the person.

Format

DATETIME (19 characters)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

NEW

Justification

The 'Decision To Admit' decision is one of the key milestones in a patient's journey. This is a key metric for staff within the hospital, and the decision to admit is always captured, as this is essential in managing the inpatient bed capacity. Therefore while this data item is nominally 'new' it is data that is routinely collected in ED's IT systems and so in practical terms will not impose a burden on staff or IT systems.

Collecting and flowing this additional data point as well as EmCare_Treatment_Complete also allows commissioners and providers to understand the point in the patient's journey that the need for admission became obvious, and therefore the point at which the hospital's resources should change from focussing on safe discharge to safe and quick admission.

Notes

If patient is to stay under the care of the ED in an observation unit, then it this will be the time at which the decision is made to admit the patient to the observation unit.

This is the time at which the ED staff treating the patient decided that the patient was not going to be able to be discharged directly from the ED. This time is what is recorded and it is recorded *irrespective of acceptance or otherwise* by the relevant inpatient specialty.

Code Set

None

2.2.15. EmCare_Complete_DateTime

AUTO

NATIONAL

CDS

Definition

The date and time at which the person's emergency care treatment is complete.

Format

DATETIME (19 characters)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE (change in name and format)

- A and E ATTENDANCE CONCLUSION TIME (change in name and format)

Justification

Most ED IT systems routinely record this data, but may be phrased as 'ready for transfer'. The timedatestamp is automatically entered when the clinician enters that the patient's emergency care treatment is complete and that they are ready to be moved.

This defines when the patient's Emergency Care treatment is complete, and the patient is ready to be admitted to the hospital or discharged back into the community. This data item is therefore essential in identifying when 'exit block' is occurring, and is an internationally recognised standard[18] for this reason.

'Exit block' from ED's is associated with adverse patient outcomes and is therefore an important quality metric.

Notes

Reported for all presentations unless patient left before treatment.

Null if patient left before assessment/treatment.

---

[18] http://www.ncbi.nlm.nih.gov/pubmed/25899754

If the patient is to be admitted, then
EmCare_Complete_DateTime = EmCare_RefAdmission_DateTime.

Code Set

None

2.2.16. EmCare_Depart_DateTime

AUTO

NATIONAL

CDS

Definition

The date and time when the patient *physically* left the Emergency Care area.

Format

DATETIME (19 characters)

Source

NHS DM&D

Entry

AUTO-POPULATED

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY DEPARTURE DATE (change in name / structure)
- A and E DEPARTURE TIME (change in name / structure)

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 indicators for Emergency Care that is calculated – the four hour standard of care, which is defined as from patient arrival to departure.

Notes

The date and time when the patient *physically* left the Emergency Care area.

The patient must have been transferred out of the Emergency Care facility. This includes internal transfers e.g. to an Observation Unit/Ambulatory Emergency Care facility.

Code Set

None

2.2.17.   EmCare_Admit_Specialty

CLERICAL

NATIONAL

NEW

Definition

The specialty to which the patient was admitted.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

All patients admitted to an inpatient unit –EmCare_Discharge_Status codes 21-59

Provenance

NEW

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.

Notes

The specialty to which the patient was admitted.

This data is routinely collected for inpatient admissions therefore there will be no extra clerical burden in providing it.

If there is no dedicated service [e.g. trauma] available for referral, or local practice is that patients with these conditions are managed by another specialty, that code option should not be offered.

If the patient is admitted to a sub-specialty not detailed on this list e.g. hepatology, the parent specialty e.g. gastroenterology should be used.

Code Set

Please see Appendix H

2.3. Clinical information

Field name	Format	Source	Entry	Requirement	Provenance
EmCare_Assessment_Type	ALPHANUMERIC (255)	SNOMED	CLINICAL	ALL	NEW
EmCare_Assessment_Score	ALPHANUMERIC (max 255)	NHS DM&D XML structured	CLINICAL	ALL - NATIONAL	NEW
EmCare_Presentation_ChiefComplaint	ALPHANUMERIC (max 18)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
EmCare_Clinical_Narrative	ALPHANUMERIC (max 4096)	NHS DM&D	CLINICAL	ALL - LOCAL	NEW
EmCare_Diagnosis	ALPHANUMERIC (max 225)	NHS DM&D - SNOMED/ XML	CLINICAL	ALL - NATIONAL	CDS
EmCare_Investigations	ALPHANUMERIC (max 4096)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
EmCare_Treatment	ALPHANUMERIC (max 4096)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
EmCare_Research	ALPHANUMERIC (4096)	NHS DM&D	CLINICAL	OPTIONAL – NATIONAL	NEW

2.3.1. EmCare_Assessment_Type

CLINICAL

NATIONAL

NEW

Definition

The type of acuity scoring system in use.

Format

ALPHANUMERIC (255)

Source

SNOMED

Entry

CLINICAL

Requirement

ALL – NATIONAL

(**OPTIONAL** to collect, but if collected, should flow nationally)

Provenance

NEW

Justification

Acuity assessment is practiced in some form in almost all ED's, although in many departments a formal scoring system is not used. This is because there is no consensus regarding the optimum scoring system, and it may be that different systems perform better in some groups of patients rather than others.

Acuity assessment is an important marker of resource use and correlates with patient outcomes (risk of death, ICU admission, hospital admission). It is therefore helpful to have a consistent measure across different modes of care when commissioning services, as without this two patients with the same Chief Complaint e.g. chest pain, may have very different outcomes. To understand the value added by any system (including healthcare), it is important to be able to measure inputs and outputs.

This data item is already an NHS Data Dictionary standard structure, together with EmCare_Assessment_Score and will allow data from the many disparate scoring systems to be collated. This will enable a consensus at some future point regarding the optimum type of acuity measurement, and that will be able to be implemented without changing the data flow arrangements.

Notes

EmCare_Assessment_Type and EmCare_Assessment_Score should be recorded by the first clinician who sees the patient.

The Emergency Care Assessment is *optional,* **and is not a triage process and does not imply or require a triage process, although the data may be collected as part of a triage process.**

Code set

SNOMED Code	Descriptor	XML Tag
tbc	Australian Triage System	<ATS>
tbc	Australian Triage System + Venous Blood Gas	<ATS_VBG>
tbc	Canadian Triage System	<CTS>
tbc	Canadian Triage System + Venous Blood Gas	<CTS_VBG>
tbc	Emergency Severity Index	<ESI>
tbc	Emergency Severity Index + Venous Blood Gas	<ESI_VBG>
tbc	Manchester Triage System	<MTS>
tbc	Manchester Triage System + Venous Blood Gas	<MTS_VBG>
tbc	Manchester Triage System (modified)	<XMTS>
tbc	Manchester Triage System (modified) + Venous Blood Gas	<XMTS_VBG>
tbc	South African Triage System	<SATS>
tbc	South African Triage System + Venous Blood Gas	<SATS_VBG>
tbc	National Early Warning Score (NEWS)	<NEWS>
tbc	National Early Warning Score + Venous Blood Gas	<NEWS_VBG>
tbc	APACHE 2	<APACHE2>
tbc	APACHE 2 + Venous Blood Gas	<APACHE2_VBG>

The XML tag is for use in EmCare_Assessment_Score – see companion data item for this below.

Some of these systems may require licenses to be purchased for use on a computer system. The ECDS project does not recommend any particular system.

The following two assessment tools are available to use without licensing fees: the NEW Score and the Australian Triage System.

National Early Warning Score (NEWS)*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

*The NEWS initiative flowed from the Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) report, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation

ACUITY ASSESSMENT

adapted from the Australian Triage Scale

Immediate life threat	Imminent life threat Time critical Ix / Tx Pain - very severe (<10 mins)	Potential life threat, limb threat Urgent Ix / Tx Pain - severe (<30 mins)	Potential limb threat Complex / requiring Ix / Tx Pain - not severe (<1hr)	No threat to life or limb Non - urgent Pain - minimal
1	**2**	**3**	**4**	**5**

1 — Immediate life threat

Cardiac arrest

Respiratory arrest

Immediate risk to airway

RR <10/min

Extreme respiratory distress

BP<80 (adult) or severely shocked child/infant

Unresponsive or responds to pain only (GCS <9)

Ongoing/prolonged seizure

Intravenous overdose and unresponsive or hypoventilation

Major trauma requiring trauma team activation

Trauma with shock or GCS<13

Behavioural / psychiatric
- Immediate threat of dangerous violence

2 — Imminent life threat

Severe stridor or drooling

Severe respiratory distress

Circulatory compromise
- clammy or mottled skin
- HR <50 or >150 (adult)
- BP < 100

- severe blood loss

Chest pain - likely cardiac

Blood glucose <3 mmol/l

Drowsy, GCS < 13 any cause

Anaphylaxis (no airway threat)

Acute hemiparesis/dysphasia

Fever with signs of lethargy

Suspected meningococcaemia

Acid or alkali splash to eye

Severe trauma
- major fracture/ amputation

Significant sedative or toxic ingestion e.g. TCA or envenomation

Severe pain suggesting PE, AAA or ectopic pregnancy

Behavioural / psychiatric
- violent or aggressive
- active threat to self or others
- requires or has required restraint

3 — Potential life threat, limb threat

Severe hypertension

Moderately severe blood loss

Moderate shortness of breath

O_2 Sat 90 – 95%

Blood glucose >16 mmol/l

Seizure (now GCS>13)

[all without resp distress]

Any fever if immunosupressed e.g. oncology patient, steroid Rx

Head injury with LOC- now alert

Chest pain likely non-cardiac

Abdominal pain *without* high risk features – mod severe or patient age >65 years

Trauma - high-risk history

Moderate limb injury
- deformity, severe laceration, crushed limb, altered sensation, acutely absent pulse, pain on passive stretch

Stable neonate

Child at risk of abuse/suspected non-accidental injury

Behavioural / psychiatric
- very distressed
- ongoing risk of self-harm
- psychotic/ thought disordered
- agitated / withdrawn
- potentially aggressive

4 — Potential limb threat

Normal vital signs

Mild haemorrhage

Foreign body aspiration

Chest injury without rib pain

Difficulty swallowing

[all without resp distress]

Minor head injury, no LOC

Vomiting or diarrhoea without dehydration

Eye prob/FB normal vision

Minor limb trauma requiring investigation/ treatment
- sprained ankle
- possible fracture
- uncomplicated laceration

Non-specific abdominal pain

Tight cast, no neurovascular impairment

Swollen "hot" joint

Behavioural / psychiatric
- no immediate risk to self or others

5 — No threat to life or limb

Minor symptoms of existing stable illness

Minor symptoms of low-risk conditions

Minor wounds
- small abrasions
- minor lacerations (not requiring Tx)

Scheduled re-visit
- wound review
- complex dressings

Immunisation only

Behavioural / psychiatric
- known patient with chronic symptoms
- Social crisis, clinically well patient

2.3.2. EmCare_Assessment_Score

CLINICAL

NATIONAL

NEW

Definition

The score from the person's acuity assessment.

Format

ALPHANUMERIC (max 255)

Source

NHS DM&D XML structured

Entry

CLINICAL

Requirement

ALL - NATIONAL

Provenance

NEW

Justification

This is the second part of a two part data item- please see EmCare_Assessment_Type

Notes

This is the second part of a two part data item- please see EmCare_Assessment_Type

Code Set

This will be specified by the NHS DM&D in standard XML structure for each data type. e.g.

For NEWS this would be

    <NEWS><SCORE>4</SCORE><NEWS>

Optional data items for the individual components of the score may be submitted e.g. :

<NEWS>

    <RR>14</RR>

    <O2_SAT>96</O2_SAT>

    <ADD_O2>0</EXTRA_O2>

    <TEMP>38.5</TEMP>

    <SYS_BP>116</SYS_BP>

```
    <HR>93</HR>

    <AVPU>A</AVPU>

</NEWS>
```

2.3.3. EmCare_ChiefComplaint

Definition

The nature of the patient's chief complaint as assessed by the clinician first assessing the patient.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLINICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- A and E PATIENT GROUP (Change in name and code set)

Justification

There is a need for Emergency Care to standardise input measurement to record accurately the type of patients attending across a range of Emergency Care services, which will help inform commissioners – both central and local - as to the likely nature and complexity of patient loads.

As the NHS moves to value-based commissioning, it is fundamentally important to be able to measure inputs and outputs. In the UK there has been no single measure of presenting symptoms, and many EDs have historically used their own set of measures or modified existing systems.

A system-wide adoption of the Chief Complaint measure will allow patient pathways to be standardised with decision support, and there is ample evidence that this improves quality of care and efficiency.

Notes

The nature of the patient's chief complaint as assessed by the clinician first assessing the patient.

Chief Complaint should generally be recorded by the first clinician who sees the patient, but could be completed by the patient themselves e.g. using a kiosk system.

Chief Complaint is not a triage process and does not require a triage process, although this data may be collected as part of a triage process.

This list is derived from the Canadian Triage Acuity Scale, with adaptations. This list has had more than 10 years use in Canada, the Caribbean and South East Asia and is in use in the UK.

This data items should be presented using a tree menu or two linked drop-down boxes

- the first box enters the category e.g. 'respiratory'/'skin'/'cardiac',

- the choice in the first box populates the second box with the specific data items.

The choices should be presented using the order defined by the sort codes to ensure that the most commonly used items are presented at the top of each list. Ensuring ease of use for those entering the data significantly aids ease of use and therefore increases the data quality.

Code Set

Please see Appendix I

2.3.4. EmCare_Clinical_Narrative

CLINICAL

LOCAL

NEW

Definition

A description detailing a person's reason for attendance, results from the diagnostic and treatment process and recommendations for further management and follow-up.

Format

ALPHANUMERIC (max 4096)

Source

NHS DM&D

Entry

CLINICAL

Requirement

ALL - LOCAL

Provenance

NEW

Justification

These are the free text notes completed by the treating healthcare professional.

All modern ED IT systems commissioned collect this data as it forms the basis for the GP letter.

These notes constitute the body of text that becomes either the electronic patient record and/or what is sent locally to the person's GP in the GP letter.

Therefore while this field is technically 'new', in reality it is just establishing a common term for a process that is already happening in almost every ED or Ambulatory Emergency Care centre.

Notes

This free text description may include detail regarding patient's reason for attendance, results from the diagnostic and treatment process and recommendations for further management and follow-up.

This field may be started on initial clinical assessment with a short history e.g.

'Tripped over paving slab and fell, hit head – 3 cm laceration R forehead. no LOC'

This field may be further elaborated by clinicians treating the patient during their journey within the Emergency Care system.

'Tripped over paving slab and fell, hit head – 3 cm laceration R forehead. no LOC – cleaned and sutured 5x5/0 nylon sutures'

It is possible to use this field to collect more detailed injury information over and above that collected in the injury surveillance fields that may be available regarding:

Product: Specific product involved in the injury e.g. Brand X shampoo, Brand Y trampoline, Brand Z scooter.

Safety Equipment: Safety devices in use or absent when injury occurred e.g. wearing steel toe capped boots, not wearing seatbelt, mouth guard used, airbag, child resistant packaging.

Similarly, there may be more information entered in the case of infectious disease e.g.

Duration of symptoms

Overseas travel

Contact with infection

Code Set

None

2.3.5. EmCare_Diagnosis

CLINICAL

NATIONAL

CDS

Definition

Diagnoses of the patient, in order of their relevance to the emergency presentation.

Format

ALPHANUMERIC (max 4096) – XML / SNOMED

XML format, incorporating the number (priority) of the diagnosis and the moderator:

<DIAG>

    <NUM>[Diagnosis number, where 1 is the most important, 10 the least important (max 1 Char)] </NUM>

    <CODE>[SNOMED code for diagnosis1 (max 18 Char)]</CODE>

    <MOD>[Moderator using the code set defined below (max 1 Char)]</MOD>

</DIAG>

e.g. for a patient with a burn to the hand

    <DIAG> <NUM>1</NUM><CODE>14893008</CODE><MOD>9</MOD></DIAG>

Up to ten diagnoses will be accepted.

Source

NHS DM&D - SNOMED / XML

Entry

CLINICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- DIAGNOSIS SCHEME IN USE (change in name, format and code set.)

- ACCIDENT AND EMERGENCY DIAGNOSIS FIRST (change in name, format and code set)

- ACCIDENT AND EMERGENCY DIAGNOSIS SECOND (change in name, format and code set)

Justification

The diagnosis + modifier structure is a key change from CDS version 010.

The need for much better diagnostic information for secondary uses e.g. commissioning providers has been one of the main drivers to update from CDS version 010, however there has been a longstanding *clinical* need to improve the quality of diagnosis coding in Emergency Care. Better clinical information reduces the risk of delayed/missed diagnosis, duplication of investigations and safeguarding of children and vulnerable adults.

Accurate diagnosis is important in secondary uses as the scope of work in Emergency Care has expanded substantially over the past 20 years, and the present CDS system of diagnosis coding does not adequately capture the complexity of work. The House of Commons Health Select Committee identified this information gap as one of the root cause of many of the current difficulties relating to acute care.

The current diagnosis systems are disparate and HSCIC analysis shows that less than 50% of patients have a *meaningful* (not null, not 'unspecified', not a 'symptom' e.g. back pain) *diagnosis*, and even then, the data quality is still highly questionable with many hundreds of medically incompatible diagnoses e.g. pregnant males.

The better diagnostic data is essential to be able to plan and deliver an optimum level of acute health service, as described by the Health Select Committee.

Accurate complete diagnostic data with no absent / imprecise 'fluffy' / or 'unspecified' codes is a pre-requisite to attaching tariff to diagnostic codes. The current system of diagnostic coding in CDS version 010 has been assessed by HSCIC Casemix team and been found to be too vague to allow tariff to be linked.

Linkage of tariff to diagnostic code is essential for ECDS to be used in an Ambulatory Emergency Care setting, as is intended. Accurate diagnostic coding also allows incentives to be constructed that reward collaboration and co-operation between networks of healthcare providers e.g. to support frail elderly patients at home. The tariff structure in recent years has had an unfortunate perverse incentive that has made it cheaper to admit a patient rather than support them in the community.

All the major ED IT systems currently include a modifier, however the modifiers they use are inconsistent

The diagnosis tables also include specific data columns to flag conditions that

- Are injury related (trigger injury data collection)

- Are identified as potentially suitable for Ambulatory Emergency Care.

- Are unlikely to occur outside populations defined by their birth sex. This is to allow data quality assessment.

Notes

The key elements of the diagnosis scheme described here were originally developed for Public Health England to aggregate data, but have been used as a primary coding system in many hospitals over five years to code more than 2 million patients. Analysis by the PHE has demonstrated that this diagnosis scheme has a higher output level of *meaningful* (not null, not 'unspecified', not a 'symptom' e.g. back pain) *diagnosis* codes than comparator systems.

This item is for the diagnoses of the patient relevant to their attendance at the Emergency Care facility, in order of their relevance to the emergency presentation. It should not generally include long-term conditions unless those are directly related to the attendance.

Up to ten diagnosis codes will be accepted.

The order of diagnosis should reflect the relevance each diagnosis to the current presentation, with the *most serious item first*. For example if a patient with heart failure has a syncopal episode due to a presumed arrhythmia and falls fracturing their neck of femur, this is coded:

#NoF / Likely arrhythmia / Heart failure

<DIAG> <NUM>1</NUM><CODE>359817006</CODE><MOD>9</MOD></DIAG>

<DIAG> <NUM>2</NUM><CODE>44808001</CODE><MOD>6</MOD></DIAG>

<DIAG> <NUM>3</NUM><CODE>42343007</CODE><MOD>9</MOD></DIAG>

If a patient with a suspected pulmonary embolus is being discharged with treatment and follow up (e.g. in Ambulatory Care clinic) the diagnosis would be coded as a 'working diagnosis' of pulmonary embolus.

<DIAG> <NUM>1</NUM><CODE>59282003</CODE><MOD>6</MOD></DIAG>

A full review of the quality of data produced by the new diagnosis coding system will be conducted as part of ECDS project.

Code Set - Diagnosis

In defining a list of diagnoses that can be used in emergency care settings, a balance needs to be struck between a code set that does not have enough detail (as is currently the case) and one that has too much detail, which results in confusion, duplication and spurious accuracy. At the same time, it must be quick to search for a diagnosis. The terms must be clearly defined so that if tariff is attached to certain codes, the commissioning organisation has assurance that the risk of gaming (manipulation of coding to maximise tariff) is minimised.

For ECDS, a list of approximately 650 SNOMED terms will be used. This is the **ECDS Diagnosis Minimum Code Set (ECDS DMCS)**. You can access the most recent version of the DMCS via the NHS England website via the following link (from the 19th October), http://www.england.nhs.uk/ourwork/tsd/ec-data-set/ .

The ECDS DMCS has been designed and refined with much review and scrutiny. The specification for the diagnosis list was that it must be:

- **exhaustive** – it must have an appropriate code for 99.9% of patients who present AND

- **exclusive** - for every condition, there must be one obviously 'best' diagnostic term.

The practical test used to define the list is what was termed the 'first day Foundation Doctor' test – for every clinical condition encountered there should be one (and only one) obviously 'best' code to choose.

The SNOMED subset list used in ECDS Diagnosis Minimum Code Set has been used in several hospitals in the last five years, and produces high quality data with minimal missing / imprecise or non-diagnosis codes.

The ECDS Diagnosis Minimum Code Set will be published on/via the ECDS website.

SNOMED codes outside the ECDS Diagnosis Minimum Code Set should not be used or submitted. This will be a data quality standard for the implementation of ECDS.

The diagnostic codes should be presented as linked dropdown boxes or menu items to allow rapid hierarchical coding.

A review of the quality of data produced by the new diagnosis coding system will be conducted as part of ECDS project.

Code Set - Diagnosis Modifier

The modifier allows the clinician to express the (un) certainty of the diagnosis.

The term 'Working Diagnosis' should be applied to all diagnoses in which the diagnostic threshold for 'confirmed' or 'proven' diagnosis is not reached. This would include situations where a diagnosis is suspected e.g. suspected Deep Vein Thrombosis, and also when a diagnosis is thought unlikely but still needs to be ruled out e.g. suspected Sub-arachnoid Haemorrhage.

The moderator structure is:

Code	Descriptor
6	Working Diagnosis
9	Proven/ Confirmed (default)

2.3.6. EmCare_Investigations

CLINICAL

NATIONAL

CDS

Definition

The investigations performed while the person is under the care of the Emergency Care facility.

Format

ALPHANUMERIC (max 4096) / XML

SNOMED encapsulated between '< INV >' and '</INV >' tags

    <INV>[SNOMED CODE (max 18 characters)]</INV>

A maximum of 20 investigations are accepted

Source

SNOMED

Entry

CLINICAL

Requirement

ALL - NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY INVESTIGATIONS FIRST (change in name, format and code set)

- ACCIDENT AND EMERGENCY INVESTIGATIONS SECOND (change in name, format and code set)

Justification

This information is currently used to capture the investigations and treatments that are thought to best predict the resource use, and this is used to determine remuneration on a patient by patient basis.

The investigations that are thought to best predict the resource use, and this is used to determine remuneration through the Payment by Results tariff, which uses data from the SUS system, into which CDS data flows.

Notes

Investigations performed while the patient is under the care of the Emergency Care facility.

Code Set

Group	Descriptor	Code	Sort1	Sort2
Bedside	Arterial blood gases	60170009	11	11
Bedside	Venous Blood gases	61911006	11	21
Bedside	Glucose measurement	275810004	11	31
Bedside	Urinalysis	27171005	11	41
Bedside	ECG	29303009	11	51
Bedside	Peak expiratory flow measurement	29893006	11	61
Bedside	Dementia test	165320004	11	71
Biochemistry	Urea and electrolytes	252167001	21	11
Biochemistry	Liver function tests	26958001	21	13
Biochemistry	Troponin measurement	105000003	21	21
Biochemistry	Human chorionic gonadotropin measurement	67900009	21	24
Biochemistry	Paracetamol blood measurement	250597008	21	31
Biochemistry	Bone profile	167036008	21	35
Biochemistry	Cardiac enzymes measurement	74500006	21	41
Biochemistry	C-reactive protein measurement	55235003	21	45
Biochemistry	Creatine kinase measurement	397798009	21	51
Biochemistry	Thyroid function tests	35650009	21	61
Biochemistry	Tryptase release from mast cell measurement	62847008	21	81
Biochemistry	Serology	68793005	21	91
Haematology	Full blood count	26604007	41	11
Haematology	Coagulation screen	3116009	41	21
Haematology	D-dimer assay	70648006	41	31
Haematology	Group and save	252316009	41	41
Microbiology	Blood culture	30088009	51	11
Microbiology	Urinary culture and sensitivities	401324008	51	31
Microbiology	Wound swab culture and sensitivities	401294003	51	41
Ophthalmology	Visual acuity testing	16830007	61	11
Radiology	Plain radiography	168537006	71	11
Radiology	Ultrasonography	16310003	71	21
Radiology	Echocardiography	40701008	71	31
Radiology	Computerised axial tomography	77477000	71	41
Radiology	Magnetic resonance imaging	113091000	71	51

2.3.7. EmCare_Treatments

Definitions

The treatments performed while the person is under the care of the Emergency Care facility.

Format

ALPHANUMERIC (max 4096)

SNOMED encapsulated between '<TRMT>' and '</TRMT>' tags

> <TRMT>[SNOMED CODE (max 18 characters)]</TRMT>

A maximum of 20 investigations are accepted

Source

SNOMED

Entry

CLINICAL

Requirement

ALL – NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY TREATMENTS FIRST (change in name, format and code set)

- ACCIDENT AND EMERGENCY TREATMENTS SECOND (change in name, format and code set)

Justification

The treatments that are thought to best predict the resource use, and this is used to determine remuneration through the Payment by Results tariff process, determined using the SUS data.

Notes

Treatments performed while the patient is under the care of the Emergency Care facility

Code Set

Please see Appendix J.

2.3.8. EmCare_Research

CLINICAL

NATIONAL

NEW

Definition

A user-configurable field designed for the IT systems to be able to work with researchers to collect patient data from one or more sites.

Format

ALPHANUMERIC (max 4096) / XML

XML tags using the Clinical Trial unique research identifier. The tags may enclose clinical data as XML e.g. patient enrolment number, or other tagged information that does not identify the patient. e.g. if a patient was entered into two clinical trials.

<RESEARCH>

    <NCT00001234>recruitment=0074</NCT00001234>

    <NCT00005678><recruitment>0074</recruitment><SBP>128</SBP><HR>83</HR></NCT00005678>

</RESEARCH>

Equally, if there were a major national emergency, this field could be used to capture and flow clinically relevant data. The flexible nature of this data item means that the structure and content of this data could be quickly adapted to adapt to collect the relevant information without needing to change the data flow.

<RESEARCH><PANFLU2016><NEWS_SCORE>4</NEWS_SCORE><CXR_GRADE>2</CXR_GRADE><PO2>9.8</PO2></PANFLU2016></RESEARCH>

Source

NHS DM&D

Entry

CLINICAL

Requirement

OPTIONAL - NATIONAL

Provenance

NEW

This item has not been previously collected as part of CDS version 010. However there are precedents for research data to be collected as part of an ISN approved clinical data set e.g. ambulance, neonatal

Justification

Promoting research, audit and benchmarking across the NHS requires embedded IT support as a key enabler. The ability to capture and flow relevant data cost-effectively enables multi-centre trials that will save the NHS many thousands of pounds in building custom IT solutions to track patient recruitment.

Facilitating multi-centre trials is particularly important because they increase the reliability of the research – the results are much more likely to be robust and applicable across a wide range of hospitals, and therefore the research itself is much more cost-effective.

As nearly all research in Emergency Care in the UK is government funded, this is an important consideration. At present, tracking recruitment of patients is a significant barrier and cost to such research.

By including this field, the data set will address key National Institute of Health Research priorities for efficient research design, and enabling research into major infectious disease health threats.

Notes

Any information outside the tags will be discarded and will not flow centrally.

Only coded information may be transmitted within the tags - the tagged information must not contain any patient identifiable data or free text.

This data item will not be part of the data anonymised and sent for SUS/HES use.

The registered Principal Investigator (or NHS Principal Investigator in the case of international trials) of the registered clinical will need to contact HSCIC to arrange for this data to be made available under a standard NHS data sharing agreement.

Code Set

None

2.4. Patient Injury

Field name	Format	Source	Entry	Requirement	Provenance
EmCare_Inj_DateTime	DATETIME (19)	NHS DM&D	CLERICAL	ALL NATIONAL	NEW
EmCare_Inj_Place_LatLong	ALPHANUMERIC (max 50)	ONS	CLERICAL	OPTIONAL NATIONAL	NEW
EmCare_Inj_Place_Exact	ALPHANUMERIC (max 255)	NHS DM&D	CLERICAL	ALL NATIONAL	NEW
EmCare_Inj_Place_Type	ALPHANUMERIC (max 2)	NHS DM&D	CLERICAL	ALL NATIONAL	CDS
EmCare_Inj_Activity	APHANUMERIC (max 18)	SNOMED	CLERICAL	ALL NATIONAL	NEW
EmCare_Inj_Mechanism	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL NATIONAL	NEW
EmCare_Inj_Drug_Alcohol	ALPHANUMERIC (max 255)	SNOMED	CLERICAL	ALL NATIONAL	NEW
EmCare_Inj_Intent	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL NATIONAL	NEW

2.4.1. EmCare_Inj_DateTime

CLERICAL

NATIONAL

NEW

Definition

The date and time that the injury occurred.

Format

DATETIME (19)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL – NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set to '1'

Provenance

NEW

This data item is currently collected as part of the 'Information Sharing to Tackle Violence' information standard ISB 1594.

Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

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

Aside from the ISTV dataset, 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.

Notes

This item could be collected from ambulance EPR where available.

Code Set

None

2.4.2. EmCare_Inj_Place_LatLong

CLERICAL

NATIONAL

NEW

Definition

The latitude and longitude of the exact place at which the injury occurred.

Format

ALPHANUMERIC (max 50)

Source

UK Office of National Statistics

Entry

CLERICAL

Requirement

OPTIONAL – NATIONAL

For presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set to '1'

Provenance

NEW

An accurate description of the place where injury occurred is a central component of the Information Sharing to Tackle Violence (ISB 1594) standard.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

The aim of the Information Sharing to Tackle Violence programme (ISB 1594) is to identify patterns of injury (these patterns may be in time or place or both) 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 particularly venue, licensing requirements can be strengthened, which reduces the further risk of injury.

To collect the exact place of injury the ECDS proposes two options – free text (see Inj_Place_Exact) or longitude and latitude. Both options are presented in the data set. Exact longitude and latitude is the preferred method of coding injury if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map. The option of free text (EmCare_Inj_Place_Exact) is also offered to ensure compatibility with all systems.

Notes

Should be collected by clerical rather than clinical staff.

Could be implemented using mapping software e.g. Google Maps geocoding API[19] to allow rapid accurate estimation of locality of injury.

Alternatively this data may be directly collected from the ambulance service EPR / satellite navigation data.

Code Set

None

---

[19] http://code.google.com/apis/maps/documentation/geocoding/

2.4.3. EmCare_Inj_Place_Exact

CLERICAL

NATIONAL

NEW

Definition

Description of the exact locality at which the injury occurred.

Format

ALPHANUMERIC (max 255)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL – NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set to '1'

Provenance

NEW

This data item is currently collected as part of the 'Information Sharing to Tackle Violence' information standard ISB 1594.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

A central component of the Information Sharing to Tackle Violence (ISB 1594) programme, this data item allows a patient to locate unambiguously where the injury occurred.

To collect the exact place of injury, there are two options – free text or exact longitude and latitude. Both options are presented in the data set. Exact longitude and latitude would be the preferred method of coding injury place if extracted from an electronic system e.g. ambulance electronic patient record system or a kiosk system with an inbuilt map. However the option of free text (EmCare_Inj_Place_Exact) is also offered to ensure compatibility with all ED IT systems.

Notes

Not a description of the exact location on the body affected by the injury.

Example: "10 metres outside the Kings Head pub in Lower Loxley".

Should be collected by clerical rather than clinical staff.

This data may be able to be directly collected from the ambulance service EPR / satellite navigation data as a latitude/longitude (EmCare_Inj_Place_LatLong).

Code Set

None

2.4.4. EmCare_Inj_Place_Type

CLERICAL

NATIONAL

CDS

Definition

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

Format

ALPHANUMERIC (max 2)

Source

NHS DM&D

Entry

CLERICAL

Requirement

ALL – NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set to '1'

Provenance

CDS replaces

- A and E INCIDENT LOCATION TYPE (change to name and code set)

[Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.]

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

Some elements of this data item are currently collected as part of the 'Information Sharing to Tackle Violence' information standard ISB 1594.

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.

Notes

Report the code which best characterises the location where the patient was situated at the time the injury occurred, on the basis of the information available at the time it is recorded.

Wherever possible, the coding should reflect the organisational area of responsibility e.g.

Sports area in a school grounds – code as 'school'

Lake on an historic National Trust estate– code as 'recreational area'

If two or more categories are equally appropriate, select the code sequenced first in above code list.

Description of each location group.

1. **Home**

Includes house, home premises, farm house, non-institutional place of residence, apartment, flat, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.

Does not include: home under construction and not yet occupied

2. **Residential institution**

Includes children's home, orphanage, home for the sick, residential home, nursing home, old people's home, hospice, military camp, prison

3. **School, educational area**

Includes School (state or private), college, university, institution for higher education, kindergarten/ pre-school, sports activities within school grounds undertaken as part of education

4. **Road**

Includes motorway/ A and B roads, minor roads, bridleways and footpaths.

Does not include private driveways on home (home)

5. **Farm**

Includes farm buildings and land

Does not include farmhouse (home)

6. **Athletics and sports area**

Includes Cricket ground, football, rugby, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool

Does not include sport undertaken in educational area as integral part of full time education, hospital recreation area, sports area, trade or service area, building under construction, residential institution

7. Medical service area

Includes hospital, clinic, GP surgery

Does not include hospice, nursing home, residential home

8. Industrial or construction area

Includes any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/ premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard, mine, quarry

9. Licensed premises

Includes bar, pub, restaurant, hotel bar area, casino, café (licensed)

Does not include hotel accommodation area (Trade or service area)

10. Trade or service area

Includes bank, petrol station, supermarket, airport, café (unlicensed), garage (commercial), petrol station, hotel, market, office building, radio or television station, service station, shop (commercial), shopping mall, station (bus/rail), warehouse

Does not include garage in private home (Home), area serving alcohol (Licensed Premises)

11. Public/ recreational area

Includes buildings and adjacent grounds used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, campsite, caravan site, public park, public playground, holiday park, theme park and zoo

Does not include sports, educational, large national park

12. Countryside/ Beach/ Sea

Includes forest, hill, mountain, large national park, water reservoir, lake, pond, canal, marsh, river, stream, beach, sea, seashore

13. Other specified place

Includes abandoned or derelict house, military training ground, car park, railway line

Code Set

Code	Group	Descriptor	Sort1	Sort2
	Home	Living room	11	11
	Home	Kitchen	11	15
	Home	Garage	11	21
	Home	Hallway	11	25
	Home	Stairway	11	31
	Home	Bathroom	11	35
	Home	Bedroom	11	41
	Home	Utility room	11	45
	Home	Study	11	51
	Home	Dining room	11	55
	Home	Home gym	11	61
	Home	Conservatory	11	65
	Home	Outbuilding/ shed	11	85
	Home	Swimming pool	11	91
	Home	Pond	11	92
244231000000106	Road	Road	15	11
981021000000108	Work	Retail service area	21	11
244201000000100	Work	Construction area	21	31
979961000000109	Work	Farm	21	41
244321000000102	Work	Workplace	21	51
244211000000103	Educational	Educational	31	11
244281000000105	Leisure	Public building	41	11
980911000000107	Leisure	Licensed premises	41	21
244301000000106	Leisure	Sports facility	41	31
979981000000100	Leisure	Recreational area	41	41
979971000000102	Outdoor	Countryside	51	11
980891000000109	Outdoor	Water/ waterside	51	21
244251000000104	Medical	Hospital	81	11
244221000000109	Medical	GP surgery	81	21
244181000000104	Medical	Other clinical area	81	31
[null]	Not applicable	Not applicable	99	99

2.4.5. EmCare_Inj_Activity

CLERICAL

NATIONAL

NEW

Definition

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

Format

APHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL – NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set

Provenance

NEW

Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1].

This data item is currently collected as part of the 'Information Sharing to Tackle Violence' information standard ISB 1594.

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.

Figure 3. *Injuries recorded in A&E by age and location (graphics courtesy of the Royal Society for the Prevention of Accidents).*
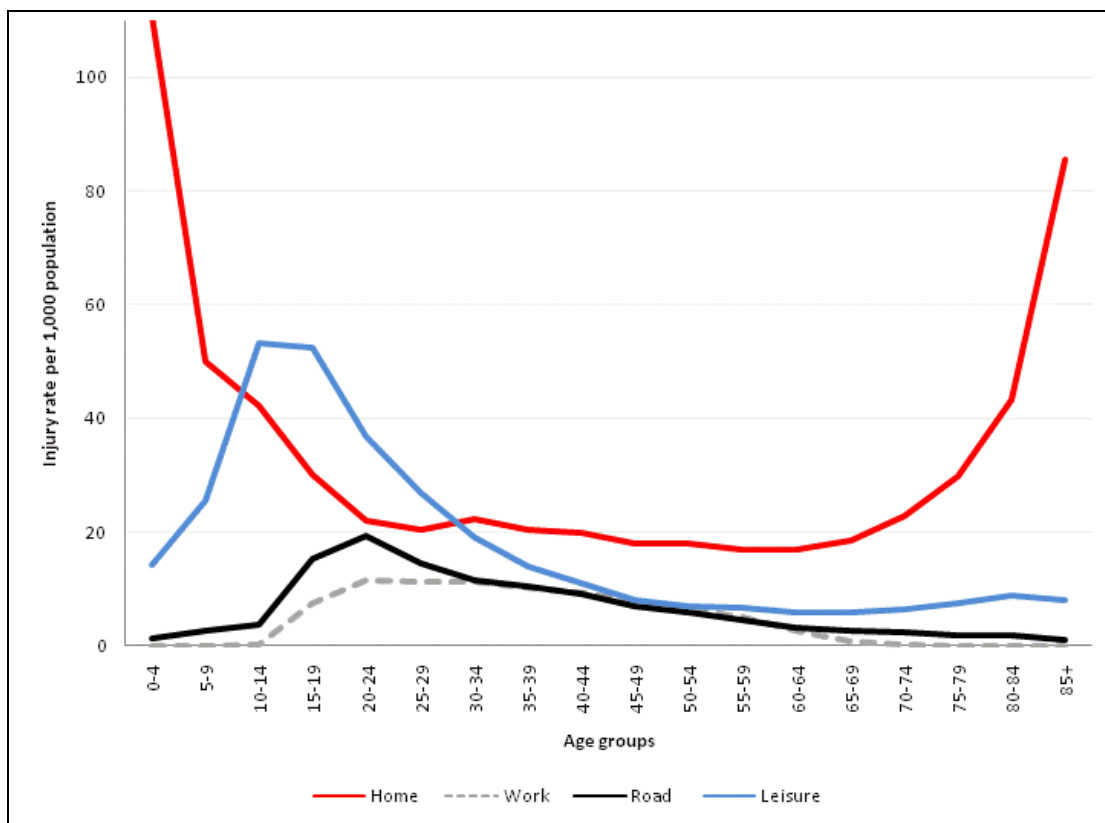
Injury prevention could not and should not prevent all injury from recreational and sporting activity. However injury surveillance should identify activities that result in significant preventable injury.

Figure 4. *Non-fatal incident rates (graphics courtesy of the Royal Society for the Prevention of Accidents).*
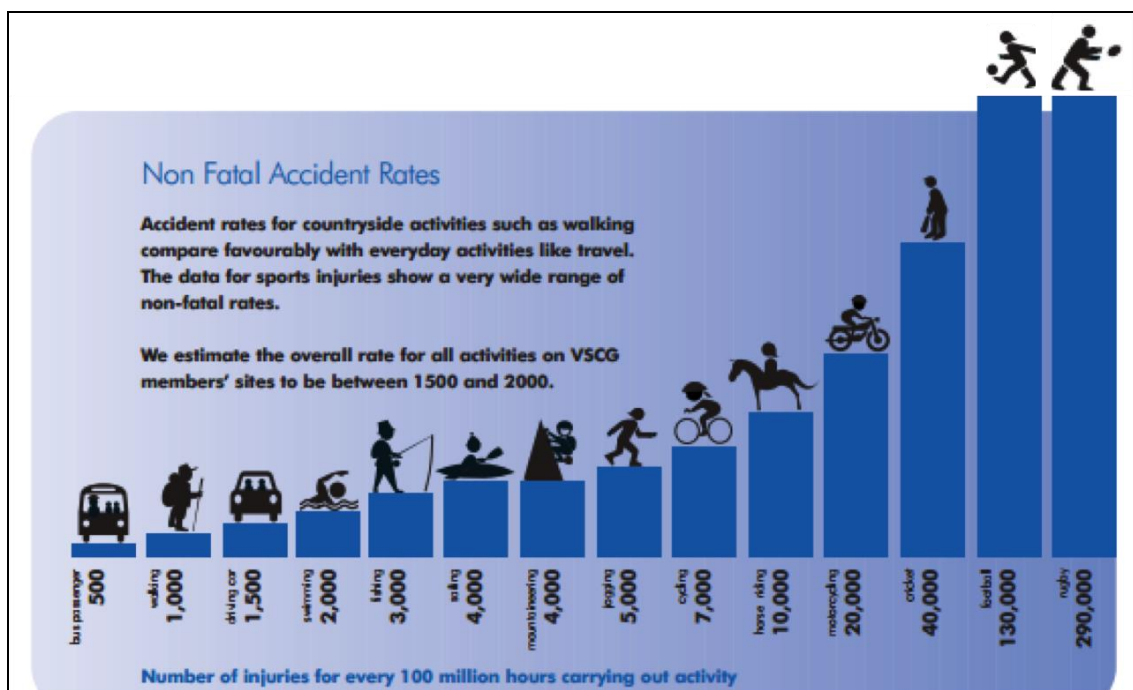
A good example of how this can work in practice is that based on evidence from NHS injury surveillance, the charity the Royal Society for the Prevention of Accidents convened a meeting between government, academic researchers and industry representatives to review patterns of injury and understand how design could better prevent injury.

Notes

The codes should be presented as linked dropdown boxes to allow rapid hierarchical searching.

If two or more categories are equally appropriate, select the code sequenced first in above code list.

This is particularly relevant in the case of Road Traffic Collisions, when the person may have been working for income. In these cases, code as the relevant RTC.

Code Set

Please see Appendix K.

2.4.6. EmCare_Inj_Mechanism

CLERICAL

NATIONAL

NEW

Definition

How the injury was caused.

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set

Provenance

NEW

Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

Elements of this data item are currently collected as part of the 'Information Sharing to Tackle Violence' information standard ISB 1594.

To understand how people injure themselves it is necessary to collect a structured description of the mechanism of injury. This is particularly important for the increasing numbers of patients who are injured in the home, as it is suspected that relatively simple measures e.g. avoid polished floors or loose floor coverings may make a very large difference.

Notes

This item captures how the injury was caused, and this must be disaggregated from injury intent.

Code Set

Code	Group	Descriptor	Sort1	Sort2
54670004	Fall	Slipping	11	11
75941004	Fall	Tripping	11	12
240871000000104	Fall	Fall from height of less than one metre	11	41
429482004	Fall	Fall from height of more than one metre	11	51
425359009	Blunt injury	Blunt force / pushed	21	11
242890000	Blunt injury	Punch with fist	21	21
242892008	Blunt injury	Kick with foot	21	22
219236005	Blunt injury	Blow from blunt object	21	51
125665001	Blunt injury	Crushing injury	21	61
425322008	Sharp injury	Stabbed / cut with knife	31	11
426058000	Sharp injury	Stabbed / cut with glass	31	21
283545005	Firearm / explosion	Gunshot wound	41	11
242999003	Firearm / explosion	Injury due to projectile	41	21
397996002	Firearm / explosion	Injury due to explosion	41	31
	Poisoning	Poisoning / overdose	45	
242669005	Threat to breathing	Respiratory obstruction due to inhaled foreign body	51	11
241121000000102	Threat to breathing	Patient found hanging	51	21
242020007	Threat to breathing	Asphyxia by obstruction of mouth and nose	51	31
66466001	Threat to breathing	Asphyxiation - other	51	41
	Environment	Burn - thermal	61	11
371704001	Environment	Burn - chemical	61	13
371708003	Environment	Burn - electrical	61	17
24803000	Environment	Burn - radiation	61	19
409702008	Environment	Hyperthermia	61	41
386689009	Environment	Hypothermia	61	42
64113006	Environment	Physical exertion	61	51
87970004	Environment	Near drowning	61	61
241977008	Environment	Diving barotrauma	61	62
[null]	Not applicable	not applicable	99	99

2.4.7. EmCare_Inj_Drug_Alcohol

CLERICAL

NATIONAL

NEW

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.

Format

ALPHANUMERIC (max 255) / XML

Should allow collection of more than one item

Source

SNOMED

Entry

CLERICAL

Requirement

ALL - NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set

Provenance

NEW

Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.

Justification

[Please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

Drugs and alcohol are frequently implicated in the cause of injury and this is a structured way to capture this data.

Elements of this data are already captured in the Information Sharing to Tackle Violence data set.

Notes

Use of drugs or alcohol by the patient, which are thought likely to have contributed to the need to attend the ED.

'Prescription' drug includes all officially packaged medication, which may or may not have been legitimately dispensed to the person who has taken it.

Code Set

Code	Group	Descriptor	Sort1	Sort2
984801000000105	Alcohol	Alcohol	11	11
984851000000106	Street drug	Cannabis	21	21
984831000000104	Street drug	Heroin	21	31
984841000000108	Street drug	Cocaine	21	41
984901000000102	Street drug	Crack cocaine	21	43
984861000000109	Street drug	Amphetamine	21	51
984911000000100	Street drug	Crystal meth	21	53
984871000000102	Street drug	Ecstasy	21	61
984881000000100	Street drug	GHB (gamma hydroxybutyrate)	21	63
984891000000103	Street drug	GBL (gamma butyrolactone)	21	65
984811000000107	Street drug	Other street drug	21	91
984821000000101	Psychoactive drugs	LSD, magic mushrooms etc	31	11
984951000000101	Prescription drug	Opiate	41	11
984941000000104	Prescription drug	Benzodiazepine	41	21
984931000000108	Prescription drug	Prescription drug	41	31
984791000000106	Other substance	Solvents, aerosols etc.	61	11
984921000000106	Unknown	Unknown drug	91	11
[null]	Not applicable	Not applicable	99	99

2.4.8. EmCare_Inj_Intent

CLERICAL

NATIONAL

NEW

Definition

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

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

CLERICAL

Requirement

ALL – NATIONAL

Required for all presentations where the

- EmCare_ChiefComplaint injury flag AND/OR
- EmCare_Diagnosis injury flag is set

Provenance

NEW

Derived from World Health Organisation, Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets, together with the Information Sharing to Tackle Violence Information Standard.

Justification

[please read in conjunction with the general description and justification of the need for Injury Surveillance in Section 1]

Preventing preventable injury is of great benefit to individuals and society, and identifying the number and severity of assaults has been very difficult. Part of the reason for the difficulty is that there needs to be

Understanding injury intent underpins all injury prevention work, whether at a local or national level. The Information Sharing to Tackle Violence Information Standard (ISB 1594) relies on this data item to identify cases of assault, and to differentiate these from other causes of injury.

Notes

Most likely *human* intent in the occurrence of the injury or poisoning as assessed by clinician.

The issue is the intent to produce the injury, **not** the intent to undertake an activity that may have happened to result in injury. A dog used intentionally as a weapon would be coded according to the human intent.

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

Code Set

Code	Descriptor	Sort1
242056005	Non-intentional injury	11
276853009	Self-inflicted injury	21
298231000000106	Apparent assault	31
35688006	Complication of medical care	41
242651001	Injury caused by animal	51
219256006	Injury due to legal intervention	61
269735005	Undetermined/ no information available	71

2.5. Patient Discharge

Field name	Format	Source	Entry	Requirement	Provenance
EmCare_Discharge_Status	ALPHANUMERIC (max 2)	NHS DM&D	CLINICAL	ALL-NATIONAL	CDS
EmCare_Discharge_FollowUp	ALPHANUMERIC (max 2)	NHS DM&D	CLINICAL	ALL-NATIONAL	CDS
EmCare_Discharge_Medication	NUMBER (2 characters)	NHS DM&D	CLINICAL	ALL - NATIONAL	CDS
EmCare_Discharge_Instructions	ALPHANUMERIC (max 4096)	NHS DM&D / AoRMC/RCP	CLINICAL	OPTIONAL LOCAL	NEW
EmCare_Discharge_Information_Given	ALPHANUMERIC (max 4096)	AoRMC/RCP	CLINICAL	ALL - LOCAL	NEW
EmCare_Discharge_Safeguarding	ALPHANUMERIC (max 18)	SNOMED	AUTO	ALL-NATIONAL	NEW
EmCare_Transfer_Destination	NUMBER (max 9 characters)	NHS DM&D ODS	CLINICAL	ALL - NATIONAL	NEW

2.5.1. EmCare_Discharge_Status

CLINICAL

NATIONAL

CDS

Definition

Patient status or destination on discharge from the ED.

Format

ALPHANUMERIC (max 2)

LINKED DROPDOWN BOXES

Source

NHS DM&D

Entry

CLINICAL

Requirement

ALL-NATIONAL

Provenance

CDS replaces

- ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL (change in name and code set)

Justification

This data item and its counterpart EmCare_Discharge_FollowUp below are necessary to understand resource needs and transfer of responsibility between different organisations.

Analysis by Public Health England has shown that there is currently confusion about how the current CDS version 010 data regarding patient discharge and transfer of responsibility is implemented. The way that current data items are arranged has made it difficult for IT suppliers to implement consistently as 'destination on discharge/ disposition' is often conflated with follow up arrangements and transfer of care. The way this data is currently collected is inconsistent even in implementations by the same supplier.

Therefore it is currently difficult to understand the outcomes of emergency care and this has frustrated the work of analysts and commissioners at a local and national level.

For ECDS these separate issues have been disaggregated and are presented as separate items:

- Discharge status
- Follow-up arrangements

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.

Notes

Used to identify the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

Should be presented as two linked drop down boxes to allow rapid coding, ordered by the sort codes.

Description of each location group.

1. **Home**

Implies that the patient will be expected to be self-caring +/- external support /carers. Includes:

- House, flat, boarding/rooming house, hotel, caravan, youth hostel accommodation.
- Sheltered housing/ warden controlled flats.
- homeless person's shelters, refuges
- No fixed abode.

Excludes all accommodation described in remainder of this code set.

2. **Residential care facility**

Implies that the patient will need some supervision or assistance with activities of daily living, but not 24 hour nursing care.

Includes: sheltered hostels, mental health residential care facilities

Excludes: nursing home, psychogeriatric nursing home, residential care respite bed and nursing home beds which are located within an acute or sub-acute hospital campus

3. **Nursing care facility**

Implies that a NMC registered nurse is available within the facility 24 hours a day.

Includes: nursing home, psychogeriatric nursing home, residential care respite bed and nursing home beds located within an acute or sub-acute hospital campus

4. **Correctional / Custodial Facility**

Includes detention centres, prison hospitals and forensic Mental Hospitals.

5. **Ward**

Includes patients who are admitted to a physical ward after attending the ED at the same hospital, and those patients who attend the ED from an inpatient ward at the same hospital and then return to the ward. *Includes* Medical/Surgical Assessment Unit. *Excludes* Virtual Ward beds, ICU, HDU, and CCU.

6. **Virtual Ward**

'Hospital in the Home' - an arrangement whereby a patient is kept as a nominal inpatient, managed as an outpatient with arranged reviews and may be readmitted if deterioration e.g. cellulitis, DVT.

7. **Emergency Department Short Stay/ Observation Unit/ Clinical Decision Unit**

Excludes Medical Assessment Unit and equivalent

8. **Another hospital campus (also record Transfer Destination)**

Excludes correctional facility / forensic mental hospital (use 'Correctional/Custodial facility').

9. **Left at own risk, after treatment started**

Patient leaves the ED after being assessed by a doctor or Emergency Nurse Practitioner but before treatment has been completed, despite being advised by clinical staff NOT to leave. The appropriate hospital forms must be completed and signed by the patient.

10. **Left after clinical advice regarding treatment options**

At or subsequent to clinical assessment, the patient has received advice about the ED and alternative treatment options. On consideration of this advice, the patient chooses to leave the ED without a doctor or Emergency Nurse Practitioner completing assessment and treatment of their condition in the ED.

11. **Left at own risk, without treatment**

Patient leaves the ED before assessed or treated doctor or Emergency Nurse Practitioner completing assessment and treatment of their condition in the ED. This may occur either:

- Without notifying staff; OR

- Despite being advised by clinical staff NOT to leave; OR

- Without receiving advice about alternatives to treatment in the ED

Common descriptions include: Did Not Wait, DNW, Failed to answer, and FTA.

12. **Died within Emergency Care facility**

Patient died after arrived in the Emergency Care facility. Includes any situation where there is an intention to resuscitate but the patient is later pronounced dead.

13. **Dead on Arrival**

Patient is pronounced dead by a medical practitioner or ambulance staff prior to attending the Emergency Care facility OR the patient is brought to the Emergency Care facility but there is no intention or attempt to resuscitate.

Code Set

The codes should be presented as two linked dropdown boxes or a menu tree that allows rapid selection. The choices should be presented using the sort codes.

Code	Group	Descriptor	Sort1	Sort2
11	Discharged	Home	11	11
13	Discharged	Residential care facility without 24 hour nursing care (e.g. Residential Home)	11	21
15	Discharged	Residential care facility with 24 hour nursing care (e.g. Nursing Home)	11	31
17	Discharged	Police/ Prison/ Custody Facility	11	41
21	Admitted	Ward – physical ward bed outside ED	21	11
31	Admitted	High Dependency Unit/ Coronary Care Unit (Level 2)	21	51
35	Admitted	Intensive Care Unit (Level 3)	21	61
41	Ambulatory/ Short stay	Short stay (<24hr) ward managed by ED	31	11
43	Ambulatory/ Short stay	Ambulatory Care	31	21
45	Ambulatory/ Short stay	Virtual ward e.g. 'hospital in the home'	31	31
55	Transfer	Transfer to another hospital	41	21
71	Left before treatment complete	Left before initial assessment	51	11
73	Left before treatment complete	Left after assessment to go to alternative provider	51	21
75	Left before treatment complete	Left after assessment but before seen by clinician	51	31
77	Left before treatment complete	Left after seen by clinician but before treatment complete	51	41
79	Died	Dead on arrival	81	11
80	Died	Died in the Emergency Care facility	81	21
99	Other	Unknown	99	99

2.5.2. EmCare_Discharge_FollowUp

CLINICAL

NATIONAL

CDS

Definition

The agency to which the patient was referred for continuing care following their ED attendance.

Format

NUMBER (2 characters)

Source

NHS DM&D

Entry

CLINICAL

Requirement

ALL - NATIONAL

All presentations where patient discharged from ED

Provenance

CDS replaces

- WAITING TIME MEASUREMENT (change to name and code set)

Justification

This data item and its counterpart EmCare_Discharge_Status above are necessary to understand resource needs and transfer of responsibility between different organisations.

Analysis by Public Health England has shown that there is currently confusion about how the current CDS version 010 data regarding patient discharge and transfer of responsibility is implemented. The way that current data items are arranged has made it difficult for IT suppliers to implement consistently as 'destination on discharge/ disposition' is often conflated with follow up arrangements and transfer of care. The way this data is currently collected is inconsistent even in implementations by the same supplier.

Therefore it is currently difficult to understand the outcomes of emergency care and this has frustrated the work of analysts and commissioners at a local and national level.

For ECDS these separate issues have been disaggregated and are presented as separate items:

- Discharge status

- Follow-up arrangements

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.

Notes

In most cases the patient will be referred back to their GP for further management and co-ordination of care.

Code set

Code	Descriptor
11	General Practitioner
21	Review in ED – Scheduled
25	Emergency Ambulatory Care service
31	Fracture clinic
33	Outpatients (not fracture clinic)
41	Medical Specialist (private)
42	Dentist
45	Physiotherapy
47	Community psychiatric support services
97	Other community service
99	No referral

2.5.3. EmCare_Discharge_Medication

CLINICAL

LOCAL

NEW

Definition

Medications **started** or **stopped** or **dosing changed** as a result of the patient's visit to the Emergency Care facility.

Format

ALPHANUMERIC (max 4096)

Free text / NHS DM&D

Source

NHS DM&D / AoRMC/RCP

Entry

CLINICAL

Requirement

OPTIONAL - LOCAL

Provenance

NEW

Justification

Discharge medication is included as part of the AoRMC / RCP discharge specification.

Clear communication regarding any changes in treatment is one of the clear messages from General Practitioners who receive communications from Emergency Care.

General Practitioners deal with a large volume of correspondence and separating narrative e.g. description of attendance from required actions e.g. change in medication minimises the risk of clinically important actions being overlooked. Therefore it is good practice to have this as a separate data item.

Notes

Medications **started** or **stopped** or **dosing changed** as a result of the patient's visit to the Emergency Care facility.

This should not be a full list of all the medications that the patient is currently taking.

At present this will be a free text description of medications on discharge - including the drug approved (generic) name, dose, frequency and duration.

The NHS DM&D are working on an XML specification for this and when this is released then it will be used.

Code set

None

2.5.4. EmCare_Discharge_Instructions

CLINICAL

LOCAL

NEW

Definition

Specific instructions relating to the patients discharge and follow up arrangements.

Format

ALPHANUMERIC (max 4096)

Free text

Source

AoRMC/RCP

Entry

CLINICAL

Requirement

ALL - LOCAL

Provenance

NEW

(Derived from Academy of Royal Medical Colleges / Royal College of Physicians Electronic Patient Record specifications).

Justification

Discharge instruction is included as part of the AoRMC / RCP discharge specification.

Clear communication regarding any further action required following Emergency Care attendance is one of the clear messages from General Practitioners who receive communications from Emergency Care.

General Practitioners deal with a large volume of correspondence and separating narrative e.g. description of attendance from required actions e.g. discharge instructions minimises the risk of clinically important actions being overlooked. A common example would be 'please refer this patient with a shadow on the X-ray to the respiratory team'.

Notes

Short free text description of the arrangements for follow-up following discharge from ED.

May include advice e.g. smoking cessation, referrals advised.

Code Set

None

2.5.5. EmCare_Discharge_Information_Given

AUTO

NATIONAL

NEW

Definition

Answers the question: "Has the GP a letter been printed and given to the patient?"

Format

ALPHANUMERIC (max 18)

Source

SNOMED

Entry

AUTOPOPULATED

Requirement

ALL-NATIONAL

(Mandatory for all patients who are discharged from the Emergency Care facility – where EmCare_Discharge_Status is less than 20)

Provenance

NEW

Justification

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.

NB this is not a substitute for an electronic copy of the letter, which will be sent anyway as part of the service specification. However it is well known that a relatively high proportion of Emergency Care

patients do not have a General Practitioner or may be itinerant, so this document may be the only record they have to take to another healthcare provider.

Notes

Answers the question: 'Has a copy of the discharge letter been printed for the patient?'

The default should always be [null] – no information entered.

Implementation: this field must be auto-populated by the IT system. This should not be manually populated.

This is designed to ensure that the patient is provided with a 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.

Code set

Descriptor	Code
Discharge letter for patient printed	787281000000102
Letter not printed	[null]

2.5.6. EmCare_Discharge_Safeguarding

CLINICAL

NATIONAL

NEW

Definition

A record of any identification of concerns regarding safeguarding during ED attendance.

Format

NUMBER (max 2 characters)

Linked Dropdown boxes

Source

NHS DM&D

Entry

CLINICAL

Requirement

ALL - NATIONAL

Provenance

NEW

Currently routinely collected locally but not flowed

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.

Notes

This does not imply that there is necessarily a problem identified by the referring clinician, merely 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.

Adapted from existing NHSDD codes 'Safeguarding Vulnerability Factors Type'.

Should be presented as two linked drop down boxes to allow rapid coding.

When two or more items may be coded, the most serious / highest risk item should be coded.

The question should be phrased as:

'Follow-up is requested regarding concerns of ED staff regarding:'

Code Set

Code	Group	Concern regarding	Sort1	Sort2
	No safeguarding concern	No safeguarding concern	11	11
	Child – this attendance	Repeated attendances to ED	21	11
	Child – this attendance	Delay in presentation	21	21
	Child – this attendance	Self-harm	21	31
	Child – this attendance	Significant injury	21	41
	Child – this attendance	Genital injury (not FGM)	21	45
	Child – this attendance	Disclosure of abuse	21	51
	Child – this attendance	Suspected drug use	21	61
	Child – this attendance	Suspected alcohol use	21	65
	Child – this attendance	Worrying parent/ child interaction	21	71
	Child – this attendance	Worrying child behaviour	21	75
	Child – this attendance	Worrying parental behaviour	21	81
	Child – this attendance	Worrying parental mental health	21	85
	Child – environment	Bullying	31	11
	Child – environment	Risk to sibling	31	21
	Child – environment	Possible grooming target	31	31
	Child – environment	Radicalisation	31	41
	Child – environment	Female Genital Mutilation	31	51
	Child – environment	Child's environment (general)	31	61
	Adult	Alcohol use	61	11
	Adult	Drug use	61	21
	Adult	Domestic Violence	61	31
	Adult	Elder abuse	61	41
	Adult	Risk to carer	61	51

2.5.7. EmCare_Transfer_Destination

CLERICAL

NATIONAL

NEW

Definition

ODS code of the destination organisation.

Format

ALPHANUMERIC (max 9)

Source

NHS DM&D/ODS

Entry

CLERICAL

Requirement

ALL - NATIONAL

All presentations where EmCare_Discharge_Status is code 55 – Transfer to another hospital, irrespective of whether or not the patient is admitted at the sending hospital e.g. to Short Stay/ CDU/ Observation ward.

Provenance

NEW

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.

Notes

This uses the stand ODS code of the destination organisation.

Code Set

NHS Organisational Data Services lists of Hospitals.

3. Appendices

Appendix A: Abbreviations

A&E	Accident and Emergency
ASCII	American Standard Code for Information Interchange
CCU	Coronary/Cardiac Care Unit
CDS	Commissioning Data Set
CDU	Clinical Decision Unit/Observation Unit
DH	Department of Health
ECDS	Emergency Care Data Set
ED	Emergency Department
EDIS	Emergency Department Information System
EM	Emergency Medicine
GP	General Practitioner
HRG	Health Resource Group
HSCIC	Heath and Social Care Information Centre
ICD-10	International statistical Classification of Diseases and Related Health Problems, 10th Revision
ICU	Intensive Care Unit
ISTV	Information Sharing for Tackling Violence
JAMIE	Joint Action for Minimisation of Injuries in Europe
LOS	Length of Stay
MAU	Medical Assessment Unit
MDEC	Minimum Dataset for Emergency Care
NHS	National Health Service
OOH	Out of Hours
PHE	Public Health England
PIA	Privacy Impact Assessment
PID	Patient Identifiable Data
RCEM	Royal College of Emergency Medicine
SCCI	Standardisation Committee for Care Information
SNOMED-CT	Systematised Nomenclature of Medicine - Clinical Terms
SSU	Short Stay Unit/Observation unit

SUS	Secondary Uses Service
XML	Extensible Markup Language – a way of tagging and organising information that is understandable to both humans and computers.
USA	United States of America
VEMD	Victorian (Australia) Emergency Minimum Dataset

Appendix B: Complete Dataset

Page	Field name	Format	Source	Entry	Requirement	Prove nance
22	**Person Demographics**					
24	Person_Given_Name	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL	ALL - LOCAL ALL - NATIONAL	CDS
25	Person_Family_Name	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL	ALL - LOCAL ALL - NATIONAL	CDS
26	Person_Stated_Gender	ALPHANUMERIC (1)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
28	Person_Birth_Date	DATE (10)	NHS DM&D	AUTO	ALL - LOCAL ALL - NATIONAL	CDS
29	Person_Age_At_Attendance	NUMBER (6)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
30	Person_NHS_Number	NUMBER (10)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
32	Person_NHS_Number_Status_Indicator	ALPHANUMERIC (2)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
33	Person_Identity_Withheld_Reason	ALPHANUMERIC (2)	NHS DM&D	CLERICAL	OPTIONAL NATIONAL	CDS
34	Person_Local_Number	ALPHANUMERIC (20)	NHS DM&D	CLERICAL AUTO	OPTIONAL - LOCAL ALL - NATIONAL	CDS
36	Person_Usual_Address1	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
37	Person_Usual_Address2	ALPHANUMERIC (max 35)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
38	Person_Usual_Address_Postcode	ALPHANUMERIC (max 10)	NHS DM&D	CLERICAL AUTO	ALL - LOCAL ALL - NATIONAL	CDS
39	Person_Residence_Org_Code	ALPHANUMERIC (max 10)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
40	Person_Residence_Type	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
42	Person_Residence_LSOA	ALPHANUMERIC (max 10)	ONS	AUTO	ALL - NATIONAL	NEW
43	Person_Preferred_Contact	ALPHANUMERIC (max 255)	NHS DM&D/XML	CLERICAL	OPTIONAL - LOCAL	NEW
45	Person_GP_Practice_Code	ALPHANUMERIC (max 6)	ODS	CLERICAL	ALL - NATIONAL	CDS
46	Person_Comm_Lang	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
47	Person_Interpreter_Rqd	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
49	Person_Interpreter_Lang	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
50	Person_Ethnic_Category	ALPHANUMERIC (max 2)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
51	Person_School	ALPHANUMERIC (max 10)	ODS	CLERICAL	ALL - LOCAL	NEW
52	Person_Companion	ALPHANUMERIC	NHS DM&D	CLERICAL	OPTIONAL - LOCAL	NEW

Page	Field name	Format	Source	Entry	Requirement	Prove nance
		(max 255)				
53	Person_Special_Patient_Note _Local	ALPHANUMERIC (max 4096)	NHS DM&D	CLINICAL AUTO	OPTIONAL - LOCAL	NEW
55	Person_Additional_Informatio n	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO	OPTIONAL - LOCAL	NEW
57	Person_Adverse_Reaction	ALPHANUMERIC (max 4096)	tbc	AUTO	OPTIONAL - LOCAL	NEW
59	Person_Cormorbidities	ALPHANUMERIC (max 255)	tbc	AUTO	ALL - NATIONAL	NEW
61	Person_Current_Meds	ALPHANUMERIC (max 4096)	SNOMED/ XML / DM&D	AUTO	OPTIONAL NATIONAL	NEW
63	**Episode Demographics**					
64	EmCare_Provider_Org_Code	ALPHANUMERIC (max 9)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
65	EmCare_Provider_Site_Code	ALPHANUMERIC (max 9)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
66	EmCare_Provider_Site_Type	ALPHANUMERIC (max 1)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
68	EmCare_Unique_ID	NUMBER (12 characters zero-filled)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
70	EmCare_Arrive_Transport_M ode	NUMBER (2 characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
72	EmCare_Amb_Unique_ID	ALPHANUMERIC (max 20)	NHS DM&D	CLERICAL	ALL - NATIONAL	NEW
74	EmCare_Arrive_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
75	EmCare_Attendance_Type	NUMBER (2 Characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
77	EmCare_Referral_Source	NUMBER (2 characters)	NHS DM&D	CLERICAL	ALL - NATIONAL	CDS
79	EmCare_Arrive_Transfer_So urce	ALPHANUMERIC (max 9)	NHS DM&D ODS	CLERICAL	ALL - NATIONAL	NEW
81	EmCare_Assess_DateTime	DATETIME	NHS DM&D	AUTO	ALL - NATIONAL	CDS
83	Em_Care_Clinicians	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
87	EmCare_Referred_Service	ALPHANUMERIC (max 4096)	NHS DM&D	AUTO CLINICAL	ALL - NATIONAL	NEW
89	EmCare_DTA_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	NEW
90	EmCare_Complete_DateTim e	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS
92	EmCare_Depart_DateTime	DATETIME (19 characters)	NHS DM&D	AUTO	ALL - NATIONAL	CDS

Page	Field name	Format	Source	Entry	Requirement	Prove nance
93	EmCare_Admit_Specialty	ALPHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
95	**Clinical Information**					
96	EmCare_Assessment_Type	ALPHANUMERIC (255)	SNOMED	CLINICAL	ALL	NEW
100	EmCare_Assessment_Score	ALPHANUMERIC (max 255)	NHS DM&D XML structured	CLINICAL	ALL - NATIONAL	NEW
102	EmCare_Presentation_Chief Complaint	ALPHANUMERIC (max 18)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
104	EmCare_Clinical_Narrative	ALPHANUMERIC (max 4096)	NHS DM&D	CLINICAL	ALL - LOCAL	NEW
106	EmCare_Diagnosis	ALPHANUMERIC (max 225)	NHS DM&D - SNOMED / XML	CLINICAL	ALL - NATIONAL	CDS
110	EmCare_Investigations	ALPHANUMERIC (max 4096)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
112	EmCare_Treatment	ALPHANUMERIC (max 4096)	SNOMED	CLINICAL	ALL - NATIONAL	CDS
114	EmCare_Research	ALPHANUMERIC (4096)	NHS DM&D	CLINICAL	OPTONAL – NATIONAL	NEW
116	**Patient Injury**					
117	EmCare_Inj_DateTime	DATETIME (19)	NHS DM&D	CLERICAL	ALL – NATIONAL	NEW
119	EmCare_Inj_Place_LatLong	ALPHANUMERIC (max 50)	NHS DM&D tbc	CLERICAL	OPTIONAL – NATIONAL	NEW A
121	EmCare_Inj_Place_Exact	ALPHANUMERIC (max 255)	NHS DM&D	CLERICAL	OPTIONAL – NATIONAL	NEW
123	EmCare_Inj_Place_Type	ALPHANUMERIC (max 2)	NHS DM&D	CLERICAL	ALL – NATIONAL	CDS
127	EmCare_Inj_Activity	APHANUMERIC (max 18)	SNOMED	CLERICAL	ALL - NATIONAL	NEW
130	EmCare_Inj_Mechanism	ALPHANUMERIC (max 2)	NHS DM&D	CLERICAL	ALL - NATIONAL	NEW
132	EmCare_Inj_Drug_Alcohol	ALPHANUMERIC (max 255)	SNOMED Dictionary of Medicine and Devices TBC	CLERICAL	ALL - NATIONAL	NEW
134	EmCare_Inj_Intent	NUMBER (max 2)	NHS DM&D	CLERICAL	ALL – NATIONAL	NEW
136	**Patient Discharge**					
137	EmCare_Discharge_Status	ALPHANUMERIC (max 2)	NHS DM&D	CLINICAL	ALL-NATIONAL	CDS
141	EmCare_Discharge_FollowUp	ALPHANUMERIC (max 2)	NHS DM&D	CLINICAL	ALL-NATIONAL	CDS
143	EmCare_Discharge_Medication	NUMBER (2 characters)	NHS DM&D	CLINICAL	ALL - NATIONAL	CDS

Page	Field name	Format	Source	Entry	Requirement	Prove nance
145	EmCare_Discharge_Instructio ns	ALPHANUMERIC (max 4096)	NHS DM&D / AoRMC/RCP	CLINICAL	OPTIONAL LOCAL	NEW
147	EmCare_Discharge_Informati on_Given	ALPHANUMERIC (max 4096)	AoRMC/RCP	CLINICAL	ALL - LOCAL	NEW
149	EmCare_Discharge_Safeguar ding	ALPHANUMERIC (max 18)	SNOMED	AUTO	ALL-NATIONAL	NEW
151	EmCare_Transfer_Destinatio n	NUMBER (max 2 characters)	NHS DM&D	CLINICAL	ALL - NATIONAL	NEW

Appendix C – Person_Comm_Lang

The data set for Person_Comm_Lang.

This data set will be available for download from the main ECDS web site.

The data items should be presented in their sort order to minimise clerical time spent searching.

SNOMED Code	Descriptor	Sort Order
315570003	English	1
408532009	Welsh	1
407648002	Albanian	2
315566006	Arabic	2
698655009	Belarusian	2
315567002	Bengali	2
970471000000104	Bosnian	2
699945003	Bulgarian	2
698891000	Burmese	2
315568007	Cantonese	2
698892007	Catalan	2
970491000000100	Chechen	2
970501000000106	Chinese	2
407650005	Croatian	2
315569004	Czech	2
698894008	Danish	2
408528003	Dutch	2
698659003	Estonian	2
408515005	Ethiopian	2
503511000000100	Filipino	2
414640006	Finnish	2
408520005	Flemish	2
315571004	French	2
408522002	Gaelic	2
698898006	Georgian	2
407643006	German	2
407652002	Greek	2
315572006	Gujarati	2
408524001	Hebrew	2
315575008	Hindi	2
698900008	Hungarian	2

SNOMED Code	Descriptor	Sort Order
698663005	Icelandic	2
698901007	Indonesian	2
698667006	Irish	2
407642001	Italian	2
407654001	Japanese	2
698906002	Kashmiri	2
698668001	Kazakh	2
395109004	Kurdish	2
698909009	Latvian	2
407656004	Lithuanian	2
698670005	Macedonian	2
698672002	Malay	2
315578005	Mandarin	2
698676004	Nepali	2
408530001	Norwegian	2
315579002	Polish	2
315580004	Portuguese	2
315581000	Punjabi	2
698678003	Romanian	2
315582007	Russian	2
408535006	Serbian	2
698920009	Slovak	2
698921008	Slovenian	2
315583002	Somali	2
315584008	Spanish	2
698681008	Sundanese	2
315585009	Swahili	2
408516006	Swedish	2
315587001	Tamil	2
408519004	Thai	2
407657008	Turkish	2
698928002	Turkmen	2
407659006	Ukrainian	2
315588006	Urdu	2
698930000	Uzbek	2
407661002	Vietnamese	2
312954003	Language not recorded	3
698651000	Abkhazian	4

SNOMED Code	Descriptor	Sort Order
698652007	Afar	4
698653002	Afrikaans	4
408525000	Akan	4
408507007	Amharic	4
809341000000106	Aragonese	4
698885002	Armenian	4
698886001	Assamese	4
970441000000105	Avaric	4
970451000000108	Avestan	4
698887005	Aymara	4
698888000	Azerbaijani	4
970461000000106	Bambara	4
609092003	Bamun	4
698889008	Bashkir	4
698654008	Basque	4
698656005	Bihari	4
698890004	Bislama	4
408513003	Brawa	4
698657001	Breton	4
698893002	Central Khmer	4
970481000000102	Chamorro	4
698935005	Chuang	4
970511000000108	Church Slavic	4
970521000000102	Chuvash	4
970531000000100	Cornish	4
698658006	Corsican	4
970541000000109	Cree	4
609093008	Dari	4
970551000000107	Dhivehi	4
698896005	Esperanto	4
970561000000105	Ewe	4
357001000000106	Faeroese	4
698660008	Faroese	4
395108007	Farsi	4
698897001	Fijian	4
408521009	French Creole	4
698661007	Frisian	4
729051000000103	Fulani	4

SNOMED Code	Descriptor	Sort Order
698662000	Galician	4
698899003	Guarani	4
970601000000105	Haitian	4
408523007	Hakka	4
315574007	Hausa	4
970611000000107	Herero	4
511841000000102	Hindko	4
970621000000101	Hiri Motu	4
315576009	Iba	4
970631000000104	Ido	4
408514009	Igbo	4
698664004	Interlingua	4
698665003	Inuktitut	4
698666002	Inupiaq	4
698903005	Javanese	4
698895009	Jonkha	4
698904004	Kalaallisut	4
698905003	Kanarese	4
970641000000108	Kanuri	4
729061000000100	Kikuyu	4
698908001	Kirgiz	4
970651000000106	Komi	4
970661000000109	Kongo	4
609094002	Konkani	4
407655000	Korean	4
970681000000100	Kuanyama	4
315577000	Kutchi	4
698669009	Lao	4
970691000000103	Latin	4
970701000000103	Limburgan	4
408526004	Lingala	4
970711000000101	Luba-Katanga	4
408527008	Luganda	4
970721000000107	Luxembourgish	4
698671009	Malagasy	4
408529006	Malayalam	4
698910004	Maltese	4
970741000000100	Manx	4

SNOMED Code	Descriptor	Sort Order
698673007	Maori	4
698674001	Marathi	4
970751000000102	Marshallese	4
698911000	Moldavian	4
698675000	Mongolian	4
698912007	Nauruan	4
970771000000106	Navajo	4
698913002	Ndebele	4
970781000000108	Ndonga	4
970801000000109	Northern Ndebele	4
970811000000106	Northern Sami	4
970821000000100	Norwegian Bokmal	4
970831000000103	Norwegian Nynorsk	4
970961000000102	Nuosu	4
729041000000101	Nyanja	4
698902000	Occidental	4
698914008	Occitan	4
970851000000105	Ojibwa	4
698915009	Oriya	4
698916005	Oromo	4
970871000000101	Ossetian	4
970881000000104	Pali	4
408531002	Pashto	4
408534005	Patois	4
970911000000104	Pushto	4
698677008	Quechua	4
698917001	Romansh	4
698907006	Ruanda	4
698679006	Rundi	4
698680009	Samoan	4
698918006	Sango	4
970921000000105	Sanskrit	4
970931000000107	Sardinian	4
970941000000103	Scottish Gaelic	4
395110009	Shona	4
698919003	Sindhi	4
408518007	Sinhala	4
970971000000109	South Ndebele	4

SNOMED Code	Descriptor	Sort Order
698922001	Southern Sotho	4
698923006	Swazi	4
315586005	Sylheti	4
408517002	Tagalog	4
970991000000108	Tahitian	4
698682001	Tajik	4
698924000	Tatar	4
698925004	Telugu	4
609095001	Tetum	4
698926003	Tibetan	4
408533004	Tigrinya	4
698927007	Tongan	4
698683006	Tsonga	4
698684000	Tswana	4
698685004	Twi	4
698929005	Uigur	4
971011000000109	Venda	4
971021000000103	Volapuk	4
971031000000101	Walloon	4
971041000000105	Western Frisian	4
698932008	Wolof	4
698933003	Xhosa	4
698934009	Yiddish	4
315589003	Yoruba	4
698936006	Zulu	4

Appendix D - Person_Interpreter_Lang

The data set for Person_Interpreter_Lang.

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

SNOMED Code	Preferred Term	Sort Order
972731000000105	Irish	1
204231000000101	Welsh	1
204331000000107	British Sign Language	2
945731000000104	Hands-on signing	2
204341000000103	Makaton Sign Language	2
936761000000104	Sign Supported English	2
945711000000107	Visual frame sign language	2
203291000000102	Albanian	3
203311000000101	Arabic	3
362261000000106	Armenian	3
203321000000107	Bengali	3
972561000000106	Bosnian	3
353921000000107	Bulgarian	3
362371000000109	Burmese	3
203381000000108	Cantonese	3
972581000000102	Chechen	3
972591000000100	Chinese	3
203391000000105	Croatian	3
203401000000108	Czech	3
361971000000101	Danish	3
203411000000105	Dutch	3
361911000000106	Estonian	3
359791000000109	Ethiopian	3
343701000000103	Finnish	3
343711000000101	Flemish	3
203441000000106	French	3
343721000000107	Gaelic	3
361471000000106	Georgian	3
203581000000102	German	3
203591000000100	Greek	3
203601000000106	Gujarati	3

SNOMED Code	Preferred Term	Sort Order
203641000000109	Hebrew	3
203651000000107	Hindi	3
360431000000104	Hungarian	3
360401000000105	Icelandic	3
362111000000101	Indonesian	3
203371000000106	Italian	3
203681000000101	Japanese	3
360281000000101	Javanese	3
360191000000109	Kashmiri	3
360221000000102	Kazakh	3
203691000000104	Korean	3
203701000000104	Kurdish	3
360071000000106	Latvian	3
203721000000108	Lithuanian	3
359971000000108	Macedonian	3
360161000000103	Malay	3
203821000000101	Mandarin	3
364251000000104	Nepali	3
203831000000104	Norwegian	3
203901000000102	Polish	3
203911000000100	Portuguese	3
353881000000101	Romanian	3
203971000000105	Russian	3
203981000000107	Serbian	3
973061000000107	Serbo-Croatian	3
352901000000108	Slovak	3
363591000000107	Slovenian	3
204021000000108	Somali	3
204031000000105	Spanish	3
363781000000103	Sundanese	3
204041000000101	Swahili	3
204051000000103	Swedish	3
204131000000109	Tamil	3
204151000000102	Thai	3
363141000000105	Tibetan	3
204191000000105	Turkish	3
204201000000107	Ukrainian	3
204211000000109	Urdu	3

SNOMED Code	Preferred Term	Sort Order
204221000000103	Vietnamese	3
362721000000106	Abkhazian	4
362691000000102	Afar	4
362571000000102	Afrikaans	4
203281000000104	Akan	4
203301000000103	Amharic	4
972511000000109	Aragonese	4
362231000000101	Assamese	4
972521000000103	Avaric	4
972531000000101	Avestan	4
362541000000108	Aymara	4
362611000000106	Azerbaijani	4
972541000000105	Bambara	4
972551000000108	Bashkir	4
362641000000107	Basque	4
362071000000107	Belarusian	4
362201000000107	Bihari	4
362171000000106	Bislama	4
359821000000104	Brawa	4
362141000000100	Breton	4
362041000000101	Catalan	4
362331000000107	Central Khmer	4
972571000000104	Chamorro	4
972601000000106	Church Slavic	4
972611000000108	Chuvash	4
972621000000102	Cornish	4
361941000000107	Corsican	4
972631000000100	Cree	4
972641000000109	Dhivehi	4
362781000000107	Dzongkha	4
361881000000106	Esperanto	4
972651000000107	Ewe	4
361791000000100	Faeroese	4
361821000000105	Fijian	4
203521000000103	French Creole	4
361501000000104	Frisian	4
972671000000103	Fulah	4
361851000000100	Galician	4

SNOMED Code	Preferred Term	Sort Order
203801000000105	Ganda	4
361441000000100	Guarani	4
972681000000101	Haitian	4
203611000000108	Hakka	4
203631000000100	Hausa	4
972691000000104	Herero	4
972701000000104	Hiri Motu	4
359881000000103	Iban	4
972711000000102	Ido	4
203531000000101	Igbo	4
972721000000108	Interlingua	4
360341000000102	Interlingue	4
360311000000103	Inuktitut	4
360251000000107	Inupiaq	4
362011000000102	Kalaallisut	4
360101000000102	Kannada	4
972741000000101	Kanuri	4
972751000000103	Kikuyu	4
360131000000108	Kinyarwanda	4
359851000000109	Kirghiz	4
972771000000107	Komi	4
972781000000109	Kongo	4
972791000000106	Kuanyama	4
343771000000106	Kutchi	4
360371000000108	Lao	4
972801000000105	Latin	4
972811000000107	Limburgan	4
203711000000102	Lingala	4
972821000000101	Luba-Katanga	4
359761000000103	Luganda	4
972831000000104	Luxembourgish	4
360011000000101	Malagasy	4
203811000000107	Malayalam	4
359731000000108	Maltese	4
972851000000106	Manx	4
359911000000103	Maori	4
359701000000102	Marathi	4
972861000000109	Marshallese	4

SNOMED Code	Preferred Term	Sort Order
359671000000101	Moldavian	4
359641000000107	Mongolian	4
364351000000107	Nauru	4
972881000000100	Navajo	4
352931000000102	Ndebele	4
972891000000103	Ndonga	4
972911000000100	North Ndebele	4
972921000000106	Northern Sami	4
972931000000108	Norwegian Bokmal	4
972941000000104	Norwegian Nynorsk	4
973071000000100	Nuosu	4
972951000000101	Nyanja	4
364311000000108	Occitan	4
972981000000107	Ojibwa	4
364211000000103	Oriya	4
362991000000107	Oromo	4
973001000000108	Ossetian	4
973011000000105	Pali	4
203961000000103	Panjabi	4
203841000000108	Pashto	4
203421000000104	Persian	4
364011000000105	Quechua	4
364481000000106	Romansh	4
363061000000105	Rundi	4
363841000000104	Samoan	4
364051000000109	Sango	4
973031000000102	Sanskrit	4
973041000000106	Sardinian	4
973051000000109	Scottish Gaelic	4
203991000000109	Shona	4
363711000000105	Sindhi	4
204011000000102	Sinhala	4
973081000000103	South Ndebele	4
363651000000100	Southern Sotho	4
363621000000105	Swati	4
204081000000109	Sylheti	4
204111000000101	Tagalog	4
973101000000109	Tahitian	4

SNOMED Code	Preferred Term	Sort Order
363681000000106	Tajik	4
363221000000107	Tatar	4
363341000000107	Telugu	4
204171000000106	Tigrinya	4
363461000000100	Tongan	4
363181000000102	Tsonga	4
363941000000108	Tswana	4
363551000000104	Turkmen	4
363301000000109	Twi	4
364141000000107	Uighur	4
362961000000101	Uzbek	4
973121000000100	Venda	4
973131000000103	Volapuk	4
973141000000107	Walloon	4
973151000000105	Western Frisian	4
973161000000108	Wolof	4
364511000000100	Xhosa	4
363021000000102	Yiddish	4
204241000000105	Yoruba	4
362911000000103	Zhuang	4
362821000000104	Zulu	4

Appendix E - Person_Ethnic_Catergory

The data set for Person_Ethinic_Catergory.

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

Code	Descriptor
A	British, Mixed British
B	Irish
C	Any other White background
C2	Northern Irish
C3	Other white, white unspecified
CA	English
CB	Scottish
CC	Welsh
CD	Cornish
CE	Cypriot (part not stated)
CF	Greek
CG	Greek Cypriot
CH	Turkish
CJ	Turkish Cypriot
CK	Italian
CL	Irish Traveller
CM	Traveller
CN	Gypsy/Romany
CP	Polish
CQ	All republics which made up the former USSR
CR	Kosovan
CS	Albanian
CT	Bosnian
CU	Croatian
CV	Serbian
CW	Other republics which made up the former Yugoslavia
CX	Mixed white
CY	Other white European, European unspecified, European mixed
D	White and Black Caribbean
E	White and Black African

Code	Descriptor
F	White and Asian
G	Any other mixed background
GA	Black and Asian
GB	Black and Chinese
GC	Black and White
GD	Chinese and White
GE	Asian and Chinese
GF	Other Mixed, Mixed Unspecified
H	Indian or British Indian
J	Pakistani or British Pakistani
K	Bangladeshi or British Bangladeshi
L	Any other Asian background
LA	Mixed Asian
LB	Punjabi
LC	Kashmiri
LD	East African Asian
LE	Sri Lanka
LF	Tamil
LG	Sinhalese
LH	British Asian
LJ	Caribbean Asian
LK	Other Asian, Asian unspecified
M	Caribbean
N	African
P	Any other Black background
PA	Somali
PB	Mixed Black
PC	Nigerian
PD	Black British
PE	Other Black, Black unspecified
R	Chinese
S	Any other ethnic group
SA	Vietnamese
SB	Japanese
SC	Filipino
SD	Malaysian
SE	Any Other Group
Z	Not stated

Appendix F – Person_Comorbidities

The data set for Person_Comorbidities.

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

SNOMED Code	Term
15167005	Alcohol abuse
26929004	Alzheimer's disease
197480006	Anxiety disorder
87486003	Aphasia
195967001	Asthma
408856003	Autistic disorder
162344009	Bilateral deafness
13746004	Bipolar disorder
193699007	Blindness - both eyes
22950006	Blindness of one eye
441509002	Cardiac pacemaker in situ
274100004	Cerebral haemorrhage
432504007	Cerebral infarction
230690007	Cerebrovascular accident
62914000	Cerebrovascular disease
63480004	Chronic bronchitis
60926001	Chronic interstitial nephritis
709044004	Chronic kidney disease
13645005	Chronic obstructive lung disease
8531006	Complete deafness
206586007	Congenital cardiac failure
82525005	Congenital cystic kidney disease
42343007	Congestive heart failure
48500005	Delusional disorder
52448006	Dementia
35489007	Depressive disorder
1855002	Developmental academic disorder
248290002	Developmental delay
73211009	Diabetes mellitus

SNOMED Code	Term
26416006	Drug abuse
40739000	Dysphagia
72366004	Eating disorder
298344006	Elderly fall
84757009	Epilepsy
84114007	Heart failure
50582007	Hemiplegia
161647008	History of anticoagulant therapy
314550003	History of Deliberate Self Harm
38341003	Hypertensive disorder
414545008	Ischaemic heart disease
18165001	Jaundice
161129001	Learning difficulties
85232009	Left heart failure
166603001	Liver function tests abnormal
105529008	Lives alone
361055000	Misuses drugs
11851006	Mitral valve disorder
253883006	Multiple renal cysts
24700007	Multiple sclerosis
28728008	Polycystic kidney disease, adult type
525791000000105	Profound acquired hearing loss
700454004	Profound sensorineural hearing loss
69322001	Psychotic disorder
87433001	Pulmonary emphysema
170727003	Registered blind
236423003	Renal impairment
409622000	Respiratory failure
267064002	Retention of urine
69896004	Rheumatoid arthritis
58214004	Schizophrenia
31027006	Schizotypal personality disorder
3561000119106	Severe hearing loss
236448000	Small kidney
77176002	Smoker
21454007	Subarachnoid haemorrhage
15167005	Alcohol abuse

Appendix G - EmCare_Referred_Service

The data set for EmCare_Referred_Service

This data set is available for download via the main ECDS web site.

If some of these services are not available locally they may be removed from the local code set.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

This data item should be presented as two linked dropdown boxes OR a tree menu, using Sort1 and Sort2 to create order the items so that those that are most frequently used are presented at the top of each list.

Code	Group	Referred to service	Sort1	Sort2
	Medical	Acute medicine	1	11
183516009	Medical	General medicine	1	12
183519002	Medical	Cardiology	1	16
183522000	Medical	Care of the elderly	1	17
183523005	Medical	Gastroenterology	1	18
306114008	Medical	Respiratory medicine	1	19
306124000	Medical	Infectious diseases	1	22
306148009	Medical	Haematology	1	23
306118006	Medical	Endocrinology	1	24
306802002	Medical	Stroke	1	25
307374004	Medical	Rehabilitation	1	26
306237005	Medical	Palliative care	1	30
183521007	Medical	Neurology	1	32
306127007	Medical	Rheumatology	1	33
306140002	Medical	Clinical oncology	1	35
183518005	Medical	Dermatology	1	39
306125004	Medical	Nephrology	1	55
306285006	Medical	Medical ophthalmology	1	70
306123006	Medical	Genitourinary medicine	1	71
306111000	Medical	Clinical allergy	1	74
	Surgical	Acute surgery	2	11
183542009	Surgical	General surgery	2	12
183545006	Surgical	Orthopaedic surgery	2	15
306200004	Surgical	Trauma surgery	2	20
183546007	Surgical	Neurosurgery	2	25
306201000	Surgical	Urology	2	28

Code	Group	Referred to service	Sort1	Sort2
306934005	Surgical	Vascular surgery	2	29
183544005	Surgical	Ear, nose and throat	2	30
306198005	Surgical	Plastic surgery	2	40
183543004	Surgical	Ophthalmology	2	42
306182003	Surgical	Cardiothoracic surgery	2	45
306184002	Surgical	Thoracic surgery	2	45
327121000000104	Surgical	Dental surgery	2	50
384712002	Surgical	Oral surgery	2	51
384711009	Surgical	Maxillofacial surgery	2	52
306107006	Critical Care	Adult intensive care	3	15
975951000000109	Critical Care	Paediatric critical care	3	21
382271000000102	Critical Care	Interventional radiology	3	31
306128002	Paediatrics	Paediatric	4	11
183547003	Paediatrics	Paediatric surgical	4	15
306132008	Paediatrics	Neonatology	4	22
850281000000109	Paediatrics	Paediatric orthopaedic	4	31
850231000000105	Paediatrics	Paediatric ear, nose and throat	4	35
417311009	Paediatrics	Paediatric cardiology	4	39
306188004	Paediatrics	Paediatric dentistry	4	50
416076006	Paediatrics	Paediatric dermatology	4	55
344131000000108	Paediatrics	Paediatric eye care	4	59
700125004	Paediatrics	Paediatric gynaecology	4	60
306130000	Paediatrics	Paediatric neurology	4	65
306131001	Paediatrics	Paediatric oncology	4	70
885391000000103	Paediatrics	Paediatric allergy	4	91
183549000	O+G	Gynaecology	5	11
183548008	O+G	Obstetrics	5	15
202291000000107	Psychiatric	Mental health assessment	6	11
306136006	Psychiatric	Liaison psychiatry	6	13
380241000000107	Psychiatric	Child and Adolescent Mental Health Service	6	15
183524004	Psychiatric	Psychiatry	6	20
306138007	Psychiatric	Psychogeriatric service	6	25
413127007	Psychiatric	Learning disability team	6	40
306137002	Psychiatric	Mental handicap psychiatry	6	41
306135005	Psychiatric	Forensic psychiatry	6	45
770411000000102	Local Medical	General practitioner out of hours	7	13
898791000000105	Local Medical	Ambulatory care	7	15
183561008	Local Medical	General practitioner	7	15

Code	Group	Referred to service	Sort1	Sort2
276490004	Local Medical	Primary health care team	7	16
306152009	Local Medical	Occupational health	7	25
247541000000106	Community/ OPD	Falls service	8	11
818861000000107	Community/ OPD	Older people rapid assessment	8	12
516511000000107	Community/ OPD	Community nursing out of hours	8	13
61801003	Community/ OPD	Psychiatric aftercare	8	14
38670004	Community/ OPD	Alcoholism rehabilitation	8	15
4266003	Community/ OPD	Drug addiction rehabilitation	8	16
78429003	Community/ OPD	Physical rehabilitation	8	17
415263003	Community/ OPD	Anticoagulant clinic	8	18
307375003	Community/ OPD	Head injury rehabilitation	8	19
823961000000102	Community/ OPD	Memory assessment service	8	20
894171000000100	Community/ OPD	Neurological rehabilitation	8	21
353961000000104	Community/ OPD	Community rapid response team	8	41
307376002	Community/ OPD	Community rehabilitation	8	42
811391000000104	Community/ OPD	Community diabetes	8	43
306129005	Community/ OPD	Community paediatric	8	43
785701000000106	Community/ OPD	Community dermatology	8	45
785761000000105	Community/ OPD	Community cardiology	8	46
307380007	Community/ OPD	Swallow clinic	8	61
785721000000102	Community/ OPD	Community ophthalmology	8	62
785781000000101	Community/ OPD	Community gynaecology	8	64
785621000000108	Community/ OPD	Community gastroenterology	8	65
785681000000109	Community/ OPD	Community ear, nose and throat	8	66

Appendix H - EmCare_Admitted_Specialty

Please find below the data set for EmCare_Admitted_Specialty. This is a list of the departments to which a patient may be admitted.

NB this is the **department responsible for the patient episode**, and *not the physical destination* e.g. a patient may be admitted to intensive care (and the EmCare_Discharge_Status would record this destination) under the care of the cardiology department – this would be coded as 'cardiology'.

If certain values do not apply in a particular hospital e.g. critical care, because all patients are admitted under the parent units (e.g. cardiology) then these should not be presented.

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

This data item should be presented as two linked dropdown boxes OR a tree menu, using Sort1 and Sort2 to create order the items so that those that are most frequently used are presented at the top of each list.

Code	Group	Department admitted to	Sort1	Sort2
	Medical	acute medicine	1	11
305368000	Medical	general medicine	1	13
305375004	Medical	care of the elderly	1	15
305357000	Medical	cardiology	1	22
305360007	Medical	respiratory medicine	1	24
305367005	Medical	gastroenterology	1	25
305366001	Medical	endocrinology	1	27
306803007	Medical	stroke unit	1	38
305379005	Medical	neurology	1	39
305376003	Medical	infectious diseases	1	40
305378002	Medical	nephrology	1	42
305381007	Medical	palliative care	1	48
308251003	Medical	clinical oncology	1	53
305382000	Medical	rehabilitation	1	65
305383005	Medical	rheumatology	1	66
305396006	Medical	haematology	1	70
305374000	Medical	genitourinary medicine	1	90
305365002	Medical	dermatology	1	91
	Surgical	acute surgery	2	11
305423009	Surgical	general surgical	2	13
305428000	Surgical	orthopaedic	2	21

Code	Group	Department admitted to	Sort1	Sort2
305433001	Surgical	trauma surgery	2	22
305425002	Surgical	neurosurgical	2	25
305435008	Surgical	vascular surgery	2	26
305434007	Surgical	urology	2	28
305417004	Surgical	ear, nose and throat-	2	29
305410002	Surgical	cardiothoracic surgery	2	31
305412005	Surgical	cardiac surgery	2	32
305411003	Surgical	thoracic surgery	2	33
305431004	Surgical	plastic surgery	2	35
306967009	Surgical	hand surgery	2	36
183450002	Surgical	burns unit	2	37
305409007	Surgical	breast surgery	2	38
305426001	Surgical	ophthalmology	2	40
305419001	Surgical	gastrointestinal surgery	2	50
305421006	Surgical	upper gastrointestinal surgery	2	51
305424003	Surgical	hepatobiliary surgical	2	52
305432006	Surgical	surgical transplant	2	53
305422004	Surgical	colorectal surgery	2	54
306732000	Surgical	general dental surgery	2	65
305427005	Surgical	oral surgery	2	66
305413000	Surgical	dental surgery	2	67
305352006	Critical Care	adult intensive care unit	3	11
398162007	Critical Care	high dependency unit	3	12
305353001	Critical Care	paediatric intensive care unit	3	20
305388001	Critical Care	special care baby unit	3	25
183448005	Critical Care	neurological intensive care unit	3	30
183446009	Critical Care	cardiac intensive care unit	3	35
183447000	Critical Care	respiratory intensive care unit	3	40
305387006	Paediatrics	paediatric	4	11
305430003	Paediatrics	paediatric surgical	4	15
	Paediatrics	paediatric cardiology	4	30
	Paediatrics	paediatric cardiothoracic	4	31
	Paediatrics	paediatric respiratory medicine	4	41
	Paediatrics	paediatric gastroenterology	4	42
305390000	Paediatrics	paediatric oncology	4	55
	Paediatrics	paediatric neurosurgery	4	61
305389009	Paediatrics	paediatric neurology	4	62
305415007	Paediatrics	paediatric dentistry	4	65

Code	Group	Department admitted to	Sort1	Sort2
	Paediatrics	paediatric ear nose and throat	4	68
	Paediatrics	paediatric burns	4	71
	Paediatrics	paediatric plastic surgery	4	72
306804001	Paediatrics	young disabled unit	4	90
305385003	O+G	gynaecology	5	11
305400006	Psychiatry	psychiatry	5	11
305386002	O+G	obstetrics	5	15
305403008	Psychiatry	psychogeriatric	5	15
305401005	Psychiatry	child and adolescent psychiatry	5	20
305404002	Psychiatry	mental handicap psychiatry	5	25
305402003	Psychiatry	forensic psychiatry	5	35
699124006	Community	substance detoxification centre	9	21

Appendix I - EmCare_ChiefComplaint

The data set for EmCare_ChiefComplaint

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

This data item should be presented as two linked dropdown boxes OR a tree menu, using Sort1 and Sort2 to create order the items so that those that are most frequently used are presented at the top of each list.

Code Set

Code	Category	Descriptor	Sort1	Sort2	Injury
29857009	Cardiovascular	Chest pain	11	11	0
80313002	Cardiovascular	Palpitations	11	12	0
427461000	Cardiovascular	Fainting episode	11	23	0
271594007	Cardiovascular	Fainting episode with loss of consciousness	11	24	0
275319005	Cardiovascular	Swollen legs (both)	11	35	0
162784002	Cardiovascular	Swollen leg (single)	11	36	0
21631000119105	Cardiovascular	Cold painful limb	11	44	0
410429000	Cardiovascular	Cardiac arrest	11	51	0
422970001	Cardiovascular	Cardiac arrest due to trauma	11	52	1
267036007	Respiratory	Short of breath	12	11	0
230145002	Respiratory	Difficulty breathing	12	12	0
70407001	Respiratory	Noisy breathing	12	13	0
66857006	Respiratory	Coughing up blood (haemoptysis)	12	31	0
262599003	Respiratory	Foreign body - respiratory tract	12	51	1
13094009	Respiratory	Infant with episodes not breathing (apnoea)	12	61	0
87317003	Respiratory	Respiratory arrest	12	71	0
21522001	Gastrointestinal	Abdominal pain	13	11	0
14760008	Gastrointestinal	Constipation	13	12	0
62315008	Gastrointestinal	Diarrhoea	13	13	0
422400008	Gastrointestinal	Vomiting +/- nausea	13	14	0
422587007	Gastrointestinal	Nausea without vomiting	13	15	0
41931001	Gastrointestinal	Abdominal distension	13	16	0
65958008	Gastrointestinal	Hiccoughs	13	17	0
18165001	Gastrointestinal	Jaundice	13	18	0
79890006	Gastrointestinal	Loss of appetite	13	21	0

Code	Category	Descriptor	Sort1	Sort2	Injury
8765009	Gastrointestinal	Vomiting blood	13	31	0
77880009	Gastrointestinal	Rectal pain	13	32	0
249624003	Gastrointestinal	Blood in stools	13	33	0
276464002	Gastrointestinal	Injury of anus	13	41	1
47609003	Gastrointestinal	Foreign body in oesophagus	13	52	1
33334006	Gastrointestinal	Foreign body in digestive tract	13	55	1
70176004	Gastrointestinal	Foreign body in rectum	13	59	1
25064002	Neurological	Headache	14	11	0
3006004	Neurological	Drowsy (altered level of consciousness)	14	12	0
40917007	Neurological	Confusion	14	13	0
309774006	Neurological	Limb weakness	14	14	0
95666008	Neurological	Facial weakness	14	15	0
404640003	Neurological	Dizziness	14	16	0
91175000	Neurological	Seizure (fit)	14	17	0
44077006	Neurological	Numbness/ tingling (parasthesia)	14	18	0
26079004	Neurological	Tremor	14	19	0
25136009	Neurological	Unsteady on feet	14	20	0
193462001	Neurological	Insomnia	14	21	0
399963005	Skin	Wound - abrasion	16	11	1
312608009	Skin	Wound - laceration	16	12	1
312609001	Skin	Wound - puncture	16	13	1
299972003	Skin	Wound - sting	16	14	1
283682007	Skin	Wound - bite	16	15	1
125666000	Skin	Burn	16	21	1
271807003	Skin	Rash	16	31	0
95320005	Skin	Localised swelling/ redness/ lumps / bumps	16	32	0
419076005	Skin	Allergic reaction	16	41	1
418363000	Skin	Itching	16	42	0
161887000	Skin	Spontaneous bruising	16	61	0
93459000	Skin	Foreign body in skin/ subcutaneous tissue	16	71	1
82271004	Head and Neck	Head injury	31	11	1
125593007	Head and Neck	Facial injury	31	12	1
95668009	Head and Neck	Facial pain (inc. toothache)	31	13	0
81680005	Head and Neck	Neck pain	31	18	0
162356005	Head and Neck	Ear - pain	31	21	0
2999009	Head and Neck	Ear - injury	31	22	1
300132001	Head and Neck	Ear - discharge	31	23	0
15188001	Head and Neck	Ear - hearing loss	31	24	0

Code	Category	Descriptor	Sort1	Sort2	Injury
60862001	Head and Neck	Ear - ringing in ears (tinnitus)	31	25	0
75441006	Head and Neck	Ear - foreign body	31	29	1
12441001	Head and Neck	Nose - bleeding	31	31	0
19491003	Head and Neck	Nose - injury	31	32	1
21719001	Head and Neck	Nose - hayfever (allergic rhinitis)	31	33	0
68235000	Head and Neck	Nose - congestion (not allergy)	31	34	0
74699008	Head and Neck	Nose - foreign body	31	39	0
267102003	Head and Neck	Throat - sore	31	41	0
49727002	Head and Neck	Throat - cough	31	42	0
14380007	Head and Neck	Throat - foreign body in throat/mouth	31	49	1
75705005	Eye	Red eye	32	11	0
55899000	Eye	Foreign body on eye	32	12	1
41652007	Eye	Pain in / around eye	32	21	0
246679005	Eye	Discharge from eye	32	22	0
63102001	Eye	Visual disturbance	32	32	0
409668002	Eye	Photophobia	32	33	0
282752000	Eye	Eye injury	32	41	1
170720001	Eye	Eye review	32	51	0
127278005	Orthopaedics/ Trauma	Injury of shoulder/arm/elbow/wrist/hand	35	11	1
127279002	Orthopaedics/ Trauma	Injury of hip/leg/knee/ankle/foot	35	12	1
90460009	Orthopaedics/ Trauma	Injury of neck	35	31	1
81102000	Orthopaedics/ Trauma	Injury of back	35	41	1
161891005	Orthopaedics/ Trauma	Backache (no recent injury)	35	42	0
102556003	Orthopaedics/ Trauma	Pain in shoulder/arm/elbow/wrist/hand	35	51	0
10601006	Orthopaedics/ Trauma	Pain in hip/leg/knee/ankle/foot	35	52	0
271771009	Orthopaedics/ Trauma	Joint swelling	35	61	0
417746004	Orthopaedics/ Trauma	Major trauma	35	81	1
262595009	Orthopaedics/ Trauma	Traumatic amputation	35	82	1
49650001	Genitourinary	Pain on passing urine	41	11	0
28442001	Genitourinary	Frequent urination	41	13	0
267064002	Genitourinary	Unable to pass urine	41	14	0

Code	Category	Descriptor	Sort1	Sort2	Injury
83128009	Genitourinary	Low urine output	41	15	0
34436003	Genitourinary	Blood in urine	41	16	0
247355005	Genitourinary	Flank pain	41	21	0
20502007	Genitourinary	Pain in scrotum/testes	41	22	0
281398003	Genitourinary	Abnormal swelling groin area	41	41	0
335977000	Genitourinary	Penile swelling	41	42	0
225565007	Genitourinary	Pain in genital area (generalised)	41	61	0
282772005	Genitourinary	Genital injury	41	62	1
271939006	Genitourinary	Vaginal discharge	41	71	0
2910007	Genitourinary	Penile discharge	41	72	0
56890008	Genitourinary	Victim of alleged sexual assault	41	81	1
428566005	Obstetrics/ Gynaecology	Pregnancy related, less than 20 weeks	42	11	0
429715006	Obstetrics/ Gynaecology	Pregnancy related, greater than 20 weeks	42	21	0
289530006	Obstetrics/ Gynaecology	Vaginal bleeding - abnormal	42	31	0
289476008	Obstetrics/ Gynaecology	Swelling of labia	42	32	0
55222007	Obstetrics/ Gynaecology	Breast tenderness	42	41	0
34124000	Obstetrics/ Gynaecology	Foreign body in vagina	42	81	1
75478009	Environmental	Poisoning from any source	61	11	1
371708003	Environmental	Electrical exposure (inc. lightening)	61	21	1
386689009	Environmental	Hypothermia	61	31	1
370977006	Environmental	Frostbite	61	32	1
87970004	Environmental	Near drowning	61	41	1
417981005	Environmental	Exposure to communicable disease	61	51	1
371704001	Environmental	Chemical exposure	61	52	1
57335002	Environmental	Noxious inhalation - gas/fumes/vapour	61	53	1
248062006	Mental Health	Deliberate self-harm	71	11	1
267073005	Mental Health	Suicidal intent	71	21	0
35489007	Mental Health	Depression	71	22	0
48694002	Mental Health	Anxiety	71	31	0
248004009	Mental Health	Behaviour - violent	71	41	0
248020004	Mental Health	Behaviour - bizarre	71	51	0
7011001	Mental Health	Hallucinations	71	52	0
66214007	Substance related	Drug/alcohol intoxication/withdrawal	72	11	0

Code	Category	Descriptor	Sort1	Sort2	Injury
386661006	General/ Minor	Fever	81	11	0
80394007	General/ Minor	Hyperglycaemia	81	21	0
302866003	General/ Minor	Hypoglycaemia	81	22	0
225358003	General/ Minor	Postoperative/ wound care (no complication)	81	31	0
385486001	General/ Minor	Postoperative complication (inc problem with medical device)	81	32	1
162214009	General/ Minor	Crying infant	81	51	0
387712008	General/ Minor	Neonatal jaundice	81	52	0
66091009	General/ Minor	Congenital disease	81	53	0
13791008	General/ Minor	Generalised weakness	81	61	0
398979000	General/ Minor	Pale complexion	81	62	0
3415004	General/ Minor	Blue colour (cyanosis)	81	63	0
161152002	General/ Minor	Social problem	81	81	0

Appendix J – EmCare_Treatments

The data set for EmCare_Treatments

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

Code	Group	Descriptor	Sort1	Sort2
57485005	Airway/ Breathing	Oxygen therapy	11	11
182692007	Airway/ Breathing	Nasopharyngeal airway insertion	11	21
56251003	Airway/ Breathing	Nebuliser therapy	11	31
428311008	Airway/ Breathing	Non-invasive ventilation	11	41
50697003	Airway/ Breathing	Sedation / Anaesthesia	11	51
425447009	Airway/ Breathing	Bag valve mask ventilation	11	55
424979004	Airway/ Breathing	Laryngeal mask airway insertion	11	61
112798008	Airway/ Breathing	Insertion of endotracheal tube	11	65
264957007	Airway/ Breathing	Insertion of pleural tube drain	11	71
392231009	Circulation	Intravenous cannulation	21	11
430824005	Circulation	Intraosseous cannulation	21	21
116859006	Circulation	Transfusion of blood product	21	25
233527006	Circulation	Central venous cannula insertion	21	31
250980009	Circulation	Cardioversion	21	41
18590009	Circulation	Cardiac pacing	21	42
89666000	Circulation	Cardiopulmonary resuscitation	21	71
392247006	Resucitation	Insertion of catheter into artery	31	11
439569004	Resucitation	Resuscitation	31	21
241740008	Resucitation	Active warming of patient	31	31
182660006	Resucitation	Cold therapy	31	41
71810007	Wound Management	Closure of skin wound by tape	35	11
410379003	Wound Management	Dressing change/wound care surveillance	35	13
127786006	Wound Management	Tetanus vaccination	35	17
85875009	Wound Management	Debridement of wound of skin	35	21
284182000	Wound Management	Gluing of wound	35	31
50015006	Wound Management	Closure by staple	35	41
302410007	Wound Management	Primary suture of skin	35	51
427035008	Analgesia	Nitrous oxide analgesia	41	11
386761002	Analgesia	Local anaesthesia	41	21

Code	Group	Descriptor	Sort1	Sort2
27372005	Analgesia	Regional anaesthesia	41	51
265778005	Analgesia	Local anaesthetic nerve block	41	61
278872003	Analgesia	Intravenous regional analgesia	41	81
410024004	Procedures	Insertion of catheter into urinary bladder	45	31
241012007	Procedures	Drainage of paronychia	45	51
88584000	Procedures	Evacuation of subungual haematoma	45	55
302421003	Procedures	Removal of foreign body from skin	45	55
265232001	Procedures	Diagnostic lumbar puncture	45	61
87750000	Procedures	Insertion of nasogastric tube	45	71
386359008	Medication	Medication administration: oral	51	11
281790008	Medication	Intravenous antibiotic therapy	51	21
103744005	Medication	Administration of intravenous fluids	51	31
226871000000103	Medication	Administration of activated charcoal	51	81
307521008	Medication	Intravenous infusion of thrombolytic	51	91
180289009	Orthopaedic	Application of plaster cast	55	11
180291001	Orthopaedic	Removal of plaster cast	55	13
239698005	Orthopaedic	Repair of plaster cast	55	15
274450004	Orthopaedic	Dislocated shoulder reduction	55	31
122944000	Orthopaedic	Reduction of dislocation	55	35
87971000	Orthopaedic	Closed reduction of fracture of radius	55	41
33630008	Orthopaedic	Closed reduction of fracture of radius and ulna	55	43
267765006	Orthopaedic	Closed reduction of fracture of upper limb	55	46
179162008	Orthopaedic	Closed reduction of fracture of ankle	55	51
150617003	Orthopaedic	Closed reduction of fracture of lower limb	55	55
90131007	Orthopaedic	Arthrocentesis	55	61
179208004	Orthopaedic	Apply Thomas splint traction	55	65
183258006	Orthopaedic	Loan of crutches	55	81
304492001	Discharge Planning	Activities of daily living assessment	61	11
9655003	ENT	Removal of foreign body from external auditory canal	71	11
172828005	ENT	Removal of foreign body from nose	71	21
35807001	ENT	Control of haemorrhage of nose	71	31
307271005	ENT	Nasal cautery	71	32
266689003	ENT	Splint teeth with orthodontic bands	71	71
49999004	Ophthalmology	Irrigation of eye	75	11
172426003	Ophthalmology	Removal of foreign body from cornea	75	21
183964008	Administration	Treatment not indicated	91	11

Appendix K – EmCare_Inj_Activity

The data set for EmCare_Inj_Activity

This data set is available for download via the main ECDS web site.

The data items should be presented in their sort order to maximise usability, and minimise staff time spent searching for the correct code.

The code set should be implemented as two linked drop down boxes or hierarchical menu system with the items arranged according to the Sort columns to ensure usability e.g. frequently used items are presented first.

Code	Group	Descriptor	Sort1	Sort2
	Road traffic collision	Pedestrian	11	11
	Road traffic collision	Cyclist	11	21
	Road traffic collision	Motorcycle rider	11	31
	Road traffic collision	Motorcycle passenger	11	32
	Road traffic collision	Motor vehicle driver	11	41
	Road traffic collision	Motor Vehicle Passenger (not public transport)	11	42
	Passenger on public transport	Passenger	15	11
	Working/education	Working for Income	21	11
	Working/education	Voluntary work	21	21
	Working/education	Other work	21	31
	Working/education	Education (student)	21	41
	Working/education	Education (teacher)	21	42
	Working/education	Professional sports	21	51
	Institutional care	Prison / custodial / detention centre / police custody	31	11
	Institutional care	Being nursed/cared for in residential facility	31	21
	Institutional care	Looked-after child	31	31
	Leisure at home	Food preparation	51	11
	Leisure at home	Food consumption	51	12
	Leisure at home	In lounge/sitting room	51	21
	Leisure at home	Using electronic device	51	22
	Leisure at home	In bedroom/sleeping	51	31
	Leisure at home	Bathing/showering	51	35
	Leisure at home	Ascending / descending stairs	51	41
	Leisure at home	Walking indoors	51	45
	Leisure at home	Walking outdoors	51	46
	Leisure at home	Play	51	51

Code	Group	Descriptor	Sort1	Sort2
	Leisure at home	DIY / garage / workshop	51	61
	Leisure at home	Gardening	51	71
	Leisure at home	Crafts and hobbies	51	81
	Leisure outside home	Social - non-food - pub / club	53	11
	Leisure outside home	Social – food (restaurant / café)	53	21
	Leisure outside home	Entertainment – cinema / theatre / bingo etc.	53	31
	Leisure outside home	Fishing	53	41
	Leisure outside home	Hunting	53	45
	Leisure outside home	Hobby	53	51
	Sports - football	Football (soccer)	61	11
	Sports - football	Rugby union	61	21
	Sports - football	Rugby league	61	31
	Sports - football	Gaelic football / Australian rules	61	41
	Sports - football	American football	61	51
	Sports - stick sports	Hockey	63	11
	Sports - stick sports	Lacrosse	63	21
	Sports - stick sports	Hurling	63	31
	Sports - ball	Basketball	65	11
	Sports - ball	Netball	65	21
	Sports - ball	Volleyball	65	31
	Sports - ball	Korfball	65	41
	Sports - ball	Handball	65	51
	Sports - ball	Fives	65	61
	Sports - ball	Ten pin bowling	65	71
	Sports - ball	Bowls	65	72
	Sports - ball	Boules	65	73
	Sports - hitting	Golf	67	11
	Sports - hitting	Cricket	67	21
	Sports - hitting	Baseball	67	31
	Sports - hitting	Softball	67	35
	Sports - hitting	Croquet / Roque	67	41
	Sports - racquet	Tennis	69	11
	Sports - racquet	Squash	69	21
	Sports - racquet	Badminton	69	31
	Sports - racquet	Table tennis	69	41
	Sports - racquet	Real tennis	69	51
	Sports - combat	Judo	71	11

Code	Group	Descriptor	Sort1	Sort2
	Sports - combat	Taekwondo	71	15
	Sports - combat	Martial arts	71	21
	Sports - combat	Boxing	71	41
	Sports - combat	Kick-boxing	71	45
	Sports - combat	Wrestling	71	51
	Sports - combat	Fencing	71	61
	Sports - athletics	Running / Jogging / Race walking	73	11
	Sports - athletics	Long distance running (>20km / 13 miles)	73	21
	Sports - athletics	Fell / mountain running	73	25
	Sports - athletics	Jumping sports	73	41
	Sports - athletics	Throwing sports	73	51
	Sports - gym	Trampoline	75	11
	Sports - gym	Gymnastics	75	21
	Sports - gym	Cheerleading	75	25
	Sports - gym	Gym class (aerobics, circuit training etc.)	75	31
	Sports - gym	Indoor gym equipment	75	41
	Sports - gym	Weightlifting / body building	75	51
	Sports - swimming	Swimming	77	11
	Sports - swimming	Water polo	77	21
	Sports - swimming	Synchronised swimming	77	31
	Sports - swimming	Diving	77	41
	Sports - swimming	SCUBA diving (recreational)	77	51
	Sports - wheeled	Cycling – road / track	79	11
	Sports - wheeled	Cycling – mountain biking	79	21
	Sports - wheeled	Cycling – BMX	79	31
	Sports - wheeled	Skateboarding	79	41
	Sports - wheeled	Rollerblades / skates	79	51
	Sports - winter	Ice-skating	81	11
	Sports - winter	Ice hockey	81	21
	Sports - winter	Skiing - downhill	81	31
	Sports - winter	Skiing – cross country	81	35
	Sports - winter	Snowboarding	81	41
	Sports - winter	Snow walking	81	51
	Sports - winter	Motorised snow vehicle	81	61
	Sports - outdoor	Hiking / hill-walking	83	11
	Sports - outdoor	Climbing / mountaineering	83	21

Code	Group	Descriptor	Sort1	Sort2
	Sports - outdoor	Caving/ pot-holing	83	31
	Sports - equestrian	Horse riding (recreational)	85	11
	Sports - equestrian	Horse riding (competition)	85	41
	Sports - watercraft	Rowing	87	11
	Sports - watercraft	Canoeing	87	21
	Sports - watercraft	Sailing	87	31
	Sports - watercraft	Windsurfing	87	41
	Sports - watercraft	Kite surfing	87	51
	Sports – Watercraft- powered	Water skiing	89	11
	Sports – Watercraft- powered	Powered boat	89	21
	Sports – Watercraft- powered	Towed behind power boat	89	31
	Sports – Watercraft- powered	Personal watercraft	89	51
	Motorsports	Off road motorcycle	91	11
	Motorsports	Road/ track motorcycle	91	31
	Motorsports	Off road car	91	51
	Motorsports	Road/ track car	91	71
	Airsports – non-powered	Gliding	93	11
	Airsports – non-powered	Hang-gliding	93	21
	Airsports – non-powered	Parachuting	93	31
	Airsports – non-powered	BASE jumping	93	35
	Airsports – non-powered	Paragliding (non powered)	93	41
	Airsports - powered	Paragliding (powered)	95	11
	Airsports - powered	Ultralight aircraft	95	21
	Airsports - powered	Fixed wing aircraft	95	31
	Airsports - powered	Helicopter	95	41
	Weapon sports	Archery	97	11
	Weapon sports	Target shooting	97	21
	Weapon sports	Clay pigeon shooting	97	31
	Not applicable	Not applicable	99	99